

***Counselling Services in
the Gynaecology Clinic
of a Municipal Hospital
in Mumbai***



Women Centred Health Project

Public Health Department of
Municipal Corporation of Greater Mumbai

Society for Health Alternatives (SAHAJ)

Royal Tropical Institute

-
- Other Publications :**
1. **'Gatha Stree Arogyachi'** — a resource book on reproductive health for health workers (Marathi)
 2. Puja Roy, **Women Centred Health Project, Prioritising Urban Women's Health Issues in a Public Health System, Mumbai, India**, The International Council on Management of Population Programme (ICOMP), November 2001
 3. **Mainstreaming Quality Assurance in the Public Health Department, Mumbai, India**
 4. **Training Manual on Women's Health for Clinicians**
 5. **Training Manual for Counselling in Gynaecology Clinics**
 6. **Stepping Stones : Training Manual for Communication on Sexuality (Marathi)**
 7. **Paving the Way for RCH - Tools for Quality and Gender Mainstreaming**

- IEC Material Produced :**
1. **'Mahiticha Bagicha'** (Wall chart on Reproductive Tract Infections, Marathi)
 2. Pamphlet on RTIs (Hindi and Marathi)
 3. Pamphlets on MTP (Hindi and Marathi)
 4. Pamphlets on ANC (Hindi and Marathi)

For further information, contact : Training Cell
IPPV Public Health Department
First Floor, F South Ward Office
Parel, Mumbai 400 014

Published by : SAHAJ
1, Tejas Apartments
53 Haribhakti Colony
Old Padra Road
Vadodara - 390 007
sahajbrc@icenet.co.in

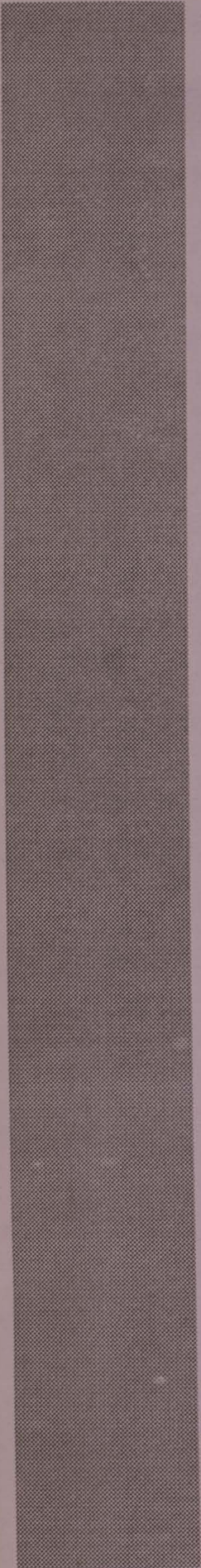
Published in : May 2004

Supported by : Ford Foundation

Printed by : INNOVATORS
Heramb Apt. No-2, Lakdi Pool, Dandia Bazar
Vadodara - 390 001. Ph. : 0265 - 242 6795, 240 6046

Cover page design : Amol Thakurdas

Edited by : Rima Kashyap



***Counselling Services in
the Gynaecology Clinic
of a Municipal Hospital
in Mumbai***

Swati Pongurlekar

Deepa Venkatesh

Renu Khanna

Anagha Pradhan

Usha Ubale

Counselling Services in the Gynaecology Clinic of a Municipal Hospital in Mumbai

Author's name

Address

City

Swati Pongunekar
Deepa Venkatesh
Renu Khanna
Anagha Prabhan
Usha Usale

Phone

Year

Page

CONTENTS

Page No.

GLOSSARY OF ABBREVIATIONS**PREFACE**

1	INTRODUCTION	05
	Goal and Objectives	05
2	RATIONALE FOR INITIATING COUNSELLING SERVICES	08
	PID Study	08
	Baseline Studies	08
	Quality Assurance	09
	Pilot Study to Monitor Provider-Client Communication at Kherwadi Maternity Home	10
	Extending Interventions to a Secondary General Hospital	11
	Summary of Observation Studies	17
	Feedback to Providers	17
	Lessons Learnt	18
	Pilot Phase	18
3	PLANNING AND ESTABLISHING THE COUNSELLING CENTRE	22
	Goals	22
	Objectives	22
	Features of the Centre	22
	Planning	23
	Staffing	23
	Expected Outcomes	23
4	INTERVENTIONS	25
	Reorganisation of Space and Infrastructure	25
	Staffing at the Centre	26
	Space and Timings	27
	Training for Counsellors	27
	Training for Clinicians	29
	IEC Materials	31
	Documentation	32
	Referral Mechanisms	33
	Organisation and Management	34
5	ACHIEVEMENTS	39
	Quantum of Clients	39
	Evaluation from the Reproductive Rights Perspective	40
	Clients' Satisfaction	41

6	EVALUATION OF COUNSELLING SERVICES	43
	Framework for Evaluation of Quality of Counselling	43
	Methodology	44
	Findings of the Evaluation	45
	Final Comments of the Evaluator	60
7	CHALLENGES AND LESSONS LEARNT	65
8	RECOMMENDATIONS FOR SUSTAINABILITY AND REPLICATION	67
	Suggestions for Sustainability and Replication	67
	WCHP's Perspective	69
	Recommendations of WCHP for Sustaining the Counselling Centre ..	70
9	TOOLS	72
T - 1.1	Orientation Package to Sensitise Resident	
	Medical Officers	72
T - 1.2	Client Card	76
T - 1.3	Case Record	77
T - 1.4	Observation Checklist for Monitoring Client - Provider	
	Communication	80
T - 1.5	Self - Administered Checklist for Doctors for Monitoring	
	Communication with Clients	84
T - 1.6	Checklist for Assessing Quality of Counselling	86
T - 1.7	Observation Checklist for MTP and Contraception	
	Counselling	88
T - 1.8	Observation Checklist for Monitoring Counselling for	
	Menstrual -Disorders	92
T - 1.9	Observation Checklist for Monitoring Counselling for	
	Major Surgery	94
T - 2.1	Tools for Evaluation	96
10	ANNEXURES	99
1.1	Existing and Proposed Plan for the Layout of the OPD	99
1.2	Schedule for 4-day Counselling Training for ANMs and MPWs	100
1.3	Schedule for the 15-day Practical Training for the Trainees	102
1.4	Patients' Rights and Responsibilities Displayed in the OPD	104
1.5	Role of Staff Displayed at Gynaecology OPD	105
2.1	Framework for Evaluating Quality of Counselling with	
	the Methods Used	107
3.1	Detailed Feedback of Providers	109

GLOSSARY OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
B.P.	Blood Pressure
BOH	Bad Obstetric History
CDO	Community Development Officer
CHVs	Community Health Volunteers
CSA	Child Sexual Abuse
Cu-T	Copper-T
FFW	Female Field Worker
FGDs	Focus Group Discussions
FHS	Foetal Heart Sound
FP	Family Planning
GO	Government
GYN	Gynaecology
HIV	Human Immuno Deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IUD	Intra- Uterine Device
LMP	Last Menstrual Period
LSTM	Liverpool School of Tropical Medicine
MCFHI	Mother and Child Friendly Hospital Initiative
MCGB	Municipal Corporation of Greater Mumbai
MDACS	Mumbai District AIDS Control Society
MOH	Medical Officer of Health
MPW	Multi-Purpose Worker
MS	Medical Superintendent
MTP	Medical Termination of Pregnancy
NGO	Non Governmental Organisation
OCP	Oral contraceptive Pills
OPD	Out Patient Department
OT	Operation Theatre

PID	Pelvic Inflammatory Disease
PV	Per Vagina
QA	Quality Assurance
QoC	Quality of Care
RH	Reproductive Health
RMO	Resident Medical Doctors
RTI	Reproductive Tract Infections
SAHAJ	Society for Health Alternatives
STI	Sexually Transmitted Infections
SUI	Spontaneous Urinary Incontinence
TB	Tuberculosis
TL	Tubal Ligation
UPT	Urine Pregnancy Test
VCTC	Voluntary Counselling and Testing Centre
WCHP	Women Centred Health Project
SRMO	Senior Medical Officer
FW & MCH	Family Welfare & Maternal and Child Health

PREFACE

This report is a process documentation of a unique effort to start counselling services within a Gynaecology Clinic in a municipal hospital in Mumbai. The counselling center, an intervention of the Women Centred Health Project, is an initiative to mainstream gender perspective and concepts of quality assurance within a public health system. The project, initiated in 1996 is a collaboration between the Public Health Department of the Municipal Corporation of Greater Mumbai (MCGM), SAHAJ, a non-government organisation based in Vadodara (Gujarat) and the Royal Tropical Institute, Amsterdam (Netherlands).

Communication with health care providers is an important aspect of "quality of care" from the perspective of poor, marginalised women seeking health services, within the urban or the rural context. The counselling centre emerged in response to the need to improve client-provider communication within the outpatient clinic.

This report describes the process through which the counselling center evolved, how it is organised and what its achievements have been. The challenges and issues that need to be addressed are also discussed.

The counselling center was evaluated by an external evaluator, Deepa Venkatesh. She was asked to assess the quality of the counselling provided, interview the users of the counselling services, the health care providers in the gynaecology clinic as well as the counsellors and the project staff. The details of the objectives and methodology of the evaluation as well as the major findings are provided. We are grateful to Deepa Venkatesh for doing this evaluation.

The tools used for research, observation, study, monitoring the quality of client-provider communication, counselling, other interventions and evaluation are included.

We take this opportunity to thank Dr. Redkar, Dr. Moorjani and Dr. Mangat, Medical Superintendents of the V.N. Desai General Hospital at various points in time, who encouraged and supported the research and project's interventions in the hospital and at the OPD. We thank Dr. Bhatki for facilitating the administrative permissions for restructuring the OPD.

We appreciate the initiative and enthusiasm of Dr. Lalita Mayadeo, honorary gynaecologist, VND Hospital, who is the facilitator of the quality assurance interventions initiated by the project in the gynaecology OPD. She is also in-charge of sustaining the process of ensuring quality care and problem-solving by facilitating the staff meetings. Her ongoing support will go a long way in demonstrating a model for ensuring quality services based on a reproductive rights perspective.

We thank Dr. Dhanu, Dr. Warty, Dr. Duggad, Dr. Rane and Dr. Parmar, the honorary gynaecologists at VND Hospital since 1999, for their valuable suggestions in planning and implementing the counselling services.

We are indebted to all the batches of resident medical officers since 1999, who consented to be part of the observation studies conducted by the project and for showing openness to receive feedback and making efforts to change their behaviour towards patients. Many patients have appreciated the information received, and the sensitivity and understanding shown by the resident medical officers. We hope they will continue to be sensitive and effective communicators in their future placements and practice.

We appreciate the suggestions and support extended by the AMOs, Sr. MOs, CDO and all the staff at the VND Hospital and the Gynaecology OPD.

We thank Dr. Ramesh Kathuria, EHO, Public Health department and Dr. Koparde, DEHO, FW & MCH for deputing the health post staff, ANMs and MPWs from H east ward and from the health posts for training in counselling skills at the counselling centre at VND Hospital. We also thank Dr. Harale, Dr. Malviya (MOH, H east ward), and Ms. Varsha Joshi (CDO of H east ward), for facilitating the permissions and co-ordinating on-the-job training of the health post staff at the counselling centre. We are thankful to all the health post staff for showing openness in learning and offering counselling services to men and women, during on-the-job training period.

We are grateful to the resource persons, Ms. Sangita Puneekar, FACSE, Ms. Bilquees Shaikh, Dr. Mayadeo, Dr. Prabhu, Dr. K. Ramnath, Ms. Vidya Lad, Dr. Radha G. Paediatrics Department, Nair Hospital, Dr. P. Deo, UNFPA, Maharashtra, and Dr. A. Shrotri, Pune, for giving inputs in training the staff at VND Hospital and the OPD, on

various issues related to quality of services, reproductive rights, counselling and communication skills.

Grindl Dockery helped by reviewing the contents of this document, we warmly acknowledge her interest and the encouragement received from her.

At this point, we would also like to especially acknowledge Asha Rilkar and Bharati Ghule, Asha and Bharati have worked as ANMs in the Public Health Department and have over the years, evolved as extremely competent counsellors. They are an example of what is possible within public health systems when there is a commitment to human resource development.

Finally, we hope that the counselling services initiated by the project will be sustained at VND Hospital so that the patients continue to get quality reproductive health services. This counselling centre could also serve as a model for replicating similar services in other hospitals. This report can be a guideline to initiate, establish and monitor counselling services and other interventions to ensure quality in a Gynaecology OPD in a general hospital.

Renu Khanna

Usha Ubale

Korrie de Koning

Various issues related to quality of service, reproductive rights, counselling and communication related to women and children, and the importance of counselling in the management of reproductive health problems were discussed. The authors noted that the importance of counselling in the management of reproductive health problems is often underestimated. At this point, we would like to especially acknowledge Asha Pillai and Brinda Ghole. Asha and Brinda have worked as APMs in the Public Health Department and have over the years evolved as extremely competent counsellors. They are an example of what is possible within public health systems when there is a commitment to human resources development.

Finally, we hope that the counselling services initiated by the project will be sustained at WVD Hospital so that the patients continue to get quality reproductive health services. The counselling centre could also serve as a model for replicating similar services in other hospitals. This report can be a guideline to initiate, establish and monitor counselling services and other interventions to ensure quality in a Gynaecology OPD in a general hospital.

Ranu Khanna
Usha Ubele
Kanta de Koning

1. INTRODUCTION

Women Centred Health Project, (WCHP) initiated in 1996, is a collaboration between the Public Health Department of Municipal Corporation of Greater Mumbai (MCGM), Society for Health Alternatives (SAHAJ), Baroda, India, Liverpool School of Tropical Medicine (LSTM), U.K. and the Royal Tropical Institute at Amsterdam. It is funded by the Ford Foundation (India).

The Municipal Corporation of Greater Mumbai (MCGM), is responsible for the administration of the city of Mumbai. Mumbai has a population of approximately 12 million (Census, 2001). For administrative purposes, the city is divided into 24 wards. The WCHP is working in two wards covering an approximate population of 11.5 lakh.

Goal and Objectives

The goal of the project was to improve the quality of the reproductive and sexual health services provided by the Public Health Department, and make these services user- friendly and gender sensitive.

The objectives of the project are to:

- Improve, strengthen and increase the quality and range of health care services for women at health posts, dispensaries, post-partum centres and maternity homes
- Enable women to have access to gender-sensitive and user-friendly health services
- Raise awareness and sensitivity on women's health and reproductive rights, gender issues, and to increase knowledge of women's health amongst men and women in the community, health workers and service providers of the MCGM.
- Develop and build the capacity of staff of the two wards of the MCGM in training, action research, monitoring and evaluation on issues related to women's health and reproductive rights
- Develop indicators for monitoring and evaluating quality, and the range of services provided

As part of its objectives of enabling women to access reproductive health (RH) services and empowering them with the necessary information, knowledge and confidence, an Information and Counselling Centre was initiated at the Gynaecology Out Patient Department (OPD) at V. N. Desai Secondary General Hospital.

The table below outlines the phases in the evolution of counselling services at the V N Desai Hospital.

Table 1 Phases in the Evolution of the Counselling Services

Phase	Period	Characteristics
ONE	1998 - 99	<ul style="list-style-type: none"> ● Quality assurance workshops to identify issues for intervention ● Pilot project at a maternity home for monitoring provider client communication ● Extended the activity to the general hospital
TWO	1999 - 2001	<ul style="list-style-type: none"> ● Initial observations of client-provider communication patterns to identify counselling needs ● Baseline study began ● Discussions with providers about concept of proposed centre ● Counselling by social work students who were on field work as part of their course and WCHP staff.
THREE	January 2001- June 2002	<ul style="list-style-type: none"> ● Baseline study completed ● Planning changes in layout of OPD to facilitate client flow - reorganisation of OPD began -first intervention ● Preparation of manual on counselling ● Training of ANMs and MPWs (4-day) in three batches begun end 2001 ● Temporary but private space inside OPD for counselling ● Permanent counsellor appointed by project ● Counselling services for men begun. At this stage there was no separate centre for men
FOUR	July 2002 - May 2003	<ul style="list-style-type: none"> ● Renovation of OPD completed ● Permanent and private space inside OPD for counselling ● Full time counsellors (2 ANMs) from the project assigned

Phase	Period	Characteristics
		<ul style="list-style-type: none"> ● Trainees (ANM and MPW) for counselling practicum of 15 days on rotation ● Supervisor appointed to review and give feedback about counselling ● Providers refer clients to the centre for counselling ● Review feedback mechanisms in place - bi-monthly review meetings, suggestion box. ● Development of recording of counselling ● Temporary counselling centre outside the OPD for men ● Creating awareness about clients' rights and principles of 'good communication' among providers through regular meetings ● Creating awareness among the clients regarding their rights and responsibilities through display of posters and relevant informative material
FIVE	June 2003- December 2003	<ul style="list-style-type: none"> ● Place for permanent counselling centre for men obtained outside the gynaecology OPD ● The hospital CDO and administrative in-charge agreed to co-ordinate the review meetings as part of their regular work ● Counselling Protocols prepared ● WCHP staff was co-opted for next 6 months to run the counselling centre till it is handed over to the hospital staff.

The next chapter describes various baseline studies conducted by the project and the rationale for initiating counselling services in the gynaecology OPD.

2. RATIONALE FOR INITIATING COUNSELLING SERVICES

PID Study

The goals and the objectives of WCHP were formulated on the basis of research findings in a study on Pelvic Inflammatory Disease (PID) conducted by the same team in the years 1993-96. The women in the study expressed:

- Lack of appropriate and accessible information, counselling and support services
- Problems in treatment and referral services provided
- Limited decision-making power of women in the family — limits their control over their reproductive health

They asserted their expectations and needs as follows:

- Complete, accurate and comprehensible information about their health problems, causes, treatment, investigations and preventive strategies
- Availability of RH services closer to their homes and comprehensive services under one roof
- Counselling for social problems like alcoholism, domestic violence and so on.
- Involving men in taking responsibility for family planning and preventing Sexually Transmitted Infections (STI)
- Emotional support for couples who are unable to have children

Apart from the findings in the PID study, WCHP conducted baseline studies with providers and administrators. A series of Quality Assurance (QA) workshops were also organised with health care providers from health posts and maternity homes from the two project wards and the project staff members. The baseline studies and the QA workshops highlighted several issues that needed to be addressed to improve quality of care.

Baseline Studies

367 exit interviews conducted as part of baseline studies by WCHP, revealed that those who expressed dissatisfaction, though small in number, mentioned disrespect shown by health care providers as one of the reasons for dissatisfaction. The clients in the same study were asked why they did not clarify with doctors when they had doubts. Responses indicated poor communication between providers and clients.

Quality Assurance Workshops

Project organised five Quality Assurance (QA) workshops with health care providers from all the levels in the public health department. The objectives of organising these workshops were, to discuss the concepts of quality of health care, to adapt them to apply to the health care facilities of MCGB, and to develop tools for monitoring the quality.

In the first Quality Assurance Workshop participants identified issues related to the provider-client communication styles and health education as one of the important factors affecting the quality of services. Lack of time to talk to the patients due to patients load, no counselling services, inadequate information services and sometimes language barrier - were among the problems hindering provider-client communication. The participants recommended better patient information and counselling services as a part of providing good quality health care.

In addition to the providers' perceptions, which emerged in the first QA workshop, baseline studies conducted by the project, in the PID study and the focus group discussions conducted with the community women, men, and adolescent girls as part of the other ongoing studies, provided more information on the state of communication between providers and patients.

The findings from all these sources are given in box 1.

Box 1: Issues related to provider-client communication affecting the quality of services

- Disrespectful staff behaviour - e.g.. shouted at if questioned
- Lack of information on treatment (diagnosis, prescribed drugs, procedures and instructions) '*Doctors do not talk to us*' (Clients)
- Lack of couple counselling for contraceptive methods, infertility and reproductive tract infection/sexually transmitted infections (RTIs/STIs)
- Limited health education with community groups; existing health education activities are not according to people's felt needs but are decided by the providers. Also, correct and complete information about available services is not provided
- Language barriers between clients and providers
- Lack of staff meetings in health care facilities; no platform to discuss issues related to interpersonal conflicts and staff co-ordination and communication with patients
- Limited time for consultation with doctors

These issues were discussed in the subsequent QA workshops and a working group prioritised three key issues related to the communication aspects namely disrespectful staff behaviour, lack of information on treatment to the clients, and health education activities not being need-based. The participants analysed how these problems relate to quality and how information could be obtained related to the measurement of each issue.

The working group also developed an observation tool to monitor the communication between the health care providers and clients. This was tested at Kherwadi Maternity Home and Post Partum Centre, where a health post, dispensary, post partum centre and maternity home were situated in the same premises, so that providers' communication styles could be observed in all the units.

Pilot Study to Monitor Provider-Client Communication at Kherwadi Maternity Home

At Kherwadi Maternity Home, Focus Group Discussions were conducted with the women attending Gynaecology and ANC OPD, to understand their perception of respectful behaviour and their expectations from health care providers. Women expressed what their requirements of simple and effective communication were and how they can understand the information given to them by the health providers.

Box 2: The women's perceptions about respectful behaviour and effective communication from the health care providers

- They feel respected and less inhibited if the providers maintain eye contact while history taking
- Listen patiently and encourage them to share their symptoms and other problems that they feel are associated with their condition
- They expect all the providers to be patient listeners and not to shout at them if they sometimes are not quick at responding or understanding the information provided
- They find it disrespectful if the providers tells them to stand or sit away from them
- Communication would be effective if the providers use simple language and local terminology
- If they are given opportunity to ask questions; if their questions are answered patiently and instructions are repeated if they did not understand them
- They appreciate if they are told what is wrong with them by the provider
- Related to internal examination, staff needs to be more patient, as they (patients) need time to loosen their clothing and enough time to climb on and off from the examination table

At Kherwadi Maternity Home, observation tools were revised based on feedback from providers and users. Client communication was monitored and feedback was obtained through peer reviews, and observations by project staff. The presence of the observers improved the communication patterns as the providers became more conscious. They also felt that this tool was a good method for keeping their own behaviour and communication style under check.

Box 3: Results of monitoring of communication style using observation checklist

- 96% providers maintained eye contact during their interaction with patients
- In 90% observation episodes, providers answered all the questions of the patients
- Only 33% of the clients were given information about their problems
- 35% patients were told about the treatment in detail
- 43% patients were given information about the necessary investigations
- For 28% of the patients, the doctor checked whether they had understood the information or instructions
 - *Basic communication skills demonstrated by the providers were good*
 - *Client's information need for diagnosis, investigation and treatment were not satisfactorily addressed*
 - *Efforts to ensure that the patients understood the information given, were limited*

Extending Interventions to a Secondary General Hospital

After the experience of monitoring communication styles in the Maternity Home, the team decided to undertake a similar study at the general hospital level as the dynamics in the OPD at the general hospital are different. A need to improve provider-client communication at that level was expressed by the providers as well as the patients participating in the Kherwadi study. At the same time UNICEF supported Mother and Child Friendly Hospital Initiative (MCFHI), was also planning interventions to make the services user - friendly at Kherwadi Maternity Home.

Based on the Kherwadi experience and suggestions, it was decided to undertake the study in the V. N. Desai General Hospital, located in the same administrative ward as that of Kherwadi Maternity Home. Thus subsequently these processes were moved from Kherwadi Maternity Home to the V.N. Desai General Hospital. In

1999, observations of provider-client communication patterns were started in the gynaecology OPD of the hospital.

Observations in the Gynaecology OPD

Unstructured, non-participant observations

WCHP research staff conducted the observation study in the gynaecology OPD over a period of one month and observed 11 out-patient clinics without disturbing the clinic process. During this period, two pairs of resident doctors, three nurses- one ayah and one sweeper were observed (on any particular OPD day). The investigator wrote a daily diary of her observations after returning from the field. This data was then compiled and analysed. Though these observations were based on a very small number of providers, they provide insights about the interactions that take place between providers-providers and client-providers and factors that help or hinder communication in the OPD.

Though these observations were based on a very small number of providers, they provide insights about the interactions that take place between providers-providers and client-providers and factors that help or hinder communication in the OPD.

The **objectives** of this exercise were

- To document the positive and negative episodes of provider-patient communication and the context in which they occur
- To document other factors and limitations (other than individual communication skills and attitudes) affecting communication between providers and patients in the OPD

In this study doctors' communication with patients was observed to be satisfactory and doctors showed understanding and sensitivity towards patients' need for information and clear instructions. But in some instances the same doctors were seen to be rude and irritated with patients. At one instance a doctor who otherwise used to be very patient, ended up yelling at the patient when the patient had language problem and she misunderstood the instructions. In the presence of the stressful factors mentioned above the doctors' communication gets adversely affected.

Box 4: Findings of the unstructured non-participant observations**Doctors**

- Showed patience, listened to patients' complaints without interrupting
- Explained, even if it took long, and counselled patients whenever required
- Were sensitive in explaining instructions for internal examination and did not disrespect any women during the observations

Nurses

- A newly placed nurse did not know about the functioning of the OPD and was unable to guide patients.
- Did not assist the doctors in one unit and disrespected the doctors
- Were rude, insensitive and yelled at the patients
- At times were nice and helpful to the patients
- Showed erratic behaviour

Attendant and sweeper

- Many times not seen at the door for managing the patient flow
- Picked fights with the relatives
- Sweeper was more tolerant than the attendant
- Ensured privacy by pulling curtains at the OPD door and around the internal examination table

Factors contributing to stressful situations for doctors were as follows:

- Over-crowded and chaotic OPD
- Managing OPD duty single handedly results in stress, when the other doctor had to leave OPD to attend to emergencies in the ward
- Queue discipline not maintained by the attendant resulting in chaos.
- Absence of interns and AMOs in assisting in history taking further increases workload on the doctors due to staff shortages

Narratives of doctor-patient communication episodes

Another observation study was undertaken by the project with different set of providers, where 50 episodes of patient doctor interactions were recorded verbatim over two weeks. A range of different kinds of situations and responses, were noted. In other words, episodes similar to those noted earlier, were not recorded. Frequently occurring similar episodes, for example, asking the men who accompanied the women to leave the consultation room, or scolding a patient who wanted a termination of pregnancy but was not ready to accept copper -T were noted separately.

The **objectives** of this exercise were

- To identify the information and counselling needs of the patients attending the OPD
- To assess the feasibility of improving communication in the given situation of over crowded OPDs and the low provider-patient ratio
- To use the episodes to create case studies and role plays for training

Results

The analysis of the data collected through the observation exercise revealed the pattern of information and counselling needs of the patient, the appropriate and inappropriate behaviour of the providers and other factors hindering communication in crowded OPDs.

Information and counselling needs of the patients

Women especially those presenting with infertility, needed emotional support. There was also a need to discuss sexual problems with those couples presenting with infertility. Privacy for such a consultation is not ensured in the OPD. This can discourage the couples from sharing sensitive information on their condition leading to delayed treatment.

Women coming for termination of pregnancy (MTP) are most times lactating mothers and they find it difficult to make decisions whether to continue the pregnancy or opt for MTP. The doctors emphasise on inserting an IUD after the MTP to prevent further unwanted pregnancy and to meet the targets. This leads to arguments between doctors and patients. Many women come up with misconceptions or social and family problems that influence their contraception decisions. Providers fail to understand the social reasons and label them as '*ganwar*' or '*morons*'.

The couples who come for MTP after the sex determination test require counselling. Sometimes the woman herself is not willing for the MTP but is being forced by her accompanying husband or mother-in-law. They wait outside the OPD while the woman seeks consultation. There is a need to talk to the decision makers and discourage them from opting for abortion.

In the absence of any information being given on gynaecological examination, many women do not follow the instructions given by the doctors. This results in them being abused by the providers. Some women are scared and not prepared for internal examination and refuse to undergo the examination. Adolescent girls who come

with menstrual disorders or with reports of white discharge find it difficult to give consent for physical examination. They find the OPD atmosphere inhibiting and scary. This again leads to doctors yelling at them and the girls further resist the examination. Some girls go without the consultation.

Sometimes the language barrier affects the history taking process and the doctors fail to understand what the woman is trying to communicate and vice-versa. Insufficient information on the timings and procedures required to avail referral services for investigations and treatment, leads to delayed treatment and adversely affects the compliance.

Box 5: When do doctors get irritated ?

When...

- patients came too close and talked to them or crowded around the table
- patients could not effectively present or express what their problems were
- patients could not tell the number of pregnancies they had or the date of their last menstrual period (LMP) or when exactly she had the spontaneous abortion etc
- patients requested for MTPs and refused contraception (especially lactating mothers)
- the husbands came and requested for their wives' MTP
- patient's could not understand after repeating instructions or advice 2 or 3 times.
- patients did not come for a follow-up when asked to do so
- patients lost case papers or reports
- ANC women did not have the blood report or sonography findings written on their case notes
- ANC women did not have the papers in their records in chronological order or if they were falling out of the files
- patients did not have any money with them if they needed to buy emergency medicine or to get the sonography done
- patients from another doctor's unit came on the wrong day

Other Factors Affecting the Patient-provider Communication

a) *Coordination and interpersonal communication between the providers*

- If one doctor sees more patients than the other; when a doctor remains absent, the caseload of the other doctors increases
- Nurses or attendants do not assist the doctors, do not perform their duties or carry out the doctor's instructions to his/her satisfaction

- Absence of nurses or attendants in the internal examination room, especially in the case of male doctors
- Sometimes lack of healthy communication between the two doctors in the OPD adversely affects communication with the patients

b) Constraints due to organisation of physical facilities

- The wash basin and toilet for the patients is situated outside the OPD. This increases the waiting time and also affects the flow of patients
- Patients who want to have a Copper -T inserted are asked to go to the ground floor (Gynaecology OPD is on the first floor) and fetch it from the health post and then come up to the OPD to get it inserted
- Patients have to stand during the consultation and history taking as there are not enough chairs or stools for all the providers and patients
- The physical set up of the OPD does not allow for a proper flow of patients. Because of this patients have to wait on the examination table until a doctor attends them. Average waiting time on the table was noted to be 10 minutes, 15 minutes, 12 minutes and 15 minutes on four different days

c) Insensitivity and attitudinal problems

- The doctors attended with great interest and took efforts to explain to the patients only when the diagnosis was of academic interest to them
- Patients who were related to the hospital staff were treated with more respect and consideration. The attitude appeared to be that poor patients do not have any self respect, they are unclean, unhygienic and of low intellect and that the staff is obliging by giving them free services

Again, as observed in the first observation study, there were times when doctors behaved sensitively and understood women's needs and responded accordingly. But these instances were rare in the observation period of the second study.

Box 6: Positive examples of doctors' communication

- Asking the person accompanying the patient to be the interpreter or explaining some reports or procedures to them
- Calling up the blood bank personally to find out whether a particular blood group could be arranged for a patient
- Explaining the sonography reports
- Student doctors spending enough time to take down the history

Summary of Observation Studies

Both the observation studies at the Gynaecology OPD showed that the quality of communication varied from person to person and even for the same person at different times depending on other background factors such as work load, non-availability of staff, communication between the doctor and the other staff at the OPD, socio-cultural gap between the patients and providers. Language, terminology and mannerisms used by the doctors are not understood by patients and vice-versa, adversely affecting the quality of care in terms of diagnosis, compliance and informed decision making.

Lack of privacy and a heavy load of patients make it difficult for the doctors to spend enough time with patients requiring counselling - women seeking services for contraception are worst affected by this.

Exit interviews of women seeking services at the gynaecology OPD at the hospital showed that 21% (67 out of 293) of the women included in the study were accompanied by their husbands. Three most commonly reported conditions for which these women had sought treatment were confirmation of pregnancy (23%), for D&C (15%) and for pain in abdomen and lower backache (15%). It was also observed that 37% of those accompanied by husbands could not read and write. Hospital policy denies entry to men into the gynaecology OPD to ensure privacy — this proves to be a negative factor for women with reproductive tract infections and sexually transmitted infections as involvement of husbands is discouraged.

Lack of sensitivity towards the anxiety experienced by women undergoing internal examination, especially unmarried women and adolescent girls, can prevent women from coming for early treatment.

Feedback to the Providers

The clinicians in the OPD were given feedback based on the findings from the observation studies and the issues and events that help and hinder effective communication in the gynaecology OPD were discussed in the meeting. Their response to the feedback was largely positive and they expressed satisfaction that the municipal system was making efforts to improve the services of municipal hospital. In relation to feedback about incongruent body language, and non-verbal communication, they expressed surprise. Many doctors were not aware of their own communication patterns. The doctors said that this kind of feedback would help them to improve their behaviour not only in the municipal hospital but would

also benefit them when they started their private practice.

Another group of doctors and their supervisors were surprised to learn that the waiting time of patients on the examination table was as long as 9-15 minutes. They said that ideally it should not be more than 3 minutes. They agreed to make conscious efforts to avoid such situations in future.

Doctors went on to say that administrative problems affected their behaviour in the OPD and as a result patients became scapegoats of their anger. Further, working and living conditions in the hospital campus affected them also and resulted in adversely affecting their communication and behaviour with the patients. As an example the resident doctors showed the project team the sorry state of their living quarters, but they agreed that effective communication is the basis of a good consultation process.

Lessons Learnt

Poor communication between providers and clients was an important factor affecting quality of care provided at the gynaecology OPD of secondary hospital and contributed to client as well as provider dissatisfaction.

The 'user satisfaction' as well as observation of the client-provider communication and assessment of the 'style of communication' revealed that the information and counselling needs of the clients were not adequately met by the public health system.

Discussions with users and providers at the hospital reflected the need for counselling services.

Pilot Phase

An exercise, of providing information, guidance and counselling to those in need, was carried out on a pilot basis. It was realised that apart from information needs related to their gynaecological conditions, women also needed a space to discuss issues and problems arising as a result of patriarchal social structures. Gender discrimination such as lack of decision making powers in relation to use of contraceptives or family planning operations, inability to make decisions for MTPs or inability to resist pressures for sex selective abortions; inability to talk to their spouses about abstinence from sex during pregnancy or treatment for reproductive tract infections and violence, were prevalent.

Hence, counselling services were started on a pilot basis by creating a corner space

inside the OPD, with the help of a screen. Though the temporary structure offered visual privacy, it did not provide a private space for women to share their problems. Clients' relatives would peep in, obstructing the conversation. The honorary consultants used the same room for consultations and patients lined up very close to the screen used as a partition for the counselling centre. In addition the room was used by the honorary consultants to conduct training sessions for student doctors. The counsellors and patients had to speak in a low tone to prevent people from hearing the conversation. But due to absence of alternative space and to create awareness about the centre, the services were continued from the same space for six months.

Need for Counselling Men

During the observation exercise it was noted that many men accompanied women and they would stand outside the OPD. The women who came to the OPD for consultation would go out and consult their husbands for decisions related to contraception use, MTP and infertility treatment. It was observed that many women were unable to explain to their husbands what the doctor had told them. Sometimes even if the women were convinced about the doctors' advice, they would not be able to convince their husbands about it. For instance, if a woman after talking to the doctor decided to continue the pregnancy, she would not be able to convince her husband waiting outside the OPD. It was observed that many women were sent back by their husbands a number of times to clarify the doubts in their husbands' mind. This would put women under pressure from both sides, one from the doctor's and other from her husband or family members. For some women who came from outside Mumbai to seek treatment, language barriers and not knowing the hospital procedures would be a problem. In such cases the accompanying person had to be involved in the history taking or had to explain the instructions again.

We observed a woman who did not understand Hindi. Her husband was not allowed in to the OPD. He wrote the symptoms on a piece of paper and asked the woman to show it to the doctors. But somehow she could not communicate with the doctor and the doctor did not see the chit nor could take down the history. Ultimately she could not access the services. In cases of women who are not familiar with the referral centres, the instructions related to an emergency investigation had to be explained to the husband or the person accompanying, who then can arrange a vehicle or accompany the woman to the referral centre.

In contraception counselling and RTIs, STIs or ANC it is necessary to talk to men about condom use, demonstrate its effective use or suggest abstinence from penetrative sex. Even in cases of infertility it is important to explain to men the probable causes and investigations. We observed one woman who requested the doctor to explain to her partner the reasons for her not conceiving a child. She said that her husband would explain to her in-laws, support her if the relatives got impatient and harassed her about not getting pregnant and also support her to complete the treatment.

Interviews with men accompanying women revealed that they wanted to understand the women's problem as well as talk about their own sexual health issues, e.g. In case of a couple having infertility problems, the man wanted to talk about his reduced sexual desire and wanted to know whether it was related to his diabetes medicines.

In another study conducted by the project, men's information needs were identified. The men wanted information about women's reproductive systems and their bodily processes like menstruation, ovulation, conception and about contraception.

Workshops with male health workers also brought out the need to work with men on the issues of gender, masculinities, violence and marital conflicts. These issues have a direct influence on contraceptive decisions. Vasectomy was discussed at length in the MPWs' Workshops. (Refer to *"Working with Men for Increasing Men's Involvement in Reproductive Health: Experiences of Women Centred Health Project"*, Pradhan Anagha, et.al., WCHP, 2004)

Another study conducted by the project, with male health workers and men in the community, was to understand health care providers', community men's and women's knowledge and perceptions of ante-natal care (ANC), and to explore strategies for involving men partners in ANC. This study revealed that male health workers as well as men in the community had specific questions about sexual relations during ANC. Men expressed that they would like health care providers to give information about ANC and would like to participate in consultations. (Refer to *"Exploring Strategies for Involving Men as Partners in Ante-natal Care"*, Pravina Kukade, et.al., WCHP, 2003)

During the pilot phase, men who accompanied women to the ANC OPD were grouped together and sessions on ANC and men's role were conducted. It was observed

that men were keen on receiving information about ANC especially if it was the first pregnancy. Many also wanted information on spacing methods using contraception, while others who had more than one or two children wanted to know about terminal methods. They also had many questions related to their wives' condition during pregnancy.

During the pilot phase 80 women and 15 men were counselled. In the interim period a permanent space was created in the OPD for the counselling centre.

After the pilot phase, doctors and other providers asked that counselling services be continued on a permanent basis in the hospital. They felt that this would save their time. The experiences of the pilot study showed that establishing a counselling centre would be beneficial and ease the stress on all levels of providers as well as clients.

Thus a process of establishing counselling services on permanent basis was initiated.

3. PLANNING AND ESTABLISHING THE COUNSELLING CENTRE

The case records of men and women counselled during the pilot phase were analysed to identify the counselling needs and to define role of a counsellor at the centre. Most of the cases (75%) were that of MTP and contraception counselling. Other cases seen at the centre were that of major surgeries, adolescent girls and infertility.

Based on the interventions carried out during the pilot phase the goals and objectives identified of the counselling centre were as follows.

Goals

- Providing information and support to enable informed decision-making
- Providing counselling services to men partners and key family members
- Providing a safe and open environment in the formal set up of OPD

Objectives

- To meet information and counselling needs of the clients (men and women) seeking care at the gynaecological OPD of the secondary hospital
- To assess feasibility in terms of availability of space at the hospital, privacy, support from the clinicians at the OPD and from the hospital administration.
- To assess willingness of clients to seek counselling in such a setting and establishing a client guidance and counselling centre at the gynaecology OPD
- To assess the effect on client - provider communications

Features of the Centre

- The information and counselling centre would focus mainly on meeting the needs of only those using services at the obstetric and gynaecology department in the hospital
- The centre would be open for the duration of the OPD hours only. (9.00 am to 4.00 pm)
- Counselling would be restricted to medical and social issues associated with gynaecological /reproductive conditions only
- For conditions / situations requiring special counselling skills, the cases would be referred to centres (NGOs / government) providing these. Such cases would include HIV positive individuals, alcoholic husband, domestic violence, marital conflicts and psychiatric problems

Planning

Many meetings were held with the RMOs, honorary clinicians and administrators to plan the functioning of, and activities at, the counselling centre. It was decided that the OPD needed to be restructured and re-organised for better patient flow as well as to accommodate the counselling centre inside the OPD. A bi-monthly report of cases counselled at the centre would be submitted to the hospital administrators and honorary clinicians. The training coordinator of WCHP would supervise the daily functioning of the OPD and report to the project coordinator regularly.

Administrative permissions were obtained by submitting the proposal from the Chief Medical Superintendent of peripheral hospitals and Medical Superintendent of the hospital.

Staffing

Auxiliary Nurse Midwives (ANMs) and multipurpose workers, mostly males (MPWs) from surrounding Health Posts would be trained in counselling and placed as counsellors on a rotational basis to staff the Centre. (The ANMs have two or three years training in nursing and are trained in conducting deliveries. The MPWs have completed a one-year course of Sanitary Inspectors.) The reason for training these ANMs, MPWs was that they would then be able to counsell clients when they go back to their health posts and also refer patients to the gynaecology OPD after the basic counselling done at their level.

Roles of ANMs and MPWs at the Centre would be as follows.

- a. Information giving
- b. Counselling
- c. Link between client and doctor
- d. Documentation and maintaining records

Expected Outcomes

The counselling centre

- The Centre would serve as a platform where women would be able to interact freely with the providers and seek answers to their queries
- The counselling services would influence efforts towards involving/sensitising husbands/partners about gender and women's reproductive health and rights
- The centre would fulfill information needs of partners and other family members regarding diagnosis, procedures, line of management, prevention etc.

- Doctors would be able to spend more time with the clients requiring detailed medical consultation
- Offering counselling services, would result in increased user satisfaction (after the user has availed of the services 2 -3 times at least) by meeting their needs for information, guidance, counselling regarding symptoms, diagnosis, investigations, course of treatment, preventive measures etc.
- Counselling protocols for gynaecological conditions would be developed, tested and ready for implementation at other facilities
- The counselling centre would encourage linkage between primary and secondary level facilities and facilitate effective two way referral system between the different levels of facilities

Apart from establishing the counselling centre, a number of interventions were carried out for improving the services at the OPD. Each of these are described in the next chapter.

4. INTERVENTIONS

Reorganisation of Space and Infrastructure

During initial observations of provider-client communication patterns it was evident that the physical layout of the OPD was a barrier to effective communication. The existing layout did not provide adequate privacy for clients during examinations. Client flow and lay out of the OPD needed reorganisation to improve privacy and avoid chaos and crowding within the OPD. There was a shortage of seats/chairs with only two stools in the OPD for clients. If there were more than two doctors, then the clients had to stand throughout.

The project decided to initiate changes in the OPD layout, in consultation with the honorary clinicians, to enable better client and provider satisfaction and quality of care. Also, making the work place pleasant and organised would motivate staff to maintain a pleasant environment in the OPD. This remodeling, it was felt would also serve as a model for other Gynaecology OPDs of municipal hospitals.

A private architect was consulted for restructuring the OPD. He submitted two alternative plans, of which the most feasible plan was selected after consulting the RMOs, honorary clinicians, Project staff, nurses, attendants, and sweepers.

(See annexure 1.1 for plans)

The change in OPD layout resulted in

- Privacy for physical examination
- Increased waiting area inside OPD for clients
- A more streamlined process in OPD – space for case paper writing
- Specific seats/places for providers which increased accessibility and identity
- A private space for counselling
- Increased storage space for papers/records
- Proper utilisation of space and convenient position of telephone
- Display board inside the OPD for information and notices and instructions for clients
- A pleasant and clean look

WCHP also provided the OPD with some infrastructure like furniture, shelves, chairs, tables, lights, and fans.

Staffing at the Centre

- 2 Project Counsellors (female)
- 1 Supervisor
- 1 Coordinator

In the beginning there were 3 full time staff in the counselling centre. They were supported by a coordinator. Of these, the counsellors and the co-ordinator were MCGM staff and were on a 'working arrangement' till the end of the Project while the supervisor was employed by the project on contract basis. Of the two counsellors one is an Auxiliary Nurse and midwife (ANMs) and the other is a Female Field Worker (FFW). They are trained in counselling by the project and the supervisor and they attend the OPD three times a week on alternate days. They were monitored and guided by the supervisor who was trained Psychologist and was present throughout the week. The coordinator facilitated all training for the counsellors and provided feedback to the supervisor and the project.

Table 2 Role of the Staff at the Counselling Centre

Staff	Responsibilities
Counsellors	<ul style="list-style-type: none"> ● Provide counselling to the clients ● Conduct group sessions in the ANC OPD ● Maintain case records
Supervisor	<ul style="list-style-type: none"> ● Monitor and provide feedback and guidance to the counsellors ● Supervise trainee ANMs and MPWs who are placed at the centre for counselling practicum.
Co-ordinator	<ul style="list-style-type: none"> ● Facilitate training for counsellors ● Provide feedback to the Project ● Prepare agenda for periodic review meetings with providers and administrators ● Liaising with the Hospital and MCGB officials, health care providers and project staff.

Since September 2003 there is no supervisor at the centre and the counsellors trained the trainee ANMs placed at the centre. It was found that the counsellors were trained to give good quality counselling services and could manage the centre in the absence of the supervisor. Currently the co-ordinator visits the centre once in a week and gives feedback on the quality of counselling to the counsellors. Observation and self-evaluation checklist and case records are used to give the feedback.

Senior medical officer of the hospital has taken over the task of organising the staff meetings and the Honorary clinician agreed to continue facilitating and problem solving role even after the Project period was over.

Space and Timings

A separate room is presently available for counselling inside the Gynaecology OPD for ensuring privacy during counselling. The room is prominently situated and can be seen as soon as one enters the OPD. A board and a poster is put on the door of the room informing the clients about the services offered at the centre. Initially this room was used only for women clients who come to the OPD. The men were counselled by male counsellors in a temporarily created structure in the waiting area outside the OPD using a screen and chairs. Recently a separate room has been allotted by the hospital for counselling men.

Right now there are no male counsellors at the centre, as the services of MPWs who came on rotation was discontinued due to their other work involvement at the health post. Currently, couple counselling and counselling to men is done in the same room inside the OPD, by the female counsellors.

The timings coincide with the OPD clinics: from 9 a.m. to 4 p.m. from Monday to Saturday.

Training for Counsellors

Preparation of a Training Manual

Women coming to the counselling centre not only require information to enable them to make informed decisions about their reproductive health problems, but also need to be counselled from a gender and reproductive rights perspective. Many of their problems like contraception decisions, treatment for infertility, multiple abortions suggesting a possibility of sex selective abortions and sexual health problems were related to gender issues. Societal expectations of women to be tolerant, obey the decisions taken by the family members or husband, affected her ability to assert her reproductive and sexual health rights and in turn affected her body and health.

Therefore the project team prepared a training manual on women centred counselling. The manual would not only assist in developing counselling skills, but enable

counsellors to look at the women's gynaecological health problems from a gender and reproductive rights perspective and counsell accordingly.

Concept of women centred counselling

Woman Centred counselling (WCC) is an integrated and empowering approach which enables women to regain control over their lives; helps them to make choices, set goals and also encourages them to believe in, and nurture, themselves.

Box 7: Sections in counselling manual

- What is Woman Centred Counselling
- Counselling Skills and Principles
- Communication Skills and Principles
- Communication around Sexuality Issues
- Counselling For Adolescent Girls' Health Issues
- Counselling For Gender Based Violence
- Counselling Around Gynaecological Health Issues
- Documentation and Recording

Consultation meeting for reviewing the manual

The draft of the training manual on Women Centered Counselling was reviewed by eminent practitioners, academics, activists and clinicians from the field of Gynaecology, Preventive and Social Medicine, Sexuality, Counselling and Social Work. A two day consultation resulted in valuable feedback in terms of content, methodologies, feasibility,

possible trainers and so on. The manual is now available with the project.

Conducting Training for Counselling

Box 8: Curriculum for the four-day training workshop

- Gender and Reproductive Health
- Gender, Sexuality and Sexual Health
- Women Centred Counselling
- Qualities of a Counsellor
- Self-realisation and Reflection
- Communication Skills
- Macro and Micro Skills in Counselling
- Technical: Understanding High risk ANC and Hysterectomy, Violence and Health, MTP and Contraception
- Practical experience of working with clients visiting the gynaecology OPD
- Effective use of IEC Material in Gynaecological Counselling

A four-day training in counselling for all ANMs and MPWs from 8 health posts (HPs) in the ward was organised from the end of 2001. These workshops were conducted

in three batches and a total number of 50 health workers were trained (30 ANMs and 20 MPWs).

Practical training

The four day training workshop was followed by practical training at V. N. Desai Hospital at the Counselling Centre. Each of the 50 participants had to complete 15 days practicum under supervision. During these 15 days the trainees upgraded their skills through feedback based on observation and review of their counselling sessions and clarification of their doubts and concerns.

See the annexure 1.3 for the detail schedule for the 15-day training.

Evaluation of the 15 days' training done by the trainee counsellors

In the written evaluation the ANMs and MPWs stated that they thought that they did counselling work at the health posts but now they realised that they had learnt a more systematic way of doing it and recording it. They realised the information needs of the patients and importance of providing counselling services. They also expressed their inability to answer certain queries of the patients due to their lack of knowledge and not being in touch with the hospital procedures, implying a need for more training inputs.

Training for Clinicians

Workshop on Reproductive Rights and Quality of Care in Contraception Services

Two half day training sessions were organised by the Project for clinicians at the OPD with the following objectives

- To examine the practical implications of the concept of quality of care in contraceptive services.
- To examine the principle of reproductive rights in relation to contraceptive services

The expected outcome of the workshop

- A consensus on principles and possible practices, action steps based on quality of care and reproductive rights

Sessions at the workshop

- Concepts in quality of care and reproductive rights in relation to contraceptive services

- Current practices in family planning services in public health department and expanding the reproductive health agenda
- Principles of quality of care and reproductive rights

Session on Child Sexual Abuse (CSA)

Some cases of sexual abuse in adolescent girls and younger girls were seen in the OPD, in the pilot stage of the counselling. These cases are generally referred from casualty. In two out of three cases, the age of the girl was recorded as above 18 (probably to avoid legal complications), though the girls looked much younger. In the third case a girl aged 9 was brought by her mother for genital infection but the doctor did not explore the possibility of sexual abuse.

The counsellor counselled these cases by getting the help of an NGO working on the issue of CSA, which needed the counsellor to attend the police station a number of times. Generally the health care providers avoid getting involved in such cases with the fear of getting into legal procedures. Hence it was felt necessary to orient and sensitise the RMOs to deal with such cases. The session was conducted by a paediatrician, social worker and psychiatrist. The two and half hour session covered

- How to identify cases of sexual abuse
- Clinical management
- Role of gynaecologists and counsellors or social workers
- Referral and counselling services

Orientation of New Batch of Resident Doctors

An orientation session is conducted for every new batch of resident medical officers (RMOs), who are posted to the OPD on six months rotation. The RMOs play a key role in improving the quality of the services offered at the OPD, ensuring smooth flow of the OPD, and also in identifying and referring the patients for counselling. Teamwork of both counsellors and doctors is important to offer quality services to the clients. Thus to sensitise the RMOs to the information and counselling needs of the patients, discuss concepts and issues in quality of care and to orient them to the functioning of the counselling centre the project designed an orientation package for the RMOs. The orientation session is conducted by the asst. honorary clinician and the project staff.

The content of the session is as follows

- Discussion on, "Is this outpatient clinic different and why?"
- How did the changes in the OPD and the counselling centre came about

(process of observation, feedback, establishing counselling centre and interventions)

- Concepts and elements in quality of care
- Findings from evaluation of counselling centre
- Expectations from the RMOs and their role vis-a-vis the counselling centre
- Functioning of the centre and cases to be referred
- Principles of counselling, do's and don't's and basic skills in counselling

(See Tool T-1.1: Orientation package to sensitise resident medical officers to importance of quality of care and counselling)

Information, Education, Communication Materials

Box 9: IEC materials displayed at the OPD

For clients

- Pictures of external and internal reproductive system of women
- Pamphlets on RTIs and MTP
- Model of uterus, penis, samples of contraceptive methods
- Flip chart on nutrition for ANC, breast feeding, STDs, HIV/AIDS, TB and breast self examination
- ANC registration timings and OPD procedures
- Precautions for BOH patients
- Patients rights and responsibilities (See annexure 1.4: Patients' Rights and Responsibilities Displayed in the OPD)
- Messages about what services are offered at the counselling centre

For the staff and RMOs

- Role of each staff in the OPD (see annexure 1.5: Role Of Staff displayed at Gynaecology OPD)
- Cases to be referred to the counselling centre

For counsellors

- List of counselling skills
- Role of counsellors and daily tasks
- Information on referrals for adoption, for unmarried pregnant women and survivors of violence

As found during the observation studies of client-provider communication and FGDs with women, women wanted information about the reproductive system and the details about their condition. Also providers complained about having to repeat the

same instructions for every patient. Providers also expressed hope that co-ordination among staff could be achieved and the role conflicts could be avoided by displaying the role of each staff member in the OPD.

Based on the needs expressed by the clients and providers, various IEC material is displayed or used at the counselling centre and the OPD (See box 9). The counsellors were trained to use these visual aids in the process of counselling for various problems.

Documentation

A fact sheet or 'client card' is filled with identification data for all the clients visiting the centre. The client card has personal information, presenting gynaecological problem, economic and family background. The card also has a unique code number. These cards are filed and are kept in a safe place such that only counsellors can access them. There is another 'case record sheet' on which the client's problem is recorded in detail. Client's gynaecological problem and associated social issues are described in this sheet. Along with the presenting problem, interventions carried out, outcome, contract for next meeting, doubts and queries of the client, skills used and counsellors' comments are recorded in detail. Client's name and identification data does not appear anywhere on this sheet to maintain the confidentiality of case records. The code number on the client card is written on the case record sheet. The client card and the case record sheets are kept in two separate files. See Tool No. T-1.2 and T-1.3 for sample of the client card and the case record sheet.

While the client card helps to identify the client, the case record sheet serves multiple purposes. It maintains counselling records for ready reference as well as serves as an evaluation and feedback tool. The case record sheet can be analysed and used for giving feedback to the counsellors on counselling approach. Gender and reproductive issues can be identified from the proceedings of the case and discussed. It can also be used in training as a perspective building tool. For example, the case records are discussed by the counsellors among themselves to identify gender and reproductive right issues and to suggest ways to intervene. The case record sheet is also used for case presentation. It is suggested by the counsellors that these sheets could be in the form of a register for better management and for ease of handling and accessing them.

Referral Mechanisms

Presently referrals to the centre are done mainly by the doctors. The various reasons for which clients could be referred are clearly listed and put on the board in the OPD. However, clients who come for follow up and those seeking information about hospital procedures can directly access the services.

Earlier the counsellor would approach clients while they were in the waiting area and brief them about the centre and the services provided. Some clients who required the services would visit the centre before meeting the doctor but subsequently this practice was discontinued because of differences in the doctor's and counsellor's advice in a couple of instances. In one case inadequate technical knowledge of possible complications, resulted in inappropriate counselling by a trainee counsellor. In a case of a woman, over 3 months pregnant and wanting MTP, there were differences in the information given by doctor and counsellor regarding the MTP method to be used in the situation. Hence it was decided that the patient would be referred to the counselling centre after consulting the doctor and getting a provisional diagnosis. The patients who were not referred by the doctors also can approach the centre independently. If the clients visit the centre before they see the doctor, they are asked to come back after consulting the doctors.

The kinds of cases to be referred to the counselling centre are as follows

Box 10: Clients referred to counselling centre

- Clients who need information about contraception
- Clients who need to discuss sensitive issues like sexual problems
- Clients who do not follow the treatment plan
- Primies who come for MTP
- If sexually or physically abused
- In cases where unable to share correct gynaecological history or discrepancy in facts
- Inconsistencies in information given by client and family members
- Unmarried pregnant women/girls
- ANC women: negative blood group, low HB, high BP, lack of support from family/husband/partner, excessive work causing problems to health, anxiety about deliveries, violence
- For pre and post operative counselling, hysterectomy, cancer, white discharge, and prolapse

Organisation and Management

In addition to the counsellors, WCHP provides administrative support like preparing reports, circulars, minutes of the meetings, invitations, agendas, display texts/information, requests for permission etc. supply of stationery (record sheets, files), and maintenance of files.

Review and Monitoring Mechanisms

Staff meetings

Review meetings are held every two months. All providers associated with the Gynaecology OPD attend these meetings – honorary doctors, project coordinator, project staff, counselors, nurses, RMOs, and support staff in the OPD. The facilitators tried to get the Medical Superintendent, who is responsible for supervision of all departments of the hospital, to attend, but she was not able to attend any meetings. In these meetings the agenda is put together by the project staff and the meeting is facilitated by the assistant honorary doctor. These meetings provide a forum to discuss problems faced in the OPD, possible solutions, provide feedback about all staff including doctors, and discuss issues related to quality of care.

Suggestion box

A suggestion box was placed in the OPD to receive feedback from the clients. The box is also utilised by the OPD staff to give feedback to each other or for expressing their problems. The contents of the box are kept confidential and are discussed in the review meetings.

Some contents of the suggestion box

- The appointment for sonography should be given on the same day of the ANC OPD
- "Can the honorary doctors (*bade doctor*) come earlier?"
- "Can we get Imferon injections free from the hospital. I cannot afford to buy them?"
- A reluctant patient who finally decided to opt for Cu-T, after counselling had lot of pain during the insertion
- If a woman delivers in the OPD other patients get scared

Box 11: Outcome of the review meetings

Display of material for educating clients and obtaining their feedback

- Patient's rights and responsibilities were discussed and it was agreed that they would be displayed on the IEC board
- Suggestion box was started for patients and OPD team to give their suggestions anonymously

Better co-ordination between the OPD staff

- The role of each provider was clarified and displayed in the OPD
- A circular for RMOs was prepared by the honorary surgeons and circulated to facilitate organised and disciplined functioning of the OPD
- Gynaecology and labour ward staff started attending review meetings
- Counsellors started reporting the details of counselling done in case of patients in the ward, to the doctor who referred the case
- The cases where the counselling done by the doctors and that done by counsellors differed, would be noted in a separate register and would be discussed with the honorary clinicians

Working out systems for addressing problems related to services

- The problem of delayed ANC laboratory reports was discussed and a system was worked out in co-ordination with laboratory staff
- HIV sessions for ANC women were initiated in co-ordination with VCTC
- A system was set up whereby in case of medical complications, concerned doctors will explain the matter to the patients in the presence of the counsellor

Provision of facilities for providers

- Extra writing board was provided in the examination room to facilitate recording of the examination findings soon after the examination is done on the request of the resident doctors

Stopping wrong practices

- Medical Representatives were asked to stop distributing prescriptions to the ANC women

Sustainability

- The hospital Community Development Officer and Senior Medical Officer agreed to co-ordinate staff meetings

Decisions taken based on patient feedback from the suggestion box

- The hospital CDO agreed to provide financial assistance for buying Imferon injections
- Interns to be supervised by the resident in case of removal of Copper -T
- Emergency full term patients to be given priority in the OPD
- A counsellor was given an appreciation certificate by the hospital based on clients' feedback for providing useful information to them

Token system

This system was introduced to inculcate queue discipline in the OPD. During the project period, before this system was introduced, a system of allowing 5 patients at a time was followed. The queue system reduced chaos and improved client flow in OPD. The clients were given tokens in the waiting area and called according to their number to further streamline the queue system. This system was discontinued as the patients lost the tokens and the nurse on duty found it difficult to sort out the confusion if patients missed their turns and came in between. Patients took the token numbers home and did not come back in OPD time, thus creating confusion regarding priority.

Regular feedback to the doctors on communication style through structured observations

On the request of the RMOs to give them feedback on their communication style, structured observations were conducted for two groups of doctors, before, and after, interventions were carried out in the OPD. (See Tool T-1.4: Observation Checklist used for Monitoring Doctor -Client Communication)

Twenty-two episodes of patient provider interaction with four resident medical officers (RMOs) were observed at the beginning of their six months' term in the hospital. The data was used to give feedback to the RMOs on their style of communication. The objective of the exercise was to improve communication and care was taken not to criticise individual doctors. Positive factors contributing to effective communication as well as factors affecting the communication adversely were discussed with them. Two months after giving the feedback, the observations were repeated to see whether there was any difference in the communication style of the providers.

Result

A marked difference was observed in the communication style of the providers where

in a number of episodes clients and accompanying persons were treated with respect and communication with the client was undisturbed. In the post feedback observations the RMOs were observed to show increased sensitivity towards clients in terms of instructions during vaginal examination and ensuring privacy during the consultation process.

The waiting time at the examination table reduced from ten minutes to five minutes after the feedback.

This exercise though helpful, was not sustainable in the absence of project support in terms of staff to make the observations and analyse them regularly. Hence a self-evaluation check list for doctors was developed by which they could monitor their own communication patterns.

Checklist for self-evaluation

A checklist for self-evaluation was developed for the last group of doctors. The checklist has markers of essential communication skills and a scale to assess self performance that ranges from poor to very good. (See Tool T-1.5: Checklist for Monitoring Communication with Client: Self- Administered Checklist for Doctors). The doctors were asked to complete at least two forms everyday and check their own performance at the end of a week. But this exercise could not be followed up due to lack of time and non -availability of project staff for monitoring the progress of the activity.

Checklist for monitoring quality of counselling

A checklist for monitoring quality of counselling was developed for the counsellors to train new recruits, by giving feedback to them, and assessing their own performance by peer feedback. It includes skills used during a counselling session. (See Tool T-1.6: Checklist for Assessing Quality of Counselling)

Counselling protocols

Counselling protocols for different gynaecological conditions were developed in the form of checklists, to have uniformity in the counselling and to maintain the quality of the content of the counselling. These protocols are useful for training the health workers and are also used as checklists for monitoring the counselling provided for MTP and contraception, menstrual disorders, major surgery and reproductive tract infections. (See Tools T-1.7, T-1.8, T-1.9)

The centre has been functioning smoothly for last two years with caseload on increase. The two counsellors find it fulfilling and useful to work at the centre. There is also a demand for counselling services from the in-patient gynaecology and labour ward.

Usefulness and effectiveness of the centre is discussed in the next chapter.

5. ACHIEVEMENTS

Quantum of Clients

The following table shows the number of women and men counselled during January 2002 and December 2003.

Table 3 Number of Clients Counsellled

Period	Clients Counsellled	
	Women	Men
January – June 2002	108	12
July – December 2002	283	113
January – June 2003	246	46
July – December 2003	370	15
Total	1007	186

During January and June 2003, only 46 men were counselled. During this period there was no male counsellor for 3 months. Also male counsellors attended the centre only five days in July 2003.

Problems/issues Addressed During Counselling

The doctors routinely refer clients for medical termination of pregnancy - Tubal Ligation (MTP-TL), MTP-Copper T, Hysterectomies, white discharge, menstrual disorders, infertility, and stitch abscess, patient unwilling for PV, Pelvic Inflammatory Disease (PID) and for other medical problems. The women came for counselling for the following conditions in the period July –December 2003

Table 4 Kinds of Issues Addressed During Counselling

Reason for counselling	Number of women (n=379)
MTP and Contraception counselling	170
Only contraception	94
ANC	42
Major surgery (eg. Hysterectomy)	20
Infertility	15
Other gynaecological conditions*	32
Unwed mothers	5
Tuboplasty	1

* For instance, white discharge, irregularity, confirming pregnancy etc.

In the course of counselling, several social issues have been identified and counselled or referred to other organisations. Of 379 cases seen during July-December -2003, 17 were counselled for social issues such as teenage pregnancy (9), HIV (1) and violence (7). Referrals have been also related to cases of child sexual abuse, adoption and others.

Evaluation from the Reproductive Rights Perspective

An evaluation of 123 counselling records of women counselled in the period January-June 2003, was carried out to analyse the counselling services from the reproductive rights perspective. An analytical framework was developed based on operational definitions derived from ICPD Reproductive Rights.

Box 12: Operational definition of rights ensured at the counselling centre

- ***Right to information:*** Accurate and detailed information related to the reproductive system, menstruation, ovulation, conception, contraceptive methods, operative procedures, treatment, investigations, reports, post natal care, ante natal care and causes of infertility is provided
- ***Right to choice:*** Clients are given choice to select the contraceptive method that suits their life style by providing information on all the contraceptive methods available
- ***Right to decision making without coercion:*** Client is encouraged to make an informed decision without coercion related to use of a particular contraceptive method or to continue pregnancy
- ***Right to shared responsibility with partner:*** Men are included in the consultation process for infertility, choice of contraception, sexual relations and taking responsibility for ANC
- ***Rights to comfort:*** Efforts are made to reduce anxiety and fear experienced by the client about the gynaecological condition or the diagnosis, contraceptive methods, operative procedure, results of investigations and treatment options suggested.
- ***Rights to discuss sexual health issues:*** Issues around sexuality in conditions like infertility, ANC, post operative care and contraceptive use are addressed

Findings (n= 123)

- ***Reproductive Rights ensured at the counselling centre were*** Right to information (79%), Choice (50%), Decision (57%), Shared responsibility with partner(41%) and Discuss sexual health issues (15%)
- ***Outcome of counselling (for MTP and contraception cases, n=95)*** Women unwilling to use any contraception decided to use contraception (39%), Women changed decisions related to contraceptive method and terminating pregnancies (18%) and Women asserted their right to decide about contraceptive method of their choice (16%)

Clients' Satisfaction

Clients repeatedly mentioned satisfaction with the OPD services through their chits in the suggestion box and appreciated the counselling services as well as the friendly treatment they received at the OPD.

Box 13: Feedback from clients

"Main Guruwar ko aai thi. Yehanpar achha jaankari मिली है, पहले ऐसा नही बतते थे" (I came on Thursday. I learnt a lot here. First it was not like this.)

"Dr. (name) के बोलने का तरीका अच्छा लगा"

(Dr....has a nice way of speaking.)

Ten clients who had availed of counselling services were interviewed to find out whether they were satisfied with the services and whether they thought that they had benefited from talking to the counsellors. All respondents believed that the role of the counselling centre was to provide them information and to clarify any doubts they may have. The respondents expressed satisfaction about the attitude of counsellors. They felt that the counsellors talked to them with respect, made them feel comfortable and ensured confidentiality. Respondents also reported that they felt free to pose questions and clarify their doubts. They appreciated patience shown by the counsellors and that they continued to give information even if the client did not understand it the first time. Feedback from the suggestion box supports these findings.

The project has demonstrated that, with inputs like feedback to providers on their communication pattern, regular staff meeting to discuss issues and problems in quality of care, educating patients, sensitising providers and providing supportive, conducive environment, physical as well as for problem solving, and demonstrating that patients are capable of taking decisions it is possible to ensure reproductive rights in a public service facility managed with scarce resources. Openness of providers to such initiatives for ensuring reproductive rights is encouraging. National policies with a focus on population control rather than reproductive health and sexual health, pose a greater challenge in implementing a reproductive rights agenda in the public health system. Despite this, the start has been made and though the response has been slow it has been positive.

Box 14: Achievements of the counselling centre

- Comprehensive information and good quality counselling services are provided to women many of them coming for family planning and MTP services
- There is informed decision making by clients/patients. An indirect spin-off of this may be that there is less scope for medico-legal problems
- The presence of a counsellor who listens to the patients' problems and provides support has improved doctor-patient communication
- Greater awareness on the part of RMOs and housemen on patient rights has meant that patients are treated with greater sensitivity and courtesy
- Counselling service is considered essential by honoraries as well as junior doctors
- Patients are highly appreciative of services

(Source: *Mainstreaming Gender and Rights In Reproductive Health Care within a Public Health System: The Experience Of Women-Centred Health Project, Mumbai. Report of a review and assessment submitted by TK Sundari Ravindran to the Women Centred Health Project October 30, 2003*)

The information presented in this chapter is based on analysis of the documents, case records maintained at the centre and the clients' feedback. This analysis was carried out by the project team. The project also invited an external evaluator to evaluate the counselling services offered at the centre. The findings of the evaluation study are presented in the next chapter.

6. EVALUATION OF COUNSELLING SERVICES

(An evaluation of the Counselling Services was done in June - July 2003 by an external evaluator, Ms. Deepa Venkatesh. Ms. Venkatesh is a professional working on women's health issues for 10 years. Her specific experience has been in evolving programmes, both community based and at the primary health centre level, for gender-based violence as a health issue.)

The objectives of the evaluation as specified by WCHP in relation to the counselling centre were:

- To assess the quality of counselling
- To elicit user and provider perspectives about the usefulness and effectiveness of counselling services
- To review systems: monitoring quality of counselling, recording and reporting, mechanisms of referral, training
- To assess sustainability and replication of services

The objectives were translated into the following framework, which was used as a guideline throughout the evaluation process.

Framework for Evaluation of Quality of Counselling

- Accessibility of counselling services: hours of services, waiting time, privacy, distance, specific location (whether inside or outside the Outpatient Department), transportation (in case of referrals from health posts-dispensaries to the secondary hospital), cost of services
- Range of issues and availability of services: Are services available to only those referred by doctors and other providers? Or available to all who access the OPD without any restrictions/limitations? Range of Ob./Gynae issues for which counselling is available
- Interpersonal relationships between the counsellor and the client
- Counselling procedures: confidentiality, information given to clients, IEC materials to support services, spouse/partner involvement
- Counsellor related factors: technical competence, personality/attitude, skills, and empathy with clients
- Mechanisms to ensure continuity and client follow up: scheduled appointments, follow up through health posts/CHVs, records, referrals,
- Usefulness of the services provided through the centre: Has the counselling centre from the perspectives of providers and clients improved Quality of Care?

- Perspective on gender, client rights, reproductive rights
- Replication and sustainability: Can and will the counselling centre be sustained in its present form? What are the preconditions/requisites for such replication? Can the centre be replicated in other health centers?

Methodology

The tools for the evaluation were prepared by the external evaluator in consultation with the project team. Refer T-2.1 for the tools used.

Annexure 2.1 is the framework for the evaluation in relation to the methods used.

The methodology for the evaluation consisted of

- study of internal reports and documents
- review of case records and peer review reports
- interviews and group discussions
- observations of counselling sessions
- review of taped counselling session
- exit interviews with clients

Table 5 gives the details of each of the above.

Table 5 Details of Methods Used and Number of Respondents

Methods / Sources of data	Observation of counselling sessions	Exit Interview with clients who accessed counselling	Review of tapes of counselling sessions	Interview with providers	Review of past records	Counsellors' peer review reports
Numbers	1 across range of problems for which counselling is accessed e.g. MTP, contraception, ANC, Infertility, Hysterectomy, Uterine prolapse	16 Men = 2 Women = 14 Of 16, Users = 12, Non - users = 4	10	29	Since Phase one	5

Table 6 provides details of the various categories of health care providers and users interviewed. The evaluation process involved forty-seven persons for feedback about the counselling services, including all categories of providers who were in one way or the other, presently or in the past associated with the counselling centre, users including men and women who had visited the centre or the OPD during this period and WCHP team members.

Table 6 Interviews and Discussions with Providers and Users

Interviewees/participants	Number	Tool / method
Health care providers in VND Hospital	17	Individual interviews
● Medical Superintendent (MS)	2 (Present+Ex)	
● Honorary Doctors	2 (Chief+Asst.)	
● Resident Medical Officers (RMOs), Registrar, Houseman	4	
● OPD Nurse, Labour ward sister	2+1	
● Attendants –support staff	4	
● Counsellors	2	
Trainee counsellors of Health Posts	10	Focus Group Discussion and one individual interview
● Auxiliary Nurse and Midwives (ANM)	6	
● Multipurpose Workers (MPWs)	4	
Users	12	Exit interviews
● Female	10	
● Male	2	
Non-users (all female)	4	Group interview
WCHP	3	Individual interviews
● Project Coordinator	1	
● Project staff	2	

Findings of the Evaluation

The findings of the evaluation have been organised under the following headings.

1. Perceptions of users and non-users
2. Feedback on quality of counselling
3. Perceptions of health care providers (including counsellors and WCHP staff)

For detailed feedback of different categories of people interviewed see Annexure 3.1

1. Perceptions of Users and Non - Users

Interviews were conducted with 16 persons, of whom 2 were men and the remaining were women. Of the 14 women, four were non-users of counselling services.

The interviews with the non-users was done in a group of four persons while they were waiting their turn to meet the doctor. All the other women were interviewed after they had accessed counselling services. Six of these women and one man had accessed the services for the first time. All the others were follow up clients. Of the follow up clients, two had accessed counselling services earlier in the week. Of the two men, one had accessed counselling that day and the other was waiting for his wife outside the OPD. He was aware of counselling services as he and his wife were counseled on their last visit to the hospital. The users had come to the OPD for ANC check up, sterilisation, pregnancy out of marriage, prolapse, hysterectomy, white discharge and MTP.

Purpose of counselling services All those interviewed felt that the purpose of the counselling centre was to provide information and clarify any doubts that they might have.

Attitude and behaviour of counsellor All the respondents were very happy with the attitude of the counsellors. They felt that the counsellors had talked with respect, made them feel comfortable, ensured confidentiality.

Changes in the OPD Some of the users said that there were changes in the OPD.

"The layout is like that of a private hospital."

"The doctors are better now. Don't know the reason maybe because they are new."

"Staff in OPD pay attention."

Clarification of doubts All the respondents said that they were able to pose questions and clarify their doubts.

"The counsellors are patient and clarify and give us information even if we ask them repeatedly."

All the users felt that the counselling services should be continued, as they were very useful. (The reasons for their present visits is given in the brackets)

*"I was scared but became confident after talking/discussing with them.
(MTP)"*

"I got information about sex and sexuality which I would not have got anywhere else. Some people may think that this is not 'right' but information can only help us. (antenatal care) "

"My fear was reduced. I was not worried about the operation. (prolapse)"

"I found it very useful. I spent over an hour asking them questions and clarifying my doubts. It was so useful that I did not give much thought to my 6 month year old child who I brought along. (MTP and contraception)"

"This is the only place where one could get information like this especially for those who are poor and illiterate. (MTP)"

"The pictures and models they used were very good. (ANC)"

Awareness of counselling services The four non-users interviewed were not aware of the counselling services being provided. They had never accessed these services but said that they would use them if need arose and would also inform others about counselling.

Two of the new users thought the counsellors were doctors. Some of them were not aware that they could avail of the counselling services without being referred by the doctor. None of them were aware that the counselling services are available till 4 p.m.

Only one man, who had accessed male counselling on that day, and another woman who had been asked to bring her husband along, knew that counselling services were also available for men.

Sharing information with others All the clients who had come for follow up said they had mentioned the counselling services to others – family, friends and neighbors. The new clients also said that they plan to inform others about these services.

Recommendations made by users

- Counselling services should continue
- Information about the services should be publicised through fliers, notices in the hospital
- All departments should have such services

2. Feedback on Quality of Counselling

As mentioned in the Methodology section, a framework was developed to review the quality of counselling. This section pulls together material from the observation of counselling sessions, review of case records and interviews and discussion with the clients, providers, counsellors, trainees and WCHP staff.

Interpersonal relationships: counsellor - client

The counsellors including the trainees were skilled at making the clients feel comfortable. They were able to build rapport with the clients. However, these skills varied according to individuals. For example, one trainee counsellor was observed speaking 'down' to the client.

Counselling procedures

Confidentiality The two full-time counsellors and one trainee were consistent in ensuring confidentiality but the remaining three trainees did not consistently ensure confidentiality in any of the counselling sessions observed.

Information given to clients The clinical information given to clients was accurate during most observations. Of the 12 complete observations, in two cases inaccurate information was given. In one instance the counsellor had wrongly interpreted the diagnosis by the doctor. The client had been diagnosed with SUI (Spontaneous Urinary Incontinence) and had been recommended to undergo a minor clinical procedure. The counsellor did not understand the term 'SUI' on the case sheet and counselled the client for uterine prolapse. The client was confused after the counselling and approached the doctor for reconfirmation.

In the second instance, one woman came for a MTP against her husband's wishes. The counsellor asked for her husband's or mother in law's signature for the MTP. The MTP Act requires any adult's signature according to the woman's choice. The counsellor should have used her judgement and not asked for the husband's signature since he was against the MTP. However the counsellor's justification was that if the MTP was done against the husband's wishes, the existing violence prevalent at home would escalate.

It was also observed that counsellors need ongoing guidance from supervisors. For example, the counsellor was unable to satisfactorily handle the case of a 14 year old girl who had come due to urinary incontinence and daily bed wetting. There was confusion about whether this was physiological or psychological. The counsellors asked her to come back when she made her next visit to the hospital and the client did not seem very satisfied with this.

It is suggested that in the absence of a supervisor, the full time counsellors could provide feedback to the trainees during their practical training.

Gender perspective

The two full time counsellors are very sensitive in counselling and demonstrate a gender perspective but some of the trainees require guidance and feedback. Avoidable statements were made by two of trainees.

For example,

Counsellor: *What do you do?*

Woman: *I am at home*

Counsellor: *Oh, so you do not work.*

In addition to the fact that the counsellor devalued domestic work, the tone used was very insensitive

Counsellors need to explore the possibility of male contraceptive methods. This was not done in most cases observed or recorded.

Gender issues in couple counselling During two observations of couple counselling, the man did all the talking, giving information and making decisions. The counsellor in one situation did ask the woman her point of view but in that situation the woman just agreed with the husband.

Couple counselling alone may compromise the empowerment of the woman to make her own decisions and be unable to explore issues of abuse/violence. In addition to couple counselling it will be worth exploring some issues separately with the woman.

Rights perspective

Any client coming to the counselling center has the right to complete information and if the center cannot provide it then there should be a referral.

For example, a doctor referred a woman and her baby to the Counselling Center. According to the woman she was a victim of the doctor's negligence. The doctor told the counsellor how to handle the woman (obviously not accepting his/her role in the negligence.) The counsellor followed the doctor's instructions but felt that she was not doing the right thing. She felt helpless. She could not and did not refer the woman to any party who could provide redressal for her complaint.

This also highlights the staff dynamics within the OPD and the independent functioning of the counselling centre.

A review of some case records for the months of November 2002 till January 2003 shows three columns filled in by the counsellor.

Table 7 Format for Review of Case Records

Kind of cases	Number of cases	Outcome
'Patient wanted MTP-Cu T and Doctor suggested TL'	4	'All 4 agreed to do TL'
'Clients want MTP. Doctor suggested continuation of pregnancy'	5	'4 opted for continuation of pregnancy. 1 was adamant on MTP'

The background of this table is not very clear. Neither is it clear on what basis the doctors were 'suggesting' what they did. In spite of the doctor's suggestion, were the counsellors providing information on other available choices? Or, was the counselling based on the doctor's suggestion? Should the doctor's suggestion play such a big role unless it is life threatening for the woman? If all options are not being given to the woman and if the counselling is based only on the suggestions of the doctor, then it certainly goes against the principles of informed choice and decision-making.

Even the language used is suspect. Use of the word 'adamant' almost seems like the counsellor wanted the woman to agree to something that she did not want. As no background details were available, these cases could not be explored further. However this issue needs to be followed up.

Systematising the counselling

In 8 out of 12 observations and in 5 out of 8 tape recordings of counselling sessions, the counsellor was not systematic in giving information. The points at which information needed to be given, were bypassed. Later while filling the case sheet, the counsellor would realise all the information that she should have provided to the client. It may be useful to use little cards with cues so that information can be given in a systematic manner.

Use of IEC Materials

Material displayed In addition to the inputs given by the WCHP which are listed earlier in the report, some materials have been provided by the honorary doctor and are exhibited on the walls inside the Counselling Centre. These materials are: posters

of uterine prolapse, parts of the vagina, cervical cancer, foetal development and exercises during pregnancy.

In the waiting area of the OPD, there is information on availability and venue of various hospital tests and procedures, details of the roles of various staff in the OPD and clients' rights and responsibilities. Some illustrated posters have also been put up by the OPD staff – 'PRACTICES TO BE AVOIDED DURING PREGNANCY'. These are however in English and Hindi and not completely compatible with the backgrounds of majority of women who access ANC services in the hospital. For example, they instruct the woman 'DO NOT WEAR FOOTWEAR WITH HEELS', 'DO NOT TRAVEL TOO MUCH IN A CAR'

All the information and posters put up inside the OPD seem to be rarely read by clients. It maybe useful to explore reasons for this and look at alternatives.

As a support to the counselling and in addition to the existing posters, visual material about various health problems should be displayed in a more organised manner. Available material like '*Mahiticha Bageecha*' (Garden of Information) about reproductive and sexual health could also be displayed.

Aids used Observations in the counselling sessions revealed the use of

- a uterus model for MTP, CuT, TL
- poster on the wall on prolapse
- different contraceptives: pills, condoms, IUDs

Two of the trainees observed were not very comfortable in using these materials. For example, the model of the uterus held in the counsellor's hand was not clearly visible to the client. Further training or feedback could help upgrade their skills.

Materials about white discharge, exercises in case of proplase and all visual aids should be user friendly. i.e. the counsellor should be able to use them easily during counselling. This would improve the quality of counselling, and would also save time.

Pamphlets are presently available for very limited problems. It would be useful to source others so that they can be given to clients in addition to the counselling.

Language used There is need to review some of the words and phrases used by counselors. For example, in the case of MTP, in Hindi 'Hathyar' is used to signify the instrument used to do the MTP. 'Hathyar' is actually 'weapon'. Counsellors make a scraping sound 'khar khar' to describe the uterus being scraped in an MTP. The process should be described more sensitively so as to provide complete information and yet not frighten the client.

Review and feedback

During the period of the evaluation the supervisor was absent and no systematic review on quality of counselling was observed. In the absence of the supervisor the counsellors could provide objective feedback as a regular feature to the trainees so that they can improve their skills.

Daily peer group reviews to discuss the doubts, issues and difficulties/challenges faced and how they were resolved may also prove supportive.

Time taken for counselling

On observation clients waited between five to 40 minutes for counselling. Each session takes as much time as the client needs but this could be reduced by being more systematic and using available teaching aids. Almost 10 minutes is spent on recording the profile of the client.

Recording

Details of information of various family members if they stay with the client need not be taken routinely but in exceptional cases. The counsellors should be oriented about this. Recording the profile and background of the clients need not be completed at the beginning, as the client will wait almost 10 minutes before discussion on her problems begins.

Follow up

Scheduling appointments is very important especially in the absence of any outreach system in the client's area or community. Counsellors and trainees should clarify with the clients the timings of the services, range of services and explore possibilities for follow up visits. As mentioned earlier, except one male user who had been counselled on the day of the interview, none of the others were aware of services for men and neither were they aware that services are available in the afternoon as well.

Publicity about counselling services

The counsellors should without fail inform the client about the availability of services - when, for whom and for what - and suggest that he/she can access these services as well as tell others (family, friends and neighbors) about them. This is not being done. Most of the exit interviews with clients revealed that they did not know that services were available in the afternoon and also for men. One of the men had been counselled along with his wife but he did not know that a male counsellor was also available. Posters could also be displayed at the health posts about the counselling services.

Timings of the counselling services

For both men and women, timings should be displayed outside the OPD and in other waiting spaces in the hospital including at the entrance. Information to raise awareness about services for men should be displayed in the waiting area where a lot of men - partners, spouses, fathers, brothers, friends and other male members of the family wait for the women.

Counselling for men

Care should be taken to avoid perpetuation of gender stereotypes. It is important to remember that counselling for men should also be women-centred. One objective of WCHP is to increase male involvement and challenge continuously gender stereotypes, such as contraception is a woman's responsibility. For example, in one counselling session observed with a male client, the counsellor could have explored male contraception instead he provided the male client with information about contraceptives that his wife could use.

If counselling is provided separately to a couple, information given to both should be similar to avoid any conflicts. Confidentiality should be a part of the introduction and should be passed on without fail.

Accessibility

The majority of respondents felt that the counselling center was accessible in a limited way such as for clients coming to the Gynaecology OPD only. Some providers felt that it was not accessible to those referred from the health posts because users would not come only for counselling. The timings coincide with the timings of the OPD, but at present very few people are aware of the availability of such services. The number of clients to the OPD has reduced over the past year. A possible reason for this was user fees are being charged for various services provided.

Counselling services are not available to all who access the OPD. Who accesses the services is dependent on the referral by the doctors in the OPD. As a result almost all clients who access these services are referred by the doctors. Only clients coming for follow up visits, access it themselves.

Adequacy of counselling facilities

Range of Ob/Gyn issues for which counselling is available The topical range of training was based on a study of reasons for which clients came to the OPD. The counselling services include referrals for issues/problems that cannot be resolved at the counselling centre. There is a need to update referral information regularly and important that all counsellors are aware of the various referrals available.

Privacy The layout of the entire OPD was changed to ensure privacy. Privacy is available for clients, especially women, inside the OPD where the counselling centre is located. However, a private space is yet to be provided by the hospital for counselling men. Men's counselling is done in the waiting area outside the labour ward in the hospital, and a screen has been provided to ensure some privacy, but it is not sufficient.

Waiting time is dependent on the doctors, as they do the referral to the counselling centre. A few first-time users who were interviewed, reported that they had to wait for as long as an hour to meet the doctor and then they were referred for counselling which took about half an hour more. One woman said that she went for counselling because the doctor told her to, even though she was very late for other personal work. She was happy that she had gone for counselling as it was very useful and the next time she could go directly to the center if she needed any information.

3. Perceptions of Health Care Providers

This section outlines the salient feedback received from the Gynaec OPD staff members, the counsellors and the WCHP team members. Detailed feedback from each category is given in Annexure 3.1

Fifteen interviews were conducted with health care providers as mentioned in Table 2. Majority of the providers shared that the main purpose of the counselling centre was to provide information to the clients who access the Gynaecology OPD. One honorary doctor felt that the purpose was to improve the quality of services. He stated that health care providers are experts at providing clinical care but lack humane interaction skills for providing information which the counselling centre provides.

Of the fifteen persons interviewed about 7 said that the purpose of the counselling was to 'motivate' clients for MTP/TL. One doctor said the main objective was to 'convert' clients opting for Medical Termination of Pregnancy (MTP), Copper-T to MTP- TL (Tubal Ligation). Counselling according to another doctor was also useful 'to promote something and make it look like her choice'.

Counselling services are very useful. They facilitate better communication between the patient/client and the provider. As a result of such services clients are more satisfied, there are fewer complaints and communication has improved. Earlier the doctors were unable to spend so much time with each patient to provide them with information, clarify their doubts etc.

—Medical Superintendent, VND Hospital

Almost all the providers, both medical and paramedical, said that having the centre was very useful because it has reduced their workload. Providers also felt that the center was useful

- Useful for clients as the counselors use 'the cafeteria approach' providing patients with information about various options
- Useful as it educates the client and reduces her fear and prepares her for clinical/surgical procedures

All providers perceived changes in infrastructure and layout of the OPD. This, they felt improved the client-flow in the OPD and reduced the chaos and confusion. The change in layout has created space for counselling and increased privacy for clients for physical examination and counselling.

Bimonthly meetings of providers associated with the Gynaec OPD were one way of monitoring the counselling services. Providers felt that these meetings were very useful for discussing difficulties faced in counselling and giving feedback to each other. However, two of the doctors were concerned that the discussions in these meetings were not objective and were biased against doctors.

A suggestion box was placed in the OPD to receive feedback from the clients. Some of the doctors felt that the feedback notes were not being placed there by the clients but by the counsellors. The Honorary Doctors and the Medical Superintendent felt that this box should be continued as should the bimonthly meeting.

Referrals to the counselling centre are done only by the doctors. The doctors refer clients mainly for MTP TL, MTP Copper T, Hysterectomy and prolapse. The various reasons for which clients were referred are clearly listed on the board in the OPD.

The clients on follow up visits and those seeking routine information about the hospital are the ones who are self referred. One honorary doctor suggested that the present system of referral should be reviewed and if necessary changes could be made.

Problems and Limitations The doctors felt that there is a shortage of time in the OPD with patients, they had no time to explain to patients. They felt that they ended up doing a lot of the OPD sister's work like guiding patients, telling them about routine procedures and talking to the patient's husbands (because they feel that the women are not able to understand.)

Some discomfort was caused because of the counselling services. This was because of the different approaches of the counsellors and doctors respectively. One doctor felt that while the counsellors focused on the 'social' the doctors emphasised the 'medical' issues, causing differences and sometime friction. The relationship between the counsellors and doctors (RMOs), was not the best which also caused discomfort.

The RMOs felt that there was not enough appreciation for their work and heavy workload because of shortage of staff. They also felt that the present full- time counsellors were Public Health Department ANMs. Being from the same system they felt subordinate to doctors. They therefore cannot liaise with BMC, doctors etc.

Counsellors are not sincere in counselling ANC patients. They do not stick to timings. They kick up a fuss and make patients emotional by interfering in everything and overreacting to situations. A woman fainted (on the day of the interview) the counsellor overreacted causing the woman to feel as if something major had happened.

Resident Medical Officer

Providers' recommendations

The health care providers interviewed recommended that

- Counsellors should be accepted as an integral part of the OPD team. The OPD staff must involve the counsellors more so that they feel motivated and their work could improve. The suggestions/opinions of counsellors should be welcomed. Involving the counsellors can also be done by including their work (i.e. number women and partners counselled) in the reports of the OPD
- If the counsellors do not understand some aspect of the diagnosis and treatment given by the doctors, they could approach the doctor. The doctor can then explain to the client in the presence of the counsellor so that the counsellor would also understand.

- The referral system should be reviewed in the future to see if any change is required.
- A prominent sign should be made on the counselling centre. The doctor who can then refer to this sign when directing the patient (clients get confused when asked to go to the last door of the OPD).
- Communication between the patient, doctor and counsellor should be more organized so that follow up is more effective. The counsellor should clarify and / or brief the doctor about any important aspects and vice versa.
- Interpersonal feedback between the doctors and counsellors should be given directly and confidentially rather than at review meeting.

The trained ANMs and MPWs could continue to provide counselling in the hospital. The Auxiliary Nurse and Midwives (ANMs) and Multipurpose Workers (MPWs) would be better at providing these services. The social workers usually lay more stress on social factors of health problems while the ANMs /MPWs usually stress/balance both social and medical factors.

Honorary Gynaecologist, VND Hospital

Feedback of Counsellors

Two ANMs from the Public Health Department, on a working arrangement with the WCHP, have been trained as counsellors and are the fulltime counsellors at the center. Each of them provides counselling three times days in a week at V N Desai Hospital. They participated in the 4-day counselling workshop but have prior experience of counselling through the earlier PID project. These two ANMs were interviewed. The two counsellors had been working in the counselling centre for almost a year.

One counsellor said that the training workshop on counselling was not sufficient and regular updates and follow up training should be conducted for counsellors.

The counsellors remarked on the changes that they noticed in the OPD staff. Earlier ayahs and sisters were very rude. Now there was some change may be because of the presence of counsellors. There were changes in attitude of MPWs who come for training. In the beginning some were disinterested and had come for the practical training only because they were duty-bound. But within a few days, few of them became interested and were quite sincere in their role as counsellor.

The counsellors felt that feedback from the supervisor helps improve quality of counselling. According to them the review meetings were useful because some

important decisions were made to improve the quality of services but there was not sufficient follow up.

A major obstacle according to the counsellors was the difference in perceptions of objectives of the centre and role of counsellors. Clients are sent to the counselling centre by the doctor to be 'motivated' to accept a certain procedure, while the counsellors believe that they should provide client with choices. This causes discomfort and differences in the OPD between doctors and counsellors. Doctors continue to expect the counsellor to counsel clients as per the decision of the doctor and not in a client centred way.

The counsellors felt that they were expected to play a larger role in the OPD other than counselling. Sometimes the doctors blame them if the client does not have their case records. In some instances the doctors expect the counsellors to manage the client-flow in the OPD and maintain discipline – which are actually the responsibility of the OPD nurse.

If clients come to the centre for counselling on their own, without being referred by the doctor the counsellors have to send them to the doctor because they are supposed to counsel only those referred by doctors based on their diagnosis. They were not too happy about this.

The suggestion box is a useful mechanism according to the counsellors, but they felt that the doctors do not accept the feedback in an objective manner.

English terms used by doctor in records are not always understood by the counsellors. 'We do refer back to the doctor now, earlier we were diffident about approaching them.'

The counsellors recommend the following to improve the quality of counselling

- Review meetings should continue and Hospital Administrators like the MS should participate in these.
- Regular debriefing and follow up should take place for counsellors so that they can clarify doubts and upgrade their technical knowledge
- There should be supervision and constant feedback so that the counsellors feel motivated and interested
- A separate room is required for counselling for men so that there is privacy.
- More IEC materials should be made available to support counselling

One fear expressed was that the BMC/Hospital system would probably perceive counselling services as additional work and give it low priority. The quality of services would then suffer

Feedback of Trainee Counsellors

Four MPWs and five ANMs from various health posts in the two wards participated in a FGD. One ANM was interviewed individually. All of them had undergone the four-day counselling training followed by the 15-day practical training at the counselling centre. The FGD and interview was conducted in V N Desai Hospital with the objective of receiving feedback from this group about the quality of counselling, their experiences as trainees in counselling, sustainability and replication options also in the health posts and recommendations for improvement

Counselling training The group felt that the four-day counselling training was not sufficient especially to upgrade technical skills. The practical training at V N Hospital was useful. Though there was constant support, it was unnerving to provide counselling after just 4-days of training.

The training had also challenged their attitudes and had resulted in changes in themselves. They strongly recommended that the entire staff of the hospital should be given such training to sensitize them.

Quality of services Group members felt that one limitation was that the counselling services were provided in isolation of other prerequisites for quality of care. e.g. Copper T would not be available at the Health Post, or the doctor would not be available to insert it, or if the staff in the OPD came late, patient would have to wait long.

Replication in health posts The ANMs and MPWs felt that the counselling services cannot be replicated in the same way in the health posts because of

- Lack of infrastructure in health posts and resultant lack of privacy
- Large number of clients at the health post and not enough time with each person
- Referrals from the health post to the hospital only for counselling was felt not very practical as clients would not go only for counselling services to the hospital

Feedback of WCHP Staff

Three WCHP team members were interviewed. According to them the purpose of the counselling services was to help clients to make informed decisions about various aspects of their health.

And also to provide a private space where the clients can clarify their doubts and receive guidance about the various procedures to be followed in a hospital. The WCHP staff felt that the counselling services are very useful and should be continued.

Recommendations of WCHP

- Orientation of RMOs regarding counselling services needs to continue. The honorary doctor, supplemented by inputs on RH, Gender and Rights, presently does this
- RMOs are very crucial to counselling services and quality of care in the OPD. It is important to work closely with them, as we have to deal with them on a day-to-day basis
- Case records of counselling should continue to be maintained. These records form the basis for training needs of counsellors
- Supervision is required. This is especially important if ANMs and MPWs or OPD nurses are going to function as counsellors. Therefore a system should be put in place so that there is a smooth transition and the quality of services is not compromised. This supervisor may have to play the role of the present supervisor and coordinator which includes maintaining monitoring the counselling and coordinating between the OPD and counselling services
- Re-clarifying the role of the OPD nurse, and necessary training should be given to sensitize her/them
- Review meetings may be continued in the same way, facilitated by the honorary doctor

Final Comments of the Evaluator

During the course of the evaluation, the persons interviewed raised several issues and I have discussed a few of these issues either directly or indirectly earlier in this document. I summarise them here with recommendations wherever possible.

The meetings and discussions with users, providers and counsellors reflected the usefulness of the counselling centre and improvements in the quality of care as a result of the counselling centre. They also reflected the efforts and the perseverance that was required by the WCHP staff in providing these services and that will be required by those who will be sustaining the centre.

The two full time counsellors at the counselling centre – ANMs of the Public Health Department - are very skilled and form a strong counselling duo which can be continued.

Access to information is limited for most women. Without the counselling centre, accessing accurate and gender-sensitive information related to reproductive and sexual health would be next to impossible. There is great need for these services in this hospital, in other hospitals and also in health posts.

There are several questions around the location of the counselling centre: should the centre continue inside the OPD? Can the counsellors function more independently outside the OPD? Will certain behaviours, attitudes, practices and systems in existence not continue if the counselling centre is not inside? Will the centre be able to manage the numbers, as it will be free accessible to all women coming to this OPD as well as from other OPD? It may be difficult to refuse information to any woman, especially as there is such a lack of it and there are no alternative services in the hospital. Will we then be able to manage the numbers of clients? What was the original objective of having it inside? Was it privacy? Was it also to make the counselling services an integral part of the Gyn OPD? Some of the accountability and review mechanisms may not be relevant if the counselling centre is outside the OPD.

Client's empowerment, informed choice and decision-making, were not perceived as the objective of the counselling centre by most of the Gyn OPD health providers. The younger doctors refer to the women as illiterate, incapable of understanding anything or making decisions. The centre's purpose was perceived as a support to the doctors, as they had very little time to talk with patients due to large numbers of people visiting the OPD. The counsellors were expected to 'motivate' the client to adopt family planning and other procedures that the doctor suggested and this caused friction and discomfort between the doctors and counsellors. Since the RMOs play a crucial role in the OPD and they are the doctors that the clients and counsellors interact with on a day-to-day basis, efforts must be made to build their perspectives. They are young and some maybe open to learning and change. Clients' right to information has to be respected and the RMOs must repeatedly be told this.

Counsellors are in an extremely stressful situation in the counselling centre. They have to constantly negotiate with and, if necessary, challenge the Gyn OPD health care providers. The full time counsellors as well as the trainees are ANMs/MPWs who are at the lowest levels in the health system hierarchy. The doctors as well as the ANMs are conscious about this and this is reflected in their interaction and communication. The ANMs are hesitant about approaching the doctors, neither are the doctors very approachable. The doctors sometimes expect the counsellors to do the work of the nurse or the attendant. Mechanisms such as the suggestion box and regular staff review meetings should be used to clarify issues regarding roles and expectations.

Ethical Issues

The counsellors face ethical dilemmas in the course of the counselling. For example, in the situations like patients complaining about perceived doctor's negligence, what

position should the counsellor take? She may need to probe further and then refer the patient to hospital management. Grievance redressal measures for patients should be set up and followed.

One instance of violation of the client's rights was observed during the evaluation. A woman whose husband was opposing her MTP was told by the counsellor that she would need the signatures of the husband and mother in law. The counsellor later explained that the doctor had said that the signature of the husband was needed for his, the doctor's protection, in case the husband came around to complain in the future. The counsellor / supervisor did not challenge this issue. Are we being too careful and compromising on such issues? Even before the project comes to an end it maybe necessary to have a committee comprising of persons who can oversee that the systems and quality that have been initiated will be continued.

Counselling Services for Men¹

During the process of the evaluation, I had the opportunity of observing only one MPW-trainee. Counselling for men was being done in a temporary structure consisting of a screen and couple of chairs, outside the OPD. The number of men who accessed the counselling services was very limited. There was no male counsellor for a period of 2 months. Awareness about the counselling services among OPD patients and their partners was also low. The MPW trainee counsellor was not keen on proactively doing awareness raising, as a result some of the men who would otherwise have done so, did not access the services. Counselling by trainees not should be continued without supervision and feedback.

Male counsellors or others who counsell men should be particularly sensitive to the fact that they don't reinforce men's decision making about women's reproductive health and choices.

Male Counsellors are being accessed by partners of women coming to the Gyn OPD and also by other men visiting other OPDs. This aspect of the counselling centre needs to be strengthened by providing private space, and supervision and feedback for the male counsellors².

Any man can access counselling services, whereas only women referred by the doctor can go to the counselling centre³. The free access to men and the limited access for women reflect the existing social paradigm. Is this going to be disempowering for women? In unequal gender relationships, will the information given to the men be shared with the woman and will it facilitate informed choice and decision-making for her ?

Should the counselling services available to men who visit other OPDs be restricted to RH and sexuality issues or include other medical issues as well? For the present, we suggest that the services should be restricted to RH issues. The limited range of health conditions in itself is a challenge for building up the counsellors' capacities.

Accessibility

All patients do not have the right to go to the counselling centre unless referred by the doctor, who decides which client needs counselling. This limits the clients' access to the counselling centre and their right to information. This system needs to be reviewed and changed so that more people for a wider range of RH issues, can access the centre³.

Sustainability Issues

There were several recommendations on who could be the counsellor, supervisor and coordinator of these services. Of the various options, the OPD sister along with one ANM on a rotation basis would be most sustainable. Ideally the OPD sister's counselling should be closely monitored for a period of a year. She may have perspectives which may need to be challenged before she can be a full fledged counsellor at the counselling centre. Another option that was suggested was rotation of all OPD sisters. This will also require monitoring and feedback for ideally a year by the project staff. ANMs and MPWs can continue on rotation but for a longer time than 15 days. Being a counsellor involves not only counselling but liaising with the doctors and other staff. Therefore 15 days maybe too short for someone to be able to do that. Approximately 6 months would be good.

Some respondents felt that frequent rotation of counsellors would prevent rapport building. This may be true to an extent, however correct management of the client and explanation for changes in counsellors may not reduce rapport.

There should be some screening of ANMs and MPWs to see their interest and screening for technical skills and knowledge. These will have a bearing on the quality of counselling.

Another option is to continue with the present counsellors and coordinator who are BMC staff and very skilled.

IEC Materials

Clients were not reading IEC materials inside the OPD. This maybe because they are not literate enough to read the notices. Maybe the print is too small. While sitting inside the OPD the clients seem on edge. They are not relaxed and are just waiting

to see the doctor. The counsellors could orient the clients to the information put up on the displays board and encourage the clients to check the display board from time to time.

Establishing a counselling centre with an emphasis on gender and reproductive rights perspective, in a bureaucratic public health system has not been an easy task. Along with obtaining administrative sanctions, changing the mind set of administrators and providers posed many challenges. In the next chapter we discuss the challenges faced and the lessons learnt.

End Note

1. Male trainees were posted as counsellors at the counselling centre after the training. Since September 2003 male trainees have not been posted because of lack of interest by some trainees. In the initial phases a trained psychologist appointed by the project monitored the quality of counselling of male and female trainee counsellors. Some male trainees were not comfortable with a woman supervisor monitoring quality of their counselling. In the later phase only ANMs staffed the counselling centre. ANMs and MPWs were both uncomfortable with the idea of ANMs supervising MPWs.

Because of all these reasons the practice of placing male trainee MPWs as male counsellors, was discontinued till an alternative feasible system is identified.

2. Recently a separate room has been allotted by the hospital for counselling men.
3. This practice was reviewed and modified. Currently all women clients who have provisional diagnosis are counselled irrespective of referral status.

7. CHALLENGES AND LESSONS LEARNT

Challenges

- Health policies that emphasise population control prevent providers from offering choice of contraceptive methods. This results in distorted communication and dissatisfaction of the clients
- Belief of some individual providers that women are incapable of understanding technical information and decision making prevents them from giving complete information to the patients
- The change of RMOs every six months requires repeated process of rapport building, orientation and working together for patient satisfaction. This requires a lot of energy and can result in burn-out in the counsellors. Individual styles of communication and attitudes of RMOs also take longer to address
- Giving patients space to discuss their dissatisfactions and encouraging them has resulted in clients talking about perceived negligent behaviour of providers. The counsellors find themselves in a difficult position. With the limited awareness of official redressal system they are faced with a dilemma. Should they refer the aggrieved patient to higher authorities? Or to any medico-legal bureau or consumer court?
- Doctors and professionals from social science backgrounds operate from different perspectives. Both need to learn from and accept viewpoints of each other. Sometimes the perspectives become huge barriers to dialogue and discussion. Also perceived hierarchies of roles - doctors are 'higher' than social workers, ANMs/ MPWs are much 'lower' - is a huge barrier to two-way, problem solving communication and team functioning
- Providing the right counsell based on ethical and rights perspective to women at the counselling centre may not be in line with the decisions taken (or promoted) by the doctors. This can result in conflict between doctors and the counsellors. These issues need to be discussed with an acceptable third party like an NGO and / or an ethics committee of the hospital
- The role of the medical social worker in the hospital needs to be reviewed and redefined to address issues like client-provider communication. With their training and experience they can co-ordinate initiatives like the counselling centre so that they can be sustained and institutionalised

Lessons Learnt

- It is important to involve all the providers in the change process and make them partners in the process. The honorary gynaecologists, medical superintendent of the hospital, RMOs and the other staff of the OPD were involved at every step of the planning and introducing new interventions

- The implementation of the proposed counselling centre and introducing other quality assurance mechanisms was possible only because of the co-operation from both the medical superintendents. The WCHP team had developed a relationship of trust between the project and the hospital. The administrators were assured that the data would be kept confidential and not misused in any way
- Having enthusiastic, sensitive, open and quality conscious honorary clinicians at the OPD is an important factor in success of this initiative. They are the role models for the RMOs. Involving honorary clinicians as team members helps in facilitating the change process eg. honorary clinicians at the V.N. Desai OPD have shown initiative in continuing the process of regular orientation to the RMOs and conducting staff meetings
- Making changes in physical structure, providing space for every provider, providing furniture, curtains etc. are essential supporting features for motivating providers to improve communication. Working only on the client-provider communication without addressing system related issues would have not worked. It is also an indication of looking at quality from provider's perspective
- The RMOs play a crucial role in the OPD and improving Client-Provider communication. They are young and some may be open to learning and change. Orientation, support from their honorary clinicians, creating space for them to express their problems, acknowledging their limitations, has helped in getting co-operation and support from them in giving better services to the patients
- Observations, initially perceived as threatening were later accepted as an important feedback tool for the RMOs to improve their communications. Good communication, they said would also help them in their private practice
- Demonstrating belief in a woman's ability to understand, providing her complete and accurate information in simple language, and with patience, as is done at the counselling centre improves client provider communication
- Regular staff meetings provide a platform for discussion on issues of quality of care, concerns and problems of providers, interpersonal problem solving and co-ordination with other departments of the hospital and the administration

In the next chapter we will talk more specifically about the sustainability and replication issues and recommend ways to address them

8. RECOMMENDATIONS FOR SUSTAINABILITY AND REPLICATION

Almost all the persons interviewed felt that the counselling services initiated in VND Hospital should be continued. The providers, trainee counsellors and WCHP staff made suggestions on how the services could be sustained and replicated and who could provide these services in the future.

Suggestion for Sustainability and Replication

Suggestions for **sustaining the existing counselling services** in VN Desai Hospital are summarised as follows.

Table 8 Sustainability and Replication – a Summary

Recommendation	Suggested By
Organisations like Rotary and Lions clubs could be approached to provide financial support or even provide volunteers/counsellors Others like retired volunteers-retired persons and women who are not working elsewhere can be trained. No staff can be recruited due to ban on recruitment. No one from hospital can play the role as workload is heavy.	Present Medical Superintendent
BMC should provide a counsellor – ideal situation. Another alternative is MSWs who can be trained in clinical aspects for counselling.	Ex Medical Superintendent
Trained ANMs and MPWs on a rotation basis would be best suited as they would be able to bring a balance of medical and social aspects to counselling. It is necessary to have someone who could supervise ANMs and MPWs. Trained counsellor who has knowledge of counselling and technical knowledge required for the OPD.	Assistant Honorary Doctor Honorary Doctor
Present counsellors who are also BMC staff can continue. It maybe possible for an OPD 'sister' to continue on condition that she has to play only this role. It is not possible to manage OPD and counselling.	OPD Nurses and Labour ward sister
Trained OPD nurse/sister. Continue present counsellors. Trained counsellor from outside (example: The present supervisor who is a postgraduate in psychology)	RMOs
Trained ANMs /MPWs on rotation. (One counsellor was against rotation. Felt trained ANM/MPW should be separately appointed for this work). Present system can continue	Counsellors

Recommendation	Suggested By
Supervision should be done by outside staff, cannot be done by present counsellors. Community Development Officer can also supervise	
Rotation of ANM/MPWs but 15 days too short. Rotation, according to some, works against rapport building with clients. Trained ANM/MPW can be permanently placed as counsellors Community Development Officer could provide supervision	Trainees-ANMs and MPWs
Present counsellors can continue with trained ANMs/MPWs for 3-6 months on rotation to prevent burnout. Monthly supervision could be done by Ward CDO and coordination by Family Welfare DHO, Hospital or by H east ward. Three BMC project staff who are on a working arrangement can continue Gynaecology ward sister to provide counselling	WCHP staff and Project Coordinator (AHO)

Review Meetings

It was recommended by all categories of persons interviewed that the review meetings should continue and the honorary doctors who are facilitating the meetings could continue to do so. The honorary doctors agreed that this was possible, but the frequency of the meetings could be reduced.

Replication

About **replication of counselling services** also the respondents had many suggestions.

- Counselling can go beyond the Gynaecology OPD and be replicated in all OPDs of V. N. Desai Hospital
- The counselling centres should be replicated in 'big' hospitals where people come to access such services
- Counselling services can be provided in the health posts, especially where there are Gynaecological clinics. These clinics function on specific days and the trained ANMs and MPWs of that particular health post can take turns to provide counselling and manage the clinic
- Counselling for men should be open to men coming to other departments for non RH problems. Right now most counselling for men is about the wife (or the woman with whom he has come) or for infertility

However several issues were articulated as needing to be addressed for the replication of counselling services in other hospitals and at the health posts

How can the replication be done?

- Replication in other hospitals can be done through similar GO-NGO partnerships
- Replication could also be initiated through partnerships with other hospitals
- About 50 ANMs and MPWs were trained in counselling so that they would be able to replicate the services in their respective health posts and provide counselling in V N Desai Hospital on rotation. Of the 50, not all may be interested in providing counselling services
- Interested ANMs and MPWs could be sent for further training in counselling and placed in hospitals where such services maybe replicated

Other issues in replication

- The cut back in resources by the Health Department has prevented the possibility of recruiting someone from outside to do the counselling or for supervision. It also rules out the possibility of incurring expenditures that may be required for replicating services
- The ban on recruitment of personnel will increase the burden on existing overworked staff if counselling services are introduced in all facilities
- For restructuring the space in the hospital and for small reconstruction and civil work, permission is required from higher levels. Lack of decentralisation and independence results in a loss of interest and motivation for hospital level administrators. Independent decision-making is not possible at the hospital level without referring to higher officials, causing delays
- Quality of services: In replicating counselling services will the quality be assured? Who is to ensure that the quality and the perspective that the project has tried to introduce will be maintained? This point becomes critical especially in light of the providers' perspective with regard to a client's rights to information and decision-making and the gender dimensions of RH

WCHP's Perspective

Discussion on the issue of sustainability is of the prime importance to the Women Centred Health Project. At the end of the project period it is necessary that the counselling services continue and the hospital establishes systems to institutionalise the counselling centre. WCHP's efforts in institutionalising the services have resulted in the hospital administrators taking responsibility for organising the staff meetings. Also, the honorary gynaecologist has agreed to continue the facilitation of the review meetings and to orienting the new batches of RMOs. But questions of staffing and supervision of the centre are not resolved yet. The project staff have been given permission to continue for the next six months till systems for the hospital to take over the monitoring and supervision are worked out.

WCHP has identified certain contextual factors within which specific recommendations are being made. The box lists some of these administrative and policy level barriers.

Box 15: Administrative and policy level constraints

- Because of stagnant and decreasing budgets in BMC, there is no possibility of hiring trained personnel. As a result, the existing staff in the hospital will be burdened by extra responsibilities
- The six monthly turnover of RMOs means that the process of sensitising them to the counselling and communication intervention is continuous. By the time one batch is oriented it, is time to start all over again with the next batch. Similarly BMC officials have to be continuously sensitised /oriented to the project interventions. With frequent transfers the process has to start over again
- The system does not give importance to small pilot projects even if they can easily be upscaled. For example, the present intervention of just restructuring the space in the OPD can lead to improvement in client – provider communication and does not require major expenditure. This kind of upscaling can easily be done in other OPDs and other hospitals

Recommendations of WCHP for Sustaining the Counselling Centre

Awareness of services

- Awareness about the counselling services can be increased by informing the Registration Assistant (RA) and by convening a meeting of all staff in the hospital

Sustainability

- All OPD nurses could be trained and placed as counsellors on rotation
- The post of the Community Development Officer should be revived in the hospital. This person can then supervise the counselling
- Present counsellors can continue for 3-6 months but there should be alternatives for rotation to avoid burn out
- All trained ANMs and MPWs maybe placed as counsellors on rotation. Screening should be done for those who may not be able to cope mentally because of personal issues
- Extra allowance or incentive can be offered to these ANMs and MPWs for the period that they work as counsellors
- Present counsellors and coordinator, who are all from the Public Health Department can continue

Systems and procedures

- Orientation of RMOs regarding counselling services needs to continue. The honorary doctor, supplemented by inputs on RH, Gender and Rights, presently does this
- RMOs are very crucial to counselling services and quality of care in the OPD. It is important to work closely with them, as counsellors have to deal with them on a day-to-day basis
- Case records of counselling should continue to be maintained. These records form the basis for training needs of counsellors
- Supervision is required. This is especially important if ANMs and MPWs or OPD nurses are going to function as counsellors. Therefore a system should be put in place so that there is a smooth transition and the quality of services is not compromised. This supervisor may have to play the role of the present supervisor and coordinator which includes maintaining monitoring the counselling and coordinating between the OPD and counselling services
- Reclarifying the role of the OPD nurse and necessary training should be given to sensitize her/them
- Review meetings may be continued in the same way, facilitated by the honorary doctor

TOOLS

T- 1.1

Orientation Package to Sensitise Resident Medical Officers

(Suggested outline)

Background

As a part of their academic requirements, students pursuing a postgraduate degree or diploma in obstetrics and gynaecology from municipal medical colleges are posted at peripheral hospitals as Resident Medical Officers on a six months' rotation. These RMOs play a key role in improving the quality of services provided through the outpatient clinics at peripheral hospitals as well as ensuring the smooth functioning of the counselling centre established within the outpatient clinic. It was observed that the content and quality of orientation package contributed to the RMOs' acceptance of the system at the outpatient clinics.

This guideline for orientation was developed to assist the honorary doctors in familiarising newly posted RMOs to the process that resulted in the present system with the counselling centre, as well as the functioning of the counselling centre and their role in the outpatient clinic.

1. Is this outpatient clinic different? Why? How?

Expected Answers

- IEC material displayed
- Roles of providers displayed
- Cleanliness
- Counselling centre

2. How did it happen?

(a) Observation study: In 1999–2000 a study was conducted to document client–provider communication at the gynaecology outpatient clinic of a secondary hospital. Fifty instances of client–provider communication were observed and documented to identify issues affecting quality of care.

The findings of the study were

- Disrespectful behaviour — during consultation and PV
- Unmet information needs
- Lack of privacy
- Stress among providers
- Men excluded from consultation process

(b) Feedback was given to the providers: providers stated that communication with clients is affected because of following factors:

- Providers not aware about the quality of their communication with patients
 - Individual traits
 - Layout
 - Lack of coordination among team members
 - Other administrative issues like inadequate number of doctors and nurses resulting in a large number of clients per provider
 - Difficulty in communication with illiterate patients — language and cultural barriers

(c) Suggestions for improvement: Following the discussion on factors affecting client-provider communication, the clinicians, nurses and attendants at the gynaecology outpatient clinic were asked to suggest ways to bring about improvement in the same. Key suggestions were:

- Feedback to providers about their communication style should continue (both positive and negative)
- Patient flow management
- Resources, e.g., curtains, seating arrangement, etc.
- External counsellors to assist
- Need to establish dialogue with administration to solve problems
- Coordination and communication between providers should be improved

(d) Interventions by WCHP: Interventions were planned on the basis of findings of the observation studies, factors identified by providers and the probable solutions suggested by them for improvement in client-provider communication. These interventions included

- Changing the layout of the gynaecology outpatient clinic at V. N. Desai Hospital
- Establishing a counselling centre at the gynaecology outpatient clinic
- Male counsellors
- Clarifying and displaying the roles of each team member across all cadres
- Holding monthly/bimonthly meetings for problem solving
- Feedback continued to every batch of Resident Medical Officers (RMOs)
- Suggestion box for clients and staff

- IEC material
- Health education sessions for ANC patients
- Orientating the team (Resident Medical Officers (RMOs), nurses and attendants to newer systems introduced in the outpatient clinic, thereby ensuring ownership
- Introducing a token system to streamline the flow of clients

3. All these interventions were based on the principles of 'Quality of Care' (QoC). So what is QoC? What is 'quality' service?

Quality Service

- Giving more than client's expectations
- Subjective - can mean different things to different people

<i>Different points of view on 'quality'</i>		
<u>Clients' perspective</u> Getting what the patient/client expects from health services	<u>Health care providers' perspective</u> Whether services meet the needs as defined by professional standards	<u>Administrators' perspective</u> Most efficient and productive use of services

4. Elements of Quality of Care : Nine elements of Quality Framework proposed by Judith Bruce

Generic Elements	Service Specific Elements
<ul style="list-style-type: none"> • Service environment • Client-provider interaction • Informed choice • Information on services • Women's participation in management 	<ul style="list-style-type: none"> • Access to services • Equipment and supplies • Professional standards and technical competence • Continuity of care

5. -Evaluation of Intervention

In July 2003 (18 months after the counselling centre started functioning), the counselling centre was evaluated by an external evaluator. Twelve clients and 15 health care providers who were posted at the gynaecology outpatient clinic at the time of evaluation were interviewed. Interviews were also conducted with six ANMs and four MPWs who had earlier been posted as counsellors at the counselling centre. Four women who had sought the services of the gynaecology outpatient clinic but had not been referred to the counselling centre were also interviewed.

The objectives of evaluating the counselling centre were

- To assess client satisfaction with the counselling services provided at the centre
- To explore providers' perspective on counselling services

The findings of the evaluation were:

- Except for one RMO, all doctors found the counselling centre very useful because it reduced their workload
- Patients were better prepared for surgical procedures and better informed about hospital procedures because of the guidance they received at the counselling centre
- Clients were satisfied with the services provided by the centre.
- Feedback from Suggestion Box in the outpatient clinic reflects on quality of services provided through this clinic and the counselling centre. This could be a means of regular monitoring

6. Expectations from Resident Medical Officers (RMOs)

- Understand your role and the roles of other team members.
- Work as a team with the counsellors
- Be conscious of the quality of care provided

Specific activities

- Self-administrated checklist for communication (see T-1.5)
- Referrals to counselling centre
- Observation and feedback to counsellor
- Provide technical information to counsellors
- Documentation and discussion of cases if there is a difference of opinion between counsellor and doctor

7. Principles of counselling

Definition: Exchange of information as a means of clarifying and resolving problems, enabling the client to make decisions for planned action.

Components of Counselling	
<ul style="list-style-type: none"> ● Establishing rapport ● Listening and questioning ● Discussion 	<ul style="list-style-type: none"> ● Obtaining information ● Giving information ● Decision making
Errors in Counselling	
<ul style="list-style-type: none"> ● Directing ● Moralising, preaching ● Denying client's feelings ● Breaking confidentiality 	<ul style="list-style-type: none"> ● Labelling ● Giving false reassurances ● Encouraging dependence ● Interrogating
Counselling Skills	
<u>Macroskills</u>	
<ul style="list-style-type: none"> ● Clarifying ● Empathising ● Summarising 	<ul style="list-style-type: none"> ● Asking open-ended questions ● Giving reassurance ● Recapitulating
<u>Microskills</u>	
<ul style="list-style-type: none"> ● Paraphrasing of content ● Appropriate use of silence ● Confrontation 	<ul style="list-style-type: none"> ● Reflection of feeling ● Focusing

3. Details of Referral

Date	Reason for referral	Referral Centre

Specific Information Needs Expressed by the Client, Client's Husband and Relative

Queries asked	Remarks

Discussion with Clinicians if any

Skills used

Problems faced by the guide

T-1.4

Observation Checklist for Monitoring Client-Provider

Communication

DURING CONSULTATION

Place: _____

Post of Observer : _____

Time: _____

Post of observed: _____

Date: _____

This observation checklist can be used to observe the following providers

- 1) FTMO - at the immunisation camp and while attending Cu-T cases
- 2) MO-PPC (Paediatrician) - at the paediatric outpatient clinic
- 3) MO-DISP - at the daily outpatient clinic
- 4) MO-Mat. Home - at the ANC and gynaecology outpatient clinic
- 5) PHN - at the immunisation camp

DATA ABOUT CONDITION

(Check case paper)

A) Problem presented by patient _____

B) Did the patient come for the first time with this complaint Yes No

COMMUNICATION

1. Did the provider look at the patient when he/she entered? Yes No

2. Did the provider ask the patient to sit? Yes No

3. Was the provider seated in a way that would allow her/him to carry out physical examination of the patient and that the patient would be comfortable? Yes No

4. Was the provider polite to the accompanying person? Yes No N.A.

a). If no, how was the behaviour? _____

b). Why? _____

5. Did the provider respectfully ask the accompanying person to wait outside in cases where privacy was required? Yes No N.A.

5 a If no, specify what happened? _____

6. Did the provider address the patient by name? Yes No

7. Did the provider ask any question about the patient's complaint? Yes No

(a) If yes, what questions were asked?

(b) Did the provider ask her patient if he/she has any other problems/complaints? (in addition to the current problem) Yes No N.A.

8. If the provider interrupted the patient, were the interruptions appropriate? Yes No N.A.

9 a. Was the provider listening in an attentive, interested way? Yes No N.A.

9 b. Give reasons for your answer in 9a. _____

10. Did the provider ask the patient whether she/he had any question? Yes No

11. Did the provider answer the question asked by the patient? Yes No N.A.

Examination

12. Was a physical examination done? Yes No N.A.

13. If yes, specify the nature of the examination.

14. Was the provider talking in a friendly and reassuring manner while conducting the examination? Yes No N.A.

Internal Examination (Gynaec. Problems)

15. Did the female attendant or nurse who positioned the patient for internal examination politely explain about it to the patient? Did the female attendant/nurse giving Gynaec. position explain to the patient politely? Yes No N.A.

16. Did the provider explain the PV procedure to the patient? Yes No N.A.

17. Was the patient hurriedly made to lie down? Yes No N.A.

18. Was the patient given time to prepare (untying, loosening clothes) for the examination? Yes No N.A.

- | | | | | |
|-----|---|-----|----|------------|
| 19. | Were the legs of the patients covered with a sheet during the examination? | Yes | No | N.A. |
| 20. | Was the woman rushed into getting up from the examination table? | Yes | No | N.A. |
| 21. | After the patient was positioned for examination, how much time elapsed before the doctor examined her? _____ minutes | | | |
| 22. | Was the PV done in a careful, gentle way? (to be judged by the reactions of the patients) | Yes | No | Don't know |

Before the Patient Leaves the Counselling Room

- | | | | | |
|-------|---|-----|----|------|
| 23. | Did the provider explain the | | | |
| | - Diagnosis | Yes | No | N.A. |
| | - Treatment | Yes | No | N.A. |
| | - Need and importance of investigation | Yes | No | N.A. |
| 24. | Did the provider ensure that the patient had understood the instructions? | Yes | No | N.A. |
| | (a) How? | | | |
| _____ | | | | |
| 25. | Did he/she repeat the instructions if the patient had not understood them? | Yes | No | N.A. |
| 26. | Describe any inappropriate or appropriate event that took place during the observation. | | | |
| _____ | | | | |
| _____ | | | | |

- | | | | | |
|-----|---|-----|----|------|
| 27. | Did the Provider explain the | | | |
| | - Diagnosis | Yes | No | N.A. |
| | - Treatment | | | |
| | - Did he tell from where to take medicines /drugs | Yes | No | N.A. |
| | - Did he tell how to take or use the medicine? | Yes | No | N.A. |
| | - Did he tell for how long to take the medicine | Yes | No | N.A. |
| | - Did he tell her when to come back? | Yes | No | N.A. |
| | - Investigations | | | |
| | - Did he tell what tests to do ? | Yes | No | N.A. |
| | - from where to do the tests? | Yes | No | N.A. |
| | - Expenditure if any | Yes | No | N.A. |

- when to come back with thge reports? Yes No N.A
- Investigative procedures
- Did the doctor explain the procedure? Yes No N.A
- Did he tell for what it has to be done ? Yes No N.A
- When and where to be done? Yes No N.A
- Did he gave any preparatory instructions? Yes No N.A

28. Did the provider ensure whether the patient has understood the instructions? Yes No N.A.

(a) How? _____

29. Did he/she repeat the instructions if patients did not understand ? Yes No N.A.

30. Did the provider ask the patient if she has any doubt questions? Yes No N.A

31. Did the patient ask any question? Yes No N.A

32. Did she ask anything related to sexual relationship or any other sensitive questuions? Yes No N.A

33. Did the doctor clarify or answer them ? Yes No N.A

34. What time did the patient finish her work? _____

35. Throughout this discussion was the provider polite to the patient ? Yes No N.A

36. Did the provider say anything insulting to the patient ? Yes No N.A

If yes what and why? _____

37. Did the provider shout at the patient? Yes No N.A

If yes why? _____

38. Describe any inappropriate or appropriate event that took place during the observation.

T - 1.5

**Self- Administered Checklist for Doctors for Monitoring Communication
with Client**

1. Was the client/patient seated while she narrated her problem?	1 Yes	2 No	3. Not applicable	4. Do not know
2. Did you politely ask the accompanying person to wait outside to ensure privacy?	1 Yes	2 No	3. Not applicable	4. Do not know
3. Did you maintain eye contact/look at the woman while you asked for her history?	1 Yes	2 No	3. Not applicable	4. Do not know
4. Did you ask the patient if she had any other complaints?	1 Yes	2 No	3. Not applicable	4. Do not know
5. Did you listen to the patient without interrupting her?	1 Yes	2 No	3. Not applicable	4. Do not know
6. Did you ensure that other patients were not crowded around the table during consultation?	1 Yes	2 No	3. Not applicable	4. Do not know
7. Did the patient ask any questions?	1 Yes	2 No	3. Not applicable	4. Do not know
8. Did you answer her questions?	1 Yes	2 No	3. Not applicable	4. Do not know
9. Did you ask the patient if she had any queries?	1 Yes	2 No	3. Not applicable	4. Do not know
10. Did the patient ask any questions related to sexual relations? (if relevant)	1 Yes	2 No	3. Not applicable	4. Do not know
11. Did you ask questions related to sexual behaviour (if relevant)?	1 Yes	2 No	3. Not applicable	4. Do not know
12. Did you tell the patient about what to expect during the PV examination?	1 Yes	2 No	3. Not applicable	4. Do not know
13. Did you ensure that the nurse or attendant instructed the patient for PV examination?	1 Yes	2 No	3. Not applicable	4. Do not know
14. Did you ensure that the woman's legs were covered during the PV examination?	1 Yes	2 No	3. Not applicable	4. Do not know
15. How long did the woman wait on the examination table? Less than 5 minutes?	1 Yes	2 No	3. Not applicable	4. Do not know
16. Did you reassure the woman during the PV examination?	1 Yes	2 No	3. Not applicable	4. Do not know
17. Did you talk to the woman during PV?	1 Yes	2 No	3. Not applicable	4. Do not know
18. Did you tell the woman about the findings of PV?	1 Yes	2 No	3. Not applicable	4. Do not know
19. (For male doctor) Did you ensure that nurse/ayabai was present during PV examination?	1 Yes	2 No	3. Not applicable	4. Do not know
20. Did you inform the woman about the diagnosis/reason for her symptoms?	1 Yes	2 No	3. Not applicable	4. Do not know

21. Did you tell her where she could buy the medicines, and the dosage and duration of medication?	1 Yes	2 No	3. Not applicable	4. Do not know
22. Did you tell the client about further investigations (if any) required, the reason why they are necessary, where the client can get them done and at what cost, etc.?	1 Yes	2 No	3. Not applicable	4. Do not know
23. Did you tell the client about any surgery/procedure she might require, the reason for it, when, where, expenses, etc.?	1 Yes	2 No	3. Not applicable	4. Do not know
24. Did you inform the client about how she should prepare for the surgery/procedure?	1 Yes	2 No	3. Not applicable	4. Do not know
25. Did you ensure that the client had understood all the instructions? Did you ask the client to repeat the instructions?	1 Yes	2 No	3. Not applicable	4. Do not know
26. If the client did not understand the instructions, did you repeat them?	1 Yes	2 No	3. Not applicable	4. Do not know
27. Did you advise the client about sexual relations?	1 Yes	2 No	3. Not applicable	4. Do not know
28. Did you tell the client about when and if follow-up visits were required?	1 Yes	2 No	3. Not applicable	4. Do not know
29. Did you shout at or insult the patient?	1 Yes	2 No	3. Not applicable	4. Do not know
30. Did your frustration at any time reflect in your communication with the patient?	1 Yes	2 No	3. Not applicable	4. Do not know

Score :

● Questions 1 to 28: One mark each for 'Yes'

● Questions 29 and 30: One mark for 'No'

Total score	Rating for communication
8 or less	Poor. Needs immediate attention.
9 to 15	Fair. Needs improvement
16 to 20	Good. Keep it up!
More than 20	Very Good. You can be a role model!

T - 1.6

Checklist of Assessing Quality of Counselling

1. Did the counsellor ask the client to take a seat? Was the client seated?	1 Yes	2 No	3. Not applicable	4. Do not know
2. Did the counsellor explain what the client should expect from the session?	1 Yes	2 No	3. Not applicable	4. Do not know
3. Did the counsellor assure the client that the discussion would be kept confidential and not shared with anyone else?	1 Yes	2 No	3. Not applicable	4. Do not know
4. Was the accompanying person politely asked to wait outside if privacy was required?	1 Yes	2 No	3. Not applicable	4. Do not know
5. Did the counsellor enquire about client's past illnesses/treatment/investigations?	1 Yes	2 No	3. Not applicable	4. Do not know
6. Did the counsellor listen to the client without interrupting her/him?	1 Yes	2 No	3. Not applicable	4. Do not know
7. Did the counsellor listen attentively to the client?	1 Yes	2 No	3. Not applicable	4. Do not know
8. Did the counsellor ensure that s/he understood correctly what the client had to say?	1 Yes	2 No	3. Not applicable	4. Do not know
9. Did the counsellor paraphrase what client had said?	1 Yes	2 No	3. Not applicable	4. Do not know
10. In case of discrepancies in the client's narrative, did the counsellor clarify them with the client?	1 Yes	2 No	3. Not applicable	4. Do not know
11. Did the counsellor answer the questions asked by the client?	1 Yes	2 No	3. Not applicable	4. Do not know
12. Did the counsellor ask the client if s/he had any questions?	1 Yes	2 No	3. Not applicable	4. Do not know
13. Did the client ask any questions?	1 Yes	2 No	3. Not applicable	4. Do not know
14.				
15. Did the client ask any questions related to sexual relations?	1 Yes	2 No	3. Not applicable	4. Do not know
16. Did the counsellor answer questions asked by the client regarding sexual relations?	1 Yes	2 No	3. Not applicable	4. Do not know
17. Did the counsellor give information regarding investigations prescribed, reason for doing the investigations, where to get them done, and the costs involved?	1 Yes	2 No	3. Not applicable	4. Do not know
18. Did the counsellor give information regarding surgery / procedure advised, the reason for it, where to get it done and what it would cost, and the procedure followed during surgery?	1 Yes	2 No	3. Not applicable	4. Do not know

19. Did the counsellor instruct the client about how to prepare for the surgery/procedure?	1 Yes	2 No	3. Not applicable	4. Do not know
20. Did the counsellor explain the admission procedure to the client?	1 Yes	2 No	3. Not applicable	4. Do not know
21. Did the counsellor ensure that the client understood the information given to her/him?	1 Yes	2 No	3. Not applicable	4. Do not know
22. Was the client asked to repeat the instructions?	1 Yes	2 No	3. Not applicable	4. Do not know
23. Did the counsellor encourage client to speak?	1 Yes	2 No	3. Not applicable	4. Do not know
24. Did the counsellor ask the client to say what s/he thought/knew about the situation/condition before giving information?	1 Yes	2 No	3. Not applicable	4. Do not know
25. Did the counsellor ask open questions? Did the counsellor probe where required?	1 Yes	2 No	3. Not applicable	4. Do not know
26. Did the counsellor modulate her/his voice while speaking to the client?	1 Yes	2 No	3. Not applicable	4. Do not know
27. Did the counsellor use technical words while giving information?	1 Yes	2 No	3. Not applicable	4. Do not know
28. Were the counsellor's expressions responsive to the emotions expressed by the client?	1 Yes	2 No	3. Not applicable	4. Do not know
29. Did the counsellor pause at appropriate times during the counselling session?	1 Yes	2 No	3. Not applicable	4. Do not know
30. Did the counsellor reassure the client?	1 Yes	2 No	3. Not applicable	4. Do not know
31. Did the counsellor help the client focus on the important issues at hand?	1 Yes	2 No	3. Not applicable	4. Do not know
32. Did the counsellor listen to the client without being critical or judgemental?	1 Yes	2 No	3. Not applicable	4. Do not know
33. Did the counsellor use IEC material to give information?	1 Yes	2 No	3. Not applicable	4. Do not know
34. At the end of the session, did the counsellor summarise the issues discussed?	1 Yes	2 No	3. Not applicable	4. Do not know
35. Did the counsellor tell the client about follow-up: whether required, when, etc.?	1 Yes	2 No	3. Not applicable	4. Do not know
36. Did the counsellor smile (if appropriate) at the end of the session?	1 Yes	2 No	3. Not applicable	4. Do not know

T - 1.7

Observation Checklist for MTP and Contraception Counselling

Name of the observer

Client number

Date

Time

For each question, please circle the appropriate option.

1.	Did the counsellor ask the date of the last menstrual period?	1. Yes	2. No	3. Not applicable	4. Do not know
2.	Did the counsellor take the history of number of children, pregnancies, abortions/MTPs?	1. Yes	2. No	3. Not applicable	4. Do not know
3.	Did the counsellor discuss in detail the reasons for aborting present pregnancy?	1. Yes	2. No	3. Not applicable	4. Do not know
4.	Did the counsellor ask if clients' husband has accompanied her?	1. Yes	2. No	3. Not applicable	4. Do not know
4.1	Did the counsellor ask the client if she would like to invite the husband inside?	1. Yes	2. No	3. Not applicable	4. Do not know
4.2	Did the counsellor ask the husband to come inside if the client so wished ?	1. Yes	2. No	3. Not applicable	4. Do not know
5.	Did the counsellor ask the client if she knew how MTP was done?	1. Yes	2. No	3. Not applicable	4. Do not know
5.1	If the client knew about the methods of MTP, did the counsellor ask her to share the information?	1. Yes	2. No	3. Not applicable	4. Do not know
5.2	If client did not have complete information, did the counsellor explain how MTP is done?	1. Yes	2. No	3. Not applicable	4. Do not know
6.	After she gave this information, did the counsellor ask the client if she wanted an MTP?	1. Yes	2. No	3. Not applicable	4. Do not know
7.	Did the counsellor then explain the risks associated with MTP?	1. Yes	2. No	3. Not applicable	4. Do not know
8.	Did the counsellor allow the client some time to think about her decision?	1. Yes	2. No	3. Not applicable	4. Do not know
8.1	Did the counsellor ask the client if she wanted to go out of the centre to think and make a decision?	1. Yes	2. No	3. Not applicable	4. Do not know
9.	Did the counsellor ask the client if she still wanted to have an MTP after she had reviewed all the information given to her?	1. Yes	2. No	3. Not applicable	4. Do not know
10.	Did the counsellor inform the client that at times MTP results in incomplete evacuation of the contents of the uterus?	1. Yes	2. No	3. Not applicable	4. Do not know
11.	Did the counsellor ask the client about her plans to prevent a pregnancy immediately after the MTP? Did the counsellor ask if the client knew of spacing methods?	1. Yes	2. No	3. Not applicable	4. Do not know
12.	Did the counsellor ask the client if she knew about the process of conception?	1. Yes	2. No	3. Not applicable	4. Do not know
12.1	If the client did not know this, did the counsellor give her the relevant information?	1. Yes	2. No	3. Not applicable	4. Do not know
13.	Did the counsellor ask if the client had used any contraceptive/spacing method in the past?	1. Yes	2. No	3. Not applicable	4. Do not know

13.1	If the client had used some method, did the counsellor encourage her to discuss it?	1. Yes	2. No	3. Not applicable	4. Do not know
14.	If the client did not know about contraceptives, did the counsellor ask if she wanted more children?	1. Yes	2. No	3. Not applicable	4. Do not know
15.	If client wanted more children, did the counsellor give information about reversible/temporary contraceptives as per the checklist given below?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1	Oral Contraceptive Pills (OCP)				
15.1.1	Did the counsellor ask the client what she knew about OCPs or what she has heard about OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.3	Did the counsellor explain the function of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.4	Did the counsellor explain the benefits of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.5	Did the counsellor explain the side effects of OCPs?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.6	Did the counsellor explain who can use OCPs and who cannot?	1. Yes	2. No	3. Not applicable	4. Do not know
15.1.7	Did the counsellor explain how to use OCPs, at least briefly?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2	Condom				
15.2.1	Did the counsellor ask the client what she knew about condoms or what she has heard about condoms?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.3	Did the counsellor discuss who should use the condom and when?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.4	Did the counsellor explain how the condom functions as a contraceptive?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.5	Did the counsellor explain the advantages of using condom?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.6	Did the counsellor explain the disadvantages of condom use?	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.7	Did the counsellor explain how to use a condom? (If male partner had accompanied the client, was he called inside and explained about condom use?)	1. Yes	2. No	3. Not applicable	4. Do not know
15.2.8	Did the counsellor demonstrate how to use condom?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3	Copper T (CuT)				
15.3.1	Did the counsellor ask the client what she knew or had heard about CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.3	Did the counsellor explain how the CuT functions as a contraceptive?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.4	Did the counsellor tell the client when the CuT should be inserted?	1. Yes	2. No	3. Not applicable	4. Do not know

T - 1.7 OBSERVATION CHECKLIST FOR MTP AND CONTRACEPTION COUNSELLING

15.3.5	Did the counsellor explain the advantages of CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.6	Did the counsellor discuss the disadvantages of CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.7	Did the counsellor discuss which women should and which women should not use CuT?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.8	Did the counsellor ask if the client had any symptoms of RTI?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.9	If the client reported symptoms of RTI, did the counsellor advise her not to insert CuT immediately and discuss about intercourse?	1. Yes	2. No	3. Not applicable	4. Do not know
15.3.10	Did the counsellor demonstrate how the CuT is inserted?	1. Yes	2. No	3. Not applicable	4. Do not know
16.	If the client did not want more children after MTP, did the counsellor give her information on permanent methods of contraception as per the checklist given below	1. Yes	2. No	3. Not applicable	4. Do not know
16.1	Female Sterilisation				
16.1.1	Did the counsellor ask the client if she knew or had heard anything about female sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.3	Did the counsellor tell the client that this is a permanent method and the woman will not be able to conceive after this?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.4	Did the counsellor explain reasons for inability to conceive after sterilisation ?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.5	Did the counsellor tell the client when this surgery should be performed?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.6	Did the counsellor discuss the advantages of female sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.7	Did the counsellor discuss the disadvantages of such sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.8	Did the counsellor inform the woman about the required length of stay at the hospital following surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.9	Did the counsellor tell the client about the duration of rest required to be taken after sterilisation surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.10	Did the counsellor explain the surgical procedure?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.11	Did the counsellor tell the client where to go for the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.1.12	Did the counsellor discuss the possibility of failure of the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2	Male sterilisation				
16.2.1	Did the counsellor ask the client if she knew or had heard anything about male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.2	Did the counsellor address misconceptions if any?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.3	Did the counsellor explain that this is a permanent method and the woman will not be able to conceive after this?	1. Yes	2. No	3. Not applicable	4. Do not know

16.2.4	Did the counsellor explain the reasons for inability to conceive after the operation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.5	Did the counsellor discuss the advantages of male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.6	Did the counsellor discuss disadvantages of male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.7	Did the counsellor tell the client about the required length of stay in the hospital after the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.8	Did the counsellor say anything about the number of days that the man will be required to rest after sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.9	Did the counsellor explain about when this surgery should be performed?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.10	Did the counsellor explain surgical procedure?	1. Yes	2. No	3. Not applicable	4. Do not know
16.2.11	Did the counsellor discuss the possibility of failure of the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
17.	Did the counsellor ask the client which of the aforementioned methods she wanted to adopt?	1. Yes	2. No	3. Not applicable	4. Do not know
18.	Counselling partner				
18.1	If the client made a decision, did the counsellor explain that it was important to inform the client's husband of this decision?	1. Yes	2. No	3. Not applicable	4. Do not know
18.2	If the client agreed, did the counsellor give all the information to the client's husband?	1. Yes	2. No	3. Not applicable	4. Do not know
18.3	Did the counsellor start the discussion with male sterilisation?	1. Yes	2. No	3. Not applicable	4. Do not know
18.4	Did the counsellor inform the client and her husband about temporary methods?	1. Yes	2. No	3. Not applicable	4. Do not know
18.5	Did the counsellor inform the client and her husband about permanent methods?	1. Yes	2. No	3. Not applicable	4. Do not know
19.	Did the counsellor ask the husband which method they (the couple??) would prefer?	1. Yes	2. No	3. Not applicable	4. Do not know
19.1	Did the counsellor ask the husband's opinion on the method preferred by the client?	1. Yes	2. No	3. Not applicable	4. Do not know
20.	Did the counsellor allow them time to think before taking a decision?	1. Yes	2. No	3. Not applicable	4. Do not know
21.	Did the counsellor repeat the information for the method selected by the couple?	1. Yes	2. No	3. Not applicable	4. Do not know
21.1	If required, did the counsellor give detailed information about the method selected by the couple?	1. Yes	2. No	3. Not applicable	4. Do not know
21.2	Did the counsellor give the client/husband the date and time for admission?	1. Yes	2. No	3. Not applicable	4. Do not know
22.	If no decision was taken, did the counsellor fix another appointment?	1. Yes	2. No	3. Not applicable	4. Do not know
23.	Did the counsellor tell the client that she could refer other women to the counselling centre for information on contraception and other reproductive conditions?	1. Yes	2. No	3. Not applicable	4. Do not know
24.	Did the counsellor smile at the end of the session?	1. Yes	2. No	3. Not applicable	4. Do not know

T-1.8

Observation Checklist for Monitoring Counselling for Menstrual Disorders

Name of the observer

Client number

Date

Time

For each question, please circle the appropriate option.

1. Assuring confidentiality: Did the counsellor					
1.1	tell the client that the discussion in the session will be kept confidential?	1. Yes	2. No	3. Not applicable	4. Do not know
2. Involving accompanying person in the counselling session					
2.1	If the woman was accompanied by a partner/relative, was the accompanying person invited into the counselling centre if the client desired? (together or separately)	1. Yes	2. No	3. Not applicable	4. Do not know
3. Description of the current problem/Exploring facts: Did the counsellor					
3.1	ask the client about her problem in detail using open-ended questions? (symptoms, since when, details about menstrual cycle, whether taken any treatment before coming to the hospital, any associated probable causes and so on)	1. Yes	2. No	3. Not applicable	4. Do not know
3.2	explore whether the patient has any other psychological or family problems or tension?	1. Yes	2. No	3. Not applicable	4. Do not know
3.3	explore the food habits and diet of the patient?	1. Yes	2. No	3. Not applicable	4. Do not know
3.4	see all reports and papers?	1. Yes	2. No	3. Not applicable	4. Do not know
4. Exploring client's understanding about her problem: Did the counsellor					
4.1	ask the client to explain what she knew about the treatment/investigations advised by the doctor?	1. Yes	2. No	3. Not applicable	4. Do not know
5. Giving information: Did the counsellor provide information about					
5.1	anatomy and physiology of menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
5.2	how the brain controls the hormone level which affects the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
5.3	the probable causes of irregular menstruation?	1. Yes	2. No	3. Not applicable	4. Do not know
5.4	the importance of investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
5.5	the importance of a balanced diet?	1. Yes	2. No	3. Not applicable	4. Do not know
5.6	the importance of completing the course of medicines prescribed?	1. Yes	2. No	3. Not applicable	4. Do not know
5.7	the importance of follow-up visits?	1. Yes	2. No	3. Not applicable	4. Do not know

6. Giving reassurance					
6.1	Did the counsellor reassure the client, telling her that the investigations and treatment may take time and that she should not become impatient?	1. Yes	2. No	3. Not applicable	4. Do not know
7. Information on men's responsibility to the partner: Did the counsellor provide information on					
7.1	the anatomy and physiology of the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
7.2	how the brain controls the hormone levels which affect the menstrual cycle?	1. Yes	2. No	3. Not applicable	4. Do not know
7.3	the probable causes of irregular menstruation?	1. Yes	2. No	3. Not applicable	4. Do not know
7.4	the importance of investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
7.5	the importance of a balanced diet?	1. Yes	2. No	3. Not applicable	4. Do not know
7.6	the importance of completing the course of medicines prescribed?	1. Yes	2. No	3. Not applicable	4. Do not know
7.7	the fact that investigations and treatment may take some time and therefore the need for patience?	1. Yes	2. No	3. Not applicable	4. Do not know
7.8	the importance of follow-up visits?	1. Yes	2. No	3. Not applicable	4. Do not know
8. Encouraging clients to ask questions and share difficulties: Did the counsellor					
8.1	ask if the client had any queries or doubts?	1. Yes	2. No	3. Not applicable	4. Do not know
8.2	answer the questions raised?	1. Yes	2. No	3. Not applicable	4. Do not know
8.3	ask the client if she had any difficulties regarding treatment or investigations?	1. Yes	2. No	3. Not applicable	4. Do not know
8.4	(If the client had any difficulties) discuss the problems and suggest ways of overcoming them?	1. Yes	2. No	3. Not applicable	4. Do not know
9. Confirming whether the information given is understood by the client before she/he leaves: Did the counsellor					
9.1	ask the client whether she had any doubts or queries regarding the information given?	1. Yes	2. No	3. Not applicable	4. Do not know
9.2	ask her to repeat the key points of the information provided?	1. Yes	2. No	3. Not applicable	4. Do not know
9.3	ask the client to repeat the date fixed for follow-up visit?	1. Yes	2. No	3. Not applicable	4. Do not know

T-1.9

Observation Checklist for Monitoring Counselling for Major Surgery

Name of the observer

Client number

Date

Time

For each question, please circle the appropriate option.

1. Involving accompanying person in the counselling session					
1.1	If women is accompanied by a relative/friend, was the accompanying person invited into the counselling centre if the client so desired?	1. Yes	2. No	3. Not applicable	4. Do not know
2. Discussing the current problem: Did the counsellor					
2.1	ask the client about her problem in detail?	1. Yes	2. No	3. Not applicable	4. Do not know
2.2	see all reports and papers?	1. Yes	2. No	3. Not applicable	4. Do not know
3. Exploring women's understanding about their problem: Did the counsellor					
3.1.	ask the client if she knew what the report said and whether she understood the information given by the doctor?	1. Yes	2. No	3. Not applicable	4. Do not know
3.2	ask the client what she knew about the surgery advised?	1. Yes	2. No	3. Not applicable	4. Do not know
4. Giving Information: Did the counsellor provide the following information					
4.1 About surgery and pre-operative preparation					
4.1.1	the nature of the surgery and how it is performed	1. Yes	2. No	3. Not applicable	4. Do not know
4.1.2	preparation for the surgery as advised by the doctor	1. Yes	2. No	3. Not applicable	4. Do not know
4.1.3	investigations to be done	1. Yes	2. No	3. Not applicable	4. Do not know
4.1.4	procedure for admission to the hospital	1. Yes	2. No	3. Not applicable	4. Do not know
4.1.5	difficulties regarding preparation, if any	1. Yes	2. No	3. Not applicable	4. Do not know
4.2 About post-operative care					
4.2.1	care of stitches	1. Yes	2. No	3. Not applicable	4. Do not know
4.2.2	diet/medicines	1. Yes	2. No	3. Not applicable	4. Do not know
4.2.3	work/rest	1. Yes	2. No	3. Not applicable	4. Do not know
4.2.4	sexual relations/intercourse	1. Yes	2. No	3. Not applicable	4. Do not know
4.2.5	menstrual cycle	1. Yes	2. No	3. Not applicable	4. Do not know
4.2.6	follow-up visit	1. Yes	2. No	3. Not applicable	4. Do not know

4.3 About men's responsibility towards their partners					
4.3.1	allowing the woman to rest/ensuring that she does not do heavy work	1. Yes	2. No	3. Not applicable	4. Do not know
4.3.2	diet/nutrition	1. Yes	2. No	3. Not applicable	4. Do not know
4.3.3	medicines	1. Yes	2. No	3. Not applicable	4. Do not know
4.3.4	sexual relations/intercourse	1. Yes	2. No	3. Not applicable	4. Do not know
4.3.5	follow-up visits	1. Yes	2. No	3. Not applicable	4. Do not know
5 Encouraging clients to ask questions and share difficulties: Did the counsellor					
5.1	ask if the client had any queries or doubts?	1. Yes	2. No	3. Not applicable	4. Do not know
5.2	answer the questions raised?	1. Yes	2. No	3. Not applicable	4. Do not know
5.3	ask the client if she had any difficulties regarding post-operative care?	1. Yes	2. No	3. Not applicable	4. Do not know
5.4	(if the client had difficulties) discuss the problems and suggest ways of overcoming them?	1. Yes	2. No	3. Not applicable	4. Do not know
6. Reducing fear and giving reassurance:					
6.1	did the counsellor reassure the client if she was worried or scared about the surgery?	1. Yes	2. No	3. Not applicable	4. Do not know
7 Confirming whether the information given is understood by the client before she leaves the room: Did the counsellor					
7.1	ask the client if she had any doubts or queries regarding information given?	1. Yes	2. No	3. Not applicable	4. Do not know
7.2	asked the client to repeat the key points of the information provided?	1. Yes	2. No	3. Not applicable	4. Do not know
7.3	ask the client to repeat the date fixed for the follow-up visit?	1. Yes	2. No	3. Not applicable	4. Do not know

T - 2.1

Tools for Evaluation

Checklist for Observation of Client – Counsellor Interaction

- Ability to build rapport with the client
- Ability to put the client at ease, make the client comfortable
- Ensure privacy and confidentiality
- Provide and elicit information from the client
- Use supporting information materials
- Ability to provide complete and accurate technical information about the problem/issue that the client has come for
- Ensuring that the client has received complete information which will enable him/her to make an informed decision
- Attitude of the counsellor: polite, respectful, non-judgmental and non prejudiced, gender sensitive
- Explanation provided in a manner that is understood without difficulty by the client eg. terms used
- Provide the client with opportunity to clarify doubts and seek explanations if something if not understood even if it is not specific to the reason for her visit
- Provide guidance to the client regarding services and procedures in the centre based on the decision of required information
- Ensure follow up by fixing a date or providing follow up etc.

Checklist for Exit Interviews with Clients

- Profile of client and background information: name, age, residence, marital status, mode of access, cost
- Reason for present visit
- Referred by: self/doctor/health post/CHV/other
- Has client accessed the services (counselling) before? Reasons for visit/s.
- Was the spouse/partner also counseled? Was that effective? Yes/no-reasons
- Satisfied with services. Probes: information, IEC materials (main message), attitude of counselors, privacy, confidentiality, waiting time, location (inside/outside) hours during which services are provided/ any other. Opportunity to clarify doubts and issues
- Has client received the services and information wanted
- Concerns if any about privacy/confidentiality/ any other
- Would client encourage a friend or relative to use the services and access them herself? Reasons if yes/no
- Should such services continue? Has it improved quality of services in OPD? How? Since when. Examples

- Was client ensured of follow up and continuity of services/treatment
- Any suggestions to improve services
- Would such services be useful in the health posts and other hospitals

Checklist for Exit Interviews with Non-users or Never-users

Ask reasons for not using: lack of info/ did not know about services, time constraints, inappropriate hours, concerns about privacy-confidentiality etc.

Suggestions to resolve any of these issues

Topic guide for Interviews and FGDS with Counselors and Trainees

- Profile
- Role in the health centre/post
- Counselling experience – when and where. Reaction of superiors/peers
- Trainings attended. Feedback and suggestions about training including 15 days practicum
- Counselling skills used in respective health posts. Experiences
- Obstacles//problems faced, overcome/resolved
- Perception of change in the OPD vis-a-vis counselling and in themselves. Yes/no. Perceived causes for change/no change
- Other review and monitoring mechanisms presently used to improve skills: feedback. Future expectations
- Need for such services: why, who can continue, who should be involved, take responsibility, any suggestions regarding systems to mainstream such services or any changes required in the present processes- Sustainability. Replication – required criteria/possibilities
- Limitations perceived by them in providing services. Possible ways of overcoming these limitations.
- Suggestions to improve quality of counselling. Should anything be different//done differently? Reasons and alternatives

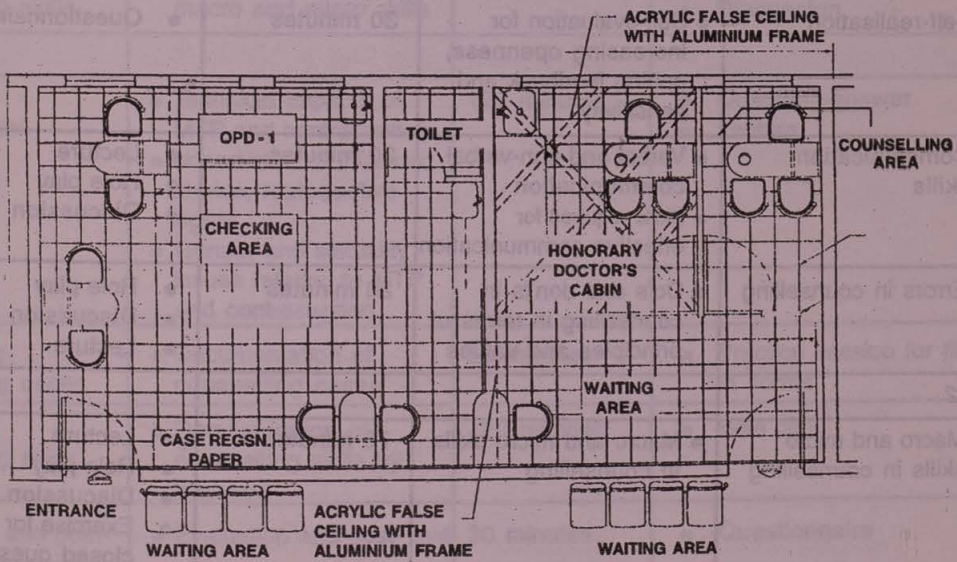
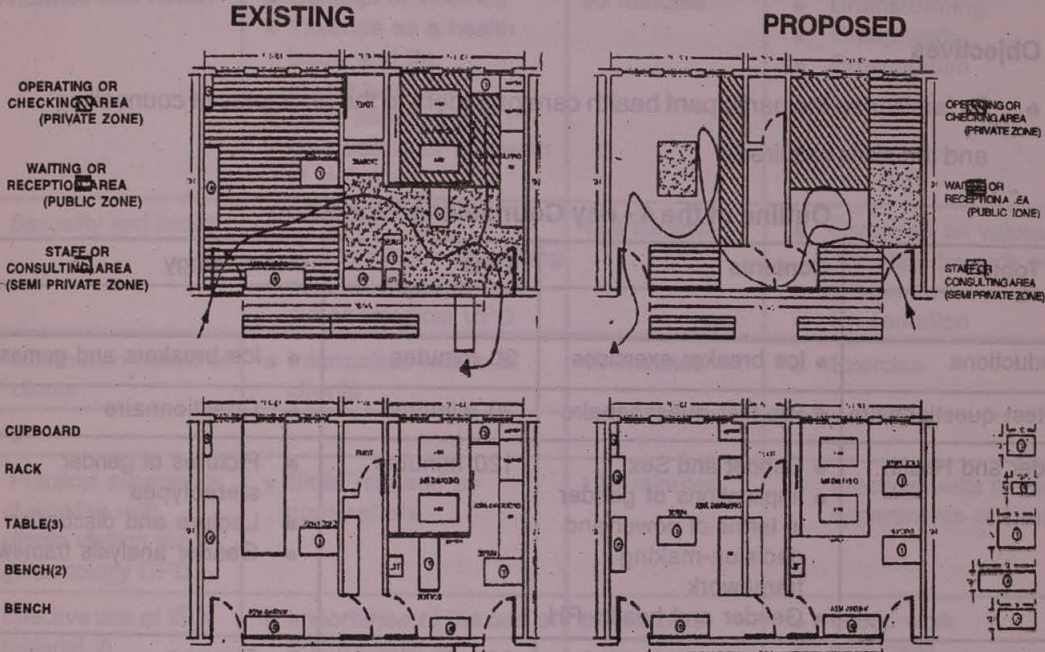
Topic guideline for Interviews with management / administration / non counsellor providers/WCHP staffs

- Profile
- Role in the health centre/post//project
- Counselling services. Has it been useful, perceived changes in quality of care if any?
- Obstacles//problems faced, overcome/resolved.
- Review and monitoring mechanisms in place. Effectiveness, frequency, participation.
- Need for such services: why, who can continue, who should be involved, take responsibility, any suggestions regarding systems to mainstream such services or any changes required in the present processes- Sustainability.
- Replication – required criteria/possibilities. If not possible -reasons

- Limitations perceived by them in providing services. Possible ways of overcoming these limitations. E.g. accessibility, acceptability of counselors
- Suggestions to improve quality of counselling. Should anything be different/done differently by BMC/WCHP? Any changes in process for e.g. referrals, lack of referrals. Reasons and alternatives.

Annexure - 1.1

Existing and Proposed Plans for Layout of the OPD



C O R R I D O R
PLAN OF GYNECOLOGY DEPARTMENT

Annexure - 1.2

**Schedule for 4 - day Counselling Training for Auxiliary Nurse
Midwives, Male Multipurpose Workers and Public Health Nurses**

Objectives

- To familiarise the participant health care providers to the principles of counselling and the skills required

Outline of the 4 - day Counselling Workshop

Session Topic	Contents	Time	Methodology
Day 1			
1. Introductions	● Ice breaker exercises	30 minutes	● Ice breakers and games
2. Pre-test questionnaire	● Pre-test questionnaire	30 minutes	● Questionnaire
3. Gender and Health	● Gender and Sex ● Implications of gender in terms of power and decision-making framework ● Gender and health-RH	120 minutes	● Pictures of gender stereotypes ● Lecture and discussion ● Gender analysis framework
4. Sensitivity in counselling and qualities of a counsellor	● Qualities desirable in a counsellor	60 minutes	● Exercise
5. Self-realisation	● Self-evaluation for increasing openness, getting feedback and sensitivity	30 minutes	● Questionnaire
6. Communication skills	● Verbal and non-verbal communication ● Skills required for effective communication	30 minutes	● Lecture ● Role play ● Discussion
7. Errors in counselling	● Do's and don'ts in counselling in terms of principles and values	20 minutes	● Role play ● Discussion ● Lecture
Day 2			
8. Macro and micro skills in counselling	● Macro and micro skills in counselling	75 minutes	● Lecture ● Role play ● Discussion ● Exercise for converting closed questions into open-ended ones
9. High-risk ANC and hysterectomy	● Technical aspects of high-risk ANC and hysterectomy	120 minutes	● Question- answer Lecture

COUNSELLING SERVICES IN THE GYNAECOLOGY CLINIC OF A MUNICIPAL HOSPITAL IN MUMBAI

Session Topic	Contents	Time	Methodology
	<ul style="list-style-type: none"> ● Gender and sexuality in the context of high-risk ANC and hysterectomy ● Men's role in ANC and hysterectomy 		
10. Violence and health	<ul style="list-style-type: none"> ● Concept of violence ● Violence as a health issue and its consequences ● Skills required for counselling of survivors of violence 	90 minutes	<ul style="list-style-type: none"> ● Brainstorming ● Group work ● Presentation
11. Sexuality and health	<ul style="list-style-type: none"> ● Sexuality ● Relevance of discussing sexual issues in gynaecological UPD 	120 minutes	<ul style="list-style-type: none"> ● Exercises on values and attitudes towards sexuality ● Discussion ● Presentation
12. Information needs of clients	<ul style="list-style-type: none"> ● Information needs of clients 	45 minutes	<ul style="list-style-type: none"> ● Exercise
Day 3			
13. Practical experience of working with clients visiting the gynaecology OPD	<ul style="list-style-type: none"> ● Skills required by counsellors 	120 minutes	<ul style="list-style-type: none"> ● Practical visits to various departments of hospital
14. Effective use of IEC material in gynaecological counselling	<ul style="list-style-type: none"> ● Importance of the use of IEC material in counselling 	90 minutes	<ul style="list-style-type: none"> ● Group work ● Exercises ● Demonstration of condom use
15. Demonstration of counselling skills	<ul style="list-style-type: none"> ● Verbal, non-verbal, macro and micro skills 	60 minutes	<ul style="list-style-type: none"> ● Role play ● Discussion
Day 4			
16. MTP and contraception	<ul style="list-style-type: none"> ● Technical aspects of MTP and contraception ● Importance of informed choice, reproductive rights ● Gender and sexuality issues relating to MTP and contraception 	120 minutes	<ul style="list-style-type: none"> ● Question-answer ● Lecture
17. Recording counselling cases	<ul style="list-style-type: none"> ● Documentation of counselling cases 	30 minutes	<ul style="list-style-type: none"> ● Practice session for filling in forms
18. Practising counselling skills	<ul style="list-style-type: none"> ● Demonstration of counselling skills by trainees 	120 minutes	<ul style="list-style-type: none"> ● Role play
19. Evaluation and post-test questionnaire	<ul style="list-style-type: none"> ● Evaluation and post-test 	30 minutes	<ul style="list-style-type: none"> ● Questionnaire

Annexure - 1.3

Schedule for the 15-day Practical Training for the Trainees

Day 1

- Revising technical knowledge related to different gynaecological conditions. Reference material: Gatha and other handouts given in the training
- Revising counselling skills
Reference material: Handout on macro and Micro skills
- Getting acquainted to the Gynaecology Department Visit to Gynaec OPD, Gynaec ward, Labour ward and Operation theatre
- Share their learning in the counsellors' group meeting

Day 2

- Continue reading
- Getting acquainted to the hospital infrastructure
Visit X-ray, laboratory, sonography and other related departments and OPDs
- Reading filed case records to get oriented in maintaining the records and documentation
- Share their learning in the Counsellors' group meeting

Day 3

- Observing the functioning of the O.P.D and the patient flow
- Observing the counsellors
Filling in observation forms
- Observing ANC group session conducted by Project Counsellors
- Making a presentation to staff about the technical information for Each condition(counselling centre staff fill in gaps, if needed)
- Discussing the observation checklist with the counselors being observed

Day 4

- Observing the functioning of the O.P.D and observing the counsellors Counsell client
- Making a presentation to centre staff about counselling skills (centre staff fill in blanks where needed)
- Role plays wherein the ANM's and MPW's are given a situation and they are expected to impart the technical information to the clients in a simple language in conjunction with appropriate skills. They are observed by the counsellors who then give them feedback

Day 5

- Counselling cases at the counselling centre under the observation of the centre staff (Observers fill in the observation checklist - based on both the information and skills)
- Observers give feedback and In depth case discussions
- Conducting group sessions for ANC clients
- Role Plays

Day 6

- Making daily rounds to the labour ward and the gynaec ward to identify cases in need of counselling
- Counselling cases at the gynaec O.P.D.
- Daily case – presentation and group discussions
- Conducting group sessions for ANC clients
- Role Plays

Day 6-13

- Follow the same pattern as on the 6th day (except the role plays)

Day 14

- Write a summary report of the cases counselled during the placement in the format specified
- Write evaluation including suggestions

Day 15

- Formal presentation at the WCHP office about experiences of the 15-day placement and any suggestions for improvement. Also submit a written evaluation

Annexure - 1.4

Patients' Rights and Responsibilities Displayed in the OPD

Rights

- **Right to information:** To learn about the benefits and availability of contraceptive methods
- **Right to Access:** To obtain services regardless of sex, creed, colour, marital status, or location.
- **Right to Choice:** To decide freely whether to use contraception and which method to use
- **Right to safety:** To be able to practise safe and effective contraception choices
- **Right to request for privacy:** To have private environment during counselling or services
- **Right to Confidentiality:** To be assured that any personal information will remain confidential
- **Right to Dignity:** To be treated with courtesy, consideration and attentiveness
- **Right to Comfort:** To feel comfortable when receiving services
- **Right to Continuity:** To receive contraceptive services and supplies for as long as needed
- **Right to Opinion:** To express views on the services offered

(Source: International Planned Parenthood Federation)

Responsibilities

- Come to the OPD in time
- Remember that new case papers are issued only between 8.30-10.30 a.m
- Get the old case papers stamped with the date every time you come to the hospital
- Get the information about the days of the doctors' units you are registered under and come on those days, only
- Give complete and true information/ history about the health problem to the doctor
- Follow the advice and treatment given by the doctor diligently
- Come on the follow-up day without fail
- Listen to the advice carefully, ask your doubts if any to the doctor or nurse and confirm the information
- Retain all the casepapers and reports (current and past) and carry them with you when seeking consultation
- Do not interrupt when the doctor is talking to another patient
- Maintain queue discipline
- Do not take your relatives inside the consulting room unless doctor calls them
- Remember, Doctors, nurses and attendants are human beings too

Annexure - 1.5

Role of Staff displayed at Gynaecology OPD

HONORARY SURGEONS

- To **guide** registrars, housesurgeons and interns
- To **complete the OT list by 12.30 p.m.** so that the registrars and housesurgeons can start the ANC OPD on time
- To **organize OPD staff meetings** along with the centre staff for problem solving and for case presentation.
- To **orient new batch of RMOs** regarding the activities at the counselling centre and case presentations.
- To **provide technical inputs** if needed, to the centre staff

INTERNS

- To **take case history of all patients** in detail on the casepaper
- To **record B.P.** gynaecological and obstetrics history
- To **record B.P of each ANC patient**, to **calculate the weeks of gestation** and refer cases to housesurgeons and registrars for further examination
- To refer the woman to the counsellor if find it difficult to elicit relevant history, if unsure of the information given by the woman, or if discrepancies between the facts are noted
- **If find difficulty to get the right history** or in case of doubt about the information given by the women, or women unable to share or in case of discrepancies in the facts **refer the case to the staff of the counselling centre**

GYNAECOLOGY OPD SISTER

- To **explain** the prescription
- To **assist the doctor in PV and in Cu-T insertion** or removal
- To **guide** patients for **UPT**
- To conduct **Stitch removal** for TL cases
- **Be present at the time of internal examination**, give instructions and make the patient comfortable
- To **record the reports** on case papers for women seeking ANC
- To **answer all queries** of patients and **guide them** to different departments.
- To **identify and refer cases** to the **counselling centre**
- To **re-assure** the patients
- To **manage** logistics, to **supervise** cleanliness in the OPD
- To **inform the appropriate authorities regarding the electricity or water related problems** faced in the OPD and to follow-up till the problem is resolved
- To ensure **curtains and draw sheet** are in place

LABOUR WARD SISTER

- To **attend to the patient** after the doctor makes entry on the case-paper
- To **assist** the doctor in the Labour room **during delivery**
- To **attend to each and every patient** who is full term and walks into the labour room so as to **reduce stress and anxiety of ANC** full term patients
- To **accept the patient** in labour ward if she is in pain **even before the doctor arrives**
- To **perform PV / FHS** if the **doctor is not available** or busy in the gynaecology OT
- To **send a call** to the doctor after doing the PV / FHS of the patient in full term labour
- To **provide information** if patients need any
- To **guide patients** to different departments
- To **identify and refer cases** to the **counselling centre staff**
- **Be nice with patients** and their family members

ATTENDANT AND SWEEPER

- **Dusting** all the furniture, frames etc. in the OPD
 - **Daily sweeping and mopping** the floor, **cleaning fans and cobwebs on the ceiling**
 - **Washing and drying** all the instruments, gloves and powdering them
 - **Maintaining queue discipline** and guiding the patients
 - **Talk lovingly** and respectfully to patients
- Every Wednesday and Thursday **bring the blood report register from the laboratory** and return the same after the OPD is over

Annexure - 2.1

Framework for Evaluating Quality of Counselling and Methods Used

- Interpersonal relationships (counsellor-client relationships)
- Accessibility: hours of services, distance, location (inside/outside OPD), transportation (in case of referrals from Health posts as this is a referral unit), cost of services
- Availability and adequacy of facilities
 - Services available to all who access the OPD may want to access without any restrictions/limitations. For example only those referred by doctors and other providers
 - Range of Ob/GYN issues for which counselling is available
 - Waiting time, privacy
- Counselling procedures (confidentiality), information given to clients, IEC materials to support services
 - Counsellor related factors- counsellor characteristics (technical competence, personality/attitude, skills, similarity with clients)
- Mechanisms to ensure continuity/follow up: records, referrals, scheduled appointments, follow up through Health posts/CHVs
 - Spouse/partner involvement
- Improving quality of care: has the centre from the perspectives of providers and clients improved Q of C. usefulness of the services provided through the centre
- Replication and sustainability: can the centre be replicated in other Health centres. Can and will it be sustained in its present form. What are the preconditions/requisites for such replication
- Probes for gender/RH and Rights

Element	Inventory of Facilities	Counsellor-client observation	Exit-interview with clients	Taped counselling	Interview with providers	Review of past records	Peer review reports
Interpersonal relationships							
Rapport established for assessing personal background		✓	✓	✓			✓
Client reports feeling welcomed, at ease/uncomfortable asking questions, providers rude/polite		✓	✓				✓
Counsellors trained in Interpersonal relations	✓				✓		
Accessibility			✓		✓	✓	
Availability and adequacy							
Privacy is adequate/not, waiting time, time with counsellor, counsellor is acceptable	✓	✓	✓				✓

2.1 FRAMEWORK FOR EVALUATING QUALITY OF COUNSELLING AND METHODS USED

Element	Inventory of Facilities	Counsellor-client observation	Exit-interview with clients	Taped counselling	Interview with providers incl. supervisor	Review of past records	Peer review reports
Range of counselling & availability for clients with/without restrictions	✓		✓		✓	✓	
Counsellor gives indepth info. about the problem, possible choices, side effects/complications, management, follow up		✓	✓			✓	✓
Client is able to explain reason for choice/ decision, possible complications, management, when and where to return, referrals			✓				
Counsellors trained/skilled in providing and getting information		✓		✓			✓
Specific information-materials available and used	✓	✓	✓		✓		
Checklist available on info to be covered for specific problems	✓	✓			✓		
Existence of education/trg.criteria for counsellors	✓				✓		
Review mechanisms (technical) and trng incl refresher/in service trg	✓				✓		
Frequency & content of supervision	✓				✓		
Mechanism to ensure continuity	✓	✓	✓		✓		
Clients encouraged to return as needed, past clients due for follow up identified, reasons for non-return identified.			✓			✓	
Spouse /partner/male counselling-effectiveness/adequacy			✓		✓	✓	
Usefulness of services: issues of replication and sustainability			✓		✓	✓	

Annexure - 3.1

Detailed Feedback of Providers

Perceptions of Health Care Providers

Fifteen interviews were conducted with health care providers as mentioned in Table 2. The present Attendant (ayah) and maintenance (*mehtrani*) could not give any feedback. They said they did not really know what was being offered inside the counselling centre. Of the 15 providers interviewed, there was one doctor who was extremely negative about the centre and felt that it was not useful and need not be continued as it had not been able to attain its objective of 'converting' clients coming for Medical Termination of Pregnancy with Copper T (MTP- CuT) to MTP- Tubal Ligation (TL).

1. Providers' Feedback

Providers' Feedback is organized under specific themes.

Purpose of the counselling centre

Provides information and guidance Majority of the providers shared that the main purpose of the counselling centre was to provide information to the clients who access the Gynaec Outpatient Department (OPD).

One honorary doctor felt that the purpose was to improve the quality of services. He stated that health care providers are experts at providing clinical care but lack humane interaction skills for providing information which the counselling centre provides.

Some providers also felt that the purpose of the counselling center was to motivate the clients to accept certain procedures/suggested by the doctors. Of the fifteen persons interviewed about 7 said that the purpose of the counselling was to 'motivate' clients for MTP/TL. One doctor said the main objective was to 'convert' clients opting for Medical Termination of Pregnancy (MTP), Copper-T to MTP- TL (Tubal Ligation). Counselling according to another doctor was also useful 'to promote something and make it look like her choice'.

..... counselling services were very useful. It facilitated better communication between the patient/client and the provider. As a result of such services clients were more satisfied, there would be fewer complaints and communication had improved. Earlier the doctors were unable to spend so much time with each patient to provide them with information, clarify their doubts etc.

Medical Superintendent, VND Hospital

Usefulness of services

Useful for doctors and other OPD staff Almost all the providers, both medical and paramedical, said that having the centre was very useful because it has reduced their workload. The doctors stated that earlier they had to spend a lot of time and effort explaining things to the

clients. Now the counsellors do the explaining and they felt that the doctors could concentrate on other aspects. One of the attendants said that now they did not have to argue with or 'listen' to clients' complaints and when hard pressed for time or in case of a language barrier the client is referred to the counsellor. Only one provider felt that the counselling centre was not useful as the set objective i.e. 'conversion' from MTP Copper T to MTP TL had not achieved a high quantum of success. According to him this objective was set by his superiors and the Government of India but he was not aware of any family planning targets. Counselling was perceived as useful to motivate those who do not agree to TL, who want MTP but no TL or CuT.

Providers also felt that the center was useful

- Useful for clients as the counselors use 'the cafeteria approach' providing patients with information about various options.
- Useful as it educates the client and reduces her fear and prepares her for clinical/surgical procedures.

Perceived Changes in the OPD

Infrastructure and layout was more organized All providers perceived changes in infrastructure and layout of the OPD. This, they felt improved the client-flow in the OPD and reduced the chaos and confusion.

Space for counselling and increased privacy The change in layout has created space for counselling and increased privacy for clients for physical examination and counselling.

Streamlined The OPD is streamlined so that every provider had a fixed place/seat. The client is now not confused, she can identify providers and know where to go.

Attitude-Discipline Two providers - one Attendant and one doctor - felt that the counselling had improved the discipline in the OPD. Medical as well as paramedical staff shouted less at clients and were less rude to them. One attendant said that the full time counsellors were role models and "if the counsellors can be polite and respect the client and talk nicely to them then why can't I?"

Services Most providers felt that it was easier to manage clients vis-à-vis TL as they were referred to the counselling centre where they could be 'motivated' about it. Few providers, mostly doctors, also mentioned that patients were better prepared for surgical procedures and also better informed about hospital procedures because of the guidance and information from the counselling centre.

Systems

Meetings Bimonthly meetings of providers associated with the Gynaec OPD were one way of monitoring the counselling services. These meetings were very useful for discussing difficulties faced in counselling and giving feedback to each other. Two of the doctors were concerned that the discussions in these meetings were not objective and were biased against doctors. One of them suggested that feedback between the counsellors and the doctors could also be done

on a one-to-one basis. She felt she would accept feedback and rectify things if necessary. She mentioned that due to heavy workload, stress triggered anger or impatience, which was taken out on clients.

Suggestion box A suggestion box was placed in the OPD to receive feedback from the clients. The contents of the box are kept confidential and are discussed in the review meetings. This had happened in the previous meeting. Some of the doctors felt that the feedback notes were not being placed there by the clients but by the counsellors. The Honorary Doctors and the Medical Superintendent felt that this box should be continued as should the bimonthly meeting.

Token system The system of a queue based on tokens was initiated to introduce some discipline. However, the token system was not regularly followed.

Referral mechanisms Referrals to the counselling centre are done only by the doctors. The doctors refer clients mainly for MTP TL, MTP Copper T, Hysterectomy and prolapse. The various reasons for which clients were referred are clearly listed on the board in the OPD. The clients on follow up visits and those seeking routine information about the hospital are the ones who are self referred.

One honorary doctor suggested that the present system of referral should be reviewed and if necessary changes could be made.

Problems and Limitations

The points listed below are not necessarily common views of all providers. Some of them were expressed only by individual providers. For example, the issue of discomfort in the OPD was mentioned only by one honorary doctor. All other respondents said that there was no discomfort.

Administrative/policy level

- There were too many administrative headaches – too much red tape; too much paper work, bureaucracy which moved very slowly.
- Ban on any recruitment of staff in Hospitals and cutting down of budget by the BMC would affect sustainability
- Independence and reduced hierarchy are necessary to improve /facilitate such initiatives
Turnover of RMOs every six months is a problem because each batch then has to be oriented to the counselling centre.
- Priority in the hospital was given to operation theatre, labour ward and only then to OPD.

Some of these issues would also be pertinent for replication of services.

3.1 DETAILED FEEDBACK OF PROVIDERS

Provision of services

- The doctors felt that there is a shortage of time in the OPD with patients - no time to explain to patients
- The doctors felt that they ended up doing a lot of the OPD sister's work like guiding patients, telling them about routine procedures and talking to the patient's husbands (because they feel that the women are not able to understand.)
- Some discomfort was caused because of the counselling services. This was because of the different approaches of the counsellors and doctors respectively. One doctor felt that while the counsellors focused on the 'social' the doctors emphasized the 'medical' issues, causing differences and sometime friction.

Providers

- The RMOs felt that there was not enough appreciation for their work and heavy workload because of shortage of staff.
- The present full- time counsellors were Public Health Department ANMs. Being from the same system they felt subordinate to doctors. They therefore cannot liaise with BMC, doctors etc.
- The relationship between the counsellors and doctors (RMOs) was not the best which also caused discomfort.

Project level

- Too much time was spent in planning and training by the WCHP leaving very little time for the implementation and thus almost no time to make changes after review evaluation.

Counsellors were not sincere in counselling ANC patients. They did not stick to timings. They kicked up a fuss and made patients emotional by interfering in everything and overreacting to situations..... an example of a woman who fainted on the day of the interview counsellor had overreacted causing the woman to feel as if something major had happened.

Resident Medical Officer

Providers' Recommendations

Administrative/Policy level

- BMC should sustain and replicate these efforts and should include counselling services as a policy in all OPDs
- Such counselling services should be started in other departments of the hospital. Counselling for men should be open to men coming to other departments too and also for men coming to the hospital for non-RH problems. Right now most counselling is about the wife or woman with whom he has come, or for infertility
- According to one doctor, if financial resources are limited, then services to be provided in the future should be prioritized - 24-hour anesthetist, blood bank, pathologist were priorities before counselling

Project level

- The Medical Superintendent should be actively involved in the Project through regular meetings
- All others who are involved should be regularly apprised of meetings and discussions that take place at WCHP and major decisions that result
- Efforts should be made to show more appreciation to the ANMs and RMOs and validating their efforts/participation, for example, by providing them with certificates

Providers

- Counsellors should be accepted as an integral part of the OPD team
- The OPD staff must involve the counsellors more so that they feel motivated and their work could improve. The suggestions/opinions of counsellors should be welcomed. Involving the counsellors can also be done by including their work (i.e. number women and partners counselled) in the reports of the OPD
- If the counsellors do not understand some aspect of the diagnosis and treatment given by the doctors, they could approach the doctor. The doctor can then explain to the client in the presence of the counsellor so that the counsellor would also understand

Systems

- The referral system should be reviewed in the future to see if any change is required.
- All the services should be reviewed on completion of a year for feedback on necessary changes
- A prominent sign should be made on the counselling centre. The doctor who can then refer to this sign when directing the patient (clients get confused when asked to go to the last door of the OPD)

Communication

- Communication between the patient, doctor and counsellor should be more organized so that follow up is more effective. The counsellor should clarify and / or brief the doctor about any important aspects and vice versa
- Interpersonal feedback between the doctors and counsellors should be given directly and confidentially rather than at review meeting

Sustainability

Health care providers gave several suggestions for sustaining and replicating the counselling services. These were:

- the present counsellors should continue and be supervised by the project staff.
- The OPD sister can be trained to provide counselling. But a separate sister should be appointed for this because the same person cannot manage OPD and counselling.
- One permanent counsellor at the centre would increase accountability. The counsellor at the centre should be someone like the present supervisor who can directly discuss issues with the doctors in the OPD

3.1 DETAILED FEEDBACK OF PROVIDERS

- There should be two counsellors, one male and one female. They should be Masters in Social Work who can be provided training in gynaecology. Even if the BMC can provide one it would be beneficial. Training paramedicals in counselling was not very effective
- Some other organization could sponsor the counsellor. For e.g. MDACS is supporting the VCTC Counsellor for HIV/AIDS in hospitals
- Review meetings can continue to be conducted by the honorary doctors in turn

The trained ANMs and MPWs could continue to provide counselling in the hospital. She felt that the Auxiliary Nurse and Midwives (ANMs) and Multipurpose Workers (MPWs) would be better at providing these services. "We can talk better with our own people". She felt that the social workers usually laid more stress on social factors of health problems while the ANMs /MPWs usually stress/balance both social and medical factors.

Honorary Gynaecologist, VND Hospital

2. Feedback of Counsellors

Two ANMs from the Public Health Department, on a working arrangement with the WCHP, have been trained as counsellors and are the fulltime counsellors at the center. Each of them provides counselling three times days in a week at V N Desai Hospital. They participated in the 4-day counselling workshop but have prior experience of counselling through the earlier PID project. These two ANMs were interviewed. The supervisor was not available at the time of evaluation so could not be interviewed.

The two counsellors had been working in the centre for almost a year. One of them felt that most of their peers (other ANMs and MPWs) were not really interested in counselling. **Counselling and other such initiatives were seen as extra work which should be avoided.**

Training

One counsellor said that the training workshop on counselling was not sufficient and regular updates and follow up training should be conducted for counsellors. Those who held this world view preferred if colleagues did not accept such work as then it would not reflect badly on those who were not interested. This was mentioned in the context of replication of services at the health post.

Perception of Change

Attitude and behaviour of staff Earlier ayahs and sisters were very rude. Now there was some change maybe because of the presence of counsellors.

There were changes in attitude of MPWs who come for training. In the beginning some were disinterested and had come for the practical training only because they were duty-bound. But within a few days, few of them became interested and were quite sincere in their role as

counsellor.

Infrastructure Changes in the layout and infrastructure had improved privacy and client-flow.

Review and Monitoring Mechanisms Feedback from the supervisor helps improve quality of counselling. Review meetings were useful because some important decisions were made to improve the quality of services but there was not sufficient follow up.

Obstacles/Limitations

Difference in perceptions of objectives of the centre and role of counsellors Clients are sent to the counselling centre by the doctor to be 'motivated' to accept a certain procedure, while the counselors believe that they should provide client with choices. This causes discomfort and differences in the OPD between doctors and counsellors. Doctors continue to expect the counsellor to counsel clients as per the decision of the doctor and not in a client centred way.

The counsellors felt that they were expected to play a larger role in the OPD other than counselling. Sometimes the doctors blame them if the client does not have their case records. In some instances the doctors expect the counsellors to manage the client-flow in the OPD and maintain discipline – which are actually the responsibility of the OPD nurse.

Providers There may be discomfort in the OPD because of presence of counsellors because providers feel that they are being observed. The counsellors are seen as a threat and have to behave better.

Systems If clients come to the centre for counselling on their own, without being referred by the doctor the counsellors have to send them to the doctor because they are supposed to counsel only those referred by doctors based on their diagnosis.

English terms used by doctor in records are not always understood by the counsellors. 'We do refer back to the doctor now earlier we were diffident about approaching them.'

Recommendations

Sustainability and replication

- Professionally trained counsellors would be suitable
- Separate staff could be appointed for this purpose from amongst the trained ANMs and MPWs. The other option maybe to continue with present counsellors.
- Rotation of MPWs and ANMs as counsellors is another possibility. The rotation period should 3 months.

Systems

- The extent of recording done presently cannot be sustained in the future because of the amount of stationery and the lengthy records. It also takes too much time to retrieve the records in case of follow up.
- These services can be replicated in other hospitals and health posts. However in

health posts the same scale may not be possible because of limited infrastructure and resources. Another limitation is the large numbers of clients resulting in not too much time being spent in counselling.

- Review meetings should continue and Hospital Administrators like the MS should participate in these
- One fear expressed was that the BMC/Hospital system would probably perceive counselling services as additional work and give it low priority. The quality of services would then suffer

Quality of counselling

- *A separate room is required for counselling for men so that there is privacy.*
- More IEC materials should be made available to support counselling
- Regular debriefing and follow up should take place for counsellors so that they can clarify doubts and upgrade their technical knowledge
- There should be supervision and constant feedback so that the counsellors feel motivated and interested

3. Feedback of Trainee Counsellors

Four MPWs and five ANMs from various health posts in the two wards participated in a FGD. One ANM was interviewed individually. All of them had undergone the four-day counselling training followed by the 15-day practical training at the counselling centre. The FGD and interview was conducted in V N Desai Hospital with the objective of receiving feedback from this group about the quality of counselling, their experiences as trainees in counselling, sustainability and replication options also in the health posts and recommendations for improvement

Purpose of the Counselling Centre

This group felt that the purpose of the centre is to provide information to the clients, to clarify their doubts and help them understand their health problems better. They also felt it was extremely useful for doctors as they did not have enough time to spend with the clients and also for clients as they could receive accurate information in a 'friendly' manner from the counsellors.

Counselling Training

The group felt that the four-day counselling training was not sufficient especially to upgrade technical skills. This was mostly felt by the MPWs. The entire group felt that too much was packed into the four days. The practical training at V N Hospital was useful. Though there was constant support, it was unnerving to provide counselling after just 4-days of training.

The respondents said that they provide counselling in their health post areas - it was part of their work. The only difference that the training had helped them to upgrade their skills. The MPWs said they had gained technical knowledge about reproductive health of women and

related issues.

The training had also challenged their attitudes and had resulted in changes in themselves. They strongly recommended that the entire staff of the hospital should be given such training to sensitize them.

Experience as Counsellors

All the participants except one had completed 15 days' supervised training in the OPD.

- Since there is no system for follow up they did not know what happened to the clients whom they counselled.
- Counselling on rotation basis: The participants felt that it was very difficult for them to work as counsellors and continue to do their work at the health posts. Initially they came to the counselling centre every alternate day and carried on with their health post work on other days. On a rotation basis it was also difficult to build rapport with clients.
- Lack of referral and reference information: The amount of information at the center with the counsellors, especially on referrals was limited, counsellors did not know where to refer clients
Lack of privacy for male counselling: The group felt it was very discouraging that there was so much delay in providing a separate room for counselling for men.

Experiences with other Health Care Providers

Group members said that in the beginning i.e. mid 2002 when the first batches of counsellors began providing services, the attitudes of the doctors were negative. The counsellors could not use their counselling skills with the client because the doctors insisted on certain procedures.

The sisters and ayahs in the OPD were rude to clients and would yell at them. Subsequent however, the trainees reported that there were changes in the attitudes and behaviour of the OPD Staff.

Quality of Services

Group members felt that one limitation was that the counselling services were provided in isolation of other prerequisites for quality of care. e.g. Copper T would not be available at the Health Post, or the doctor would not be available to insert it, or if the staff in the OPD came late, patient would have to wait long.

Continuation of Services

This group also felt that the counselling services should certainly continue.

Review Mechanisms

Group members felt that they were not able to comment about the review meetings and suggestion box as they were at the counselling centre only for 15 days.

Replication in Health Posts

The ANMs and MPWs felt that the counselling services cannot be replicated in the same way in the health posts because of

- Lack of infrastructure in health posts and resultant lack of privacy.
- Large number of clients at the health post results and not enough time with each person.
- Referrals from the health post to the hospital only for counselling was felt not very practical as clients would not go only for counselling services to the hospital.

Recommendations of Trainee Counsellors

Services

- Counselling services for men should be more visible so that men coming to other departments can also access services.
- The name 'Samaupdeshan Kendra' is not understood by a majority of people. It is necessary to change the name to something simpler for example Mahiti v Madad Kendra' (Information and Help Centre)
- Recording of counselling provided should be reviewed and made concise.
- Publicity about counselling services: The group felt that there was need to put up notices, posters, information boards and pointers all over the hospital about the counselling services being provided in the hospital. One MPW suggested that a stamp with the timings of the Centre could be stamped on all case-papers.

Training of staff

- Training of all health staff in counselling so that they are sensitive towards clients
- Regarding the 15 day practical training at the center it was suggested that there should be some mock practices before actually counselling clients at the hospital.
- More materials and information was also required for the counsellors to upgrade their knowledge, e.g.referral information about where to refer clients – names and addresses of various organizations.
- System of regular feedback and debriefing to provide feedback to counsellors should be continued. A supervisor was also important

Sustainability

Supervision and coordination

- Committee of persons who are presently involved in counselling services could provide supervision and coordination. This need not be full time.
- The community development officer (CDO) of the ward could be responsible for supervising the counselling in the future.
- Group members recommended that full time counsellors were required in the centre. Some of them were willing to work as counsellors but felt they should not be expected

to play that role in addition to the role of ANM or MPW. Some of the participants felt that it would be best for professionally trained counselors (MSW) to provide these services. Another suggestion was to send some of the interested ANMs and MPWs for further training in counselling and placing them in hospitals where such services may be replicated. It was also felt that the ANMs and MPWs should be given a choice about whether to be a counsellors or not. Interest in being a counselor varied from individual to individual, and it reflected in the quality of services provided. For example, if a provider thought of it as a duty forced upon him/her, the effort and interest would also reduce.

4. Feedback of WCHP Staff

Three WCHP team members were interviewed. This included the Project Coordinator (an AHO in the Public Health Department), and two other project staff involved with counselling. Their perceptions and view points are as follows.

Purpose of Counselling Services

- To help clients to make informed decisions about various aspects of their health.
- To provide a private space where the clients can clarify their doubts and receive guidance about the various procedures to be followed in a hospital.

The WCHP staff felt that the counselling services are very useful and should be continued. During the provision of counselling services some problems emerged as mentioned below:

Problems and Limitations

Differences between counsellor and doctors in the understanding of counselling and role of counsellors

- Doctors see counselling as a tool to 'convert' clients in accordance with their own ideas. Doctors do not view counselling as based on clients' charter of right to information and informed decision-making.

Relationship between providers

- The hierarchical system makes it difficult for the counsellors to communicate with doctors in case of clarifications. The doctors are not very approachable and the counsellors feel diffident.
- Counsellors are seen as watchdogs. They are not viewed as part of the OPD team.

Other limitations

- Too much time was spent in the planning and training stages by the project so that only one year was available for implementation. One year is not sufficient time to receive substantive feedback and should have continued for at least another year

- The ANMs and MPWs trained in counselling were expected to replicate these services in their respective health posts. They were also expected to orient the CHVs in their health posts. WCHP has been unable to follow up on counselling in health posts.
- The process of handing over of the Counselling Services by the project to the hospital administration should have started earlier so that the takeover could have been monitored. Monitoring and review mechanisms initiated by WCHP may not be sustained once the project is over.

Sustainability and Replication

Administrative and Policy level Problems

- Because of stagnant and decreasing budgets in BMC there is no possibility of hiring trained personnel. As a result, the existing staff in the hospital will be burdened by extra responsibilities.
- The six monthly turnover of RMOs means that the process of sensitizing new RMOs to the counselling and communication intervention will be a continuous one. By the time one batch is oriented it is time to start all over again with the next batch. Similarly, with frequent transfers new BMC officials will have to be continuously sensitized / oriented to the project interventions.
- The system does not give importance to small pilot projects even if they can be upscaled. e.g. the present intervention of just restructuring the space in the VND Gynaec OPD can lead to improvement in client – provider communication is cost effective.

Recommendations of WCHP

Services

- Awareness about the Counselling Services can be increased by informing the Registration Assistant (RA) and by convening a meeting of all staff in the hospital

Sustainability

- All OPD nurses could be trained and placed as counsellors on rotation
- The post of the Community Development Officer should be revived in the hospital. This person can then supervise the counselling
- Present counsellors can continue for 3-6 months but there should be rotation to avoid burn out
- All trained ANMs and MPWs may be placed as counsellors on rotation after screening
- Extra allowance or incentive can be offered to these ANMs and MPWs for the period that they work as counsellors
- Present counsellors and coordinators from the Public Health Department can continue

Systems and procedures

- Orientation of RMOs regarding counselling services needs to continue. The Honorary Doctor, supplemented by inputs on RH, Gender and Rights, presently does this
- RMOs are very crucial to counselling services and quality of care in the OPD. It is important to work closely with them, as we have to deal with them on a day-to-day basis
- Case records of counselling should continue to be maintained. These records form the basis for training needs of counsellors
- Supervision is required. This is especially important if ANMs and MPWs or OPD nurses are going to function as counsellors. Therefore a system should be put in place so that there is a smooth transition and the quality of services is not compromised. This supervisor may have to play the role of the present supervisor and coordinator which includes maintaining monitoring the counselling and coordinating between the OPD and counselling services
- Re-clarifying the role of the OPD nurse, and necessary training should be given to sensitize her/them
- Review meetings may be continued in the same way, facilitated by the Honorary

Systems and procedures

- Orientation of RMOs regarding counselling services needs to continue. The Honorary Doctor, supplemented by inputs on RH, Gender and Rights, presently does this.
- RMOs are very crucial to counselling services and quality of care in the OPD. It is important to work closely with them, as we have to deal with them on a day-to-day basis.
- Case records of counselling should continue to be maintained. These records form the basis for training needs of counsellors.
- Supervision is required. This is especially important if ANMs and MPWs or OPD nurses are going to function as counsellors. Therefore a system should be put in place so that there is a smooth transition and the quality of services is not compromised. This supervisor may have to play the role of the present supervisor and coordinator which includes monitoring the counselling and coordinating between the OPD and counselling services.
- Re-defining the role of the OPD nurse, and necessary training should be given to sensitize her/him.
- Review meetings may be continued in the same way facilitated by the Honorary

WCHP Team (2003)

Dr. Usha Ubale

Swati Pongurlekar

Ashalata Rilkar

Bharati Ghule

Veena Savinkar

Shailaja Ajgarni

Shubhangi Joshi

Renu Khanna

Korrie de Koning

Sneha Khandekar

Anagha Pradhan

Pravina Kukade

Vidya Lad

Rashmi Shinde

Dhananjay Gaikwad

Sweta Barve

Jayant Pawar

Women Centred Health Project

1st Floor, BMC Building,
Nehru Road, Vile Parle (East),
Mumbai - 400 057, INDIA.
Tel : 91-22-2616 2436
e-mail : wchpadmn@vsnl.net

SAHAJ

1, Tejas Apartments,
53 Haribhakti Colony,
Old Fadra Road,
Vadodara - 390 007, INDIA
Telephone No: 91-265 - 2340223

Royal Tropical Institute

Mauritskade 63
P.O. Box 95001
1090 HA Amsterdam
The Netherlands
Telephone No. 0031 -020-5688 239
