ACKNOWLEDGEMENTS

Preparation of the Abdominal Tubectomy Tubal Ligation Under Local Anesthesia Induction training curriculum was the combined effort of many individuals.

The Abdominal Tubectomy Refresher training reference materials have been developed by EngenderHealth and pre-tested in 33 PERFORM districts where abdominal tubectomy refresher trainings have been conducted. Suggestions for modifications in the content were accepted from trainees and trainers who were involved with these trainings.

We thank the following individuals for their efforts in preparing the curriculum:
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The TAG committee who met at Queen Mary’s Hospital, Lucknow on October 22, 2001 consisting of Dr. Chandrawati, Retd., HOD Queen Mary’s Hospital, Lucknow, Dr. Sushma Pandey, Retired HOD, Queen Mary’s Hospital, Lucknow. Late Dr. Snehlata Agarwal, Dr. Manju Shukla. Dr. Indu Tandon, Dr. Hem Prabha Gupta. Assistant Professors. KGMC. Lucknow. Dr. Meera Pathak. CMS. Virangana Avanti Bai Hospital. Dr. Radha Vats. MS. Virangana Jhalkari Bai Hospital. Dr. Madhu Nigam, SMO PPC. Virangana Avanti Bai Hospital. Dr. Asha Rai. Trainer. Abdominal Tubectomy Ligation, Dr. Sulabha Swaroop. Sr. Program Coordinator, SIFPSA. Dr. Shabina Hussain. Program Coordinator. SIFPSA. Dr. Kamaljyoti. Joint Director. Dr. Hari Om Dixit. MO. Directorate of Family Welfare, Uttar Pradesh and Ms. Barbara J. Spaid. Country Director. Engenderhealth, India Country Office for providing valuable feedback on the content.

Dr. Brijendra Singh, General Manager, Public Sector, SIFPSA for his continuous support in facilitating the process.

Kapil Dev. IAS
Executive Director
SIFPSA
The Government of India, the Government of Uttar Pradesh (UP) and the United States Agency for International Development (USAID) have embarked upon the Innovations in Family Planning Services (IFPS) project in Uttar Pradesh for the improvement and expansion of family planning and related reproductive health services in the public and private sectors. To undertake this project, the State Innovations in Family Planning Services Agency (SIFPSA) has been created as an autonomous society.

As part of their work in strengthening training, SIFPSA and the Department of Health and Family Welfare of Uttar Pradesh have collaborated with EngenderHealth to strengthen the service delivery skills of family planning service providers.

Female sterilization remains a commonly used method for a large number of family planning acceptors. Abdominal Tubectomy is a popular method of sterilization in U.P. The twelve-days Abdominal Tubectomy Induction training course aims to induct additional doctors in providing Abdominal Tubectomy.

The curriculum is designed to provide participants introduction in theory as well as skill practice, so that by the end of twelve days the doctors are competent to perform Abdominal Tubectomy and the nurses are competent to assist them in this procedure. The curriculum consists of a facilitator's guide and a reference Manual for the trainers and for the participants. The curriculum covers counseling, informed consent, indications and precautions, client assessment, infection prevention, anaesthesia, surgical procedure, post-operative recovery, discharge and follow-up, management of complications, practice on ZOE models, Abdominal Tubectomy demonstration on clients, provision of quality services, emergency preparedness and Cardiopulmonary Resuscitation (CPR). Nurses will be trained for the six working days so that they can work together with the doctor as a team.
<table>
<thead>
<tr>
<th>Particulars</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agenda</strong></td>
<td>i-iv</td>
</tr>
<tr>
<td>Instruction for users</td>
<td>1-2</td>
</tr>
<tr>
<td>Session Objectives</td>
<td>3-5</td>
</tr>
<tr>
<td><strong>Day I</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>• Introduction, expectations &amp; objectives of the training</td>
<td>6-13</td>
</tr>
<tr>
<td>• O.T. Demonstration by trainers</td>
<td>14</td>
</tr>
<tr>
<td>• Review of O.T. activity</td>
<td>15</td>
</tr>
<tr>
<td>• Wrap-up and the daily evaluation</td>
<td>16</td>
</tr>
<tr>
<td><strong>Day II</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>• Re-cap and warm-up</td>
<td>17</td>
</tr>
<tr>
<td>• Surgical procedure demonstration and practice on Zac.</td>
<td>18-19</td>
</tr>
<tr>
<td>• O.T. activity - abdominal tubectomy procedure on client</td>
<td>20-30</td>
</tr>
<tr>
<td>• Video film on abdominal tubectomy</td>
<td>31</td>
</tr>
<tr>
<td><strong>Day III</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Session</strong></td>
<td></td>
</tr>
<tr>
<td>• Counseling clients on sterilization</td>
<td>32-36</td>
</tr>
<tr>
<td>• Values and attitudes</td>
<td>37-39</td>
</tr>
<tr>
<td>• Informed consent and informed choice</td>
<td>40-45</td>
</tr>
<tr>
<td><strong>Day IV</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>• Infection prevention</td>
<td>46-47</td>
</tr>
<tr>
<td>• Video film on infection prevention</td>
<td>48</td>
</tr>
<tr>
<td><strong>Day V</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>• Outreach mobile services</td>
<td>49</td>
</tr>
<tr>
<td>• Visit to the camp</td>
<td>50</td>
</tr>
<tr>
<td><strong>Day VI</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sessions</strong></td>
<td></td>
</tr>
<tr>
<td>• Emergency preparedness</td>
<td>51</td>
</tr>
<tr>
<td>• Cardio pulmonary resuscitation</td>
<td>52-53</td>
</tr>
<tr>
<td>• Mid-course questionnaire for doctors and post-test for nurses</td>
<td>54-59</td>
</tr>
</tbody>
</table>
Day VII
Sessions
- Indications and precautions ......................................................... 60-62
- Client assessment and practical ................................................. 63-64
- Skills of a counselor ................................................................. 65-66

Day VIII
Sessions
- Anesthesia and pain management .............................................. 67-68
- Practice on Zoe for local anesthesia ....................................... 69
- Management of complications ............................................... 70-71

Day IX
Sessions
- Post-operative recovery and discharge .................................... 72-73
- Follow-up Instructions on discharge and post operative medication 74

Day X
Sessions
- Providing quality Services ....................................................... 75

Day XI
Sessions
- Standards for female and male sterilizations – GOI .................. 76
- Visit to the camp ..................................................................... 77

Day XII
Sessions
- Post-test and programme evaluation ....................................... 78-79
- Mop-up .......................................................... 80-83

Appendices ............................................................. 84-103

Appendix A: Instructions for using the Zoe® Gynaecologic simulator 85-88
Appendix B: How people learn .................................................. 89-91
Appendix C: Conducting the course ........................................... 92-96
Appendix D: Emergency Preparedness ....................................... 97-103
## Agenda for Abdominal Tubectomy Induction Training

<table>
<thead>
<tr>
<th>DAY - I</th>
<th>DAY - II</th>
<th>DAY - III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TIME</strong></td>
<td><strong>ACTIVITY</strong></td>
<td><strong>TIME</strong></td>
</tr>
<tr>
<td>09:00 - 09:30</td>
<td>Registration</td>
<td>09:00 - 09:30</td>
</tr>
<tr>
<td>09:30 - 10:30</td>
<td>Welcome and introduction</td>
<td>09:30 - 10:30</td>
</tr>
<tr>
<td>10:30 - 10:45</td>
<td>Tea-Break</td>
<td>10:30 - 10:45</td>
</tr>
<tr>
<td>10:45 - 12:30</td>
<td>Objectives, Schedule on standard AT procedure</td>
<td>10:45 - 11:30</td>
</tr>
<tr>
<td>12:30 - 13:00</td>
<td>OT demonstration by train</td>
<td>12:30 - 13:00</td>
</tr>
<tr>
<td>13:00 - 14:0</td>
<td>Lunch</td>
<td>13:00 - 14:0</td>
</tr>
<tr>
<td>14:00 - 14:45</td>
<td>Warm-up</td>
<td>14:00 - 14:45</td>
</tr>
<tr>
<td>16:15 - 17:15</td>
<td>Logistics for the participants</td>
<td>16:15 - 17:15</td>
</tr>
<tr>
<td>17:15 - 18:0</td>
<td>Wrap-up and Assignments – Chapter Eight and Nine from Reference Manual Experience sharing</td>
<td>17:15 - 18:0</td>
</tr>
<tr>
<td>TIME</td>
<td>ACTIVITY</td>
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<tr>
<td>09:00</td>
<td>Warm-up and Re-cap</td>
<td>09:00 - 9:30</td>
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<td>Infection Prevention</td>
<td>09:30 - 10:30</td>
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<td>Tea</td>
<td>10:30 - 10:45</td>
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<td>10:45</td>
<td>Infection Prevention contd.</td>
<td>10:45 - 11:30</td>
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<tr>
<td>11:30</td>
<td>OT activity</td>
<td>11:30 - 1:30</td>
</tr>
<tr>
<td>1:30</td>
<td>Lunch</td>
<td>1:30 - 2:30</td>
</tr>
<tr>
<td>2:30</td>
<td>Warm-up</td>
<td>2:30 - 2:45</td>
</tr>
<tr>
<td>2:45</td>
<td>Review of OT activity</td>
<td>2:45 - 3:30</td>
</tr>
<tr>
<td>3:30</td>
<td>Tea-break</td>
<td>3:30 - 4:00</td>
</tr>
<tr>
<td>3:45</td>
<td>Practical on Infection Prevention &amp; video film on Infection Prevention</td>
<td>3:45 - 4:15</td>
</tr>
<tr>
<td>4:15</td>
<td>Wrap-up and Assignment - chapter thirteen from the Reference Manual Experience sharing</td>
<td>4:15 - 4:30</td>
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<tr>
<td>DAY - VII</td>
<td>ACTIVITY</td>
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<td>Indications and Precautions</td>
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<td>Tea</td>
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<tr>
<td>10:45 - 11:30</td>
<td>Client Assessment and Practical for Client Assessment in FP- OPD</td>
<td>10:45 - 11:30</td>
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<td>11:30 - 1:30</td>
<td>OT activity</td>
<td>11:30 - 1:30</td>
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<tr>
<td>1:30 - 2:30</td>
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<td>Review of OT activity</td>
<td>2:45 - 3:30</td>
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<td>Tea-break</td>
<td>3:30 - 3:45</td>
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<td>3:45 - 4:15</td>
<td>Skills of a counselor Practice Role-Play on counseling</td>
<td>3:45 - 4:15</td>
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<td>DAY - X</td>
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<td>9:30 - 10:30</td>
<td>Providing Quality Services</td>
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<td>10:30 - 10:45</td>
<td>Tea</td>
<td>10:30 - 10:45</td>
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<td>10:45 - 11:30</td>
<td>Practice of the standardized</td>
<td>10:45 - 11:30</td>
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<td></td>
<td>procedure on Zoe</td>
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<td>11:30 - 1:30</td>
<td>OT activity</td>
<td>11:30 - 1:30</td>
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<td>Warm-up</td>
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<td>Review of OT activity</td>
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<tr>
<td>3:30 - 3:45</td>
<td>Tea-break</td>
<td></td>
</tr>
<tr>
<td>3:45 - 4:15</td>
<td>Practical on CPR</td>
<td></td>
</tr>
<tr>
<td>4:15 - 4:30</td>
<td>Wrap-up and Assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Standards of Female</td>
<td></td>
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<td></td>
<td>and Male Sterilization - GOI</td>
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<td></td>
<td>Experience sharing</td>
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INSTRUCTIONS FOR USERS

PURPOSE
The purpose of the facilitator’s session guide along with the manual “Abdominal Tubectomy Under Local Anesthesia” is to help trainers prepare to conduct a twelve-day induction training for service providers on Abdominal Tubectomy. The curriculum is designed to induct doctors for Abdominal Tubectomy.

PARTICIPANTS FOR THE TRAINING
The curriculum is designed for M.B.B.S. doctors and nurse assistants who need an introduction to Abdominal Tubectomy under local anesthesia.

CURRICULUM STRUCTURE
The curriculum is divided into sessions, each of which focus on an aspect of providing Abdominal Tubectomy under local anesthesia. The curriculum provides theory and practical sessions and seeks active participation of all trainees throughout the course.

Each session begins with the critical information that you, as the trainer, will need to conduct the module: objectives for the participants, estimated time required, and advance preparation needed. An instructional grid summarizes the content of each training step, the time estimated for the step, the training techniques, and any special aids that are needed. Before using this curriculum, you should familiarize yourself with the content of each chapter of the manual that is provided to both the trainers and the participants, “Abdominal Tubectomy Under Local Anesthesia” Manual for Uttar Pradesh. In addition, tips on training techniques are given in the appendix.

TIME ALLOCATION
The time assigned to each module are estimates and should be used as a guide for planning the training. The training is estimated to last twelve whole days for Doctors, if the curriculum is followed without major modifications.

LANGUAGE
The language used in this curriculum is, to a large extent non-technical so as to familiarize participants with simple terminology that can be used with clients.

MATERIALS FOR THE TRAINERS
In addition to this session guide, you will require below listed items to conduct the training:

- Adequate copies of the pre and post-test papers, handouts and manuals for both doctors and assistants, ZOE, Abdominal Tubectomy kit.
- Writing paper and pens for participants
- Sample copies of the informed consent form and the guidelines for assessing client’s decision for Abdominal Tubectomy under local anesthesia.
- Boxes containing samples of commonly available contraceptives
- Video film of Abdominal Tubectomy standard procedure, CPR and I.P.
MATERIALS FOR THE PARTICIPANTS

The participants will receive
- A copy of the training schedule and checklists.
- A manual on Abdominal Tubectomy Under Local Anesthesia.
- Standards for Female and Male Sterilization - GOI.

EVALUATION

Evaluation is a fundamental part of training that donors, implementing organizations, and trainers should plan and budget for in advance of each training. Proper evaluation helps ensure that the training is not merely a one-time intervention, but part of a broader strategy to develop participants’ skills and help them apply those skills upon return to their work-sites. Evaluation can also help to improve future training activities. Evaluation of this training includes the following:

- A pre and post-test of participants' knowledge and attitudes
- An assessment of the training course by the participants
- An assessment of the application of skills and attitudes acquired during the practicals

PRACTICUM

Gives participants a chance to practice their skills on real clients.

IMPORTANT TIPS FOR THE TRAINER

1. Familiarize yourself with the content of each chapter in the 'Abdominal Tubectomy Under Local Anesthesia Manual' as well as the corresponding session guide. In addition the appendix provides instructions on how to use the ZOE model.

2. Advance preparation is the key to a successful session. Use the guide to prepare thoroughly in advance and avoid using the guide as a reference during a session. When trainers/facilitators constantly refer to the guide during the training sessions, it hinders the trainees concentration and the messages do not carry as much impact on them.

3. As far as possible trainers need to work together as a team - subtly supporting each other in every session. This will also set the tone for teamwork among the participants in their assignments.

4. In order to provide continuity to the training each day starts with a re-cap session and ends with a wrap-up session.

5. The seating arrangement should be informal, preferably in a semi circle without any dias for the trainers. Training is most effective when trainers adopt a warm and friendly attitude towards the participants and take care not to ridicule any trainee.

6. Through discussions, and the use of leading questions draw from participants the information that you are trying to impart and where necessary fill in the gaps. That way trainees will find it easier to assimilate the knowledge and experiences.
SESSION OBJECTIVES

INTRODUCTORY SESSION

- Provide an overview of the induction course for personnel involved in Abdominal Tubectomy services.
- Assess participants' knowledge through a pre-test.

COUNSELING

- List the benefits of counseling clients on family planning especially sterilization.
- Describe the counseling process with special emphasis on method-specific counseling for sterilization clients
- List the important facts about Abdominal Tubectomy and the warning signs that need to be addressed during the counseling session.
- List the benefits and limitations of Abdominal Tubectomy

INFORMED CONSENT

- Describe and apply the principles of informed consent for voluntary sterilization.

INDICATIONS & PRECAUTIONS

- Explain the indications and precautions for Abdominal Tubectomy under local anesthesia.

CLIENT ASSESSMENT

- Describe the main features of a client assessment – conditions that are acceptable and those that are not, what is asked when taking a medical history, what is carried out in a physical examination and what laboratory examinations are asked for.

INFECTION PREVENTION

- Describe recommended infection prevention practices in the provision of Abdominal Tubectomy that minimize the risk of post-operative infections including Hepatitis - B and HIV/AIDS.
- Describe recommended infection prevention practices in the decontamination, cleaning and high-level disinfection or sterilization of instruments gloves and waste disposal.

ANESTHESIA

- Describe the principles of and requirements for the use of local anesthesia, including the importance of emotional preparation of the client and continual communication during surgery.

SURGICAL PROCEDURE

- Describe standard Abdominal Tubectomy procedure under local anesthesia.
PRACTICE ON ZOE

- Perform the standard Abdominal Tubectomy procedure under local anesthesia using the ZOE model.

POST-OPERATIVE RECOVERY, DISCHARGE & FOLLOW-UP

- Describe post-operative monitoring, post-operative instructions, discharge and follow-up for a client after Abdominal Tubectomy under local anesthesia.

VIDEO FILM

Audio-visual presentations – (a) standard surgical procedure of Abdominal tubectomy (b) cardio pulmonary resuscitation (CPR) and (c) infection prevention.

WRAP-UP

- Summarize the day’s learning.

RE-CAP

- Recapitulate the previous day’s proceedings to provide continuity to the forthcoming sessions

MANAGEMENT OF COMPLICATIONS

- Explain how to recognise and manage surgical and anesthesia-related complications.

ABDOMINAL TUBEECTOMY DEMONSTRATION ON CLIENT

- Perform standard Abdominal Tubectomy procedure under local anesthesia.

PROVIDING QUALITY SERVICES UNDER LOCAL ANESTHESIA

- Discuss Rights of the client, needs of the service provider in providing quality services.

POST-TEST & TRAINING EVALUATION

- Provide opportunity through a post-test to gauge how much knowledge the participants have gained through the induction course.
- Provide feedback to the facilitators and organizers on how the participants felt about the course.
MOP-UP

- Provide opportunity to clear any doubts that the participants may still have related to Abdominal Tubectomy services.
- Provide information on the post-training follow-up of participants.

EMERGENCY PREPAREDNESS

- Importance of emergency preparedness and prevention of emergencies
- List all necessary drugs and equipment for emergency preparedness.
- Emergency conditions and their management

CPR

- Explain and demonstrate cardio-pulmonary resuscitation.
Day I

Session Title: INTRODUCTION, EXPECTATIONS & OBJECTIVES OF THE TRAINING

ADVANCE PREPARATION:

- Prepare the objectives on the flip-chart
- Ensure that you have sufficient copies of the schedule for distribution to participants
- Ensure that you have sufficient copies of the pre-test (one for each participant)

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
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<tbody>
<tr>
<td>30 minutes</td>
<td>Registration</td>
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<tr>
<td>60 minutes</td>
<td>Welcome &amp; Introduction of participants</td>
<td>Partners exercise</td>
<td>None</td>
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<tr>
<td>30 minutes</td>
<td>Objectives &amp; Schedule</td>
<td>Presentation</td>
<td>Flip chart. handouts</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Participants expectations &amp; training norms</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Pre-test</td>
<td>Written test</td>
<td>Pre-test forms</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

Introduce yourself and then tell participants that to facilitate informal introductions you are splitting the group into pairs. Split the group into pairs and tell each pair that they will be given 3 minutes to find out about each other before they introduce each other to the entire group. Pair the facilitators/organizers too. To lead the introductions, introduce your partner. Moving clockwise allow every pair in the room to introduce themselves very briefly.

OBJECTIVES & SCHEDULE

Explain the general objectives of this training and the participants' responsibilities. Distribute the training schedule to the participants. Explain that in order to complete the sessions effectively everyone is expected to be on time for the training sessions.

PARTICIPANT'S EXPECTATIONS AND TRAINING NORMS

Ask participants what they expect to get out of this training program as (a) professionals and (b) individuals. Write down their needs and expectations on a flip chart and post it on the wall, where they can be referred to periodically to see if participants' needs are met.

Explain:
- Participation is key to the training success
- Each participant is expected to be on time and actively participate in all the sessions.
- Through exercises, role-plays and practicals, participants will have the opportunity to try out and improve their skills.
- They should consider each other as well as facilitators as resource persons.
PRE-TEST

Explain that participants will be required to undergo a pre-test which will help both the participants and the trainers to gauge the level of knowledge prior to training. Explain that it will also help facilitators to identify the areas that need more attention during the sessions. Tell them that they will undergo a similar test at the end of the training, which will be used to gauge their gain in knowledge through the training. Explain that throughout the training they will be observed during the exercises and during the practicals on skill development. Give participants 30 minutes to finish the test and return their sheets to you.
**PRE/POST TEST (DOCTORS/NURSES)**

Name:  
Place of posting:  
Designation:  
Date:  

**Instructions:** In the space provided, write a capital T if the statement is **true** or a capital F if the statement is **false**.

<table>
<thead>
<tr>
<th>Statement</th>
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<tbody>
<tr>
<td>1. Counseling ensures that the client understands the benefits, risks, implications and alternatives to Abdominal Tubectomy ligation.</td>
<td></td>
</tr>
<tr>
<td>2. The immediate postpartum period may be the best time for the woman to decide on having postpartum Abdominal Tubectomy.</td>
<td></td>
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<tr>
<td>3. The provider is the best person to decide on the method the client should use.</td>
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<tr>
<td>4. Sterilization lasts for only 5 years after the tubes are occluded.</td>
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<tr>
<td>5. A woman who is certain that she wants no more children is a potential client for ligation.</td>
<td></td>
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<tr>
<td>6. A woman with diabetes under control can tolerate Abdominal Tubectomy.</td>
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<tr>
<td>7. A precaution for not performing Abdominal Tubectomy is the finding of a retroverted uterus.</td>
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<td>8. It is essential to take client's medical history.</td>
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<td>9. Extensive laboratory examinations are not required prior to Abdominal Tubectomy.</td>
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<td>10. Decontaminated and cleaned metal instruments can be sterilized by boiling in water for 20 minutes.</td>
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<td>11. To minimize transmission of Hepatitis B Virus (HBV) or HIV to the staff during the cleaning process, all soiled instruments should first be soaked in 0.5% chlorine solution for 10 minutes.</td>
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<td>12. Verbal support from the operating doctor and nursing staff minimizes client fear and discomfort.</td>
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<td>13. Taking baseline vital signs of the client is not necessary in elective Abdominal Tubectomy.</td>
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<td>14. After injecting local anesthesia, the operating doctor should wait for 2-3 minutes before making the incision.</td>
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<td>15. Using a smaller volume of 2% lignocaine will provide better anesthesia than a larger volume of 1%.</td>
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<td>16. A woman who has had Abdominal Tubectomy and misses her period should return to the clinic because she may be pregnant.</td>
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<td>17. Anesthesia-related complications are more likely to occur in heavily sedated clients.</td>
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<td>18. Bladder voiding is not an essential step in performing Abdominal Tubectomy.</td>
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**Instructions:** Circle the best option in the following:

19. The best time to perform an Abdominal Tubectomy under local anesthesia is
   a. Any time during the menstrual cycle
   b. Within the first 48 hours postpartum or more than 6 weeks after delivery
   c. Within the first 6 weeks postpartum
   d. Within the first 10 days postpartum or more than 6 weeks after delivery

20. Prior to performing an abdominal Tubectomy procedure, the operating doctor must verify informed consent by
   a. Noting that the consent form is signed and discussing about the client with the counselor
   b. Ensuring that the consent form is signed by both the client and her husband
   c. Examining the consent form to see that the client's signature was witnessed
   d. Reviewing the consent form for completeness and talking with the client to ensure that she understands the procedure she has requested
21. A pelvic examination by the operating doctor
   a. Must be performed on the same day of the surgery
   b. Must be performed after the procedure to ensure that the uterus has not been perforated
   c. Is unnecessary
   d. Should be performed by the nurse to check for infection

22. If a systemic or local (pelvic) infection is noted on the day of the surgery
   a. The procedure should be performed anyway
   b. The client should be sent home and told to return when she feels that the infection has been resolved
   c. Laparoscopy should be performed instead of Abdominal Tubectomy
   d. The procedure should be postponed until the client has been treated for the infection and a temporary method should be prescribed

23. When faced with an obese client who requests Abdominal Tubectomy under local anesthesia, the operating doctor should
   a. Plan to use more assistants during the procedure
   b. Plan the procedure at a facility where general anesthesia can be given
   c. Suggest that the client lose weight and ask her to return in three months
   d. Use a vertical instead of a horizontal incision

24. After an Abdominal Tubectomy procedure, the only acceptable method for processing soiled instruments is
   a. Cleaning followed by sterilization
   b. Decontamination with 0.5% chlorine solution, cleaning, then disinfecting with Dettol
   c. Soaking in Dettol for at least 24 hours
   d. Decontamination with 0.5% chlorine solution, cleaning, followed by sterilization or high-level disinfection

25. The human immunodeficiency virus (HIV) and the Hepatitis - B virus (HBV) are reliably killed by
   a. Thoroughly rinsing instruments with sterile water which has been boiled
   b. Air drying instruments for at least 48 hours before re-use
   c. Soaking instruments in a 0.5% chlorine solution for 10 minutes
   d. Soaking instruments in a povidone iodine solution immediately after use

26. When preparing the client for surgery, the staff should tell her that
   a. There will be a lot of pain during the procedure but that she won’t feel it because of the medication she will receive
   b. She will probably feel some discomfort, pulling and slight cramping during the procedure
   c. The doctor is very good and that she will probably not feel anything during the surgery
d. Even though she might be feeling some cramping and discomfort during the procedure, she should not mention it during the surgery.

27. When infiltrating 1% lignocaine to produce local anesthesia for an Abdominal Tubectomy procedure
   a. The operating doctor must be sure that only the skin and subcutaneous tissue are infiltrated before starting the procedure.
   b. The incision may be made as soon as the lignocaine is injected.
   c. Epinephrine should always be used along with the lignocaine.
   d. The operating doctor must attempt to infiltrate all the layers from the skin to the peritoneum with anaesthetic.

28. The following conditions indicate that the client is ready for discharge
   a. Her 8-year-old son has arrived to take her home.
   b. She can walk upright with minimal support.
   c. She complains of nausea and vomiting.
   d. She still feels very drowsy.

29. During the post-operative period
   a. Check and record vital signs every 15 minutes until client is stable.
   b. Review the client record upon transfer.
   c. Complete client record form.
   d. All of the above.

30. When performing the Abdominal Tubectomy procedure, intra-abdominal bleeding
   a. Occurs solely in the operating theatre.
   b. Is related to the level of the anesthesia.
   c. May occur in the operating theatre or at any time during the post-operative period.
   d. Usually occurs in women with a previous history of postpartum haemorrhage.
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# ABDOMINAL TUBECTOMY: DOCTORS/ASSISTANTS INDIVIDUAL AND GROUP PERFORMANCE MATRIX

Abdominal Tubectomy Induction Training – EngenderHealth

District ................................ Dates ........................................... Trainers ..............................................................

Participants  

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TOTAL PERCENTAGE OF QUESTIONS ANSWERED CORRECT
ADVANCE PREPARATION:

- Read the facilitator’s notes, and ensure that there are clients for Abdominal Tubectomy in the O.T.
- Inform O.T. sister and staff.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip Chart</td>
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<tr>
<td>50 minutes</td>
<td>Demonstration of Abdominal Tubectomy under local anesthesia in O.T.</td>
<td>Demonstration</td>
<td>Client</td>
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<tr>
<td>5 minutes</td>
<td>Summary</td>
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FACILITATOR’S NOTES

OBJECTIVES

- To demonstrate the procedure of Abdominal Tubectomy (AT) under local anesthesia in O.T.

Tell the participants that the standardized Abdominal Tubectomy procedure under local anesthesia will be demonstrated in the O.T. Explain each step as you perform. Discuss the procedure afterward in the classroom.

SUMMARY

Summarize the steps of the procedure: clear any doubts that the participants may have.
Session Title: REVIEW OF O.T. ACTIVITY

ADVANCE PREPARATION

Prepare the objectives of the session on the flip chart.

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<tr>
<th>Estimated Time</th>
<th>Content</th>
<th>Training technique</th>
<th>Materials required</th>
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<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentations</td>
<td>Flip chart</td>
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<tr>
<td>35 minutes</td>
<td>Review of O.T. activity</td>
<td>Discussion</td>
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<td>5 minutes</td>
<td>Summary</td>
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FACILITATOR’S NOTES

OBJECTIVES

- To review O.T. activity
- To discuss the O.T. activity just observed.
- To take feedback from the participants with emphasis on procedure and infection prevention practices.

SUMMARY

Summarize the contents of the procedure and address any questions that participants may have.

NOTE: Same procedure to be repeated every day during O.T. activity
ADVANCE PREPARATION

Prepare flip chart for the session.

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<th>Techniques</th>
<th>Materials required</th>
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<tbody>
<tr>
<td>5 minutes</td>
<td>Objective</td>
<td>Presentation</td>
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<tr>
<td>10 minutes</td>
<td>Wrap-up / Daily evaluation and sharing experience</td>
<td>Discussion</td>
<td>Flip chart</td>
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FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To give the facilitators feedback about how the participants feel about the day's program.
- To provide suggestions for improving the next day's program.
- To ensure that every participant has a chance to give her/his opinion and share experiences.

DAILY EVALUATION

The daily evaluation is primarily to help facilitators and organisers receive feedback as mentioned above, in order to improve upon forthcoming sessions and training environment where necessary.

Divide participants into four groups (use the alphabet method to divide the participants everyday) – A B C and D. Explain to participants that the aim of this exercise is to help the organisers and facilitators improve upon performance and content etc., and that they should feel free to express their honest opinions.

Ask all the 'A's What is the most useful thing you have learned this day? Ask all the 'B's Which session was least useful for your work and why? Ask all the 'C's What is it that you liked most about the training today? Ask all the 'D's How do you suggest we improve the training to make it more interesting, useful and enjoyable? Note the responses.

Explain to the participants that they will be responsible for the re-cap session the next day. Explain that this is an opportunity to display their creativity in presenting the re-cap; to share their experience working together as a team and to allow each member to participate in the session in harmony. The re-cap will be for 10 minutes only. The facilitators will conduct the warm-up exercise.

Next, if you have anything that you want participants to do a preparation for the next day's sessions, now is the time to tell them. For a start, ask them to carefully read through the material on the sessions conducted so far.
Day II

Session Title: RE-CAP AND WARM-UP

ADVANCE PREPARATION

- Ask a team to prepare the re-cap on the previous day’s proceedings
- Decide on a good warm-up activity that will not only enliven participants but also give them something to think about.

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<td>Presentation</td>
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<tr>
<td>10 minutes</td>
<td>Recapitulation of the previous day's proceedings</td>
<td>Team presentation</td>
<td>(Depends on the team’s requirements)</td>
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<td>15 minutes</td>
<td>Warm-up activity</td>
<td>Group activity</td>
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FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To bring to focus the key points of the previous day’s work to refresh the memory.
- To provide continuity to the program.
- To ensure that every participant has a chance to participate actively.
- To provide opportunity for participants to work as a team.
- To provide opportunity to participants to make use of their creative talents and skills.

RECAPITULATION

Team should be allowed to present this in their own way. It should include information on the content - key messages, program organization, the day’s proceedings in general, presentation of material and other informal events etc. The participants could use a news reporter's format if they wish.

WARM-UP EXERCISE

Select an exercise that is interesting, thought provoking and related to their course. All participants must be actively involved in the activity chosen.
Session Title: SURGICAL PROCEDURE, DEMONSTRATION AND PRACTICE ON ZOE

ADVANCE PREPARATION

- Read the facilitator’s notes and chapter eight of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.
- Ensure sufficient copies of the learning guide of counseling skills.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>100 minutes</td>
<td>Surgical Procedure on the Zoe</td>
<td>Demonstration of the standardized technique by trainer/trainees on the Zoe</td>
<td>ZOE, all instruments as given for AT, sponge holder-1, Allis forceps-2, small artery forceps-2, dissecting forceps (tooth-1, non tooth-1) babcocks forceps-2 kidney tray, B.P. knife with blade, scissors (straight-1 curved-1), needle holder, small round body needle-1 and curved cutting needle -1,1-0 chromic cat gut-1, non absorbable suture-1.</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTE

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To describe standard Abdominal Tubectomy procedure under local anesthesia.
- To tell the assistant how to prepare the client for surgery and assist the doctor during Abdominal Tubectomy procedure.
- To practice standard surgical procedure on Zoe.
- To discuss the use of the learning guide and checklist.

Distribute the learning guide checklists to doctors and nurses and discuss their uses.

TRAINER DEMONSTRATION

Now state that you will demonstrate on the Zoe model, the standard Abdominal Tubectomy procedure under local anesthesia. Explain the how and why of each step as you carry out the procedure. Trainees observe the procedure carefully using the Learning Guide.
VOLUNTEER DEMONSTRATION

Ask one of the participants to volunteer to demonstrate on the Zoe model the standard Abdominal Tubectomy procedure under local anesthesia. Ask the rest to observe the procedure carefully. Once the procedure has been completed, thank the volunteer and state that now the demonstrated procedure will be reviewed. Ask the observers to comment on what was right and what was wrong in the demonstration and why. Allow a free flowing discussion.

Divide the participants into doctor, nurse team and let them practice the procedure on the Zoe.
Session Title: O.T. ACTIVITY - ABDOMINAL TUBECTOMY PROCEDURE ON CLIENTS

ADVANCE PREPARATION

- Read the facilitator's notes and ensure that you have clients for the participants to operate upon.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>115 minutes</td>
<td>Practical with clients</td>
<td></td>
<td>Clients, all necessary equipment and supplies</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To perform standard Abdominal Tubectomy procedure under local anesthesia.

PRACTICALS

Participants are divided into two or three teams depending on the number of participants. Take one team to the O.T. while the other team stays back in the classroom with one trainer and practices on Zoe. Explain that while one trainee performs the others observe the procedure using learning guide. Discussions will be held after all the O.T. activity. Let the participants assist the trainer. Inform participants that they will be observed on how they carry out the whole process beginning with counseling upto post-operative instructions.

DISCUSSION

Ask participants how they felt using the standard procedure. Ask participants to comment on their observations. Provide feedback on their performance, being careful to encourage them on good performance and then highlighting areas that need improvement.

SUMMARY

Briefly summarize the content covered in the session and address any questions that participants may have.
LEARNING GUIDE FOR INTERVAL ABDOMINAL TUBECTOMY
CLINICAL SKILLS CHECKLIST FOR DOCTORS
(To be used by Participant)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

3. **Proficiently Performed**: Step or task performed efficiently and precisely in proper sequence (if necessary)

<table>
<thead>
<tr>
<th>STEP / TASKS</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY AND ASSESSMENT OF CLIENT</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greet client respectfully and establish rapport.</td>
<td></td>
</tr>
<tr>
<td>2. Review client history, physical examination and haemoglobin and urine report.</td>
<td></td>
</tr>
<tr>
<td>3. Check that informed consent was obtained and verify client's identity.</td>
<td></td>
</tr>
<tr>
<td>4. Ensure that client has thoroughly washed abdominal and pelvic areas.</td>
<td></td>
</tr>
<tr>
<td>5. Ensure that client has recently voided.</td>
<td></td>
</tr>
<tr>
<td>6. Help position client flat on her back on operating table.</td>
<td></td>
</tr>
<tr>
<td>7. Determine that sterile or high level disinfected instruments and emergency tray are present.</td>
<td></td>
</tr>
<tr>
<td>8. Take and record vital signs.</td>
<td></td>
</tr>
<tr>
<td>9. Wash hands thoroughly with soap and water and air dry or dry with clean cloth</td>
<td></td>
</tr>
<tr>
<td>10. Place client in a lithotomy position.</td>
<td></td>
</tr>
<tr>
<td>11. Put new examination or high level disinfected surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>12. Perform a per speculum examination to rule out any lesion in the cervix</td>
<td></td>
</tr>
<tr>
<td>13. Perform a gentle bimanual pelvic examination to assess uterine size, position and mobility and presence of any pelvic abnormality.</td>
<td></td>
</tr>
<tr>
<td>14. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes</td>
<td></td>
</tr>
<tr>
<td>15. Give IV medication, if needed (initial or maximum dose based on client's weight). If IM premedication is</td>
<td></td>
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</tbody>
</table>
to be used, give it 25-30 minutes before the procedure

16. Change into surgical apparel.

17. Perform surgical scrub (3-5 minutes) and put on clean or sterile gown

18. Put sterile or high level disinfected surgical gloves on both hands.

19. Apply antiseptic (Betadine) solution to the incision area two times using a circular motion inside out.

20. Drape client for the procedure.

21. Throughout procedure talk to the client (verbal anaesthesia)

22. Select incision site about 3 cm above pubic symphysis

ABDOMINAL TUBECTOMY PROCEDURE

LOCAL ANESTHESIA

1. Raise a small skin wheal at the centre of incision site using 1% lignocaine (or equivalent) in a 10 or 20 ml sterile or high level disinfected syringe (dose 5mg/kg).

2. Starting at the centre of the planned incision, administer local anesthesia (about 3-5 ml) just under the skin along both sides of the incision line.

3. Again starting at the centre of the incision line, insert needle into the fascia at a 45° angle with the needle directed slightly superior the incision line.

4. Aspirate to ensure the needle is not in a blood vessel; then, while injecting 3-5 ml of lignocaine, withdraw the needle slowly upto subcutaneous level and repeat on the other side of incision line.

5. Insert the needle down through the rectus sheath to the peritoneum, aspirate and inject 1-2 ml into the peritoneal layer.

6. Withdraw needle and place in a safe area to prevent accidental needle pricks.

7. Massage the skin to spread the anaesthetic within the tissues.

8. Test incision site with forceps tip for adequate anesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).

ABDOMINAL ENTRY

9. Make transverse/vertical, suprapubic skin incision, approximately 3 cm long at the preselected incision site 3 cm above symphysis pubis

10. Bluntly dissect subcutaneous tissues with scissor tips or fingers.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>11.</td>
<td>Identify and grasp fascia at two places with the Allis forceps and cut with scissors.</td>
</tr>
<tr>
<td>12.</td>
<td>Separate rectus muscles in the midline (longitudinally) using blunt dissection with artery forceps and clean off preperitoneal tissue if needed.</td>
</tr>
<tr>
<td>13.</td>
<td>Confirm identification of peritoneum.</td>
</tr>
<tr>
<td>14.</td>
<td>While elevating the peritoneum with the forceps, make a small nick in the peritoneum with knife/scissors after confirming that there is no underlying bowel or abdominal viscera.</td>
</tr>
<tr>
<td>15.</td>
<td>Enlarge opening vertically with scissors/fingers, place artery forceps on upper and lower cut edges of peritoneum (Place client in head-down, Trendelenburg position, as needed.)</td>
</tr>
</tbody>
</table>

**Locating Fallopian Tubes**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>16</td>
<td>Insert index finger or index and middle finger of the one hand inside the incision and feel for the fundus of the uterus.</td>
</tr>
<tr>
<td>17</td>
<td>Slide the finger/s along the fundus laterally and a little posteriorly and feel for the Fallopian tube.</td>
</tr>
<tr>
<td>18</td>
<td>Trace the tube laterally with the fingers and roll it between them to confirm that it is the Fallopian tube. If using one finger then hook the tube, lift it and roll it against the anterior abdominal wall.[ the Fallopian tube will be soft and mobile]</td>
</tr>
</tbody>
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**Grasping the Fallopian Tubes**

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<thead>
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<tbody>
<tr>
<td>19</td>
<td>Holding the tube between the two fingers or hooking over one finger gently bring it out through the abdominal incision.</td>
</tr>
<tr>
<td>20</td>
<td>Gently grasp the mid portion of the tube with the Babcock's forceps</td>
</tr>
<tr>
<td>21</td>
<td>Identify fimbriated end of the tube by tracing the tube till the fimbrial end.</td>
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</tbody>
</table>

**Tubal Occlusion**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>22</td>
<td>While grasping the midportion of tube, transfix the tube with chromic catgut 1-0 making loop of tube about 3 cm</td>
</tr>
<tr>
<td>23</td>
<td>Tie the knots on both sides of the tube.</td>
</tr>
<tr>
<td>24</td>
<td>Cut out one end of the loop and then the other with scissors ensuring that at least 1 cm. of the tubal stump above the ligature has been left behind.</td>
</tr>
<tr>
<td>25</td>
<td>While still holding ligature inspect the stump for haemostasis and then release the tube, allowing it to return to abdomen.</td>
</tr>
<tr>
<td>26</td>
<td>Repeat procedure on opposite side for second tube.</td>
</tr>
<tr>
<td>Closure (When haemostasis assured, close wound in layers)</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>27. The closure of peritoneum (optional).</td>
<td></td>
</tr>
<tr>
<td>29. Close skin with same absorbable/non absorbable suture material</td>
<td></td>
</tr>
<tr>
<td>30. Dress the wound</td>
<td></td>
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</tbody>
</table>

**POST-OPERATIVE TASKS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure that client is safely transferred to the post-operative (Recovery) area.</td>
</tr>
<tr>
<td>2</td>
<td>Ensure that the assistant disposes of disposable needles and syringes in a puncture-proof container or fills re-usable needles and syringes with 0.5% chlorine solution and soaks for decontamination for 10 minutes.</td>
</tr>
<tr>
<td>3</td>
<td>Ensure that assistant decontaminates instruments by soaking in 0.5% chlorine solution for 10 minutes.</td>
</tr>
<tr>
<td>4</td>
<td>Check that assistant disposes of waste materials according to infection prevention guidelines.</td>
</tr>
<tr>
<td>5</td>
<td>Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.</td>
</tr>
<tr>
<td>6</td>
<td>Wash hands thoroughly with soap and water and air dry or dry with clean cloth.</td>
</tr>
<tr>
<td>7</td>
<td>Ensure that client is monitored at regular intervals and that vital signs are taken.</td>
</tr>
<tr>
<td>8</td>
<td>Determine that client is ready for discharge (at least 2 hours after IV medication).</td>
</tr>
<tr>
<td>9</td>
<td>Ensure that post-operative instructions and follow-up schedule are given.</td>
</tr>
</tbody>
</table>
LEARNING GUIDE FOR POST PARTUM ABDOMINAL TUBECTOMY
CLINICAL SKILLS CHECKLIST FOR DOCTORS
(To be used by Participant)

Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

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<td>4. Ensure that client has thoroughly washed abdominal and pelvic areas.</td>
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<td>5. Ensure that client has recently voided.</td>
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<td>6. Help position client flat on her back on operating table.</td>
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<td>7. Determine that sterile or high level disinfected instruments and emergency tray are present.</td>
<td></td>
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<td>8. Take and record vital signs.</td>
<td></td>
</tr>
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<td>9. Wash hands thoroughly with soap and water and air dry or dry with clean cloth</td>
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</tr>
<tr>
<td>10. Place client in a lithotomy position.</td>
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<td>11. Put new examination or high level disinfected surgical gloves on both hands.</td>
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<td>12. Perform a per speculum examination to rule out any lesion in the cervix</td>
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<td>14. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes</td>
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</tr>
<tr>
<td>15. Give IV medication, if needed (initial or maximum dose based on client's weight). If IM premedication is to be used, give it 25-30 minutes before the procedure</td>
<td></td>
</tr>
</tbody>
</table>
16. Change into surgical apparel

17. Perform surgical scrub (3-5 minutes) and put on clean or sterile gown

18. Put sterile or high level disinfected surgical gloves on both hands.

19. Select incision site about 1-2 cm inferior to uterine fundus

20. Apply antiseptic solution to the incision area two times using a circular motion.


22. Throughout procedure talk to the client (verbal anesthesia)

**LOCAL ANESTHESIA**

1. Raise a small skin wheal at the centre of incision site using 1% lignocaine (or equivalent) in a 10 or 20 ml sterile or high level disinfected syringe (dose 5mg/kg).

2. Starting at the centre of the planned incision, administer local anesthesia (about 3-5 ml) just under the skin along both sides of the incision line.

3. Without withdrawing the needle again starting at the centre of the incision line, insert needle into the fascia at a 45° angle with the needle directed slightly superior the incision line.

4. Aspirate to ensure the needle is not in a blood vessel. Then, while injecting 3-5 ml of lignocaine, withdraw the needle slowly upto the subcutaneous level and repeat on the other side of incision line.

5. Insert the needle down through the rectus sheath to the peritoneum, aspirate and inject 1-2 ml into the peritoneal layer.

6. Withdraw needle and place in a safe area to prevent accidental needle pricks.

7. Massage the skin to spread the anaesthetic within the tissues.

8. Test incision site with forceps tip for adequate anesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).

**ABDOMINAL ENTRY**

9. Make transverse/vertical, subumblical skin incision, approximately 3 cm long at the preselected incision site (about 1-2 cm inferior to uterine fundus.

10. Bluntly dissect subcutaneous tissues with scissor tips or fingers.

11. Identify and grasp fascia at two places with the Allis forceps and cut with scissors.

*Facilitator's Session Guide*
12. Separate rectus muscles in the midline (longitudinally) using blunt dissection with artery forceps and clean off preperitoneal tissue if needed.

13. Confirm identification of peritoneum.

14. While elevating the peritoneum with the forceps, make a small nick in the peritoneum with knife/scissors after confirming that there is no underlying bowel or abdominal viscera.

15. Enlarge opening vertically with scissors/ fingers, place artery forceps on upper and lower cut edges of peritoneum. (Place client in head-down, Trendelenburg position, if needed.)

**Locating Fallopian Tubes**

16. Insert index finger/index and middle finger of one hand inside the incision and feel for the fundus of the uterus.

17. Slide the finger/s along the fundus laterally and a little posteriorly and feel for the Fallopian tube.

18. Trace the tube laterally with the fingers and roll it between them to confirm that it is the Fallopian tube. If using one finger, hook the tube, lift it and roll it against the anterior abdominal wall [Fallopian tube will be soft and mobile.]

**Grasping the Fallopian Tubes**

19. Holding the tube between the two fingers or hooking over one finger gently bring it out through the abdominal incision.

20. Gently grasp the mid portion of the tube with the Babcock’s forceps.

21. Identify the tube by tracing the tube laterally till the fimbrial end

**Tubal Occlusion**

22. While grasping the midportion of tube, transfix the tube with chromic catgut 1-0 making a loop of about 2-3 cms.

23. Tie the knots on both the sides of the tube.

24. Cut out one end of the loop and then the other with scissors ensuring that at least one cm. of the tubal stump above the ligature has been left behind.

25. While still holding the ligature inspect the stump for haemostasis and then release the tube, allowing it to return to the abdomen.

26. Repeat procedure on opposite side for the second tube.
Closure (When haemostasis assured, close wound in layers)

27. The closure of peritoneum is optional.
28. Secure the rectus sheath: edges with interrupted/continuous sutures.
29. Close skin with the same absorbable/non absorbable suture material.
30. Dress the wound.

**POST-OPERATIVE TASKS**

1. Ensure that client is safely transferred to the post-operative (recovery) area.
2. Ensure that the assistant disposes of disposable needles and syringes in a puncture-proof container or fill re-usable needles and syringes with 0.5% chlorine solution and soaks for decontamination for 10 minutes.
3. Ensure that assistant decontaminates instruments by soaking in 0.5% chlorine solution for 10 minutes.
4. Check that assistant disposes of waste materials according to infection prevention guidelines.
5. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.
6. Wash hands thoroughly with soap and water and air dry or dry with clean cloth.
7. Ensure that client is monitored at regular intervals and that vital signs are taken.
8. Determine that client is ready for discharge (at least 2 hours after IV medication).
9. Ensure that post-operative instructions and follow-up schedule are given.
Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed**: Step or task performed correctly in the proper sequence (if necessary) but participant does not progress from step to step efficiently
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<table>
<thead>
<tr>
<th>PARTICIPANT</th>
<th>Course Dates</th>
</tr>
</thead>
</table>

| LEARNING GUIDE FOR ABDOMINAL TUBECTOMY CLINICAL SKILLS FOR NURSE ASSISTANTS |
|-----------------------------------|----------------|
| **STEP/TASK**                     | **CASES**      |
| **PRE-OPERATIVE**                 |                |
| 1. Change into surgical apparel (scrub suit or dress). |                |
| 2. Wash hands thoroughly with soap and water and dry with a clean cloth or air dry. |                |
| 3. Ensure that all supplies including narcotic and sedatives are present and equipment for monitoring vital signs is available. |                |
| 4. Prepare instruments for procedure:  |
|   • Ensure that instruments are sterile or high-level disinfected. |                |
|   • Ensure that emergency instruments, equipment and drugs are available. |                |
|   • Place sterile or high-level disinfected packs on the table. |                |
| 5. Arrange instruments on instrument table. |                |
| 6. Greet client and help to make her comfortable. |                |
| 7. Take and record vital signs. |                |
| 8. Give IV medication (initial or maximum dose based on client's weight). |                |
| 9. Assist with vaginal examination. |                |
| 10. Perform surgical scrub (3-5 minutes) and put on sterile gown. |                |
| 11. Put sterile surgical gloves on both hands. |                |

**Facilitator's Session Guide**
12. Assist operating doctor in preparing the skin.

13. Assist operating doctor in draping the client.

14. After verifying drug strength, withdraw local anaesthetic from vial held by the attendant, as advised by the operating doctor.

**DURING SURGERY**

1. Throughout the procedure, talk to the client.

2. Anticipate and respond to needs of the operating doctor:
   - Provide additional local anaesthetic to the operating doctor.

3. Report to the operating doctor any increase in client's discomfort or stress regarding allergic reactions.

4. Record end time of surgery on client record.

5. Place dressing on wound at end of procedure.

**POST-OPERATIVE**

1. Remove drape when wound is dressed.

2. Record final vital signs before leaving operating theatre.

3. Keep appropriate records during procedure and ensure that record is complete regarding:
   - Vital signs
   - Instrument and gauze counts
   - Time of procedure (total and skin to skin)

4. Brief the operating theatre attendant on the client's condition (vital signs and any complications or problems).

5. Place instruments and other items in 0.5% chlorine solution for decontamination (in OT).

6. Dispose of disposable needles and syringes in a puncture proof container or fill re-usable needles and syringes with 0.5% chlorine solution and soak to decontaminate for 10 minutes.

7. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.

8. Wash hands thoroughly with soap and water and dry with clean cloth or air dry.

Session Title: VIDEO FILM ON ABDOMINAL TUBECTOMY

ADVANCE PREPARATION

- Read the facilitator’s notes and ensure you have the TV video photoset, VCR/VCP and generator in working condition for the session.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>20 minutes</td>
<td>Video film</td>
<td>Audio-visual presentation</td>
<td>VCR, video photo-set &amp; T.V.</td>
</tr>
<tr>
<td>7 minutes</td>
<td>Discussion &amp; Summary</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

- To view the standard Abdominal Tubectomy procedure under local anaesthesia by audio-visual presentation.

Tell participants that they will now view a video photo-set on the standard technique of performing an Abdominal Tubectomy. Any discussions can be conducted after they have viewed the entire procedure.

After the tape has been viewed, let participants air their comments and discuss their queries.

NOTE: Same procedure to be repeated during Video Film Sessions on CPR and Infection Prevention.
Day III

Session Title: COUNSELING CLIENTS ON STERILIZATION

ADVANCE PREPARATION

- Read the facilitator's notes and chapter two of the manual to prepare for this session.
- Prepare flip charts for the objectives, steps of GATHER, general counseling, method-specific counseling and follow-up counseling.
- Ensure you have sufficient copies of case studies on principles of counseling and barriers to counseling.
- Ensure a tray with all the contraceptives.

<table>
<thead>
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<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>5 minutes</td>
<td>An overview</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>60 minutes</td>
<td>General counseling</td>
<td>Presentation and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td></td>
<td>Method specific counseling</td>
<td></td>
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<tr>
<td></td>
<td>Follow-up counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 minutes</td>
<td>Principle of counseling</td>
<td>Group exercise and case study</td>
<td>Copies of case study</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Barriers to counseling</td>
<td>Discussion case study</td>
<td>Copies of case study</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip Chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared present the objectives of the session to the participants.

- To define counseling and steps of counseling.
- To list the benefits of counseling clients on family planning, especially sterilization.
- To describe the counseling process with special emphasis on method-specific counseling for sterilization clients.
- List the important facts about Abdominal Tubectomy and the warning signs that need to be addressed during the counseling session. List the benefits and limitations of Abdominal Tubectomy.
- To list the principles of counseling and barriers in counseling.
COUNSELING AN OVERVIEW

Present the following: Concept of counseling, benefits of counseling, warning signs that need to be addressed when counseling clients for sterilization and the GATHER steps in the counseling process. Emphasize that this session will focus on the method-specific counseling stage.

State that it is necessary to inform the client about the important facts about Abdominal Tubectomy and its benefits and limitations. Describe general counseling, method-specific counseling and follow-up counseling.

Method-specific counseling for clients who choose voluntary sterilization: Explain that this stage in counseling has three steps that are very important for those opting for sterilization. (Refer chapter 2 of your manual). Display the prepared flip chart of the items to be discussed in step 1 of this stage. Read out each statement giving explanations or examples. Repeat the same process for step 2 and then for step 3. Tell the important facts of Abdominal Tubectomy and the fact that even in the last minute a client can decide not to undergo sterilization without fear of losing out on other options available. Also address all the possible rumours connected with female sterilization and that non-scalpel vasectomy is an easier option with less morbidity. Distribute copies of learning guide for Abdominal tubectomy counseling skills.

Discuss and conduct the group work on case studies based on the principles of counseling and barriers to family planning counseling.

SUMMARY

Briefly summarize the content covered in the session and address any questions that participants may have.
Module 1 - Exercise 1: Principles of Counseling

Identify which of the principles of counseling are supported -- or threatened -- in each case. Write T for threatened or S for supported against the principles given under each case.

Case 1
A woman with three children comes to the clinic for family planning. She is not sure if or when she wants another child, but she knows she wants to wait. The nurse says she should be sterilized since she already has three children. The woman says no, because she is still young and they may want more children after her husband’s business gets established. The nurse then tells her about the IUD, which is not permanent but effective for a long time and completely reversible.

Acceptance/Non-judgmental .......... Self-determination by the client
Individualisation .............. Confidentiality

Case 2
A 19-year-old mother of two children comes to the CHC to request oral pills. The doctor believes that, since the woman is illiterate, she will not be able to take pills correctly, and he urges her to accept an IUD.

Acceptance/Non-judgmental .......... Self-determination by the client
Individualisation .............. Confidentiality

Case 3
A woman comes to the health center complaining of itchiness between her legs and pain when she urinates. During registration in the crowded waiting area, the health worker learns that her last menstrual period was four months ago, yet her husband has been away from her for six months. The health worker makes note on the file that this woman should be seen separately for further assessment and counseling, and hands the file to the nurse.

Acceptance/Non-judgmental .......... Self-determination by the client
Individualisation .............. Confidentiality

Case 4
A woman with two children comes to the PHC because her youngest child is sick. In the waiting area, the ANM sees the woman and asks her in a loud voice if she has finally decided to accept sterilization. When the woman says no, the ANM points out that she can’t take care of the children she already has, yet she won’t protect herself from having more.

Acceptance/Non-judgmental .......... Self-determination by the client
Individualisation .............. Confidentiality

Case 5
A man with two children comes to the sterilization camp requesting vasectomy. When he learns that the procedure is meant to be permanent, he is not sure that he wants to go ahead with it. The health worker explains that the pill, IUD, and condom are available for people who are not sure whether they want more children. He gives the man condoms and recommends that, until he is sure about sterilization, he and his wife should go to the PHC nearest their home to get one of the other methods.

Acceptance/Non-judgmental .......... Self-determination by the client
Individualisation .............. Confidentiality
Module 1 – Exercise 2: Barriers to family planning counseling

Case studies:

A. A 28-year old woman with two children (6 years old and 3 years old) is visited regularly by the local ANM. The woman and her husband want to have another child, but he has finally established his own business and they want to wait until the shop begins to be profitable. The ANM visits the woman at home every week, trying to convince her that she should not have any more children and that she is past the childbearing years and that her children may not accept another child in the family now. The woman becomes confused and wonders if their desire to have another child is selfish. She and her husband finally decide that it would be best for them and their children if she has the sterilization done. She goes to the camp and has Abdominal Tubectomy, which gives her a lot of discomfort. After that, she always complains of pain in her belly and wonders if the operation damaged her in some way.

1. What is the main problem in this case? Whose problem is it?
2. Was the problem solved? If yes, how? If not, why not?
3. How could counseling have been helpful?
4. What barriers to counseling exist in this case?

B. A couple with two children want to use family planning to give them time to decide if they want or are able to afford more children. The man is 35 and his wife is 25; their children are 5 and 7 years old. They talk with a referral agent who describes a very simple procedure that the man can have for family planning -- it is called vasectomy, and the referral agent says that it is much simpler than the method used by the woman, which requires surgery. The couple think this vasectomy sounds good and the referral agent recommends them to a camp where it is provided.

At the camp, they are registered by a health worker who has recently been trained in counseling. He explains the procedure and goes through the informed consent form with both the man and his wife. When the man learns that the procedure is permanent, he is not sure that he wants to go ahead with it. The health worker explains that other methods are available for people who are not sure whether they want more children. He gives them condoms and recommends that, until they are sure about sterilization, they should go to the PHC nearest their home to get one of the temporary methods.

The doctor has overheard the end of the counseling. He has recently been to a workshop where he saw slides on no-scalpel vasectomy and is eager to practice the technique. He stops the couple as they are leaving and tells them the benefits of the new vasectomy technique, emphasizing the problems from using other methods. The man is now completely confused.

1. What is the main problem in this case? Whose problem is it?
2. Was the problem solved? If yes, how? If not, why not?
3. How could counseling have been helpful?
4. What barriers to counseling exist in this case?

C. A 20-year old woman with one child comes to the CHC requesting pills for family planning. The woman has heavy bleeding and usually some pain with her menstrual periods. The health worker at the clinic tells her that hormonal methods cause menstrual irregularities, which means that her periods will be worse! Plus, she says, the pills are not very effective and cause cancer. So since she is too young for sterilization, the health worker tells her to use the IUD.
The woman has the IUD inserted, but finds that her menstrual bleeding is heavier than ever and the cramps almost unbearable. After two months, she returns to the CHC. The health worker tells her that she is too sensitive and should be happy that she has the best method for her situation. The health worker refuses the woman’s request to remove the IUD, telling her to give it more time.

The woman has another period with heavy bleeding and pain. She feels desperate and tries to pull the IUD out with the string. The string breaks off. Now there is even more pain than before, so the woman goes to a private doctor for help.

1. What is the main problem in this case? Whose problem is it?
2. Where was the problem solved? If yes, how? If not, why not?
3. How could counseling have been helpful?
4. What barriers to counseling exist in this case?

D. A 25-year old woman with one child who has been using the IUD for several years comes to the clinic where it was inserted, complaining of bad-smelling discharge and some pain during sex. The service provider determines that she has some kind of vaginitis and tells her she should not use the IUD anymore. The IUD is removed and the woman is given oral contraceptives.

Several years later the woman returns complaining of frequent illness and general weakness. Her blood is tested as part of a specially funded research project and she is found to be HIV-positive. On further questioning, it is learned that the woman was a prostitute at the time she was using the IUD.

1. What is the main problem in this case? Whose problem is it?
2. Where was the problem solved? If yes, how? If not, why not?
3. How could counseling have been helpful?
4. What barriers to counseling exist in this case?

E. A 28-year old woman with two children comes to the District Hospital. She is two months pregnant and is requesting MTP. Since she wants no more children, she is also requesting sterilization. However, her husband wants to have more children, but not now; and her in-laws definitely want to have more children. After hearing the arguments of the husband and the in-laws, the health worker counsels the woman that it would be best to keep this pregnancy and have the baby that everyone else wants now -- and then she can have the sterilization. The woman starts to sob and cries out, “Why is no one listening to what I want?”

1. What is the main problem in this case? Whose problem is it?
2. Where was the problem solved? If yes, how? If not, why not?
3. How could counseling have been helpful?
4. What barriers to counseling exist in this case?
Session Title: VALUES AND ATTITUDES

ADVANCE PREPARATION

- Read the facilitator’s notes and chapter two of the manual to prepare for this session.
- Prepare flip charts for the objectives of the session as required.
- Ensure that you have sufficient copies of case studies and three cards with AGREE and DISAGREE and UNDECIDED.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
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<tbody>
<tr>
<td>3 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Values and attitudes</td>
<td>Group exercise</td>
<td>Posters of AGREE, DISAGREE and UNDECIDED</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Case study “who is responsible”</td>
<td>Discussion</td>
<td>Copies of case study</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip Chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart that you have prepared present the objectives of the session to the participants.

- Define values and attitude.
- Describe how values and attitudes can affect counseling.

Exercise I - Tell the participants the definition of values and attitude.

Value: A value is a belief that is an important to an individual. Values can be influenced by religious, educational, cultural or by other personal experiences.

Attitude: An attitude is a view or an opinion that is formed on the basis of values and belief.

The participants will now complete an exercise in which they will examine their values. Post the 3 signs in 3 different corners of the room. The participants are to move individually to position themselves at the sign agree, disagree and undecided as their response matches the statement you read out. Read out the statement and wait for participants to move around. Ask 1-2 volunteers to explain the reason behind the choice.

Exercise II - Ask participants to read the exercise sheet – “Who is responsible”? And choose the character who they feel is the most responsible. Ask participants which character they choose and why.
SUMMARY

Briefly summarize the content covered in the session and address any questions that participants may have.

Exercise: VALUES AND ATTITUDES

Read each statement. (Case study – agree, disagree and undecided)

1. If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.
2. Unmarried people should not engage in sexual activity.
3. A 21-year-old woman with only one child should be refused a tubal ligation.
4. If a woman never experiences childbirth, she will feel like less of a woman.
5. Most people with sexually transmitted diseases have had many sex partners.
6. Schools should provide sex education.
7. Some clients want to continue getting pregnant until they have children of both sexes. Providers should discourage this behavior.
8. Family planning methods should be available to unmarried adolescents.
9. It is the woman who should be responsible for using contraception.
10. If a couple has two healthy children they should adopt a permanent method of contraception.
Module 1 – Exercise 3 : Values and Attitude (Case study - Who is responsible?)

Mrs. X has brought three daughters into the world with much difficulty; she had to have a caesarean section each time.

Mr. X is a businessman, happy with his wife and three daughters. All he is missing is a son.

Dr. Y, Mrs. X’s doctor, has warned her that a fourth pregnancy would be dangerous. Knowing that Mr. X wants a son, however, he does not want to perform a tubal ligation.

Mrs. X has stopped breastfeeding her youngest child and has asked her doctor to help her avoid becoming pregnant, or to guarantee her that her next pregnancy will be her last and to explain to her how to have a son. Dr. Y explains that it is the sperm of her husband that determines the sex of the baby. He sends Mrs. X to the family planning clinic.

The midwife in charge of the family planning services, refuses to help Mrs. X without the knowledge of her husband.

Mrs. X goes to her religious counselor. He scolds her, telling her she is obliged to accept the will of God, and submit to her husband.

Remembering what Dr. Y said concerning the sperm, Mrs. X goes to see her cousin Emile, a handsome young man who has only sons. She proposes to him that they have sex so that she can have a son and her husband will agree to the tubal ligation. Emile accepts. Mrs. X conceives and dies of a ruptured uterus at 38 weeks of pregnancy.

Who is responsible for this death? Mr. X? Mrs. X? Dr. Y? The midwife? The religious counselor? Emile? Or perhaps the baby?

Decide for yourself.
ADVANCE PREPARATION

- Read the facilitator's notes and chapter three of the manual to prepare for this session.
- Prepare flip charts for the objectives and the content as needed.
- Ensure that you have sufficient copies of the revised Informed Consent Form and Guidelines for assessing client's decision for Abdominal Tubectomy.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Informed Consent and Informed Choice</td>
<td>Brainstorming, Large group discussion and presentation</td>
<td>Flip chart, copies of the mandatory G01 Informed Consent Form</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Guidelines for assessing client's decision for Abdominal Tubectomy Ligation</td>
<td>Presentation and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Grid chart</td>
</tr>
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</table>

FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objective of the session to the participants. 

- To describe and apply the principles of informed consent for voluntary sterilization.
- Provide opportunity through a post-test to gauge how much knowledge the nurse assistant have gained through the induction course.

Informed Consent: Write 'Informed Consent' at the top then divide your flip chart or writing board into two columns. Title one column as 'what it is' and the other as 'what it is not'. Now allow participants to brainstorm quickly on what is informed consent and what it is not. Fill the columns as they proceed. Review each column asking for clarification and fill the gaps in their knowledge.

State that while assessing a client's decision for sterilization it is good to use a guideline to ensure that the person responsible does not miss any important point. Display a prepared flip chart on the 'Guidelines for assessing client's decision for Abdominal Tubectomy under local anesthesia.' Quickly walk them through the entire process providing clarifications as you proceed.

State that when they will have their practice, they will be observed on how they assess the client's decision for Abdominal Tubectomy.
SUMMARY

Distribute copies of the post-test to nurse assistants and programme evaluation forms and ask them to complete it and return the forms to you.

Briefly summarize the content covered in the session and address any questions that the participants may have.
APPLICATION AND INFORMED CONSENT FORM FOR
STERILIZATION OPERATION

Name of Client

Address of Client

Spouse’s name

Father’s name

Operating centre

Dear Doctor,

Please arrange to have me sterilized. My age is ____________ and my spouse’s age is ____________.

I am/was married. I/We have ________ male and ________ female living children. The age of the youngest child is ____________ years.

- The decision to undergo the sterilization operation has been taken independently by me without any outside pressure, inducement, or force.
- I am aware that other methods of contraception are available to me which have been properly explained.
- The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to the criteria.
- I know that for all practical purposes this operation is permanent and that, after the operation I will be unable to have any more children.
- I also know that there are some chances of failure of the operation, for which the hospital/institution and operating doctor will not be held responsible by me or my relatives or any other person whomsoever. I will report to the center/doctor if there is any missed menstrual cycle of mine/my spouse within two weeks.
- My spouse has not been sterilized previously.
- I am aware that I have the option to decide against the sterilization procedure at any time without sacrificing my rights to other reproductive health services.
- I am aware that I am undergoing an operation, which carries an element of risk.
- I agree to come for follow-up to the center/doctor as instructed, failing which I shall be responsible for consequences, if any.
- I agree to undergo the operation under any type of anesthesia which the doctors think suitable for me and to be given other medicines as considered appropriate by the doctors concerned.

The above information has been read/read out and explained to me, in my own language.

Signature, Name & Address of Witness*

Signature of Client

* Witness can be any person not associated with the Service Center.
Applicable to the cases where the client can not read and the above information is read out.

1. The client has been fully counseled about various available methods of contraception and the above method.

   Signature of Counselor**
   Name and Full Address

2. I certify that I have satisfied myself and Shri/Smt. ________________________ is within the eligible age group and is mentally and medically fit for a sterilization operation. There is no evidence that he/she has undergone a sterilization operation previously). I have explained to the client that this form has the authority of a legal document.

   Signature of Operating Doctor
   (Name and Address)

   Signature of Medical Officer
   (Name and Address)

DENIAL OF STERILIZATION

I certify that Shri/Smt. ________________________ is not a suitable client for sterilization for the following reasons:

1. 

2. 

He/She has been provided the following alternative method of contraception.

   Signature of Counselor** or
   Doctor making decision
   (Name and Address)

** Counselor can be any health personnel including doctor.

Source: India; Ministry of Health and Family Welfare, Department of Health and Family welfare. 1999. Standards for Female and Male Sterilization - GOI. New Delhi
APPLICATION AND INFORMED CONSENT FORM FOR RESTERILIZATION OPERATION

Name of Client
[ ]

Address of Client
[ ]

Spouse's name
[ ]

Father's name
[ ]

Operating centre
[ ]

Dear Doctor,

Please arrange to have me resterilised/sterilised as my/my spouse's previous operation has failed. My age is [ ] and my spouse's age is [ ].

I am/ was married and my spouse is alive. I/We have [ ] male and [ ] female living children. The age of the youngest child is [ ] years.

- The decision to undergo the resterilization/sterilization operation has been taken independently by me without any outside pressure, inducement, or force.
- I am aware that other methods of contraception are available to me which have been properly explained.
- The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to the criteria.
- I know that for all practical purposes this operation is permanent and that, after the operation I will be unable to have any more children.
- I also know that there are still some chances of failure of the operation, for which the hospital/institution and operating doctor will not be held responsible by me or my relatives or any other person whomsoever. I will report to the centre/doctor if there is any missed menstrual cycle of mine/my spouse within two weeks.
- My spouse has not been sterilised previously.
- I am aware that I have the option to decide against the resterilization / sterilization procedure at any time without sacrificing my rights to other reproductive health services.
- I am aware that I am undergoing an operation which carries an element of risk.
- I agree to come for follow-up to the centre/doctor as instructed, failing which I shall be responsible for consequences, if any.
- I agree to undergo the operation under any type of anesthesia which the doctors think suitable for me and to be given other medicines as considered appropriate by the doctors concerned.

The above information has been read/read out and explained to me, in my own language.

Signature, Name & Address of Witness*
[ ]

Signature of Client
[ ]

* Witness can be any person not associated with the Service Centre.
Applicable to the cases where the client can not read and the above information is read out.

1. The client has been fully counseled about various available methods of contraception and the above method.

Signature of Counselor**
Name and Full Address

2. I certify that I have satisfied myself and Shri/Smt. ___________________________ is within the eligible age-group and is mentally and medically fit for a re-sterilization/sterilization operation. I have explained to the client that this form has the authority of a legal document.

Signature of Operating Doctor
(Name and Address)

Signature of Medical Officer
(Name and Address)

DENIAL OF STERILIZATION

I certify that Shri/Smt. ___________________________ is not a suitable client for sterilization for the following reasons:

1.

2.

He/She has been provided the following alternative method of contraception.

_____________________________

Signature of Counselor** or
Doctor making decision
(Name and Address)

** Counselor can be any health personnel including doctor.

Day IV

Session Title: INFECTION PREVENTION

ADVANCE PREPARATION

- Read the facilitator's notes and chapter six and Appendix C, D, E, F, G and H from the Abdominal Tubectomy reference manual and prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.
- Ensure availability of IP equipment - plastic bucket and tub, bleach powder, tea-spoon, cheattle forceps, bottle/jars, tooth-brush, detergent powder, multi-dose vial, syringe and needle, Abdominal Tubectomy kit, autoclave drum, glove, mask, apron, antiseptic solution, puncture-proof box.

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<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Need for IP and disease-transmission cycle</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>5 minutes</td>
<td>List the standard precautions for IP</td>
<td>Presentation, discussion and demonstration</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Hand-scrub and wearing glove</td>
<td>Presentation, discussion and demonstration</td>
<td>Flip chart, gloves</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Processing instruments</td>
<td>Presentation, discussion and demonstration</td>
<td>Plastic bucket and tub, bleach powder, tea-spoon, tooth-brush, detergent powder, cheese forceps, bottle/jars, Abdominal Tubectomy kit, autoclave drum</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Disinfectant and antiseptics</td>
<td>Presentation and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Handling sharps</td>
<td>Presentation, discussion and demonstration</td>
<td>Flip chart and kidney tray, sharp instruments and needles/syringes</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Packing linen, wrapping instruments and gloves for sterilization</td>
<td>Presentation, discussion and demonstration</td>
<td>Abdominal Tubectomy kit, autoclave drum, gloves, apron</td>
</tr>
<tr>
<td>10 minutes</td>
<td>House-keeping and waste disposal</td>
<td>Presentation, discussion and demonstration</td>
<td>Flip chart, puncture-proof box, plastic bucket</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>
FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To describe the importance of IP practices and disease transmission cycle
- To list the standard precautions for IP
- To describe and demonstrate the standard Hand-scrub and wearing glove required for Abdominal Tubectomy
- To demonstrate processing of instruments
- To discuss the definition and difference between disinfectant and antiseptics and their uses
- To describe the precautions for preventing needle pricks and handling of sharps
- To demonstrate the standard technique of packing linen, gloves and instruments for sterilization
- To discuss house-keeping and waste disposal

INFECTION PREVENTION PRACTICE

Open a short discussion (3 minutes) on how they prepare the OT and instruments for an Abdominal Tubectomy under local anesthesia. The discussion is intended to help them share their experiences. State that infection prevention is a very important part of any procedure at any clinic and it is imperative that all staff are trained and alert to the practice of infection prevention.

Ask participants for some examples of antiseptics and disinfectants that they use in their hospitals. Also ask them what is the difference between the two. Then present the difference between antiseptics and disinfectants and their uses. Allow participants to comment and provide clarifications as you proceed.

PROCESSING INSTRUMENTS

Present the concepts of decontamination, cleaning, sterilizing and high-level disinfection. Provide clarifications as you proceed.

Ask participants what infection prevention practices they follow in high volume clinics or camp settings. Allow participants to share their experiences. Now present the standard infection prevention practice that must be followed at high volume clinics and camp settings.

SUMMARY

Briefly summarize the content covered in the session and address any questions the participants may have.
ADVANCE PREPARATION

- Read the facilitator's notes and ensure you have the TV video photoset and VCR/VCP and generator in working condition for the session.

<table>
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<tr>
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<th>Content</th>
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<th>Materials required</th>
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<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>20 minutes</td>
<td>Video film</td>
<td>Audio-visual presentation</td>
<td>VCR, video photo-set &amp; T.V.</td>
</tr>
<tr>
<td>7 minutes</td>
<td>Discussion &amp; Summary</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

- To view the standard Infection Prevention practices by audio-visual presentation.

Tell participants that they would now view a video photoset on infection prevention. Any discussions can be conducted after they have viewed the entire procedure.

After the tape has been viewed, let participants air their comments and discuss their queries.
Day V

Session Title: OUTREACH MOBILE SERVICES

ADVANCE PREPARATION

- Read the facilitator’s notes and chapter thirteen of the manual to prepare for the session.
- Prepare flip charts for the objectives, facility requirements, staffing and responsibilities, timing and number of cases, equipment and emergency preparedness.

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<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
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<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
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<tr>
<td>15 minutes</td>
<td>Facility requirements</td>
<td>Brain-storming and presentations</td>
<td>Flip chart</td>
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<tr>
<td>15 minutes</td>
<td>Staffing and responsibilities</td>
<td>Brain-storming and presentations</td>
<td>Flip chart</td>
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<tr>
<td>5 minutes</td>
<td>Timing and number of cases</td>
<td>Group discussion and presentation</td>
<td>Flip chart</td>
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<tr>
<td>5 minutes</td>
<td>Equipment</td>
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<td>10 minutes</td>
<td>Emergency preparedness</td>
<td>Brain-storming and presentations</td>
<td>Flip chart</td>
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<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
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FACILITATORS’S NOTES

OBJECTIVES

Using the flip chart you have prepared present the objectives of the session to the participants.
- To enlist standard facility requirement at CHC/PHC for Abdominal Tubectomy camp.
- To list the staffing and responsibilities of the staff during camp.
- To identify timings and number of cases to be conducted by a team.
- To list the equipment required.
- To list the emergency preparedness in outreach mobile unit.

Brainstorm each issue and write on the flip chart and then summarize by presenting the pre-prepared flip chart.

SUMMARY

Briefly summarize the content of the session and address any question.
ADVANCE PREPARATION

- Ensure/verify camp date and site in advance
- Inform CMO/CMS about camp visit
- Inform MOI/C and O.T. staff of the site
- Ensure vehicle and driver
- Ensure working lunch
- Review the activities of the camp visit

The participants along with the trainers visit a camp site and observe the camp activities—registration, client assessment, pre-operative tasks, O.T. preparation, surgical procedure, IP practices and post-operative care and instructions.

Discuss the activities observed in the camp. Take feedback from the participants. Lay emphasis on the procedure and infection prevention practices.

FACILITATORS'S NOTES

OBJECTIVES

To observe the Abdominal Tubectomy procedure at a camp facility.

SUMMARY

Briefly summarize the day's activities and give assignment of chapter eleven from the reference manual.
Day VI

Session Title: **EMERGENCY PREPAREDNESS**

**ADVANCE PREPARATION**

- Read the facilitator's notes and appendix D of the Facilitator's Session Guide.
- Prepare flip charts for the objectives, the contents as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
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<td>Introduction</td>
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<td>40 minutes</td>
<td>Emergency Preparedness</td>
<td>Brainstorming, small group</td>
<td>Flip chart, emergency</td>
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<td>exercise</td>
<td>tray, kit, drugs</td>
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<tr>
<td>2 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
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</table>

**FACILITATOR'S NOTES**

**OBJECTIVES**

- To describe the importance of emergency preparedness.
- To describe the principles of emergency preparedness.
- To describe the requirements to deal emergencies.

a. **Brainstorming**

Using the brainstorm technique ask the participants what are the requirements to deal with emergencies. Note down on the flip chart and complete the list.

b. **Small Group Exercise**

Divide the participants into two groups. Ask the group 1 to write on a flip chart the "Emergency Medicines" required and group 2 - "Emergency Kit" required. One volunteer from each group will present the chart to the whole group. Fill gaps where necessary.

**SUMMARY**

Ask one of the participants to summarize all the medicines and emergency kit discussed in the session.
ADVANCE PREPARATION

- Read the facilitator's notes and appendix D of the Facilitator's Session Guide to prepare for this session.
- Prepare flip charts for the objectives, the contents as needed and the key messages.
- Ensure that you have the T.V., VCR/VCi, Videophotoset and generator in working condition.

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<th>Estimated time</th>
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<th>Training techniques</th>
<th>Materials required</th>
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<tr>
<td>5 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
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<tr>
<td>35 minutes</td>
<td>CPR Discussion</td>
<td>Demonstration</td>
<td>Flip chart. Model and necessary equipment</td>
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<tr>
<td>15 minutes</td>
<td>CPR practical/Video film</td>
<td>Demonstration/audio-visual presentation</td>
<td>Video cassette. T.V. and VCR</td>
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<tr>
<td>5 minutes</td>
<td>Summary</td>
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FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared present the objectives of the session to the participants.

- To describe the technique of CPR.
- To describe the principles of CPR.
- To describe the importance of CPR.
- To demonstrate and practice CPR

TECHNIQUE OF PERFORMING CPR

Describe the technique of performing CPR.

TRAINER DEMONSTRATION

Now state that you will demonstrate the procedure of CPR on the model. Explain the how and why of each step as you proceed. Ask the trainees to observe the procedure carefully.

Show the video film on CPR to the participants. Let them air their views after the tape is over.

VOLUNTEER DEMONSTRATION

Ask one of the participants to volunteer to demonstrate on the model the procedure of CPR. Ask the rest to observe the procedure carefully. Once the procedure has been completed, thank the volunteer and state that now the demonstrated procedure will be reviewed. Ask the observers to comment on what was right and what was wrong in the demonstration and why. Allow a free flowing discussion on the practices they currently follow.
SUMMARY

Ask one of the participants to summarize what they have learnt during the session. Answer any queries that the participants may have.
ADVANCE PREPARATION

- Ensure that you have sufficient copies of mid-course questionnaire forms and Nurse post-test and evaluation forms

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<th>Estimated time</th>
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<tr>
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<td>25 minutes</td>
<td>Solving mid-course questionnaire (for doctors)</td>
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<td>Post-test (for nurses)</td>
<td>Answer Matrix</td>
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<td>Post-test and evaluation forms</td>
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</table>

FACILITATOR'S NOTES

- The post-test and course evaluation for nurses and mid-course questionnaire for doctors will be carried out simultaneously.

OBJECTIVES

- Tell the participants that this questionnaire is designed to help them monitor their progress during the course.
- Provide opportunity through a post-test to gauge how much knowledge the nurse participants have gained through the induction training.

USING THE QUESTIONNAIRE

This questionnaire is designed to help the participants monitor their progress during the course. By the end of the course all participants are expected to achieve a score of 85%

You should give the questionnaire at the time in that course when all subject areas have been presented. An 85% or more correct score indicates knowledge-based mastery of the material presented in the manual. For those scoring less than 85% in the first attempt you should review the result with the participant individually and guide her/him on using the manual to learn the required information. Participants scoring less than 85% can retake the questionnaire at any time during the remainder of the course. Repeat testing should however be done only after the participant has had sufficient time to study the manual.
MID-COURSE QUESTIONNAIRE

Instructions: Circle the single best answer to each question.

1. When performing an Abdominal Tubectomy under Local Anesthesia, the minimum acceptable operating theatre staff consists of
   a. One qualified nurse  
   b. Two surgical assistants, a trained attendant and a specialist in infection prevention  
   c. A surgical assistant and a trained attendant who will also provide support for the client  
   d. A counselor, a surgical assistant, an anesthetist and infection prevention nurse

2. The best time to perform an Abdominal Tubectomy under local Anesthesia is
   a. Any time during the menstrual cycle  
   b. Within the first 48 hours postpartum or more than 6 weeks after delivery  
   c. Within the first 6 weeks postpartum  
   d. Within the first 10 days postpartum or more than 6 weeks after delivery

3. Tubal ligation by Abdominal Tubectomy is best described as
   a. Performed on a postpartum or interval basis  
   b. Requiring an abdominal incision not more than 5 cm long  
   c. Done under local anesthesia and on an outpatient basis  
   d. All of the above

4. Prior to performing an Abdominal Tubectomy procedure, the operating doctor must verify informed consent by
   a. Noting that the consent form is signed and discussing the client with the counselor  
   b. Ensuring that the consent form is signed by both the client and her husband  
   c. Examining the consent form to see that the client's signature was witnessed  
   d. Reviewing the consent for completeness and talking with the client to ensure that she understands the procedure she has requested

5. A pelvic examination by the operating doctor
   a. Must also be performed on the same day as the surgery  
   b. Must also be performed after the procedure to ensure that the uterus has not been perforated  
   c. Is unnecessary  
   d. Should be performed by the nurse to check for infection

6. If a systemic or local (pelvic) infection is noted on the day of the surgery
   a. The procedure should be performed anyway  
   b. The client should be sent home and told to return when she feels that the infection has been resolved  
   c. Laparoscopy should be performed instead of Abdominal Tubectomy  
   d. The procedure should be postponed until the client has been treated for the infection and a temporary method should be prescribed

7. When faced with an obese client who requests Abdominal Tubectomy under local anesthesia, the operating doctor should
   a. Plan to use more assistants during the procedure
b. Plan the procedure at a facility where general anesthesia can be given
c. Suggest that the client lose weight and ask her to return in 3 months
d. Use a vertical instead of an horizontal incision

8. After an Abdominal Tubectomy procedure, the only acceptable method for processing soiled instruments is
   a. Cleaning followed by sterilization
   b. Decontamination with 0.5% chlorine solution, cleaning, then disinfection with Dettol
   c. Soaking in Dettol for at least 24 hours
   d. Decontamination with 0.5% chlorine solution, cleaning, followed by sterilization or high-level disinfection

9. The human immunodeficiency virus (HIV) and the Hepatitis -B virus (HBV) are reliably killed by
   a. Thoroughly rinsing instruments with sterile water which has been boiled
   b. Air drying instruments for at least 48 hours before re-use
   c. Soaking instruments in a 0.5% chlorine solution for 10 minutes
   d. Soaking instruments in a povidone iodine solution immediately after use

10. The operating theatre should be cleaned with a disinfectant solution like 0.5% chlorine solution
    a. Between all cases and thoroughly on a weekly basis
    b. After any contaminated case and weekly
    c. Between all cases and also on a monthly basis
    d. After all cases with more than 250 cc of blood loss

11. When preparing the client for surgery, the staff should tell her that
    a. There will be a lot of pain during the procedure but that she won’t feel it because of the medication she will receive
    b. She will probably feel some discomfort, pulling and slight cramping during the procedure
    c. The doctor is very good and that she will probably not feel anything during the surgery
    d. Even though she might be feeling some cramping and discomfort during the procedure, she should not mention it during the surgery

12. Local anesthesia for Abdominal Tubectomy involves
    a. Using 1% lignocaine and adrenaline
    b. Sedating all clients with 50 mg pentazocine and atropine 10 mg
    c. Infiltrating all abdominal wall layers with 1% lidocaine
    d. All of the above
13. When infiltrating 1% lignocaine to produce local anesthesia for an Abdominal Tubectomy procedure
   a. The operating doctor must be sure that only the skin and subcutaneous tissue are infiltrated before starting the procedure
   b. The incision may be made as soon as the lignocaine is injected
   c. Epinephrine should always be used along with the lignocaine
   d. The operating doctor must attempt to infiltrate all the layers from the skin to the peritoneum with anaesthetic

14. Successful use of local anesthesia for an Abdominal Tubectomy procedure requires
   a. An anesthetist
   b. Use of enough sedation so that the client is asleep
   c. Continuous communication with the client during surgery
   d. At least 25 cc of 2% lidocaine

15. The following conditions indicate that the client is ready for discharge
   a. Her 8-year-old son has arrived to take her home
   b. She can walk upright with minimal support
   c. She complains of nausea and vomiting
   d. She still feels very drowsy

16. During the post-operative period, the client monitor should
   a. Check and record vital signs every 15 minutes until client is stable
   b. Review the client record upon transfer
   c. Complete client record form
   d. All of the above

17. When performing the Abdominal Tubectomy procedure, intra-abdominal bleeding
   a. Occurs solely in the operating theatre
   b. Is related to the level of the anesthesia
   c. May occur in the operating theatre or at any time the post-operative period
   d. Usually occurs in women with a previous history of postpartum haemorrhage
MID-COURSE QUESTIONNAIRE ANSWER KEY

1. C
2. B
3. D
4. D
5. A
6. D
7. B
8. D
9. C
10. A
11. B
12. C
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17. C
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Day VII

Session Title: INDICATIONS AND PRECAUTIONS

ADVANCE PREPARATION

- Read the facilitator's notes and chapter four of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Indications</td>
<td>Brainstorming, Small group exercises, Large group discussions</td>
<td>Flip chart for facilitators, Flip chart sheets with titled grids for participants to use</td>
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<tr>
<td>30 minutes</td>
<td>Precautions</td>
<td>Brainstorming, Small group exercises, Large group discussions</td>
<td>Flip chart for facilitators, Flip chart sheets with titled grids for participants to use</td>
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<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
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FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To explain the indications and precautions for Abdominal Tubectomy under local anesthesia.

Explain that the participants will do a simple exercise in groups to identify and explain the conditions that indicate Abdominal Tubectomy under local anesthesia, conditions that require precautions and conditions that require action. Divide participants into three groups.

INDICATIONS

On the top of a flip chart write 'Indications' and then divide the page into two columns – 'Conditions' and 'Rationale.' Provide them one example on how to fill the grid.

PRECAUTIONS

On the top of a flip chart write 'Conditions Requiring Precautions' and then divide the page into a three-column grid. Write 'Conditions', 'Precautions' and 'Rationale' at the top of each column respectively. Provide one example on how to fill the grid.

Give each group a sheet marked with the empty grid and ask them to fill the columns. Give them 15 minutes to do this exercise and then post the grids on the wall. Review (15 minutes) the conditions with the precaution, action and the rationale for each, allowing discussion for clarifications. (Refer chapter four) Fill gaps if any.
PROBLEMS REQUIRING ACTIONS

Write 'Problems Requiring Action' on the top of the page and then divide the page into a three-column grid. Write 'Problem,' 'Action' and 'Rationale' at the top of each column. Provide participants with one example of how to fill the grid.

Divide the participants into three groups A, B and C. Distribute copies of the empty grids giving one topic to each group (i.e. group A - indications, B - precautions and C - problems). Give the groups 15 minutes to fill the grids. Post the filled grids from the three groups on the wall and quickly review them one by one allowing for clarifications and (refer Chapter 4) fill the gaps if any.

SUMMARY

Briefly summarize the content covered in the session and address any questions the participants may have.

Indications for Abdominal Tubectomy Under Local Anesthesia

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman who understands and voluntarily gives informed consent for the procedure</td>
<td>A client who understands and voluntarily gives informed consent for the procedure is less likely to regret the decision and will be more satisfied after the procedure.</td>
</tr>
</tbody>
</table>

Conditions Requiring Precautions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Precaution</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained vaginal bleeding</td>
<td>Delay procedure only if serious problem is suspected.</td>
<td>If serious problem is suspected, evaluate (and treat) before surgery.</td>
</tr>
<tr>
<td>Problem</td>
<td>Action</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Excessive interest in reversal</td>
<td>Further assess concerns and, if appropriate, help client choose another method.</td>
<td>Tubal occlusion is permanent. Help couples who might be interested in more children choose another method.</td>
</tr>
</tbody>
</table>
ADVANCE PREPARATION

- Read the facilitator's notes and chapter five of the manual to prepare for this session.
- Prepare flip charts for the objectives and the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objective &amp; Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Client Assessment</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Client Assessment</td>
<td>Practicum</td>
<td>Real clients</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

OBJECTIVES

Using the flip chart you have prepared present the objectives of the session to the participants.

- Describe the main features of a client assessment – conditions that are acceptable and those that are not, what information is gathered when taking a medical history, what physical examination are carried out and what laboratory examinations are asked for.

CLIENT ASSESSMENT

State that during this stage, the assessing doctor needs to follow what conditions are acceptable. Ask participants 'What conditions are acceptable when selecting a client for Abdominal Tubectomy under local anesthesia'. Write their responses on the flip chart or the board. Review them and if there are any gaps fill them. (Refer Table 5-1, chapter five of the manual). Now repeat the same procedure for 'What conditions are not acceptable' when selecting a client for Abdominal Tubectomy under local anesthesia.

MEDICAL HISTORY

Ask participants what they normally ask a client when taking the medical history. Write their responses on the flip chart seeking clarification for each as you proceed. Review the list and fill the gaps if necessary. (Refer chapter five).

PHYSICAL EXAMINATION

Ask participants to list what the physical examination do they conduct and why? Write their responses on the flip chart seeking clarification for each as you proceed. Review the list and fill the gaps if necessary. (Refer chapter five).
LABORATORY EXAMINATIONS

Ask participants what laboratory examinations they ask for and why ? Write their responses on the flip chart and review the answers.

PRACTICUM

The participants should do client assessment in FP O.P.D on the clients opting for tubal ligation and select clients meeting the standard criterion.
ADVANCE PREPARATION

- Read the facilitator’s notes and chapter two of the manual.
- Prepare flip charts for the objectives of the session as required.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>25 minutes</td>
<td>Skills of a counselor – asking good questions</td>
<td>Brainstorm and discussion Group exercise – case study</td>
<td>Flip chart Copies of the case study</td>
</tr>
<tr>
<td>3 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip Chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart that you have prepared present the objectives of the session to the participants.

- To discuss the skills of a counselor.
- To discuss types of questions with examples (asking good questions).
- To practice role play on counseling.

Explain to the participants that FP counseling requires certain skills. Using the brainstorm technique, have participants list the skills as they perceive them. Write their answers on the flip chart. Where necessary use lead questions to guide participants to provide the right answers. Sum up their responses and then present the list of the skills of a good counselor.

- Ability to listen actively.
- Ability to show empathy.
- Ability to give encouraging feedback.
- Ability to identify and reflect client’s feelings.
- Ability to remain non-judgmental
- Ability to present information clearly in simple terms.
- Ability to encourage questions.
- Ability to create a comfortable atmosphere for the client.
- Ability to ask questions effectively so as to encourage the client to share information and feelings.
- Ability to speak the clients language.
- Ability to understand and use non-verbal behavior to communicate effectively.
SUMMARY

Briefly summarize the content covered in the session and address any questions that participants may have.

Module 1 – Exercise 4: Asking Good Questions (Case studies)

Facilitator’s guide: Divide the large group into triads for this exercise. Have sufficient number of copies of the cases on individual slips of paper (one set of three individual cases per group). Call one person from each of the triads, outside the room. Give them each a copy of the case (identical). Tell them that they will play the role of the client and will not volunteer information but will give information to the health provider according to the questions asked. Let participants read the case and decide how to play the role of the client in their respective triads.

Of the remaining two persons in each triad, nominate one to be the health provider and the other to be the observer. Instruct the observer to note down the questions asked and to indicate whether it was an open question or closed question also whether it involved information or feelings or both.

Give participants 5 minutes to role play each case.

For each case change the roles for the persons in the triads so that each one gets a chance to ask questions, observe and also play the client.

A. Client is 18 years old. She is planning to be married in three months time. She wants to start using a contraceptive before she gets married so that she can delay having a baby. She is very embarrassed about asking for information about any method. In her nervousness she refers to her partner sometimes as her ‘fiancé’, sometimes as her ‘friend’ and sometimes as her ‘husband’. She knows very little about contraception but she is sure that she does not want to have a baby immediately after marriage.

B. Client is 32 years old. She has three children. She has tried different methods of family planning but they have failed. She had her first pregnancy when she was on the pill; her second pregnancy when she had had an IUD inserted and her third pregnancy four years after her tubectomy! Her youngest child is only six months old and she is worried. She wants to adopt an FP method which will ensure that she has no more children.

C. The client is a 26-year old woman with two children. She had an IUD inserted a year ago. Recently, she begun to suspect her husband of having an affair with another woman and that he no longer loves her. She is desperate. She feels that if she has the IUD removed and gets pregnant then she will be able to win back her husband’s love and attention.
Day VIII

Session Title: ANESTHESIA AND PAIN MANAGEMENT

ADVANCE PREPARATION

- Read the facilitator’s notes and chapter seven of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Local Anesthesia</td>
<td>Demonstration &amp; discussion</td>
<td>Zoe, 20cc syringe with needle, kidney tray, 2% xylocaine vial, distilled water/normal saline, sponge holder, betadine, cotton swabs, small bowl, gauze piece.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Pain Management and pre-medicati</td>
<td>Discussion</td>
<td>Flip charts</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Complications of local anesthesia and their management</td>
<td>Group exercise</td>
<td>Flip charts</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To describe the principles of and requirements for the use of local anesthesia, including the importance of emotional preparation of the client and continual communication during surgery.
- To demonstrate the standard technique of local anesthesia on Zoe.
- To discuss pain management and precautions required for Abdominal Tubectomy.
- To discuss complication of local anaesthesia and their management.

GOAL OF ANESTHESIA

Ask participants what is the goal of anesthesia. Having ascertained that the goal of anesthesia is to prevent pain, discomfort and anxiety, state that when operating on clients not under general anesthesia, the operating team uses a three pronged approach to allay anxiety, discomfort and pain with the use of sedatives, verbal anesthesia and local anesthesia. Ask participants what they would do for each of these, including the drug and the dosage used for sedation and local anesthesia. Then present what is verbal anesthesia, how and when is it used; what is local anesthesia, what is the drug and dosage and how and when is it administered.
Ask a volunteer to come up and demonstrate the administration of local anesthesia using the Zoe model. Once the demonstration is over ask, the group to comment on the procedure just shown touching upon what was right and what was wrong in the demonstration. Follow this with a demonstration by the trainers using the standard technique of administering local anesthesia.

Explain each step as you proceed slowly.

Discuss pain management and pre-medication required for Abdominal Tubectomy

SUMMARY

Briefly summarize what you had covered in the session, emphasizing the importance of continual verbal communication with the client, use of the appropriate drugs and dosage for sedation and local anesthesia. Also emphasize on how the right technique of administering local anesthesia, increases its effectiveness.
ADVANCE PREPARATION

- Read the facilitator's notes and chapter seven of the manual to prepare for this session.
- Ensure that you have the Zoe model and all equipment for giving local anesthesia ready.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip Chart</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Practice of local anesthesia on Zoe</td>
<td>Demonstration</td>
<td>Zoe, sponge holder-1, cotton swabs, forceps-1, kidney tray, xylocaine vial - 1, distilled water/normal saline, betadine, cut sheet, syringe 10/20 ml</td>
</tr>
<tr>
<td>2 minutes</td>
<td>Summary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTE

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.
- To describe the technique of giving local anesthesia
- To practice the technique on Zoe

TRAINER DEMONSTRATION

Now state that you will demonstrate on the Zoe model the technique of giving local anesthesia. Explain the how and why of each step as you carry out the procedure. Trainees observe the procedure carefully.

VOLUNTEER DEMONSTRATION

Ask one of the participants to volunteer to demonstrate on the Zoe model the correct the technique of giving local anesthesia. Ask the rest to observe the procedure carefully. Once the procedure has been completed, thank the volunteer and state that now the demonstrated procedure will be reviewed. Ask each participant to demonstrate and practice the technique. Allow a free flowing discussion on the practices they currently follow.
ADVANCE PREPARATION

- Read the facilitator’s notes and chapter eleven of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objective and introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Anesthesia-related complications</td>
<td>Brainstorming</td>
<td>Flip chart for facilitators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small group exercises</td>
<td>Flip chart sheets with titled grids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Large group discussions</td>
<td>for participants to use</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Surgery-related complications</td>
<td>Brainstorming</td>
<td>Flip chart for facilitators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small group exercises</td>
<td>Flip chart sheets with titled grids</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Large group discussions</td>
<td>for participants to use</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objective of the session to the participants.

- To explain how to recognise and manage anaesthesia and surgery related complications.

MANAGEMENT OF COMPLICATIONS

Begin the session by stating that complications can be categorized as Anesthesia-related complications and Surgery-related complications. Divide the space on the flip chart or writing board into two columns and title them Anesthesia-related complications and the other as Surgery-related complications. Give the participants 5 minutes to brainstorm the possible complications under each head, fill the columns as they proceed. Then review the list and add any that you think the participants missed.

Tell participants that they will be called to do a small exercise – to list on a grid the symptoms presented, the possible cause of the complication, and the management for each of the complications that they had listed under Anesthesia-related complications. Now divide participants into two groups and give them a large sheet with the grid and the titles marked on it. Let groups choose their own moderator and reporter and give them 10 minutes to complete the exercise. Call the groups back to the large group and post their grids on the wall. Quickly (5 minutes) review the entries, allowing discussions as you proceed across the listings.

Repeat the same pattern for the Surgery-related complications. Allow 25 minutes for the small group exercise and follow it up with 10 minutes for the review of the filled grids and discussion.

SUMMARY

Ask one of the participants to summarize what was covered in this session.
Anesthesia-related complications

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Complication</th>
<th>Cause</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Surgery-related complications

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Complication</th>
<th>Cause</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
DISCHARGE

Enquire from the participants when do they discharge a client after Abdominal Tubectomy under local anesthesia. Write the responses and discuss them with the group. Fill gaps.

Enquire from the participants the criteria for discharge of a client after Abdominal Tubectomy. Write the responses on the flip chart and seek clarifications as you proceed. Fill gaps where necessary.

SUMMARY

Briefly summarize the content covered in the session and address any questions the participants may have.
Day IX

Session Title: POST-OPERATIVE RECOVERY AND DISCHARGE

ADVANCE PREPARATION

- Read the facilitator’s notes and chapter ten of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Post-operative recovery</td>
<td>Brainstorming and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Discharge</td>
<td>Brainstorming and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>3 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To describe post-operative monitoring, post-operative instructions and discharge for a client after an Abdominal Tubectomy procedure under local anesthesia.

POST-OPERATIVE MONITORING

Ask participants at what intervals do they carry out post-operative monitoring and what do they check and record. Write their responses on the flip chart and review the responses (refer chapter ten), clarify and fill gaps as necessary.

POST-OPERATIVE INSTRUCTIONS

Enquire from the participants what post – operative instructions they give to the clients, whether in written or verbal and in what language. Also ask them also whether these instructions are given during pre-procedure counseling. Write their responses on the flip chart and review. Clarify doubts and fill gaps as necessary.
Session Title: FOLLOW-UP INSTRUCTIONS ON DISCHARGE AND POST OPERATIVE MEDICATION

ADVANCE PREPARATION

- Ensure availability of standardized discharge card to be provided to the clients on discharge
- Ensure the availability of medicine kit given to the clients at the time of discharge

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 minutes</td>
<td>Introduction</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>25 minutes</td>
<td>Follow-up</td>
<td>Discussion</td>
<td>Flip chart, standardize</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>discharge card and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>medicine kit.</td>
</tr>
<tr>
<td>3 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FOLLOW-UP

State that there are two types of follow-up for clients who have undergone Abdominal Tubectomy

a) Routine follow-up
b) Emergency follow-up.

Ask participants when and where should the first follow-up be conducted. Write the responses and discuss them with the group. Fill gaps where necessary.

Ask participants under what conditions should a client seek immediate medical attention in and where. Write the responses and discuss them with the group. Fill gaps where necessary.

Show the participants the standardized discharge card with instructions to be given at the time of discharge.

SUMMARY

Briefly summarize the content covered in the session and address any questions the participants may have.
Day X

Session Title: PROVIDING QUALITY SERVICES

ADVANCE PREPARATION

- Read the facilitator's notes and chapter twelve of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and the key messages.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>50 minutes</td>
<td>Rights of the client</td>
<td>Brainstorm and discussion</td>
<td>Flip charts</td>
</tr>
<tr>
<td></td>
<td>Needs of the service provider for giving</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>quality services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

Using the flip chart you have prepared, present the objectives of the session to the participants.

- To provide quality services

Using the brainstorm technique ask the participants what are the “Rights of the Client and Needs of the service provider” in providing quality services. Fill gaps where necessary.

SUMMARY

Briefly summarize the content covered in the session and address any questions the participants may have.
Day XI

Session Title: STANDARDS FOR FEMALE AND MALE STERILIZATION - GOI

ADVANCE PREPARATION AND MEDICO LEGAL ASPECTS

- Ensure availability of sufficient copies of Standards of Female and Male Sterilization - GOI
- Ensure availability of sufficient copies of annexure on Medico legal aspects

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 minutes</td>
<td>Standards of Female and Male Sterilization - GOI</td>
<td>Brainstorm and Discussion</td>
<td>Copies of Standards of Female and Male Sterilization - GOI</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Medico legal aspects</td>
<td>Brainstorm and Discussion</td>
<td>Annexure on Medico legal aspects</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

- Get the participants knowledge on the Standards for Female and Male Sterilization - GOI
- Ask the participants to read the important chapters of the Standards for Female and Male Sterilization - GOI . Discuss the main issues.
- Get the participants knowledge on the Medico legal aspects of sterilization.
- Ask the participants to read the handout on Medico legal aspects on sterilization and discuss the important issues.
ADVANCE PREPARATION

- Ensure/verify camp date and site in advance
- Inform CMO/CMS about camp visit
- Inform MOI/C and O.T. staff of the site
- Ensure vehicle and driver
- Ensure working lunch
- Review the activities of the camp visit

The participants along with the trainers visit a camp site and observe the camp activities—registration, client assessment, pre-operative tasks, O.T. preparation, surgical procedure, IP practices and post-operative care and instructions.

Discuss the activities observed in the camp. Take feedback from the participants. Lay emphasis on the procedure and infection prevention practices.

FACILITATORS’S NOTES

OBJECTIVES

To observe the Abdominal Tubectomy procedure at a camp facility.

SUMMARY

Briefly summarize the day’s activities and give assignment of chapter eleven from the reference manual.
Day XII

Session Title: POST-TEST AND PROGRAMME EVALUATION

ADVANCE PREPARATION

- Ensure you have sufficient number of copies of the post-test and evaluation forms

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Post-test</td>
<td>Test forms</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Program Evaluation</td>
<td>Evaluation forms</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

- Provide opportunity through a post-test to gauge how much knowledge the participants have gained through the induction.

Distribute copies of the post-test to all participants and give them 30 minutes in which to complete the test and return the test sheets back to you.

Distribute copies of the program evaluation forms and ask participants to complete them and return the forms to you.
TRAINING EVALUATION

Sample End-of-Training Evaluation Form
Please complete all sections of this evaluation form, using the reverse side for comments, if needed. Your responses will assist the organizers of the training to determine what modifications, if any, should be made to this program.

Overall Evaluation
Select the choice that best reflects your overall evaluation of this training:

- Excellent  
- Very good  
- Good  
- Fair  
- Poor

Specific Aspects
1. Evaluate each of the following elements of the training (circle the number of your response for each):

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sufficiency of information</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Organization</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Materials and Visual Aids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Usefulness</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Instructor Presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of subject</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Presentation style</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Practicum</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

3. The length of training was: 
   - Too long  
   - Just right  
   - Too short

4. The most important thing I learned in this training was:

For the Future
Please think about this training event and all the elements (content, materials, presentation, practicum etc.) you feel should be the same if this training is repeated. Also think about what aspects you feel could be improved and what elements you feel should be eliminated from this training.

1. I suggest the following be SAVED and included in future training (include reasons why):

2. I suggest the following be CHANGED for future training (include reasons why):

3. I suggest the following be REMOVED from future training (include reasons why):

Comments

Facilitator's Session Guide
Session Title: MOP-UP

ADVANCE PREPARATION

- Read the facilitator's notes

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Clearing doubts</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Follow-up</td>
<td>Presentation</td>
<td>Flip chart &amp; checklists</td>
</tr>
<tr>
<td>3 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

OBJECTIVE

- To provide opportunity to clear any doubts related to Abdominal Tubectomy services that the participants may still have.
- To explain the post-training follow-up of the participants at their work sites.

CLEARING DOUBTS

Return the corrected pre-test, mid-test and post-test papers to the participants. Review the questions that were incorrectly answered. Clear participants' doubts and encourage them to ask as many questions as possible and answer them patiently.

FOLLOW-UP

Explain that all participants will be followed up at their work sites within three months of their training. The observer will use the learning guide checklists to assess their performance in the field. Ensure that each person has a copy of the relevant checklists.

SUMMARY

Briefly summarise the content covered in the session and answer any queries the participants may have.
### Tasks

<table>
<thead>
<tr>
<th>Assessor: When rating tasks for assessment, use the following codes:</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S= Satisfactory: Performs the step or task according to the standard guideline.</td>
<td>Please write any comment, or any extra explanation of what occurred for any step in that space (and continue on reverse if needed.)</td>
</tr>
<tr>
<td>U= Unsatisfactory: Unable to perform the step or task according to the standard guideline.</td>
<td></td>
</tr>
<tr>
<td>N/O = Not Observed: Step, task or skill not performed by providers during assessment</td>
<td></td>
</tr>
</tbody>
</table>

All critical steps must be performed satisfactorily for the participant to be assessed as performing to standard (PTS) during follow-up.

### Getting Ready

1. Greets client respectfully and reviews medical records.

2. Checks that informed consent was obtained and verifies client's identity.

3. Ensures that client has voided and abdominal and pelvic areas are clean.

### Preoperative Tasks

1. Ensures that sterile or high level disinfected instruments and emergency tray are present.

2. Ensures that vital signs are taken and sedation has been given.

3. Washes hands thoroughly with soap and water and air dries or dries with clean or sterile cloth.

   - one ---- air dries ---- clean cloth ---- sterile cloth

4. Puts new examination or high level disinfected or sterile surgical gloves on both hands.

   - one --- exam glove --- HLD surgical glove --- sterile surgical glove

5. Performs a bimanual pelvic examination. (Record as “S” if done now, or earlier in the day by the person being assessed, or by another examiner if the doctor being assessed is a male doctor.)

6. Performs surgical scrub, puts on sterile gown and sterile surgical gloves.

7. Applies antiseptic two times to incision area and drapes client for procedure.

8. Throughout procedure talks to client (verbal anesthesia)

### Procedure

### Local Anesthesia

1. After raising a small skin wheal, administers local anesthesia just under the skin along both sides of the incision line and deeply (rectus sheath and peritoneum) as well.
<table>
<thead>
<tr>
<th>TASKS</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Code</td>
</tr>
<tr>
<td>2. Massages the skin and tests with needle tip.</td>
<td></td>
</tr>
<tr>
<td><strong>ABDOMINAL ENTRY</strong></td>
<td></td>
</tr>
<tr>
<td>3. * Makes transverse/vertical/suprapubic skin incision (3-4 cm.)</td>
<td></td>
</tr>
<tr>
<td>4. Bluntly dissects subcutaneous tissues down to the anterior fascia.</td>
<td></td>
</tr>
<tr>
<td>5. Cuts anterior rectus fascia, separates rectus muscles and identifies peritoneum.</td>
<td></td>
</tr>
<tr>
<td>6. Lifts the peritoneum with Ellis forceps, and makes sure that there is no underlying bowel or abdominal viscera.</td>
<td></td>
</tr>
<tr>
<td>7. Makes a small incision in the peritoneum and enlarges it vertically</td>
<td></td>
</tr>
<tr>
<td>8. If the client is put in Trendelenburg position ensures that it does not exceed 20°</td>
<td></td>
</tr>
<tr>
<td>7. * Inserts index finger or index and middle finger of one hand inside the incision and locates the Fallopian tube of one side</td>
<td></td>
</tr>
<tr>
<td>10. * Brings out the Fallopian tube through the incision and identifies the midportion</td>
<td></td>
</tr>
<tr>
<td>11. Delivers Fallopian tube through the incision using the Babcock.</td>
<td></td>
</tr>
<tr>
<td>12. * Identifies fimbriae, transfixes the tube making a loop of about 3 cms. and ties knots on both sides of the tube.</td>
<td></td>
</tr>
<tr>
<td>13. * Cuts the loop of the tube above the ligature ensuring that at least 1 cm. of the tubal stump has been left.</td>
<td></td>
</tr>
<tr>
<td>15. * When haemostasis is assured, closes wound in layers.</td>
<td></td>
</tr>
<tr>
<td>16. Dresses the wound.</td>
<td></td>
</tr>
<tr>
<td><strong>POSTOPERATIVE TASKS</strong></td>
<td></td>
</tr>
<tr>
<td>1. * Ensures that the assistant</td>
<td></td>
</tr>
<tr>
<td>• disposes of disposable needles and syringes in a puncture proof container or</td>
<td></td>
</tr>
<tr>
<td>• fills re-usable needles and syringes with 0.5% chlorine solution and soaks for 10 mts for decontamination.</td>
<td></td>
</tr>
<tr>
<td>2. Ensures that assistant decontaminates instruments by soaking in 0.5% chlorine solution for 10 minutes.</td>
<td></td>
</tr>
<tr>
<td>· Ensures that assistant disposes of waste materials according to infection prevention guidelines.</td>
<td></td>
</tr>
<tr>
<td>TASKS</td>
<td>ASSESSMENT</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>4. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- If disposing of gloves, places in leakproof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>- If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>5. Washes hands thoroughly with soap and water and air dries or dries with clean or sterile cloth.</td>
<td></td>
</tr>
<tr>
<td>[ one ---- air dries ---- clean cloth ----- sterile cloth]</td>
<td></td>
</tr>
<tr>
<td>6. Ensures that vital signs are being monitored regularly.</td>
<td></td>
</tr>
<tr>
<td>7. Instructs client on wound care and return visit.</td>
<td></td>
</tr>
</tbody>
</table>

** A critical step that must be performed satisfactorily for the participant to be assessed as performing to standard during training or on follow-up
Appendices

Appendix A: Instructions for using the Zoe® Gynaecologic simulator
Appendix B: How people learn
Appendix C: Conducting the course
Appendix D: Emergency Preparedness
APPENDIX A

INSTRUCTIONS FOR USING THE ZOE® GYNAECOLOGIC SIMULATOR

The Zoe gynaecologic simulator is a full-sized, adult female lower torso (abdomen and pelvic). It is a versatile training tool developed to assist health professionals to teach the processes and skills needed to perform many gynaecologic procedures. The Zoe model is ideal for demonstrating and practicing the following:

- Bimanual pelvic examination including palpation of normal and pregnant uterus
- Vaginal speculum examination
- Visual recognition of normal cervixes and cervical abnormalities
- Uterine sounding
- IUCD insertion and removal
- Diaphragm sizing and fitting
- Laparoscopy inspection and occlusion of fallopian tubes (Fallope rings or other clips)
- Abdominal and Minilaparotomy (both interval and postpartum tubal occlusion)
- Treatment of incomplete abortion using manual vacuum aspiration (MVA)

CONTENTS

The contents of the Zoe Gynaecologic Simulator include the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal ante- and retroverted uteri with transparent tops, attachments for round and ovarian ligaments as well as fallopian tubes and normal patent cervical os for pelvic examination and IUCD insertion.</td>
<td>2</td>
</tr>
<tr>
<td>6 to 8 weeks uterus (incomplete abortion) with dilated, patent cervical os which allows passage of a 5 or 6 mm flexible cannula.</td>
<td>1</td>
</tr>
<tr>
<td>10 to 12 weeks uterus (incomplete abortion) with dilated, patent cervical os which allows passage of a 10 or 12 mm flexible cannula.</td>
<td>1</td>
</tr>
<tr>
<td>Postpartum uterus (20 weeks size) with attached fallopian tubes for practicing postpartum tubal occlusion by minilaparotomy.</td>
<td>1</td>
</tr>
<tr>
<td>Cervices (nonpatent) for use in visual recognition:</td>
<td>4</td>
</tr>
<tr>
<td>• Normal cervix</td>
<td>(1 of each)</td>
</tr>
<tr>
<td>• Cervix with proliferation of columnar epithelium (ectropion)</td>
<td></td>
</tr>
<tr>
<td>• Cervix with inclusion (nabothian) cyst and endocervical polyp</td>
<td></td>
</tr>
<tr>
<td>• Cervix with lesion (cancer)</td>
<td></td>
</tr>
<tr>
<td>Simulated round and ovarian ligaments (set of 2 each)</td>
<td>4</td>
</tr>
<tr>
<td>Normal tubal fimbriae and ovaries (2 each)</td>
<td>10</td>
</tr>
<tr>
<td>Extra normal cervixes with patent os for IUCD insertion/removal</td>
<td>4</td>
</tr>
<tr>
<td>Extra cervixes for 6 to 8 week and 10 to 12 week uterus (2 of each size)</td>
<td>4</td>
</tr>
<tr>
<td>Extra thin cervical locking rings</td>
<td>3</td>
</tr>
<tr>
<td>Flashlight with batteries</td>
<td>1</td>
</tr>
<tr>
<td>Soft nylon carrying bag</td>
<td>1</td>
</tr>
</tbody>
</table>

The 3cm incision (reinforced at each end) located just below the umbilicus can be used to insert a laparoscope to look at the uterus, round ligaments, ovaries and fallopian tubes, and practice laparoscopy tubal occlusion. This incision also can be used for practicing postpartum tubal ligation by abdominal and minilaparotomy.
The 5cm incision located a few centimetres above the symphysis pubis is used for practicing interval abdominal and minilaparotomy. This incision is also reinforced allowing the skin to be retracted to facilitate demonstration of the abdominal and minilaparotomy technique.

CERVICES

The normal cervices have a centrally located, oval-shaped os which permits insertion of a uterine sound, uterine elevator or IUCD. The abnormal cervices are not patent (open) and can be used for demonstration only.

Each of the cervices for treatment of incomplete abortion has centrally located, oval-shaped os which is dilated to allow passage of a 5 or 6 mm or 10 or 12 mm flexible cannula, respectively.

The normal cervices and interchangeable uteri feature the patented 'screw' design for fast and easy changing.

ASSEMBLY

To use the Zoe pelvic model for demonstrations or initially to learn how to change the parts (e.g. cervices and uteri), you need to know how to remove the skin.

REMOVING AND REPLACING THE DETACHABLE SKIN AND FOAM BACKING

First, carefully remove the outer skin and its foam lining away from the rigid base at the 'top' end of the model. ('Top' refers to the portion of Zoe nearest to the metal carrying handle located above the umbilicus.)

Lift the skin and foam up and over the legs, one leg at a time.

Be as gentle as possible. The detachable skin is made of material that approximates skin texture and it can tear.

If you wish to change the antverted uterus and normal cervix which are shipped attached to Zoe, first you must remove the uterus.

Start by pulling the round ligaments away from the wall.

Then grasp the uterus while turning the wide grey ring anti-clockwise until the cervix and uterine body are separated.

To remove the cervix, turn the thin grey ring anti-clockwise until it comes off.

You then can push the cervix out through the vagina.

To reassemble, simply reverse this process.

To replace the skin and foam lining, start by pulling them down around the legs.

Then make sure the rectal opening is aligned with the opening in the rigid base.

Pull the skin and foam over the top of the model.
Finally, make sure both are pulled firmly down around the rigid base, and the skin is smoothly fitted over the foam.

Once you understand how the anatomical parts of Zoe fit together, we suggest you change them through the opening at the top of the model. This helps to preserve the outer shell of the Zoe, as you will only have to remove it for demonstrations or to change the postpartum (20 week size) uterus.

The anteverted and retroverted uteri have transparent top halves and opaque lower halves for use in demonstrating IUCD insertion. These uteri are supported by round ligaments attached to the pelvic wall. The round ligaments, ovaries and fallopian tubes are removable.

To remove the uterus:
- Unscrew the wide locking ring attached to the uterus using a anti-clockwise rotation.

To remove the cervix:
- Unscrew the thin locking ring immediately outside the apex of the vagina.
- The cervix should be pushed through the vagina and removed from the introitus.

To reassemble, proceed in the reverse order.

Performing Procedures

Speculum examination:

Use a medium bivalve speculum.

- Prior to inserting the speculum, dip it into clean water containing a small amount of soap. (This makes inserting the speculum easier.)
- To see the cervix, fully insert the speculum, angle it posteriorly (as in the human, the vagina in the ZOE model is angled posteriorly), then open the blades fully.
- To increase the diameter of the opening, use the speculum thumb screw (Pederson or Graves specula).

Passing instruments (uterine sound, uterine elevator, dilator or cannula) through the cervical os:

- Apply a small amount of clean water containing a drop or two of soap solution to the cervix (just as you would apply it with antiseptic solution in a client). This will make passing the instrument through the cervical os easier.

Sounding the uterus, inserting an IUCD and interval abdominal and minilaparotomy or Laparoscopy Tubal Ligation: use either the normal (non-pregnant) anteverted or retroverted uterus with a cervix having a patent os.

Postpartum abdominal and minilaparotomy (tubal occlusion): use the postpartum uterus (20 week size) with a cervix having a patent os.

Treatment of incomplete abortion using MVA: use either the 6 to 8 or 10 to 12 week uteri (incomplete abortion) with appropriate sized cervix.
CARE AND MAINTENANCE

- Zoe is constructed of material that approximates skin texture. Therefore, in handling the model, use the same gentle techniques as you would in working with a client.
- To avoid tearing Zoe skin when performing a pelvic exam, use a dilute soap solution to lubricate the instruments and your gloved fingers.
- Clean Zoe after every training session using a mild detergent solution; rinse with clean water.
- DO NOT write on Zoe with any type of marker or pen, as these marks may not wash off.
- DO NOT use alcohol or Betadine® or any other antiseptic which contains iodine on Zoe. They will damage or stain the skin.
- Store Zoe in the carrying case and plastic bag provided with your kit.
- DO NOT wrap Zoe in other plastic bags, newspaper, plastic wrap or any other kinds of material, as these may discolor the skin.
APPENDIX B

HOW PEOPLE LEARN

1. Training must be relevant. Learning experiences should relate directly to the job responsibilities of the participants.

2. People often bring a high-level of motivation to training:
   - Desire to improve job performance
   - Desire to learn
   - Desire to improve their life

3. People need involvement during training. This can be accomplished by:
   - Allowing participants to provide input regarding schedules, activities and other events
   - Using questioning and feedback
   - Using brainstorming and discussions
   - Providing hands-on work
   - Conducting group and individual projects
   - Setting up classroom activities or games

4. People desire variety. Ways to provide this include:
   - Varying the schedule
   - Using a variety of audiovisuals aids
     - Slides
     - Videotapes
     - Overhead transparencies
     - Flip chart or blackboard
     - Models or real objects
   - Using a variety of teaching methods:
     - Illustrated lectures
     - Demonstrations
     - Small group activities
     - Group discussions
     - Role plays and case studies
     - Guest speakers

5. People need positive feedback. Positive feedback is letting participants know how they are doing, and providing this information in a positive manner. The clinical trainer provides positive feedback when s/he uses one or more of the following:
   - Verbal praise either in front of other participants or individually
   - Recognizing appropriate responses during questioning:
     - "That's correct!"
     - "Good answer!"
     - "That was an excellent response!"
   - Acknowledging appropriate skills while coaching in a clinical setting:
     - "Very good work!"
     - "I would like everyone to notice the incision that was just made. Alka did an excellent job and your incisions should look like this one."
   - Letting the participants know how they are progressing toward achieving the learning objectives.
6. The clinical trainer must recognize that participants may come to training with a number of personal concerns such as:
   - A fear of failure or embarrassment
   - Fitting in with the other participants
   - Getting along with the trainer
   - Understanding the content
   - Being able to perform the skills being taught

The clinical trainer must be aware of these concerns and begin the course with an opening exercise that allows all participants to get to know each other in a safe and positive climate.

7. People prefer to be treated as individuals who have unique and particular backgrounds, experiences and learning needs. The clinical trainer can ensure that participants feel like individuals by one or more of the following methods:
   - Using participant names as often as possible
   - Involving all participants as often as possible
   - Treating participants with respect
   - Allowing participants to share information with others during classroom and clinical sessions

8. Participants need to maintain high self-esteem to deal with the demands of clinical training. Respect on the part of the clinical trainer, which includes avoiding negative feedback, is essential to maintaining participant self-esteem and confidence while learning.

9. The clinical trainer must maintain participants' high expectations by:
   - Conducting a training course which enhances the participant’s self-esteem and sense of competence level
   - Setting high expectations for himself and his fellow trainers
   - Allowing participants to get to know and respect the trainer
   - Understanding and recognizing the participants’ career accomplishments

10. All participants have personal needs during training. Timely breaks from instruction, the best possible ventilation, proper lighting and an environment as free from distractions as possible reduce tension and create a positive atmosphere.

STAGES OF LEARNING CLINICAL SKILLS

- **Skill acquisition** represents the initial phase in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and the sequence (if necessary) in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

- **Skill competency** represents an intermediate phase in learning a new clinical skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.

- **Skill proficiency** represents the final phase in learning a new clinical skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary).
PRINCIPLES OF LEARNING (KEYS TO SUCCESS)

- The most productive way of learning is by doing. Practice is necessary for proficiency.

- The more realistic the content, the more productive the learning.

- Learning is:
  - Most productive when the participant is ready to learn (It is up to the clinical trainer to create a climate that motivates participants.)
  - Most productive when it builds on what the participant already has experienced or knows
  - Easier when the participant knows what s/he is expected to learn
  - More fun when a variety of training methods and techniques are used
APPENDIX C

CONDUCTING THE COURSE

CREATING A POSITIVE TRAINING CLIMATE

A positive training environment does not come about by accident, but through careful planning. This planning takes time, preparation and often some study on the part of the clinical trainer. Although no one can anticipate everything that can happen during a training course, the objective is to minimize the unexpected and then deal with any unplanned events as gracefully as possible.

- It is important for the trainer to know basic information about participants:
  - How many participants will be attending the course. For the trainer to plan for seating arrangements, course materials, clinical activities, etc., it is critical to know how many will be attending the course. Some training methods, such as coaching and clinical demonstrations work best with small groups, while other methods, including illustrated lectures, are better suited to larger groups.
  - Why the participants enrolled in the course. Sometimes this can be found out in advance, although often one has to ask participants on the first day of training. Knowing why they are attending and how they feel about coming to the course is important for the clinical trainer.
  - The experience and educational background of the participants. The trainer should attempt to gather as much information about participants as possible prior to training. An effective way to do this is to meet the participants before the course begins and talk with them about their background and expectations. When this is not possible, the trainer should do this during the first day of the course.
  - The types of clinical responsibilities participants will perform in their daily work after training. Knowing the exact nature of the work that participants must perform after training is critical to the clinical trainer. It is important to use appropriate, job-specific examples throughout the course so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.
  - The socio-cultural background of the participants. Beliefs and values are a critical part of acceptance or rejection of family planning and of specific methods. Thus they must be considered when conducting the training course.

- In some cases the clinical trainer may be responsible for selecting the training methods and activities to be used in the course. Increasingly, however, clinical trainers are given a training package consisting of a reference manual, course schedule and outline, audiovisuals and competency-based knowledge and skill (performance) assessments. In this instance, clinical trainers may need to adapt the course to the local setting. Occasionally, supplemental or new materials needed to customize or localize the course must be developed in advance.

Even if most of the training activities and methods (e.g., case studies, group discussion, brainstorm, use of assessment instruments) are specified in a training package, considerable thought and planning are needed to determine the timing, sequence and progression from one activity to another.
• A variety of pre-course activities is important to the clinical trainer's self-preparation. Before the course, the clinical trainer should:

  • Update her/his knowledge about the course topics (e.g., contraceptive technology, infection prevention, STIs)
  • Assure that her/his clinical training skills are up to standard (e.g., coaching, training with models, conducting demonstrations and role plays)
  • Revise training aids such as slide sets and transparencies to be sure they are updated
  • Prepare and personalize a set of trainer's notes. Colored pens or markers can be used to:
    - Highlight key points
    - Add key questions
    - Insert reminders to conduct the activities presented in the course outline (case studies, role plays, discussions, demonstrations, problem-solving activities, etc.)

Trainer's notes such as key content points or questions for the participants can be outlined on the writing board, flip chart or in transparencies. Notes and reminders can also be written directly on the manual pages.

• The clinical trainer must consider the physical resources at the training site:
  • Is the space appropriate to the participant group? Is proper furniture available such as tables, chairs and desks?
  • Is the room properly heated/cooled and ventilated?
  • Is there a writing board with chalk or marking pens? Is there an information board available for posting notes and messages for participants?
  • Is the lighting adequate? Can the room be darkened in order to show audiovisuals and still permit participants to take notes or follow along in their training materials?
  • Is there proper audio-video and demonstration equipment? Is it in working order, with spare parts such as bulbs and electrical extension cords readily available?

• The physical arrangement of the furniture and participants within the room will affect the interaction and communication that occurs during the course. The most common arrangements for classroom tables and chairs are:

  • U-shaped. This arrangement allows the trainer to move about the room and maintain eye contact. It works well with audiovisuals such as projectors, videotapes or flip charts.
  • Rectangular or circular. This arrangement is excellent when training uses primarily group discussion and brainstorming; it is not well-suited to using audiovisuals.
  • Small group arrangement. Several groups of tables and chairs arranged in separate workstations provides space for small groups to work together.

• Planning to meet the requirement of participants is essential. Some of the questions that must be addressed include:

  • Will participants be able to see the audiovisuals? Is the projection screen well placed? Is the video monitor big enough?
  • Will there be adequate electric power throughout the course? What will happen if the power fails?
  • What plans will be made for meals? Will there be refreshments such as tea, coffee, soft drinks, water provided during the breaks?
  • Does the facility have a policy regarding smoking?
  • Are there toilet facilities and are they adequately maintained?
Establishing and maintaining a positive training climate during training depends on how the clinical trainer delivers information because the trainer sets the tone for the course. In any course, how something is said may be just as important as what is said.

- **Verbal communication** refers to how something is said. In order to capture and maintain participants' interest, clinical trainers should:
  
  - Vary the **pitch, tone and volume of their voices** to emphasize the important points. Avoid monotone speech which will cause boredom no matter how important the content.
  - Begin each session and each topic with a **strong introduction** to capture interest and draw attention to important points.
  - **Communicate on a personal level** with each of the participants by using their names; however, be sensitive to cultural norms. In some settings using first names may make the participants more comfortable while in other settings, use of first names may be inappropriate.
  - **Try to incorporate participants' ideas and examples** into the training. Remembering a participant's comments, either from a previous session or from outside the training environment, will encourage participant interest and further participation.
  - **Avoid repeating words or phrases** such as 'Do you know what I mean?' '...you know?' and 'Do you understand?' These can be extremely annoying after a short time.
  - **Vary the pace and delivery.** Make important points slowly and cover less important material more quickly. Use terms that are familiar or easily understood by the participants.
  - **Try to make logical and smooth transitions** between topics. Where possible, link topics so that the concluding review or summary of one presentation introduces the next topic. In any case, clearly state the beginning of a new topic and use audiovisual aids (chalk or writing board, flip chart, projection screen) to show it. **Abrupt transitions between topics can cause confusion.**
  - **Take the time to give clear directions for all classroom and clinical activities** so that participants will not be confused or lose interest. Participants should not have to wonder what will come next, what they are supposed to do or how activities will be conducted.
  - **Remember that family planning involves consideration of intimate issues. Sexual matters may be difficult to talk about because they involve strongly held views, taboos and religious beliefs. Using words which are acceptable to participants will encourage them to do the same when they work with clients and fellow staff members.**

- **Nonverbal communication** is as important as verbal communication. Such things as dress, eye contact, body language and movement about the room can have a significant impact on establishing and maintaining a positive training climate. To use nonverbal communication effectively:
  
  - Remember the **importance of a first impression.** How you greet participants and the initial 'message' you convey can set the tone of the course.
  - Use **eye contact** to 'read' faces. This is an excellent technique for establishing rapport, detecting understanding or confusion and getting feedback.
  - Use **positive facial expressions** to aid in the process of communication.
  - **Walk about the room** as you make your points. A skilled clinical trainer coordinates movements and gestures with instructional delivery. Be energetic.
- Walk toward participants as they respond to questions or make comments. A slow nodding of the head while maintaining eye contact demonstrates interest and encourages active participant involvement.
- Avoid distracting gestures or body language, such as fidgeting, excessive pacing, jingling keys or coins in pockets or playing with chalk or marking pens.
- Limit the use of desks or lecterns that establish an artificial barrier between the clinician and participants.
- Display enthusiasm about the topic and its importance. Energy and excitement are contagious and directly affect the enthusiasm of participants.

PRACTICING CLINICAL PROCEDURES ON CLIENTS

The final stage of clinical skill development involves practice of the procedure with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling and reacting human being.

The disadvantages of using real clients during clinical skills practice are obvious. Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. To minimize these risks, it is recommended that the following guidelines be observed:

- When possible and appropriate, participants should be allowed to practice with clients only after they have demonstrated skill competency and some degree of skill proficiency on an anatomic model or in a simulated situation.
- During pre-operative counseling, clients should be informed that their procedure will be performed by a clinician-in-training under the supervision of an experienced clinical trainer. Standard clinic practices regarding counseling and signed informed consent should be followed.
- The clinical trainer should be present in the operating or procedure room when participants are performing clinical procedures. Furthermore, the clinical trainer should be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.
- Clients should be chosen carefully to ensure that they are appropriate for clinical training purposes. For example, participants should not practice on ‘difficult’ clients until they are proficient in performing the procedure.

CLIENT’S RIGHTS DURING CLINICAL TRAINING

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in an environment in which the right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual involved (e.g., clinical trainers, individuals undergoing training, support staff, researchers, etc.).

The client’s permission should be obtained before having a clinician-in-training observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training. Furthermore, a client’s care should not be rescheduled or denied if she does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.
Clinical trainers must be careful in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.
**APPENDIX - D**

**MANAGING EMERGENCIES IN FAMILY PLANNING SERVICES**

- Think A,B,C,D. A-assess/airway, B-breathing, C-circulation, D-drug
- Get help from other staff, call doctor, stay with patient
- Ready emergency kit, drugs and equipment

<table>
<thead>
<tr>
<th>What you see</th>
<th>What is the cause</th>
<th>What to do</th>
</tr>
</thead>
</table>
| Very slow respirations (< 8 per minute) | Over sedation, from opiates such as pethidine/ pentozocine, or from other drugs, such as Diazepam | Assess – Airway  
  - Talk with client, stimulate  
  Breathe  
  - Give oxygen by mask, ready ambu bag  
  - Assess lungs, if wheezing and stridor, follow anaphylactic guidelines  |
| Or | Anaphylaxis/ Severe asthma | Circulation  
  - Assess for blood loss and treat*  
  - Take vital signs  
  - Start IV  
Drug  
- Give Naloxone 0.4 mg SQ/IM/IV and may repeat every 2 minutes to maximum of 10 mg. (reverses opiate drugs) |
| Severe blood loss | **Very fast respirations** (> 30 per minute) | Hyperventilation due to fear/anxiety  
Assess – Airway  
  - Reassure, talk with patient, comfort  
Breathe  
  - Assess lungs – clear. If lungs not clear, see anaphylaxis below  
  - Take vital signs |
| Very fast respirations (> 30 per minute) | Allergy – early signs of rash and hives | Assess – Airway  
  - Hives, rash, itching  
Breathe  
  - Give oxygen by mask, ready ambu bag  
  - Assess lungs – wheezing, stridor, constriction, shallow fast respirations  |
| OR | Anaphylaxis or severe asthma – includes symptoms of respiratory distress | Circulation  
  - Start IV and take vital signs  
Drug  
1. If early signs, give Avil (pheniramine) 25 mg. IM/IV and observe. If symptoms worsen, go to #2.  
2. Give Dexamethasone 0.8 mg IM/IV or hydrocortisone 200 mg IM/IV.  
3. Give Adrenaline 1:1000, 0.5 ml SC/IM. May repeat adrenaline every 10 minutes for maximum of 3 doses. |

---

* Stop bleeding with pressure and/or prepare to assist physician with surgical intervention to stop bleeding, i.e laparotomy. Give 1 – 2 liters NS or RL IV solution quickly (1 liter over 15 – 20 minutes), in order to increase blood volume and prevent hemorrhagic shock.
### Unconscious with twitching and violent movements

<table>
<thead>
<tr>
<th>Cause</th>
<th>Description</th>
</tr>
</thead>
</table>
| Seizures | Caused by  
  - Seizure Disorder  
  - Drug induced |
| Fainting | Vaso-vagal reaction caused by severe pain or fear  
  Rule out other reason for loss of consciousness, such as cardiac arrest or blood loss |
| Shock | Due to  
  - Blood loss  
  - Cardiac or Respiratory difficulty |

#### Assess-Airway
- Maintain airway. Make client to lie on side and/or turn head to side—clear mouth of vomitus/secretion
- Do not restrain, but clear area to prevent self injury

#### Breathe
- Give oxygen by mask. Ready ambu bag

#### Circulation
- Start IV if seizure continues for more than few minutes
- Drug
  - If lasts more than 4 minutes, given Diazepam 5mg. IV slowly. May repeat every 5 minutes to total of 20 mg.

#### Assess-Airway
- Make client to lie down
- Assess lungs

#### Circulation
- Take vital signs
- Assess for blood loss and treat
  - If fainting continues, give Atropine 0.4 mg. IM

#### Assess-Airway
- Lie down, raise legs 6 – 12 inches
- Reassure

#### Breathe
- Give oxygen by mask, ready ambu bag

#### Circulation
- Start IV and give 1 – 2 liters Ringer Lactate or Normal saline. IV fluids quickly (each liter in 15 minutes)
- Monitor vital signs
- Assess for blood loss and treat

#### No respiration and no heart beat

<table>
<thead>
<tr>
<th>Cause</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac or Respiratory Arrest</td>
<td></td>
</tr>
</tbody>
</table>
  - No pulse or very weak pulse  
  - No breathing  
  - Unable to obtain BP  
  - Cyanotic  
  - Unresponsive |

#### Assess-Airway
- Position head, head tilt-chin thrust  
  - Insert oral airway

#### Breathe
- Resuscitate with ambu bag
- If connector available, attach ambu bag to oxygen

#### Circulation
- Take carotid pulse
- If no pulse, start chest compressions
- Start IV and run in 1 – 2 liters Ringer Lactate or Normal saline quickly

#### Drug
- Atropine 1 mg IV, May repeat up to 3 mg. total
- Adrenaline 1:1000 0.5 ml. diluted in 10 - 20 ml of IV fluid—Intracardiac. Repeat adrenaline after 5 minutes
Always try to find out what happened

- Was the client well before collapsing?
- What happened immediately before collapsing?
- Check what drugs were administered?
- Is the client suffering from a drug reaction, an overdose of medication or an improper administration (e.g. accidental intravenous lignocaine)

Remember!

Before any drug is given to the client, two different members of the clinical staff should check it. This is especially important with any drugs that are to be administered intravenous or intramuscular.

Always Check!

- Did she get the right dose for her weight?
- Is the client immediately post-op?
- Does the client suffer from fits, diabetes or other major health problems
- Is the client bleeding

Drugs and supplies

Every clinic should be equipped with basic drugs and supplies and certain drugs and supplies for dealing with an emergency. Because emergency drugs are not used routinely it is easy for them to be overlooked or out of date.

All sites should have an emergency kit. This kit should contain all the essential drugs and supplies so that it can be quickly taken to the site where an emergency has occurred. Oxygen cylinders should be on a stand with wheels or easily movable. Everyone at the site should know the location of the emergency kit and other equipment.

The emergency drugs and equipment should be checked daily. The senior nurse should take the responsibility for this task. She should ensure that:

- The required drugs and supplies are available
- The drugs are not expired
- Sterile items are periodically reprocessed and returned to the kit
- Equipment is kept clean and in working order
- Used or broken items are replaced, and
- Battery operated items are in working condition

Check that the following are functioning:

- Filled oxygen cylinder with key.
- Suction machine.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Situation</th>
<th>Dose</th>
<th>Precautions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avil (Pheniramine)</strong></td>
<td>Allergic reaction or anaphylactic reaction</td>
<td>With early symptoms (rash, hives, rhinitis), give 25 mg. Orally. If symptoms include respiratory difficulty, give 50 mg. SC/IM or IV and follow with adrenaline.</td>
<td>Causes drowsiness. Do not exceed 75 mg. If anaphylaxis worsens, give Adrenaline.</td>
</tr>
<tr>
<td>25 mg tablets, PO 2 cc Vial – 25 mg/cc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adrenaline (Epinephrine) 1:1000</strong></td>
<td>Severe Asthma or Anaphylactic Reaction</td>
<td>0.5 mg. SC or IM (massage injection site) may repeat every 10 minutes until symptoms improve.</td>
<td>1:1000 is not the concentration for IV use. 1:1000 must be diluted in 10 – 20 cc IV fluids to give by IV route. If symptoms progress, give Dexamethasone.</td>
</tr>
<tr>
<td>Adrenaline 1:10,000 or 1:1000 diluted in 10–20ml. IV fluid</td>
<td>Cardiac Arrest Faint or no pulse No breathing</td>
<td>0.5 mg. of 1:1000 diluted in 10 – 20 ml. IV fluids or 0.5 mg of 1:10,000 IV. May repeat every 3 minutes.</td>
<td>Do not give Adrenaline 1:1000 IV undiluted or quickly. Adrenaline will precipitate if mixed with other IV drugs.</td>
</tr>
<tr>
<td><strong>Atropine 0.6 mg/ml 1 cc Vial – 0.6 mg/cc.</strong></td>
<td>Vaso-vagal reaction/ syncope (fainting)</td>
<td>0.6 mg SC/IM</td>
<td>Side effect of dry mouth and tachycardia (fast heart rate).</td>
</tr>
<tr>
<td><strong>Atropine 0.6 mg/ml 1 cc Vial – 0.6 mg/cc.</strong></td>
<td>Cardiac Arrest</td>
<td>1 mg. IV, may repeat every 5 minutes to total of 3 mg.</td>
<td></td>
</tr>
<tr>
<td><strong>Dexamethasone Vial – 4mg./cc.</strong></td>
<td>Anaphylaxis or Severe Asthma</td>
<td>8 mg. IV</td>
<td>Hydrocortisone 200 mg IM/IV if Dexamethasone is not available.</td>
</tr>
<tr>
<td><strong>Diazepam 2 cc Vial – 5 mg./cc.</strong></td>
<td>Seizure</td>
<td>5 mg. IV, may repeat every 10 minutes to maximum of 20 mg.</td>
<td>Give slowly over 2 minutes. Side effect of respiratory depression</td>
</tr>
<tr>
<td><strong>Naloxone 1 cc Vial – 0.4-mg/1 cc.</strong></td>
<td>Narcotic drug overdose</td>
<td>0.4 mg SC/IM/IV and may repeat every 2 minutes to maximum of 10 mg.</td>
<td>Reverses respiratory depression from narcotic medications. Client’s pain will reappear.</td>
</tr>
<tr>
<td><strong>Promethazine (phenergan) 2cc Vial – 25mg./cc.</strong></td>
<td>Nausea and vomiting</td>
<td>25 mg. IM/IV/Orally</td>
<td></td>
</tr>
<tr>
<td><strong>IV Fluids</strong></td>
<td>Hemorrhage, shock, cardiac arrest</td>
<td>Give 1 – 2 liters IV quickly (15 minutes per liter) through large IV needle (16g, 18g or 20g.)</td>
<td>Corrects circulatory volume depletion and raises BP.</td>
</tr>
<tr>
<td><strong>Ringer's Lactate or Normal Saline</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Avil (Pheniramine)
- Allergic Reaction or Anaphylaxis: Pheniramine is an antihistamine and will reduce the rash, hives, itching, congestion, and inflammation caused by the allergic reaction (histamine release). It is the first drug to be given when allergic symptoms are first observed.

Adrenaline (Epinephrine)
- Asthma and Anaphylaxis: Adrenaline produces bronchodilation, which relieves breathing difficulties during bronchospasms. In small doses Adrenaline causes vasodilation which can correct lung constriction and wheezing. Giving Adrenaline during an anaphylactic reaction or acute asthma attack may save the client’s life.
- Anaphylactic Shock: In large doses, Adrenaline is a vasoconstrictor that will raise blood pressure and pulse rate. Thus, Adrenaline is a life saving drug in anaphylactic shock.
- Cardiac Arrest: Adrenaline produces cardiac and central nervous system stimulation. When there is no breathing and no or faint pulse, giving Adrenaline is to attempt to stimulate the heart to begin beating again.

Atropine
- Vaso-vagal syncope (fainting from severe fear or pain): Atropine increases the heart rate and cardiac output. Atropine is effective in faintness after/during a procedure (Mini-laparotomy, IUD insertion).
- Cardiac Arrest: Atropine increases the heart’s rate of pumping and may correct dysrythmias caused by a slow heart rate.
- Pre-surgery: Atropine is used as a pre-medication for surgery, as it decreases secretions (respiratory and GI tracts) and may prevent a slow heart rate (bradycardia) which is the side effect of some pain medications (pentazocine) used during Mini-laparotomy.

Dexamethasone and Hydrocortisone
- Anaphylaxis or Severe Asthma: During an asthma attack or severe allergic reaction the body reacts with inflammation/swelling. Dexamethasone and Hydrocortisone are corticoid steroids that decrease inflammation and increase the capillary permeability. In asthma or anaphylactic reaction, a steroid will ease the breathing difficulties. Steroids also are used in cerebral edema and septic shock.

Diazepam (Calmose, Valium)
- Seizures: Diazepam causes skeletal muscles to relax and is used to stop status epilepticus and/or tetanic muscle spasms.
- Pre-surgery: Reduces feelings of anxiety and helps client be calm and cooperative during pain/fear producing procedures.

Naloxone (Lethidrone)
- Opiate overdose: Naloxone reverses the effect of narcotics (pethidine, pentazocine, morphine, etc.). In the case of a narcotic overdose, Naloxone will reverse respiratory depression and thus, is a life-saving drug.

Promethazine (Phenergan)
- Nausea/Vomiting: Promethazine is an antihistamine that produces sedation and reduces nausea. Vomiting in a sedated patient has potential risk of aspiration. Promethazine is also used as an adjunct drug to prevent nausea from pre-surgical medications (pethidine).

Drug List

Drugs used during routine Family Planning surgery

<table>
<thead>
<tr>
<th>Drug</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atropine</td>
<td>0.6 mg In 1 ml vial</td>
</tr>
<tr>
<td>Diazepam (calmose)</td>
<td>5 mg, 10 mg. Tablets</td>
</tr>
<tr>
<td>Ketamine</td>
<td>10 mg/ml and 50 mg/ml ampoules</td>
</tr>
<tr>
<td>Lignocaine (Xylocaine)</td>
<td>1%, 20 ml vial</td>
</tr>
<tr>
<td>Pentazocine (Fortwin)</td>
<td>30 mg. Vial</td>
</tr>
<tr>
<td>Pethidine (Demoral)</td>
<td>25-50 mg vial</td>
</tr>
<tr>
<td>Promethazine (Phenergan)</td>
<td>10-50 mg ampoules</td>
</tr>
</tbody>
</table>
Drugs that may be used in an emergency

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline</td>
<td>1 in 1000 ampoule</td>
</tr>
<tr>
<td>Atropine</td>
<td>0.6mg in 1 ml ampoule</td>
</tr>
<tr>
<td>Diazepam (Calmose)</td>
<td>2-10mg ampoule</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>100mg; Powder for reconstitution</td>
</tr>
<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>5-20mg IM or IV ampoules</td>
</tr>
<tr>
<td>Lignocaine (Xylocaine)</td>
<td>1%, 20ml ampoule</td>
</tr>
<tr>
<td>Naloxone (Letisedrone)</td>
<td>0.4mg/ml ampoule</td>
</tr>
<tr>
<td>Methyl Ergometrine (Methergin)</td>
<td>0.2mg ampoule</td>
</tr>
<tr>
<td>Morphine sulphate</td>
<td>15mg/ml ampoule</td>
</tr>
<tr>
<td>Pentazocine (Fortwin)</td>
<td>30mg ampoule</td>
</tr>
<tr>
<td>Pethidine (Demoral)</td>
<td>25-50mg ampoule</td>
</tr>
<tr>
<td>Pheniramine (Avil)</td>
<td>22.75mg/in 2ml ampoules or tablets</td>
</tr>
<tr>
<td>Promethazine (phenergan)</td>
<td>50mg in a 2ml ampoule</td>
</tr>
<tr>
<td>Sodium bicarbonate</td>
<td>7.5% or 8.4% in 25ml</td>
</tr>
<tr>
<td>IV fluids</td>
<td>500ml or 1 liter bottles or bags</td>
</tr>
</tbody>
</table>

Drugs that may be useful post-operatively

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
<td>500mg tablets</td>
</tr>
<tr>
<td>Trimethoprim</td>
<td>200mg tablets</td>
</tr>
<tr>
<td>Pheniramine</td>
<td>25mg tablets</td>
</tr>
</tbody>
</table>

A nonsteroid anti-inflammatory drug such as ibuprofen (Brufen), mefenamic acid or naproxen should be included.

Emergency Equipment and supplies:

Basic Equipment
- Demand resuscitator OR manual resuscitator (Ambu bag) Emergency drugs tray
- Oxygen masks
- Oxygen Cylinder with oxygen, key and flow meter, flow meter tubing, oxygen nipple and tubing
- Suction machine with tubing and two traps, manual/electrical
- Suction catheter - metallic
- Flexible suction catheter (rubber)
- Oral airways (Size 90 mm and 100 mm)
- Nasopharyngeal airways (Size 28 and 30)
- Tourniquet
- Folley's/urethral catheter (size 16 or 18) and drainage bag
- Sphygmomanometer (Blood pressure apparatus)
- Torch or emergency light with batteries
- Stethoscope
- Emesis basin
- Blanket
Basic Supplies:
- Oxygen
- Intravenous fluids (normal saline and 5% dextrose in water)
- Hypodermic syringes and needles, butterfly set, venflon no. 18
- Infusion sets, with large caliber needles (14 or 16 gauge) and tubings
- Adhesive strapping or tape
- Sponge / gauze squares, 2x3 inches or 4x4 inches
- Antiseptics to clean skin (Betadine)
- Lubricants for naso-pharyngeal intubation
- Standard surgical instruments including a sterile laparotomy set
- Sutures, atraumatic catgut no. 20 e.g. Bladder, bowel repair
- 10/20 ml syringe
- Sterile saline 500ml
- Naso-gastric tube
- Corrugated drain

Optional Equipment:
- Laryngoscope with spare bulb and spare battery
- Endotracheal tubes
- Electrocardiogram (ECG) machine with leads
- Defibrillator

Optional Supplies:
- ECG paper
- ECG GEL