**CONCEPT NOTE on SUPPORTIVE MENTORING FOR COUNSELLORS OF ASSAM**

**Background**

The PPTCT programme was introduced in India as a component of the National AIDS Control Program Phase-II in the year 2002. Many states provide PPTCT services through the ante-natal clinics mostly located in tertiary level (medical colleges) and secondary level health facilities (district hospitals and CHCs). The PPTCT services were initiated in Assam in 2005. As on date, 23 Centres (Medical Colleges, District Hospitals, CHCs and PHCs) are providing these (PPTCT) services. All these centres also have ICTCs (General).

In 2008, Dr. Bir Singh of the All India Institute of Medical Sciences, New Delhi was invited to review the quality of the PPTCT programme in Assam and suggest recommendations. His report revealed that there were large numbers of pregnant women accessing emergency labour services who were not covered by counselling and testing services; these systems were not in place. In addition, the medical and nursing staff was not oriented to the PPTCT programme and ownership of the programme by hospital authorities was absent. Supervision plan for Assam was non-existent. Networking and linkages needed strengthening both internally (within the hospital - intradepartmental) as well as between the hospital and other services/organisations, such as CBOs, Positive Networks and others. In some centres, counsellors and laboratory technicians were found to be over-worked, leading to a high possibility of burn out.

He therefore recommended that **State level Counsellors Review meetings be held at least yearly**, if not six-monthly, where issues related to counselling could be brought out into the open and deliberated upon to find appropriate solutions. He felt it was important to **assess the quality of counselling services** either annually or bi-annually by exit interviews or by using mystery clients. He recommended that **counselling & testing services for un-booked pregnant women coming directly in labour** needed to be put in place at all centres. For this purpose, staff nurses and medical officers working in the labour rooms could be trained in basic counselling skills and rapid (“on the spot”) test kits made available in the Labour rooms. **Round-the-clock duty for counsellors & laboratory technicians after optimization of work load** was also considered as a useful alternate. ANC/PPTCT services to **encourage couple counseling, partner counseling where risk assessment of partners needed to be ensured** [[1]](#footnote-2).

The most recent review was conducted by South India AIDS Action Programme (SIAAP) in Assam in November 2009. This review revealed the following gap[[2]](#footnote-3)s:

* *Counselling is understood and/or practiced as more of information giving and education rather than engaging with the clients concerns, emotions, needs and attempting to understand/address them.*
* *Lack of uniformity in following pre-test counselling procedures across centres.*
* *Risk assessment and risk reduction was found to be highly inadequate. Counsellors, at most times assumed that the woman’s risk for HIV was through her husband’s sexual encounters alone, leaving the woman’s direct risk unexplored.*
* *No exploration/assessment of the most recent sexual encounter of the antenatal woman; therefore no assessment of the ‘window period’.*
* *Inadequate time and information provided to clients during counselling.*
* *No penis model available with counsellors, therefore, condom demos are not done with any client.*
* *Lack of understanding of the “opt-out” procedure, with women not being given an option to refuse the HIV test.*
* *Absence of post-test counselling sometimes where the result is handed over to the husband/ASHA – missed opportunity to talk about breast-feeding, importance of institutional delivery and related matters.*
* *Need for individual post-test counselling for women testing negative not understood and not given importance.*
* *Lack of focus on spouse counselling and testing; counsellors were unaware of clients being accompanied by their husbands to the centre and therefore, did not engage with them. In addition, the husband and wife were seen by separate counsellors, going against the principle of couple counselling and making accurate risk assessment and risk reduction impossible.*

**This highlights the need for ongoing mentoring of counsellors to help them enhance their capacity in terms of knowledge, skills and attitude as well as support each other through these learning experiences.**

**What is Supervision?**

Supervision is a combination of supportive, educative and managerial skills that aids the personal and professional growth of supervisees. Supervision ensures provision of quality service to the end users of services, i.e. clients. Supervision means more than just monitoring. It lends an opportunity for the supervisor to go beyond the task of counsellor and understand this individual from a holistic perspective.

**Why is Supervision important for Counsellors?**

* A Counsellor's work is essentially person/people oriented where there is a constant and intense interchange of emotions. Supervision guides Counsellors to handle these emotions in a healthy manner.
* Counselling requires a good degree of self-awareness in order to help clients appropriately. Supervision helps Counsellors introspect from within to gain insights about self which results in effective helping strategies with their client/s
* Supervision provides the necessary support in coping with Counsellor burnout
* Supervision assists Counsellors in problem solving by helping them look at varied options
* Supervision as a group process helps in learning new ways of handling similar problems/difficult situations of clients through transfer of learning from one to the other.

**The *SIAAP* Experience:**

*Siaap* has trained more than 500 Counsellors in the field of HIV/AIDS. We have found that Counsellors (irrespective of their educational qualifications), find it difficult to proceed with some of their clients, feel emotionally drained with some others and require specific inputs to help them deal with their clients more effectively. Receiving ongoing supervision has helped them overcome many of these situations, thereby enhancing their professional and personal growth.

**Method:**

*Siaap* will provide mentoring training for a maximum of 12 supervisors for a total of 8 days in Assam, staggered in 2 phases of 4 days. This will help them to provide ongoing mentoring services for PPTCT/ICTC counsellors at government hospitals in Assam. Specific criteria will be drawn up based on which counsellors can be selected by SACS and UNICEF with assistance from SIAAP.

Assam may be sub-divided into 4 regional clusters and the contiguous districts may be clubbed under one region. Three Peer Supervisors may be allotted to each region and will make site visits every month for the first 6 months. Each supervisor will be responsible for about 4 counsellors. This will be followed by group supervision sessions on a bi-monthly basis by a pair of Peer Supervisors for a group of about 8 counsellors for the next 12 months. By the end of the first year, a detailed report will be available about each individual counsellor and feed into the training plan as well.

**Way Forward - Next Steps:**

* On-site Peer Supervision**:** Peer Supervisor visits the site, sits in on a session after obtaining the permission of the client, assures confidentiality and observes the counsellor in the session. After the client leaves, the Peer Supervisor then provides feedback on the use and appropriateness of skills and knowledge to the counsellor, and suggests areas for improvement while exploring alternatives with the counsellor.
* Group Supervision**:** After having supervised all the Counsellors in a particular region/area individually, the Peer Supervisor then invites them for a group session. Updating information, case discussions and group support are the methods used.
* Supervision of Peer Supervisors**:** All supervisors will be supervised once a quarter by *Siaap* trainers in collaboration with appropriate ASACS & UNICEF personnel.

**Suggested Frequency of Supervision:**

# Site-supervision, once a month for all counsellors for the first 6 months

# Group Supervision (ideally of 8 counsellors) once in 2 months for the next 12 months where SIAAP will assist with 1-2 sessions in each region

# Supervision of Peer Supervisors, once a quarter to be undertaken by SIAAP

**Suggested Outcomes:**

* Resource pool of a minimum of 12 trained peer supervisors in the region
* Improvement in the quality of counseling as reflected in increase in post-test counselling and follow-up rates
* Guidelines for case management in HIV/AIDS counselling
* 50 documented case studies available

**Reports:**

Supervisors will make available monthly reports to be submitted to ASACS and UNICEF. In addition, reports of all supervisory sessions (site supervision & group supervision) will be maintained. These reports will be confidential and available only to their immediate supervisors. Specific requests for reports will be discussed with the concerned counsellor and his/her supervisor before details are released.

**Budget**

Enclosed

**Note:**

Number of PPTCT sites - 23

Number of PPTCT counsellors - 25

Number of VCCTC sites - 23

Number of VCCTC counsellors - 23

Total number of sites to be supervised - 23

Total number of counsellors to be supervised- 48

1. *Services for Prevention of Parent to Child Transmission (PPTCT) of HIV/AIDS in Assam: Current Status, Challenges and Recommendations for Strengthening systems to Scale up; Dr. Bir Singh-AIIMS, Aug-Sep 2008 .* [↑](#footnote-ref-2)
2. *Report on the quality of counselling in PPTCT centres of Assam, November-December 2009, SIAAP* [↑](#footnote-ref-3)