# IMPACT OF COUNSELLING AMONG WOMEN LIVING WITH HIV AIDS IN KOTIDO TOWN, KOTIDO DISTRICT

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SEPTEMBER, 2016

## DECLARATION

I,Kiyonga Isa Safia, hereby declare that this dissertation is my work and has never been submitted to any institution of higher learning for any award.

Signature..... Date 31-10-2016

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(Student)

## APPROVAL

I certify that the candidate has been under my supervision. The work presented is original and it is for the award of a degree in Bachelor of Social Work and Social Administration.

Signature:..... Date: 30-10-2016.

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(University Supervisor)

## DEDICATION

This dissertation is dedicated first to God who enabled me to go through my studies smoothly. I also dedicate it to my Mum for being always there providing financial and moral support. I finally dedicate to my course mates in the department of applied psychology.

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## ABSTRACT

This research sought to investigate the impact of counselling among women living with HIV AIDS in Kotido town, Kotido district. A total of 50 respondents participated in the study. The researcher used self-administered questionnaires which consisted of closed end questions to collect information from the respondents. A Pearson correlation coefficient was used to establish the relationship between counselling and HIV AIDS. The researcher found that as the counselling regimen improved, the negative psychological impacts of HIV AIDS on AIDS patients decreased. The Statistical Package for Social Scientists analysis was used to establish the relationship. The results indicated that there is a negative significant relationship between counselling and HIV AIDS ($r=-.321^*$, $P<0.05$). This implied that the variables were inversely related.

# CHAPTER ONE

# INTRODUCTION

## 1.1: Background

Counselling in HIV and AIDS has become a core element in a holistic model of health care, in which psychological issues are recognized as integral to patient management. HIV and AIDS counselling has two general aims: (1) the prevention of HIV transmission and (2) the support of those affected directly and indirectly by HIV. It is vital that HIV counselling should have these dual aims because the spread of HIV can be prevented by changes in behaviour (Chippindale S. 2001). One to one prevention counselling has a particular contribution in that it enables frank discussion of sensitive aspects of a patient's life. Such discussion may be hampered in other settings by the patient's concern for confidentiality or anxiety about a judgmental response. Also, when patients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through a fear of rejection, social stigma, disease progression, and the uncertainties associated with future management of HIV. Good clinical management requires that such issues be managed with consistency and professionalism, and counselling can both minimize morbidity and reduce its occurrence. All counsellors in this field should have formal counselling training and receive regular clinical supervision as part of adherence to good standards of clinical practice (Chippindale S. 2001).

Counselling has been conceptualized as a means to advise, to recommend, to advocate, to exhort, to suggest, and to urge (Oxford Dictionary 1996:131). However, counselling as a concept, as observed by Miller and Bor (1991), has many interpretations. Whatever its goals, counselling is directed towards assisting people to take decisions, to effect a change, to prevent problems or crises or to manage them when they arise. Hopson (1981) thus, from a problem-solving perspective, saw counselling as helping people to explore problems and clarify conflicting issues,

and to discover alternative ways of dealing with the problems by taking appropriate decisions and action.

HIV counselling is a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes evaluating the personal risk of HIV transmission, and discussing how to prevent infection. It concentrates specifically on emotional and social issues related to possible or actual infection with HIV and to AIDS. With the consent of the client, counselling can be extended to spouses, sex partners and relatives (family-level counselling, based on the concept of shared confidentiality). HIV counselling has as its objectives both prevention and care. A counsellor is a person trained in the skills of the job: listening to the client, asking supportive questions, discussing options, encouraging the client to make his or her own informed decisions, giving practical information and suggesting follow-up (UNAIDS best practice collection, 2007).

HIV counselling and testing (HCT) is a key intervention for HIV/AIDS control in Uganda and other developing countries. HIV Counselling and Testing (HCT) increases knowledge of HIV status, encourages safer sex, and is an entry point for HIV care and treatment services. Increasing HIV counselling coverage can reduce HIV-associated denial, stigma, and discrimination, and mobilize communities to respond to the HIV epidemic. Uganda was the first African country to offer HCT services in 1990, yet population coverage is still low.

Both counselling and testing are key components of HIV prevention and care programmes. Through HIV counselling and testing (HCT), uninfected individuals can take steps to avoid becoming infected, while infected individuals can avoid transmission to sexual partners or children. Moreover, HCT is the first step in referral to care and support services. It has also become important for preventing mother-to-child transmission and

increasing access to HIV/AIDS care, including antiretroviral therapy (ART). Even with limited availability of ART, early diagnosis of HIV and access to basic preventive care, including co-trimoxazole, can slow progression to AIDS. Providing HCT for family members of HIV-positive patients can identify other HIV-infected individuals in their households, facilitate partner disclosure and testing, identify HIV-discordant couples, and support care and medication adherence in HIV infected individuals. Worldwide, it is estimated that over 90% of HIV infected individuals are still unaware of their status. In Uganda, 15% of the general population has received HCT, while more than 70% would like to be tested (Wanyenze, 2008).

Hospitals in high-prevalence settings are crowded with HIV/AIDS patients, though the majority only learn about their infection late in the disease course, if ever. A survey at Mulago hospital in Uganda found that half of medical inpatients with HIV related diagnoses left hospital without HCT. It has been proposed that offering HCT routinely in health-care settings will increase access to care. Routine HIV counselling is initiated by healthcare providers and offers counselling to all patients irrespective of their presenting illness. This approach differs from voluntary counselling and testing, which is client-initiated (Nawavvu C, 2008).

**1.2: Problem statement**

HIV AIDS counselling including pre-test and post-test counselling is being provided free by the government of Uganda at different health centres country wide but unfortunately many people are not taking it especially those who have been tested positive for the virus where they leave immediately after receiving their results. These has caused them a lot of psychological and psychosocial issues including denial, stress because they lacked information on how to handle such a situation hence causing them an early death.

### 1.3: Purpose of the study

The purpose of the study was to investigate the impact of HIV AIDS counselling (pre-test and post-test) on women in Kotido town council, Kotido district.

### 1.4: Objectives of the study

1- To examine Counselling

2- To establish the impact of counselling among women living with HIV AIDS

### 1.5: Scope of the study

#### 1.5.1: Geographical scope

The study was carried out among women in Kotido town council, Kotido district, Northern Uganda. This area has a significant number of HIV Positive women who go through a lot stigmatization on a daily basis caused by cultural factors.

#### 1.5.2: Content scope

The study covered the meaning of counselling especially HIV AIDS counselling and its impact on HIV AIDS positive women. Counselling is defined as a helping relationship to help a person help himself deal with an aspect of his life that causes discomfort (problem/concern).

### 1.6: Significance of the study

The study would help HIV positive women and their care givers understand the psychological benefits of counselling especially post-test counselling where they are helped to approach the situation with a positive mind, encouraging them to continue living their lives with hope and courage.

The study highlighted the underlying gaps in the current strategies and the weaknesses among counsellors. This can help the authorities to start considering using lay counsellors who stay in the area as they can fully understand the primary concerns and conditions of the people living and who interact with them on a daily basis.

The study would work to reduce on the stigma associated with being HIV positive. Because too much cultural inclinations, people who are HIV positive especially women in Kotido district are

discriminated against. Through providing counselling to even those close to the infected person, this kind of thinking is controlled.

The study would indicate to the authorities, care givers and health officials that the intended objectives of the counselling regimen have or have not been achieved. Through analysing psychosocial behaviours of the infected, a conclusion can be drawn to continue with the drive, change the strategies or call it off.

**1.7: Conceptual framework**

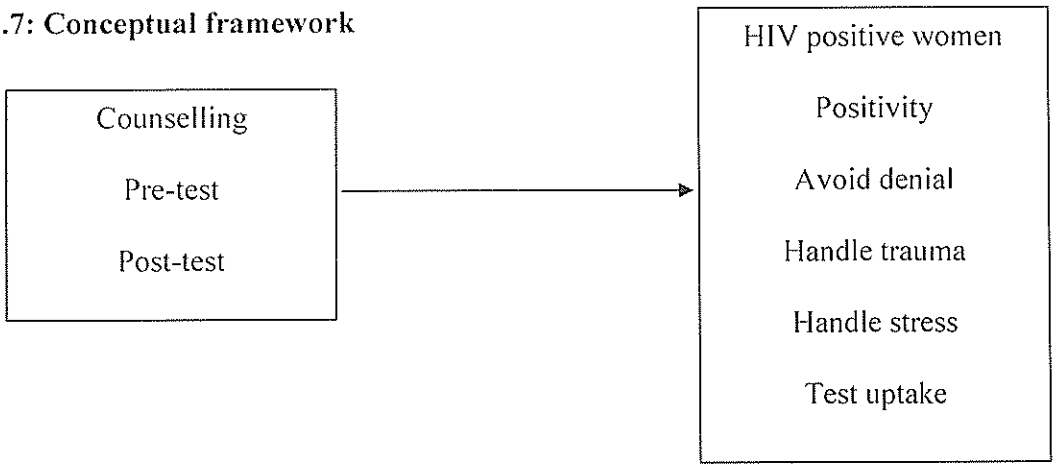


*Figure 1: Relationship between Counselling and HIV positive women*

Figure 1 above indicates that individuals or .couples can go for pre-test counselling which helps them to mentally prepare for any result they get from the test. On the other hand, post-test counselling empowers them to approach the situation with positivity if they are infected or avoid catching the virus if they are negative.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1: Introduction

This chapter presents a critical review of literature and the impact of counselling on HIV positive women. It has the two sections where section 1 presents literature on counselling and section 2 presents literature on the impact of counselling on HIV infected women. It also includes the hypothesis and the conclusion.

## 2.2: Counselling

To counsel means to advise, to recommend, to advocate, to exhort, to suggest, to urge (Oxford Dictionary, 1996:131). However, counselling as a concept, as observed by Miller and Bor (1991), has many interpretations. Whatever its goals, counselling is directed towards assisting people to take decisions, to effect a change, to prevent problems or crises or to manage them when they arise. Hopson (1981) thus, from a problem-solving perspective, saw counselling as helping people to explore problems and clarify conflicting issues, and to discover alternative ways of dealing with the problems by taking appropriate decisions and action.

Counselling for general health promotion, the avoidance of diseases, is both individualistic and group-oriented and usually considered an essential component of public health. The emphasis is on adopting what are considered good health habits. Issues considered include good personal and environmental hygiene, good nutrition and safe drinking water, adequate exercise, relaxation and rest, and avoiding high levels of stress and health-risk behaviours such as smoking and excess alcohol consumption. These issues can be discussed openly and without fear of isolation or stigmatization. Counselling to help a client attain quick recovery during an acute illness, however, usually incorporates more focused information about meeting needs specific to the particular illness. This is often rewarding for the counsellor as the time during which the client is

intensely dependent is shorter than that required to manage a chronic illness. When the disease is not life-threatening, stigmatizing and expensive to manage, although it may be chronic, there are fewer demands and less stress on the clients, their significant others and the counsellor (Irinoye, 1999).

According to Irinoye (1999), counselling is a complex and active process, and can be learned only through practice and dynamic interaction. The process of learning counselling skills requires constant practice and feedback from trainers or peers. Counselling differs from conversation in the following ways:

- It is purposeful: every counselling session has a particular aim that is achievable
- Specific: the counselling session deals with a specific concern or issue;
- Focused toward a desired goal.

Counselling aims to:

- Clarify the problems presented by the client;
- Provide necessary information;
- Explore alternative options and resources;
- Enable selection of realistic alternatives;
- Stimulate motivation toward effective problem solving and decision making.

Common features and requirements of effective counselling include:

- Time: it is essential to provide enough time for the effective counselling to take place. Also, it takes time to develop trust in the relationship. However, in many work situations, it is very difficult to make time to complete a whole counselling session. In this case, it should be noted that effective interpersonal communication can occur in a very limited amount of time. That is, effective communication can often occur in a brief encounter.

Some people may require many counselling sessions in order to explore their problems, acknowledge the need to change a particular behaviour, to learn protective methods, begin to effectively solve problem and learn some necessary negotiating skills.

- Acceptance and Respect: people with should feel that they are fully accepted by the counsellor. The counsellor must be self-aware and non-judgemental in the counselling session.
- Consistency and accuracy: any information provided in the counselling session must be consistent over time. The counsellor therefore, needs to have a full knowledge of the facts related to a problem, or have the ability to seek out the knowledge that he/she lacks.
- Confidentiality: trust is one of the most important factors in the relationship between the counsellor and the client. It enhances the opportunity for deep exploration of the client's condition and improves the chances that the client will act decisively on the information provided. Confidentiality ensures that any reference to or discussion about a client (except within a professional relationship) will not be undertaken without the express consent of the client.
- Sensitivity and tactfulness: although it is essential to raise issues related to sexuality and/or drug use, such discussions should be undertaken with sensitivity to the client's concern and presenting problem. These sensitive topics should be directed toward helping the client explore emotional issues, solve important concerns and make healthy decisions.

**Stages in the Counselling Relationship**

Each counselling session should be structured around a beginning, middle and end. In some circumstances, there might only be an opportunity for one counselling session. However, whenever possible, follow-up counselling sessions should be planned. The stages of each counselling session should include:

**Beginning Stage:** The beginning of the counselling session is very important as it provides an opportunity to establish a respectful, trusting relationship. Confidentiality should be discussed at this stage. Allow time for the client to tell his/her story. This story telling might appear disjointed, however, providing time to let the client express him/herself is very important. At this stage, do not interrupt the client except to summarize or paraphrase certain issues. The most important counselling strategy in the early stages is to listen attentively. In follow up counselling sessions, a recap of the activities that the client has undertaken or an exploration of the issues and problems he/she has faced since the previous session should be explored. (Mazher K. 2001).

**Middle Stage:** Once the client begins to trust the counsellor and the initial story has been told, open-ended questions can now be raised and a case history taken. At this stage a plan of action is put in place. One of the most difficult and critical tasks is to encourage the client to share his/her condition with a spouse, partner, or family and friends. In addition, the counsellor should, (a) support the continuing expression and discussion of feelings, (b) if necessary, refer to available formal and informal resources, (c) monitor progress and modify plans as necessary, (d) promote the continuation of changes in behaviour and (e) help the person to move towards acceptance and control ( Mazher K. 2001).

**End Stage:** Each counselling session should be brought to a satisfactory conclusion. The client should be aware of the progress he/she is making and have plans for further behavioural change. This strategy provides a sense of completion to the counselling session with a planned movement forward. When the counselling sessions are to be completed, this final stage should be carefully planned. The counsellor may increase the interval between visits so as to let the client gain increased independence with the knowledge that the counsellor is still available if necessary. The counsellor should end the counselling sessions only when it is certain that the client can cope and adequately plan for day-to-day functioning and has a support system (eg. Family, friends, support group etc.) in place. Finally, the counsellor should support the maintenance of behavioural change and make sure that all needed and available resources have been identified and are being used. It is important to provide an opportunity for the client to re-enter counselling if it is deemed nenecessary (Mazher K. 2001).

**Effective Interpersonal Communication Skills**

According to Saeed A. (2001), counselling involves communication about sensitive issues and requires deep exploration of the client's issues and concerns. For this reason, the counsellor should develop the following interpersonal communication skills:

- *Active Listening:* The counsellor indicates be words, expression and gesture that he/she understands what the client is saying. Such skill as nodding and reflecting back what the client has said are important.
- *Encouraging:* Some people do not express their feelings openly, even though they may feel them deeply. The counsellor should encourage the expression of feelings. It is only when people work through their feelings that they can begin constructive change. Words like, "yes- please continue" can be very encouraging.

- *Recognising*: The counsellor should be skilled in recognising and distinguishing various emotions the client is experiencing. Statements such as "that must be very difficult to accept" demonstrate the counsellor's ability to recognise particularly difficult issues.
- *Acknowledging*: The counsellor should acknowledge feelings such as anger, sadness and fear in a direct, unemotional way. Statements such as "I understand that this is not easy for you" are helpful.
- *Effective Questioning:* Counsellors use questions to help clients express their feelings and problems. These questions should be open-ended, aimed promoting further exploration. Therefore, rarely are closed questions that require only a "yes" or "no" answer helpful. They should also enable the client to give a variety of answers "please tell me what you know about...", or "how do you think your wife will respond to this information?" are exploratory open-ended questions.
- *Empathising*: Empathy is more than sympathy; it involves trying to place oneself in another person's situation. This is a difficult skill to fully master as it requires the counsellor to suspend their own feelings and judgement and to enter the experience of the other. This is not to say that the counsellor loses his/herself in the process, instead, it is a skill of placing oneself into the "shoes" of another, and reflecting on the events experiences, emotions, and concerns. A statement such as I can see you're feeling very anxious about..." is an effective empathic response. This response captures the feeling of the client while being specific about the reason the feeling has occurred (Chippindale, 2001).
- *Respecting*: Counsellors should respect clients' views and beliefs. They can show this respect by asking a client to explain unfamiliar aspects of their beliefs and values.

These beliefs and values might be cultural, traditional or based on personal experience. Statements such as, "I am not familiar with this, can you tell me more". Another way to show respect is to listen attentively and paraphrase what is heard.

- *Clarifying*: The counsellor tries to clarify either what the client has said. For example, "do you mean...?", or presenting factual information. For example, "no, HIV is not transmitted by touching the infected person".
- *Paraphrasing*: Clients can tell when they are being understood when the counsellor repeats what the client has said, using his/her own words. Statements such as, "so you are saying that...." In this way, the client can either agree with the paraphrase, or clarify his/her statement.
- *Challenging*: The counsellor should confront the client if he/she appears to be avoiding important issues or when the client has not followed through with an agreed rather than one answer. For example upon action plan. This challenging can be sensitive so that the client can see it as a positive act, and not an expression of anger or blame. An effective challenge might be, "last week you said that you were going to talk to your wife about your illness, what has got in the way of you doing this?"
- *Repeating*: At times of stress and crisis, people may not understand everything they are told because they are in a state of denial, or feel overwhelmed. The counsellor should not hesitate to repeat important information. In fact, most people need to be told more than once, in order for certain information to be fully understood and retained.
- *Emphasizing*: Often people avoid focusing on the real problem. The counsellor should highlight the most critical issues. For example "of all the things we have covered today, the point that stands out for me is...", or, "can I just emphasize the following points...?" In

this way, the client has an opportunity to focus on some important issues that have been raised in the counselling session.

- *Structuring*: Structuring determines which problems or issues need immediate attention and those that can be postponed to a latter session. It is an essential planning and helps to structure the ongoing counselling process. However, it is important to note that the structuring that occurs in one session might not be appropriate in subsequent. Structuring provides the counsellor and the client with a sense of movement. Such statements as, "there are three main issues we are facing" help focus and structure the session and subsequent sessions.
- *Motivating*: Counsellors should try to motivate clients by offering positive encouragement of new behaviours. For example, the counsellor might explain how the changed behaviours will help protect the client's loved ones. This may be a critical source of motivation. Another source of motivation is to explore what might happen if the client does not change their risk behaviour. Anticipating potential problems can be another source of motivation. For example, "what do you think might happen if you continue to have sex with commercial sex workers?"
- *Summarizing*: This is very much like paraphrasing in that it helps to ensure that the client and the counsellor understand one another correctly. Summarizing can be done by the client or the counsellor. At the end of the session, it might be important to summarize the important points that have been covered that session. Such statements as, "To summarize then, these are the issues..." help focus and highlight the major issues in the counselling session.

**Common Errors in Counselling**

According to Saeed A (2001), the principles of effective counselling are easy to read but difficult to apply. Continuous practice with feedback is essential to fully incorporate these skills into a helping relationship. Some common counselling error include:

- *Controlling* the session rather than encouraging the client's spontaneous expression of feelings and need.
- *Judging* by showing non-verbal disapproval or by making statements that indicate that the client is not meeting the counsellor's standards.
- *Moralizing*, preaching, and patronizing telling people how they out to behave or lead their lives.
- *Labelling*, rather than trying to find out the person's motivation, fears and anxieties.
- *Unwarranted reassuring* - trying to induce undue optimism by making light of the client's version of the problem. Not accepting the client's feelings - saying they should feel differently.
- *Advising* before the client has enough information or time to arrive at a personal solution.
- *Interrogating* - using questions in an accusatory way. "Why" questions often sound accusatory.
- *Encouraging dependence* - increasing the client's need for the counsellors continuing presence and guidance.
- *Cajoling* - persuading the client to accept new behaviour by flattery or deceit.

**AIDS counselling**

According to the World Health Organization, AIDS counselling is a confidential dialogue between a patient and the counsellor or care provider aimed at enabling the patient to cope with the stress and to take personal decisions relating to HIV infection and AIDS morbidity and mortality (WHO 1995). Counselling in HIV/AIDS care is an interaction of information exchange, skill acquisition and emotional support between the counsellor, the person infected with HIV and others significant to the client who include family members, friends, health practitioners, employers and people who give spiritual support. The interaction is directed at meeting the physical, psychological and socio-economic needs of the client to enable him or her to attain optimal physical, mental and social health and functioning: to provide continuous support and to prevent HIV transmission to others. Counselling not only assists people who already have the infection to cope with the consequent problems, but also evaluates the risks of HIV transmission and facilitates behaviour to prevent further infection. Counselling in HIV/AIDS means giving information, facilitating risk reduction behaviour, and providing unconditional emotional support to the people affected.

**2.3: Impact of counselling on women with HIV AIDS**

HIV/AIDS is currently spreading in the world as an epidemic form at the rate of new infection in every 50 seconds. This disease is not confined to any one class, community, religion, age, gender, group or profession. So today, it is the major concern of health psychologists to fight with AIDS because it is a major health problem of this century (Lefton, 1997). One of the greatest challenges faced by Uganda is HIV/ AIDS and no other STI has greater impact on sexual behaviour or created havoc and fear in the mind of people other than AIDS (Santrock, 2007).

The country has taken up an aggressive treatment scale up effort and current data shows that Uganda achieved the programmatic tipping point in 2013 of having fewer new adult infections of 140,000 than the net increase in adult patients on treatment of 161,028 per year. The figure above shows the comparison of the estimated number of annual new infections, the number of adults on treatment and estimated death overtime from 2004 to 2014. The estimated AIDS death declined by 19,583 between 2012 and 2014. HIV incidence rate is projected to fall from approximately 0.76% in 2014 to 0.46% in 2020, and annual new infections from 139,086 in 2013 to just over 100,000 in 2020 according to the Uganda Investment case 2014.

The advent of HIV/AIDS in the world has forced all of us to accept a paradigm shift from curing towards caring. Because there is no cure for HIVAIDS, focus has to be on interventions of caring for the physical as well as the psychological welfare of the HIV positive individual and their significant others. The HIV positive individual needs to find ways to live a psychologically healthy life after diagnosis. The need for counsellors to assist HIV positive individuals and their loved ones are so great, that we need to equip everyone in the helping professions with the necessary skills to be effective HIV/AIDS counsellors (Chippindale, 2001).

The single most important requirement to be an HIV/AIDS counsellor, is to have compassion for another person's struggle to live beyond the confines of a disease, and the willingness and commitment to walk the walk with this person and her significant others (Johnson, in Van Dyk, 2001.) The aims of counselling or helping a client must always be based on the needs of the client. The purpose of counselling is twofold: (1) to help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully, and (2) to help and empower clients to become more effective self-helpers in the future (Egan, 1998). Helping is

about constructive change and making a substantive difference to the life of the client. But only the client can make that difference: the counsellor is merely an instrument to facilitate that process of change.

Many people need support at some time in their lives. Some people seek help from friends or relatives, who may offer advice or guidance because they have had the same experience or are more knowledgeable the subject, or because it simply helps to get a different point of view. Counselling aims at helping people resolve issues, but it is a more professional and structured way of assisting people than guidance and advice. Counselling helps women with HIV AIDS to explore their life, feelings, strengths and weaknesses and to find new perspectives that can lead to real changes in sexual behaviour and ways of relating to other people (Santrock, 2007).

**Pre-test counselling**

Pre-test HIV counselling is often given in connection with a voluntary HIV test. Such counselling helps to prepare women for the HIV test, explains the implications of knowing that one is or is not infected with HIV, and facilitates discussion about ways to cope with knowing one's HIV status. It also involves a discussion of sexuality, relationships, possible sex- and drug-related risk behaviours, and how to prevent infection. It helps women to correct myths and misinformation around the subject of AIDS. Whenever resources permit, pre-test counselling should be made available to those women who desire it. Women who do not want or do not have access to pre-test counselling should not be prevented from taking a voluntary HIV test, however. In contrast, informed consent is always required before an HIV test where the individual's name will be linked to the result. To allay anxieties while awaiting the test result,

some women may seek support not only from their own families or a knowledgeable community worker.

Both counselling and testing are key components of HIV prevention and care programmes especially among women. Through HIV counselling and testing (HCT), uninfected women can take steps to avoid becoming infected, while infected women can avoid transmission to sexual partners or children. Moreover, HCT is the first step in referral to care and support services. It has also become important for preventing mother-to-child transmission and increasing access to HIV/AIDS care, including antiretroviral therapy (ART).

Women infected with HIV, can harbour it for several years without developing AIDS. But, whenever the people especially women develop this deadly infectious disease, they are confronted with devastating psychological consequences (Lefton, 1997). However, some persons fearing contamination shun AIDS patients. Most of the AIDS patients who are women are infected through sexual contact and some attach a moral stigma to the disease. So, psychologically and socially they suffer more and are unable to cope up with the environment. Such women's self-esteem fades quickly as they develop guilt feelings and blame themselves for having contracted the disease. And this self-blame leads to depression, anxiety, self-anger and pessimistic outlook towards life (Lefton, 1997).

Family members and friends also become similarly affected as they cope with a dying loved one and fails to understand the disease. Sometimes the woman is not responsible for the disease but she is blamed for. Such traumatic experience results in acute depression and greater anxiety. Higher level of anxiety and depression are of great concern in disease that are difficult to cure. Women with AIDS show comparatively higher level of anxiety and depression due to social, physiological and psychological factors.

Women with HIV/AIDS experience the threat of major negative life events and medical conditions. Probability of premature death, physical disability and pain, loss of employment, social isolation, coasts of medical treatment, anxiety for future of family members etc. may act as a potential and actual stressors and such persons may respond with signs of psychological distress. Early reports of psychological responses of HIV infection revealed pervasive feelings of anxiety and depression (Fleishman & Fugal, 1994). Depression is either mood of clinical syndrome, such as emotional, motivational, cognitive, somatic and behavioural. And the feeling associated with a depressed mood includes disappointment, helplessness and hopelessness (Comer, 1995). It is a sad stage, in which life seems bleak, challenging and its challenges are overwhelming. Similar experiences are also shared by AIDS patients. Several researchers have shown that experiences of stressful major life events are associated with depression (Pestonjee, 1992).

The other symptom found in AIDS patients most especially females is anxiety. It is a state of apprehension, tension and worry. In the general sense anxiety is a duff use, vague, very unpleasant feelings of fear, nervousness and apprehension without any apparent stimulus, associated with physiological change (Reus, 1998; Sarason & Sarason, 2000). Most of the women with HIV AIDS are also eager to improve their quality of life including their psychological well-being. So, patients and their family members and close friends seek counselling to help them cope with emotional stresses resulting from AIDS. To reduce the psychological distresses, like anxiety and depression of women with HIV/AIDS, counselling must go side by side with medical treatment. The counselling approach offers real hope among women to fight against AIDS (Coates, 1990).

Likewise, HIV and AIDS counselling is a kind of discussion after establishing rapport between patient and counsellor. Duration may be for long term of short term and it has following two major aims: (a) The prevention of HIV transmission, and (b) Direct and indirect support to HIV/AIDS patients. Counselling brings a voluntary change in the women with AIDS. So, counsellor provides facilities to the client to achieve the desired change. So, the client alone is responsible for the decisions she makes, but the counsellor assist in the critical moment with his warmth and understanding relationship. A human being has the capacity to experience awareness, is capable of understanding the factors responsible for psychological maladjustment and has the capacity to move away from them, that is, she can move towards psychological adjustment.

Fundamental to the counselling process is the client's perception of the experience. So, therapeutic change depends upon the client's perceptions, follow her expectations as determined by herself regard. Her expectations vary from feelings of fear to feelings of ambivalence. The counsellor, by conditional acceptance of the client, helps her to explore and try and modify her perceptions. For this purpose client must have feeling of security, acceptance and belongingness. The counsellor provides these by an unconditional acceptance of the client, showing positive regard, warmth, interest and understanding. In this friendly and warm atmosphere the client may, without any hesitation or fear of criticism of ridicule, be able to do a little self-exploration and self-examination leading to self-understanding. In this process, several experiences distorted or rejected hitherto are experiences without any anxiety. The client slowly and steadily progress towards self-realization. So, counselling is essential because it can help in preventing the spread of HIV and it can also reduce the psychological and psychosocial stresses among women with HIV AIDS (Gupta, 2010).

The major objectives of counselling for women living with HIV AIDS are to enhance personal development, to resolve the conflicts, to develop necessary social skills for proper social adjustments in order to meet new challenges of modern life. Following are the major objectives of preventive and supportive counselling of AIDS patients (Munjal et al, 1995). Counselling, care and support for people play a crucial role in preventing the spreading HIV/AIDS and also reduce its personal and social impact (Madhav & Chattopadhyay, 2008). In such circumstances, counsellors must be more supportive to the AIDS patients especially women since they lack social support from both family members and friends which can adversely affect their ability to cope.

Counselling techniques prove to be very effective for reducing anxiety and depression levels among women with HIV AIDS. In the wake of crisis, counselling is the only solution to prevent and reduce psychological and psychosocial stress of AIDS patients. Counselling also help to obverse the trauma of the disease and also able to lead a normal life through better communication with family members and society. In other words, counsellors help in proactive coping where the patients understand how people live their lives. The AIDS patients do not appraise the situation as a threat, harm or loss but perceive it as a personal and it render life as meaningful and find purpose in life. Besides AIDS patients counselling, family counselling, social support, awareness of the diseases especially in rural areas and in low SES sectors are the essential requirements to overcome their anxiety and depression (Gupta, 2010).

Post-test counselling helps women with HIV AIDS understand and cope with the HIV test result. Here, the counsellor prepares the client 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 or transmission. HIV test results should

always be given with counselling. The form of post-test counselling will depend on what the test result is. Where it is positive, the counsellor needs to tell the client clearly, and as gently and humanly as possible, providing emotional support and discussing with the client on how best to cope, including information on relevant referral services. Ongoing counselling helps women accept their HIV status, and take a positive attitude to their lives. Through ongoing counselling the infected woman may choose to invite a trusted family member to share confidentiality and participate in the counselling—enabling the family to start practising family level counselling (Gupta, 2010).

But counselling is also important after a negative result. While the client is likely to feel relief, the counsellor must emphasize several points. First, because of the "window period", a negative result may not mean absence of infection, and the client might wish to consider returning for repeat test after 3-6 months. Second, counsellors need to discuss HIV prevention, providing support to help the client adopt and sustain any new safer practices (UNAIDS best practice, 1997).

The availability of HIV counselling for women, even without HIV testing, may create a private environment for discussing sexual matters and personal worries. Counselling augments AIDS education by making HIV related information personally relevant. Counselling of this type for behavioural change has been successfully provided in the Medical Research Council project in western Uganda (Mugula F et al., 1995).

**2.4: Conclusion**

With the associated psychological and psychosocial effects of HIV AIDS like trauma, stigma, depression, social isolation, stress, rejection especially among women in Uganda, many of them have increased their uptake of both pre-test and post-test counselling and this helps them to look

at the positives and avoid dwelling on the negatives. Counselling prepares them and to accept the situation, reflecting to them that there is still a life to live even after contracting the virus. Additionally, counselling is provided to family members and those close to the victim which makes them discard the stigma towards the victim and focus on caring about her.

**2.5: Hypothesis**

There was a negative significant impact of counselling among women living with HIV AIDS in Kotido town.

# CHAPTER THREE

# METHODOLOGY

## 3.1: Introduction

This chapter presents methodology that will be used while conducting the study on the impact of counselling among women living with HIV AIDS. The chapter will be organized under subsections: research design, target population and sample design, instruments and measures of variables, procedure of data collection, data management and analysis, reliability and validity, anticipated problems and ethical considerations.

## 3.2 Research Design

The study used a correlation study design that was quantitative and descriptive in nature. The study design was correlational since it was used to establish absence or existence of relationships between counselling and women living with HIV AIDS. It was quantitative since numerical data was used and descriptive since the study aimed at describing the nature of the relationships between the variables (Creswell, 2003). This approach is based on facts, data, information and logic which can be objectively measured without guesses.

## 3.3: Target Population

The target population comprised 100 women living and working in Kotido town, Kotido district and the target population was attained from their different places of work and residence surrounding the township. The sample was taken from this population as it is further clarified by Saunders, Lewis and Thornhil (1996), who indicate that cases from which a sample is taken is referred to as population.

## 3.4: Sampling Design and Size

To minimize sampling errors, Krejcie and Morgan (1970) table for determining sample size for any population of a defined size was used to confirm a sample of 50 respondents. These included

respondents from different age groups (15-25, 26-35, 36-45 and 45+), education levels (primary, secondary, diploma, degree & masters) and marital status (Married, Single, Divorced & cohabiting). With a convenience approach, these respondents were selected based on who was willing and available to take part in the sample.

### 3.5: Instruments

The researcher used a structured self-administered questionnaire instrument in the collection of data. Counselling was measured using a questionnaire developed by Egesa (2013) where respondents were expected to answer twelve items in the questionnaire ranging from almost always to never. HIV AIDS was measured using items designed by Genty, Atiku and Akinlabi (2011) where a respondent was required to answer Yes or No. Validity of the instruments was assured by the supervisor who cross checked the correctness of the questionnaires to be used then it was piloted. To ensure reliability of the research instrument, it was pre-tested to establish the acceptable Cronbach's alpha value $\leq 0.7$:

### 3.6: Procedure for Data Collection

An introductory letter was obtained from Kampala International University (KIU), Department of applied psychology; this letter would help the researcher to seek permission from the town council authorities. The researcher proceeded to establish rapport with selected respondents who assisted the researcher in filling the questionnaires. The researcher gave the respondents 2 weeks or more to answer the questionnaires righteously. When the filling in process was completed, the researcher collected the questionnaires, checked them for completeness, errors, and proceeded to analyse them.

### 3.7 Data Processing and Analysis

The data was edited, coded and entered into the computer then cleaned, and organized for consistency, accuracy and effectiveness. The results were then computed using SPSS (Statistical package for social scientists). Frequency procedures were applied to do preliminary analysis. Through the quantitative method the relationship between counselling and HIV AIDS was gauged using Pierson correlation coefficient.

### 3.8: Ethical Consideration

The researcher assured the respondents that the information obtained would be kept confidential and strictly for the research purpose. The respondents were also informed that they were free to participate or withdraw from the study at their free will.

Normally respondents have a tendency to mute out when they are asked to volunteer with research studies or reactivity on being checked. The researcher ensured that the study wasn't meant for any harm and that she was obligated ethically and professionally to keep respondents personal information confidential.

### 3.9: Problems encountered & solutions

Reluctance by respondents to participate in the study. Respondents normally have concerns when it comes to participating in studies because they feel their privacy can be comprised. This was handled by assuring them confidentiality of their responses.

Tendency of respondents to take forever to fill the questionnaires. Some respondents take long to fill the research instruments which cost the researcher a lot of time yet they have a deadline to meet. The researcher handled this problem by encouraging and motivating respondents to fill the questionnaires right away when she was still around.

# CHAPTER FOUR

# RESULTS AND INTERPRETATION

## 4.1: Introduction

In this chapter, findings from the study are presented using tables starting with background characteristics of the respondents. It also includes results of responses to the items for counselling and HIV AIDS and the relationship between counselling and HIV AIDS.

## 4.2: Results and Interpretation

**Table 1** *Respondents background characteristics*

| Characteristics | Categories | Frequencies | Percentages (%) |
|---|---|---|---|
| Age | 15-25 | 8 | 16 |
| | 26-35 | 24 | 48 |
| | 36-45 | 11 | 22 |
| | 45+ | 7 | 14 |
| Marital status | Married | 18 | 36 |
| | Single | 18 | 36 |
| | Divorced | 13 | 26 |
| | Cohabiting | 1 | 2 |
| Education level | Primary | 3 | 6 |
| | Secondary | 22 | 44 |
| | Diploma | 14 | 28 |
| | Degree | 9 | 18 |
| | Masters | 2 | 4 |

From table 1 above, majority of the respondents (48%) were in the 26-35 age range while those who are 45+ constituted the least number at 14%. On Marital status, both Married and single respondents made 18% each while those cohabiting were 2%. On Level of education, those with only secondary level had the largest percentage at 44% while master degree holders made only 4%.

**Table 2***Percentage responses to counselling*

| Item | Almost always | Most of the time | Some of the time | Almost never | Never |
|---|---|---|---|---|---|
| Do you find the best way to deal with hassles and problems is to consciously avoid thinking or talking about them? | 24.0 | 36.0 | 30.0 | 10.0 | 0.0 |
| Do you feel anxious or frightened about problems you can't really describe? | 0.0 | 20.0 | 62.0 | 18.0 | 0.0 |
| Do you worry a lot? | 2.0 | 14.0 | 40.0 | 44.0 | 0.0 |
| Do your emotions change unpredictably and without any apparent reason? | 0.0 | 20.0 | 40.0 | 40.0 | 0.0 |
| Generally aren't you optimistic about your future | 0.0 | 12.0 | 72.0 | 16.0 | 0.0 |
| Do you have a hard time feeling really relaxed? | 2.0 | 26.0 | 44.0 | 28.0 | 0.0 |
| Compared to most people, do you have a very small or a very large appetite? | 0.0 | 26.0 | 54.0 | 20.0 | 0.0 |
| In the past two weeks, how often have you felt down, depressed, or hopeless? | 0.0 | 22.0 | 30.0 | 44.0 | 4.0 |
| Have you had any thoughts of suicide?" | 2.0 | 2.0 | 10.0 | 44.0 | 42.0 |
| Do you sleep well? | 16.0 | 40.0 | 44.0 | 0.0 | 0.0 |
| Do you feel enough energy? | 20.0 | 36.0 | 44.0 | 0.0 | 0.0 |
| Do you prefer to stay at home rather than going out and doing new things? | 2.0 | 16.0 | 60.0 | 22.0 | 0.0 |

Table 2 shows the findings presented from interviewed women on counselling. Majority of the respondents experience the feelings highlighted in the items of counselling some of the time. For example, 72% of the respondents are not optimistic about their future some of the time which indicates mixed feelings and emotions about how to live in the future.

**Table 3** ***Percentage responses on HIV AIDS***

| Item | Yes | No |
|---|---|---|
| Have you been HIV positive for a long period? | 38.0 | 62.0 |
| Are as a woman living with HIV AIDS stigmatised? | 24.0 | 76.0 |
| Do you go for HIV counselling so often? | 52.0 | 48.0 |
| Did you receive pre-test counselling before taking up the HIV AIDS test? | 68.0 | 32.0 |
| Do you often interact freely with HIV negative people? | 76.0 | 24.0 |
| Has your family been supportive and caring towards your health given your HIV status? | 88.0 | 12.0 |
| Are you worried about how people perceive you in your society? | 26.0 | 74.0 |
| Are women affected by HIV epidemic discriminated against in your community? | 18.0 | 82.0 |
| Has the HIV/AIDS epidemic affected the employment status of HIV positive women in Kotido town? | 24.0 | 76.0 |
| Has your community especially leaders been supportive and caring towards HIV positive women in Kotido town? | 84.0 | 16.0 |

Table 3 above shows the findings presented from interviewed women on HIV AIDS. The results are split on the items where half of the items respondents agreed with them and disagreed with another half. For example, 88% of the interviewed women accepted that their families have been supportive and caring towards their health given their HIV status. On the other hand, 82% refused to accept that women affected with HIV AIDS are discriminated against in the community.

**Table 4** ***Pearson correlation coefficient for the relationship between counselling and HIV AIDS.***

| | | Counselling | HIV AIDS |
|---|---|---|---|
| Counselling | Pearson correlation | 1 | -.321* |
| | Sig.(2- tailed) | | .023 |
| | N | 50 | 50 |
| HIV AIDS | Pearson correlation | -.321* | 1 |
| | Sig.(2-tailed) | .023 | |
| | N | 50 | 50 |

*correlation is significant at the 0.05 level (2 tailed)

A Pearson correlation was employed in establishing the correlation between counselling and HIV AIDS.

From table 4 above, the results show that there is a negative significant relationship between counselling and HIV AIDS at ($r=-.321^*$, $p<0.05$). This implies that counselling and HIV AIDS

are inversely correlated. This implies that the impact of HIV AIDS tends to reduce when counselling efforts are increased or given priority.

# CHAPTER FIVE

# DISCUSSION, CONCLUSION AND RECOMMENDATIONS

## 5.1: Introduction

This chapter focuses on the discussion of the results in relation to the purpose and objectives of the study. It also includes a conclusion, possible recommendations and suggestions for further research.

## 5.2: Discussion

### 5.2.1: Descriptive statistics

**Age.**

The findings of the study indicated that majority of the respondents belonged to the 26-35 age range making 48% of the respondents. This can be attributed to the fact that young people within that age range are involved in too much risky sexual behaviours and having multiple partners which increases their chances of contracting the HIV virus. This is in agreement with the report released by Uganda AIDS commission in 2014 which indicated that majority of the new infections among women (12%) were of those women 26 years and above or early 30s.

**Marital status**

The findings of the study indicated that both married and single respondents were many in the study at 36% each. This is due to the fact that when married women aren't satisfied with the sexual life of their husbands, they tend to get other partners outside the wedlock an act of infidelity which exposes them to HIV AIDS. On the other hand, single women normally look for multiple partners who can cater for both their financial and sexual needs.

The findings are in agreement with the Uganda HIV AIDS country progress report (2014) which highlights the fact that high unmet need for Family Planning among married people at 34% is one of the factors that increase missed opportunities for prevention of HIV transmission in Uganda.

**Education level**

The findings of the study indicated that respondents with secondary level education constituted the majority of the respondents at 44%. This can be attributed to the fact that because of their low educational status, these women experience low social and economic status.

The findings are congruent with USAID AIDS report on Uganda in 2000 which indicated that women with low social and economic status combined with greater biological susceptibility to HIV, put them at high risk of infection. Deteriorating economic conditions make it difficult for women to access health and social welfare compound this vulnerability.

### 5.2.2: Inferential statistics

**Counselling and HIV AIDS**

The hypothesis stated that there is no significant relationship between counselling and HIV AIDS. The findings however revealed that there is a negative significant relationship between counselling and HIV AIDS ($r=-.321^*, p<0.05$) implying that the variables are inversely related meaning as counselling efforts were increased among women, the negative impacts of the infection especially psychological ones reduced which has enabled them to live longer and to be optimistic about their future.

The findings are in concert with the Uganda HIV AIDS country progress report (2014) which indicated that as counselling and Anti-Retroviral therapy uptake increased among AIDS patients, AIDS mortality rate decreased by 19,583 between 2012 and 2014.

The findings are also congruent with Mugula F et al (1995) who asserts that the availability of HIV counselling for women, even without HIV testing, creates a private environment for discussing sexual matters and personal worries. Counselling augments AIDS education by making HIV related information personally relevant. Counselling of this type for behavioural change has been successfully provided in the Medical Research Council project in western Uganda.

**5.3: Conclusions**

In this study, both statistical and theoretical findings indicated that counselling can have a profound impact on HIV AIDS patients. The findings showed a negative and significant relationship among the variables. Pre-test counselling helps an individual to prepare for an HIV test which if comes out positive, to approach the situation positively and start receiving post-test counselling immediately. It also helps if someone finds themselves negative to live a responsible sexual life.

However it can be concluded that individuals of different social and economic demographics should receive AIDS counselling so often. These include children, teenagers, young people, adults and old people. This also helps their families to plan for those who are infected which helps them to live a long and hopeful life.

## 5.4: Recommendations

The aim of the study was to investigate the impact of counselling among women living with HIV AIDS in Kotido town, Kotido district and the following were recommendations made:

1. Given its positive impact on the psychological well-being of positive patients, the government should make extend counselling to every social demographic including families of the infected and children.
2. Because of the incessant divorce among families where one partner is infected, community leaders should encourage discordant couples to stay together and support each other. This can be achieved through extension of counselling services to them.
3. Free interaction with no biases and discrimination is good in every society. With that, communities should promote interaction between health individuals and positive individuals and avail employment opportunities to them.

## 5.5: Suggestions for further research

Following the above study, it was found out that counselling can reduce on the negative psychological impacts of HIV AIDS among AIDS patients. Thus the following suggestions for further research were made:

A study of the same variables should be carried out over a long period of time to confirm or disconfirm the findings.

The instrument could be better refined for more precise results

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## Appendix 1

## Questionnaire

Dear respondent,

I am a student of Kampala International University, Department Applied of Psychology doing research. As part of the requirements in partial fulfilment for the award of degree, we are required to carry out research. My area of interest is Impact of Counselling among Women living with HIV AIDS in Kotido town, Kotido district. You have therefore been selected to participate in this study. Results will only be used for research purposes. Please do not indicate your name anywhere on this questionnaire.

### SECTION A: Demographic Factors

**1-Age**

15-25

26-35

36-45

45+

**2- Marital Status**

Married

Single

Divorced

Cohabiting

**3- Education level**

Primary level

Secondary level

Diploma

Degree

Masters

## SECTION B: COUNSELLING (Egesa, 2013)

Tick the most appropriate

| NO | ITEM | Almost always | Most of the time | Some of the time | Almost never | Never |
|---|---|---|---|---|---|---|
| 1 | Do you find the best way to deal with hassles and problems is to consciously avoid thinking or talking about them? | 1 | 2 | 3 | 4 | 5 |
| 2 | Do you feel anxious or frightened about problems you can't really describe? | 1 | 2 | 3 | 4 | 5 |
| 3 | Do you worry a lot? | 1 | 2 | 3 | 4 | 5 |
| 4 | Do your emotions change unpredictably and without any apparent reason? | 1 | 2 | 3 | 4 | 5 |
| 5 | Generally aren't you optimistic about your future. | 1 | 2 | 3 | 4 | 5 |
| 6 | Do you have a hard time feeling really relaxed? | 1 | 2 | 3 | 4 | 5 |
| 7 | Compared to most people, do you have a very small or a very large appetite? | 1 | 2 | 3 | 4 | 5 |
| 8 | In the past two weeks, how often have you felt down, depressed, or hopeless? | 1 | 2 | 3 | 4 | 5 |
| 9 | Have you had any thoughts of suicide?" | 1 | 2 | 3 | 4 | 5 |
| 10 | Do you sleep well? | 1 | 2 | 3 | 4 | 5 |
| 11 | Do you feel enough energy? | 1 | 2 | 3 | 4 | 5 |
| 12 | Do you prefer to stay at home rather than going out and doing new things? | 1 | 2 | 3 | 4 | 5 |

## SECTION C: HIV AIDS (Genty, Atiku & Akinlabi, 2011)

Tick the most appropriate that applies to you

| NO | ITEM | YES | NO |
|---|---|---|---|
| 1 | Have you been HIV positive for a long period? | 1 | 2 |
| 2 | Are you as a woman living with HIV AIDS stigmatised? | 1 | 2 |
| 3 | Do you go for HIV counselling so often? | 1 | 2 |
| 4 | Did you receive pre-test counselling before taking up the HIV AIDS test? | 1 | 2 |
| 5 | Do you often interact freely with HIV negative people? | 1 | 2 |
| 6 | Has your family been supportive and caring towards your health given your HIV status? | 1 | 2 |
| 7 | Are you worried about how people perceive you in your society? | 1 | 2 |
| 8 | Are women affected by HIV epidemic discriminated against in your | 1 | 2 |

| | | | |
|---|---|---|---|
| | community? | | |
| 9 | Has the HIV/AIDS epidemic affected the employment status of HIV positive women in Kotido town? | 1 | 2 |
| 10 | Has your community especially leaders been supportive and caring towards HIV positive women in Kotido town? | 1 | 2 |

**Thank you for your cooperation**