FACILITATOR’S SESSION GUIDE
for
REFRESHER TRAINING IN
ABDOMINAL TUBECECTOMY

January 2005

SIFPSA
State Innovations in Family Planning Services Agency, Lucknow

USAID
United States Agency for International Development

EngenderHealth
Improving Women’s Health Worldwide

Department of Health and Family Welfare Government of Uttar Pradesh

Office of Population, Health and Nutrition
ACKNOWLEDGEMENTS

The Government of India (GOI), the Government of Uttar Pradesh (GOUP) and the United States Agency for International Development have embarked upon the Innovations in Family Planning Services (IFPS) Project in Uttar Pradesh (UP) for the improvement and expansion of family planning 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 UP have collaborated with AVSC International to prepare this manual. The Reproductive Health Resource Document for UP (SIFPSA and the Department of Health and Family Welfare, GOUP) and the Standards for Male and Female Sterilization (GOI) served as resources for the preparation of the initial draft. The Reference Manual, Abdominal Tubectomy Under Local Anaesthesia was adapted by the participants at a workshop on the Standardization of Abdominal Tubectomy at Women’s Hospital, Jhansi from July 17th – 19th, 2000. Special thanks goes to the participants of the standardization workshop which includes Prof. Usha Sharma, Principal and Head of the Dept. of Obstetrics and Gynaecology, LLRM Medical College, Meerut, Prof. Mridula Kapoor, Head of the Dept. of Obstetrics and Gynaecology, MLB Medical College, Jhansi and Prof. S.L. Agarwal, Dept. of Obstetrics and Gynaecology, KG Medical College, Lucknow. Appreciation is also extended to participants from Jhansi, Dr. Manju Dubey, CMS, Dr. Savita Dubey, Dr. Sandhya Misra, Dr. Prabhawati Jain, Dr. Anamika Richaria, Dr. Shahida Parveen and participants from Haldwani, district Nainital, Dr. Manorama Bahuguna, Dr. Savitri Singh, Dr. Meena Bhatt and Dr. Tara Arya. Representative from SIFPSA, Dr. Dinesh Singh, Project Co-ordinator, deserves special mention for the organizing the workshop. Representatives from AVSC International, Dr. Jyoti Vajpayee, Medical Associate, Dr. S.S. Bodh, Dr. Asha Kochchar and Dr. Nayara Shakeel. Training Associates, are also thanked for their great contribution to this workshop. Dr. Daya Shankar, CMO, Jhansi and Dr. Q. Anwar Ahmad, Additional Director, MH & FW, Jhansi Division, made special efforts to organize this workshop.

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Aradhana Johri, IAS
Executive Director
SIFPSA
Female sterilization remains a common method for a large number of family planning acceptors. Although abdominal tubectomy under local anaesthesia has been offered in Uttar Pradesh by surgeons trained in the method for quite some years, there was a need to standardize the service delivery skills of all the surgeons providing these services. It is with this premise that a three-day refresher course on this subject was initiated.

The three-day abdominal tubectomy refresher training course aims to standardize the service delivery skills of surgeons already performing these services.

The curriculum is designed to provide participants a re-orientation to theory as well as skill practice, culminating in practicals in service delivery skills at their work sites. The curriculum consists of a trainer's session guide and a reference manual for the trainers and participants. The curriculum covers counselling, 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 client and providing quality services.

The training course is conducted by master trainers using a participatory approach that is learner oriented. Brainstorming exercises, large and small group exercises, demonstrations and skill practice make the three-day refresher training an active learning exercise for all the participants.

This course is meant for doctors already providing abdominal tubectomy to refine their existing skills and is not meant to be used as a training course for freshers.
# TABLE OF CONTENTS

Acknowledgements

Preface

Table of Contents i-ii

Instructions for Users 1

Course Schedule 3

Introduction 5

Pre/Post Test 7

Pre/Post Test Answer Key 11

Session Title: Abdominal Tubectomy Training Course Individual and Group Assessment Matrix 12

Counselling Clients on Abdominal Tubectomy and Informed Consent 13

Application and Informed Consent for Sterilisation Operation 16

Application and Informed Consent for Re-Sterilisation Operation 18

Session Title: Indications, Precautions and Client Assessment 20

Session Title: The Day’s Evaluation 24

Session Title: Warm-Up and Recap 25

Session Title: Infection Prevention 26

Session Title: Anaesthesia 27

Session Title: Fundamentals of Abdominal Tubectomy Under Local Anaesthesia 28

Session Title: Demonstration in O.T. 29

Session Title: Review of O.T. Activity 30

Session Title: Post-operative Recovery, Discharge and Follow-up 31

Session Title: Complications and their Management 33

Session Title: Quality Assurance in Family Planning Practices 35
Abdominal Tubectomy Course Evaluation

Session Title: Future Plan

Appendices

Appendix A: Instructions for using ZOE

Appendix B: How People Learn

Appendix C: Conducting the Course

Appendix D: Principles of Learning

Appendix E: Basic Training Skills

Appendix F: Training Methods

Appendix G: Use of Learning Guide

Learning Guide for Interval Abdominal Tubectomy
Clinical Skills Checklist for Doctors

Learning Guide for Postpartum Abdominal Tubectomy
Clinical Skills Checklist for Doctors
INSTRUCTIONS FOR USERS

Purpose:
The purpose of this facilitator’s session guide along with the manual for Abdominal Tubectomy under local anaesthesia is to prepare trainers to conduct three day refresher training in Abdominal Tubectomy.

Participants for the training:
This curriculum is intended for doctors who are providing services of Abdominal Tubectomy in the state of Uttar Pradesh.

Curriculum structure:
The curriculum is divided into sessions, each of which focuses on an aspect of providing Abdominal Tubectomy under local anaesthesia. The curriculum provides theory and practical sessions and seeks active participation of all trainees throughout the course.

Each session begins with the critical information required to present the objectives for the participants, estimated time 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 session of the manual that is provided to both the trainers and the participants. In addition, tips on training techniques are given in the appendix.

Time allocation:
The time assigned to each session are estimates and should be used as a guide for planning the training. The training is estimated to last three working days, if the curriculum is followed without major modifications.

Material for the trainers:
In addition to the session guide, you will need the items listed below to conduct the training:
Sufficient copies of Reference Manual and Standards for Male and Female Sterilisation Abdominal Tubectomy kit ZOE model Flip charts and markers 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 anaesthesia Boxes containing samples of commonly available contraceptives Videaset of standardised Abdominal Tubectomy procedure TV, VCR/VCP.

Material for the participants:
(The participant’s kit): The participant shall receive a copy of the workshop schedule and Learning Guides, Reference Manuals—Abdominal Tubectomy Under Local Anaesthesia and Standards for Male and Female Sterilisation.
Evaluation:
Evaluation is a fundamental part of training that doctors, host 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 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 by the trainers.

Practicum:
Gives participants a chance to practice their skills with real clients.

IMPORTANT TIPS FOR THE TRAINER

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

2. Advance preparation is 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 concentration and the messages do not carry as much impact on the trainees.

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. Every day ends with a wrap-up session and is followed by a recap and warm up session on the next day to provide continuity in the workshop.

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. This way trainees will find it easier to assimilate the knowledge and experiences.
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<tr>
<th>Time</th>
<th>Day I</th>
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<th>Day II</th>
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<td>9:00 - 9:15</td>
<td>Welcome</td>
<td>9:00 - 9:15</td>
<td>Recap and Warm-up</td>
<td>9:00 - 9:15</td>
<td>Recap and Warm-up</td>
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<td>9:30 - 10:30 a.m.</td>
<td>Introduction to epoch and norms</td>
<td>9:15-10:30</td>
<td>Infection prevention</td>
<td>9:30-10:30</td>
<td>Management of complications</td>
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<td>10:30 - 10:45</td>
<td>Pre-test</td>
<td>10:45 - 11:45</td>
<td>Anesthesia</td>
<td>10:45 - 11:45</td>
<td>Providing quality services</td>
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<td>10:45 - 11:45</td>
<td>Counselling</td>
<td>11:45 - 2:00</td>
<td>Review of O.T. Activity</td>
<td>11:45 - 2:00</td>
<td>O.T. Activity</td>
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<td>11:00 - 1:30</td>
<td>Role play</td>
<td>2:00 - 3:00</td>
<td>Warm-up</td>
<td>2:00 - 3:00</td>
<td>Lunch</td>
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<td>1:30 - 3:30</td>
<td>Review of O.T. Activity</td>
<td>3:00 - 3:15</td>
<td>Warm-up</td>
<td>3:00 - 3:15</td>
<td>Lunch</td>
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<td>3:15 - 4:00</td>
<td>Informed Choice</td>
<td>3:15 - 4:15</td>
<td>Standardized Surgical practice for Abdominal Tubectomy &amp; demonstration on ZOE</td>
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<td>3:15 - 4:00</td>
<td>Informed Consent</td>
<td>3:15 - 4:15</td>
<td>Standardized Surgical practice for Abdominal Tubectomy &amp; demonstration on ZOE</td>
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<td>3:30 - 4:30</td>
<td>Post Test and Programme Evaluation</td>
<td>4:30 - 4:55</td>
<td>Wrap-up</td>
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<td>4:00 - 4:30</td>
<td>Closing Ceremony</td>
<td>4:45 - 5:00</td>
<td>Wrap-up and assignment</td>
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<td>4:45 - 5:00</td>
<td>Post-op, recovery, Discharge Follow-up</td>
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</table>
Session Title: INTRODUCTION

ADVANCE PREPARATION:

Prepare the objectives/schedule 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>5 minutes</td>
<td>Introduction of participants</td>
<td>Partners exercise</td>
<td>None</td>
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<td>20 minutes</td>
<td>Participants' expectations &amp; workshop norms</td>
<td>Discussion</td>
<td>Flip chart</td>
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<tr>
<td>15 minutes</td>
<td>Objectives &amp; Overview Schedule</td>
<td>Presentation</td>
<td>Flip chart, Handouts</td>
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<tr>
<td>20 minutes</td>
<td>Pre-test</td>
<td>Written test</td>
<td>Pre-test forms</td>
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FACILITATOR’S NOTES

Introduce yourself and then tell participants that you are splitting the group into pairs to facilitate informal introductions. 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 their partners to the entire group. They should find the name, designation, place of posting, one strength and one weakness of their partner. 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

Present the objectives of the workshop from a previously prepared flip chart.

1. To describe the principles and requirements for performing Abdominal Tubectomy under local anaesthesia.
2. To describe the principles of informed consent for voluntary sterilisation.
3. To explain the indications and conditions requiring precautions for Abdominal Tubectomy under local anaesthesia.
4. To perform a client assessment, including a limited reproductive health history and an abdominal examination.
5. To use recommended infection prevention practices in the provision of Abdominal Tubectomy which minimize the risk of post-operative infections and contracting Hepatitis B and HIV/AIDS.
To describe the principles of and requirements for the use of local anaesthesia, including the importance of emotional preparation of the client and continual communication during surgery.

To perform standardized Abdominal Tubectomy procedure under local anaesthesia.

To recognize and manage surgical and anaesthesia-related complications.

To provide routine follow-up management for Abdominal Tubectomy, including appropriate management of side effects and other health problems.

To describe the skills needed to organize and manage quality Abdominal Tubectomy services.

PARTICIPANTS' EXPECTATIONS AND WORKSHOP NORMS

Ask participants what they expect to get out of this training programme 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 workshop's 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 opportunities to try out and improve their skills.
They should consider each other as well as facilitators as resource persons.

PRE-TEST

This questionnaire is designed to assist both of you, the trainer and the participant, as you begin your work together in the course. The questions focus on the knowledge, attitude and behaviour essential to providing quality Abdominal Tubectomy services.

The questions are presented in the TRUE/FALSE and multiple choice format. A special form, the Individual and Group Assessment Matrix, is provided to record the scores of all course participants. Using this form, you and the participants can chart quickly the number of correct answers for each of the 38 questions. By examining the data in the matrix, the group can easily determine their collective strengths and weaknesses and jointly plan how best to use the course time to achieve the desired learning objectives. For you, the questionnaire results will identify particular topics, which may need additional emphasis during the learning sessions.
PRE/POST TEST

Name: 
Designation: 

Place of posting: 
Date: 

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

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<table>
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<tbody>
<tr>
<td>1. Counselling ensures that the client understands the benefits, risks, implications and alternatives to Abdominal Tubectomy ligation.</td>
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<td>2. The immediate postpartum period may be the best time for the woman to decide on having postpartum Abdominal Tubectomy.</td>
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<td>3. The provider is the best person to decide on the method the client should use.</td>
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<td>4. Sterilisation lasts for only 5 years after the tubes are occluded.</td>
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<td>5. A woman who is certain that she wants no more children is a good candidate for ligation.</td>
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<td>6. A woman with diabetes under control can tolerate Abdominal Tubectomy.</td>
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<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 sterilised by boiling in water for 20 minutes.</td>
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<tr>
<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.</td>
<td>Taking baseline vital signs of the client is not necessary in elective Abdominal Tubectomy.</td>
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<td>14.</td>
<td>After injecting local anaesthesia, the operating doctor should wait for 2–3 minutes before making the incision.</td>
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<td>15.</td>
<td>Using a smaller volume of 2% lignocaine will provide better anaesthesia than a larger volume of 1%.</td>
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<td>16.</td>
<td>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.</td>
<td>Anaesthesia-related complications are more likely to occur in heavily sedated clients.</td>
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<td>18.</td>
<td>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 anaesthesia 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 counsellor
   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 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
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 anaesthesia, the operating doctor should
   a. plan to use more assistants during the procedure
   b. plan the procedure at a facility where general anaesthesia and laparotomy can be performed
   c. suggest that the client lose weight and ask her to return in three months
   d. use a vertical instead of an horizontal incision

24. After an Abdominal Tubectomy procedure, the only acceptable method for processing soiled instruments is
   a. cleaning followed by sterilisation
   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 sterilisation or high-level disinfection

25. The human immunodeficiency virus (HIV/AIDS) 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 anaesthesia 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 anaesthesia
   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.
**ANSWER KEY TO PRE/POST TEST**

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ABDOMINAL TUBEectomy TRAINING COURSE: INDIVIDUAL AND GROUP ASSESSMENT MATRIX

DATE: ___________ TRAINER(S): __________________________

Participants

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</tbody>
</table>
Session Title: COUNSELLING CLIENTS ON ABDOMINAL TUBECTOMY AND INFORMED CONSENT

ADVANCE PREPARATION

- Read the facilitator’s notes and Chapters 2 & 3 of the manual to prepare for this session.
- Prepare flip charts for the objectives, the content as needed and separate flip charts for each step of the method-specific stage.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>Overview of Counselling</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Important facts about Abdominal Tubectomy under Local Anaesthesia: An overview</td>
<td>Small group exercise and large group discussion</td>
<td>Flip chart, Titled grids for participants</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Method-specific Counselling</td>
<td>Presentation, large group discussion and demonstration. Role-Play</td>
<td>Flip chart and case for demonstration</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Informed choice and consent</td>
<td>Brainstorming, large group discussion and presentation</td>
<td>Flip chart, copies of mandatory GOI informed consent form, copies of guidelines</td>
</tr>
<tr>
<td>10 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.

- List the benefits of counselling clients on family planning, especially sterilisation.
- Describe the counselling process with special emphasis on method-specific counselling for sterilisation clients.
- List the benefits and limitations of Abdominal Tubectomy.
- List the important facts about Abdominal Tubectomy and the warning signs that need to be addressed during the counselling session.
- Describe and apply the principals of informed consent for voluntary sterilisation.
COUNSELLING — AN OVERVIEW

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

State that it is necessary to inform the client about the important facts about Abdominal Tubectomy and its benefits and limitations. Divide the participants into two groups. Tell them that they will do a small exercise on the important facts about Abdominal Tubectomy. Give one group a large sheet with a two-column grid titled benefits and limitations and to the other group give a large sheet with a two-column grid titled ‘Who can have an Abdominal Tubectomy and who cannot.’ For each provide one example. Give each group 5 minutes to discuss amongst themselves to fill their respective grids. When finished, paste their grids on the wall. Quickly review the responses and fill any gaps in their knowledge (refer Table 2-2 in the manual).

Method-specific counselling for clients who choose voluntary sterilisation: Explain that this stage in counselling has three steps that are very important for those opting for sterilisation. (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. When you have finished all three, tell the participants that now the facilitators will demonstrate a counselling session. Use a case where the client has come to the camp after receiving information from health workers. Ensure that you and your colleague address all the possible rumours connected with female sterilisation. Reiterate the important facts about Abdominal Tubectomy and the fact that even at the last minute a client can decide not to undergo the sterilisation without fear of losing out on other options available.

Important facts about Abdominal Tubectomy Under Local Anaesthesia

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable, permanent method of contraception.</td>
<td>Is a surgical procedure and therefore may be associated with infection, bleeding and / or bruising.</td>
</tr>
<tr>
<td>Abdominal Tubectomy is appropriate for women who:</td>
<td>Abdominal Tubectomy is not appropriate for women who:</td>
</tr>
<tr>
<td>Are certain they do not want no more children.</td>
<td>Are not sure whether they want to have another child at a later period.</td>
</tr>
</tbody>
</table>
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 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 sterilisation, 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 Anaesthesia.’ 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

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

Name of client | Shri/Smt. 
---|---
Address of client | Shri 
---|---
Spouse’s name | Shri/Smt. 
---|---
Father’s name | Shri 
---|---
Operating centre | 
---|---

Dear Doctor,

Please arrange to have me sterilised. 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 sterilisation 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 purpose 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 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 sterilisation 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 anaesthesia 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 cannot read and the above information is read out.
1. The client has been fully counselled about various available methods of contraception and the above method.

________________________________
Signature of Counsellor**

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 sterilisation operation. There is no evidence that he/she has undergone a sterilisation 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 STERILISATION

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

1.

2.

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

________________________________
Signature of Counsellor** or
Doctor making decision
(name and address)

** Counsellor can be any health personnel including doctor.

APPLICATION AND INFORMED CONSENT
FOR RE-STERILISATION OPERATION

Name of client

Shri/Smt.________________________________________

Address of client

_____________________________________________________

Spouse’s name

Shri/Smt.________________________________________

Father’s name

Shri_____________________________________________

Operating centre

_____________________________________________________

Dear Doctor,

Please arrange to have me re-sterilised/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 re-sterilisation/sterilisation 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 purpose 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 re-sterilisation/sterilisation 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 anaesthesia 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 cannot read and the above information is read out.

Facilitator’s Session Guide 18
1. The client has been fully counselled about various available methods of contraception and the above method.

__________________________________________________________
Signature of Counsellor**
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-sterilisation/sterilisation 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 STERILISATION

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

1. ______________________________________________________________________

2. ______________________________________________________________________

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

__________________________________________________________
Signature of Counsellor** or
Doctor making decision
(name and address)

** Counsellor can be any health personnel including doctor.

INDICATIONS AND PRECAUTIONS

ADVANCE PREPARATION

- Read the facilitator’s notes and Chapters 4 & 5 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>10 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>
</tr>
<tr>
<td>10 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>
</tr>
<tr>
<td>10 minutes</td>
<td>Client assessment</td>
<td>Discussion</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.

☐ Explain the indications and precautions for Abdominal Tubectomy under local anaesthesia.
☐ Describe the criteria for client selection for Abdominal Tubectomy under local anaesthesia.

Explain that the participants will do a simple exercise in groups to identify and explain the conditions that indicate Abdominal Tubectomy ligation under local anaesthesia, 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' on 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 4). Fill gaps if any.

PROBLEMS REQUIRING ACTION

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' on the top of each column. Provide participants with one example on how to fill the grid.

Divide the participants into three groups A, B and C. Distribute copies of the empty grids—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 summarise the content covered in the session and address any questions the participants may have.

Indications for Abdominal Tubectomy under local anaesthesia

<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>
</tbody>
</table>

## Problems requiring action

<table>
<thead>
<tr>
<th>Problem</th>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<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>
CLIENT ASSESSMENT

State that during this stage the assessing doctor needs to follow a selection criteria that indicate what conditions are acceptable and what are not. Ask participants, What conditions are acceptable when selecting a client for Abdominal Tubectomy under local anaesthesia? 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 5 of the manual). Now repeat the same process for 'What conditions are not acceptable when selecting a client for Abdominal Tubectomy under local anaesthesia?'

MEDICAL HISTORY

Ask participants what they normally ask of 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 5).

PHYSICAL EXAMINATION

Ask participants to list what they do during the physical examination 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 5).

LABORATORY EXAMINATIONS

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

SUMMARY

Briefly summarise the content covered in the session and address any questions the participants may have.
Session Title: DAY’S EVALUATION

ADVANCE PREPARATION

- Prepare flip chart for the session.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>10 minutes</td>
<td>Wrap-up</td>
<td>Discussion</td>
<td></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 give the facilitator feedback about how the participants felt about the day’s programme.
- To provide suggestions for improving the next day’s programme.
- To ensure that every participant has a chance to give her/his opinion.

DAILY EVALUATION

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

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

Ask all the ‘A’s—What is the most useful thing you learnt 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 workshop today? Ask all the ‘D’s—How do you suggest we improve the workshop to make it more interesting, useful and enjoyable? Note the responses.

Explain to the participants that they will be responsible for the recap session the next day. Explain that this is an opportunity to display their creativity in presenting the recap; working together as a team and allowing each member to participate in the session in harmony. The recap 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 as 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.

Give assignments as shown in course schedule.
Session Title: WARM-UP AND RECAP

ADVANCE PREPARATION

- Ask a team to prepare to present the recap 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.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Objectives &amp; Agenda</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Warm-up activity</td>
<td>Group activity</td>
<td></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 bring to focus the key points of the previous day’s work to refresh memory.
- To provide continuity to the programme.
- 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

The team should be allowed to present this in their own way. It should include information on the content—key messages, programme organisation, the day’s proceedings in general, presentation of material and other informal events, etc. 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.
ADVANCE PREPARATION

- Read the facilitator's notes and Chapter 6 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>15 minutes</td>
<td>Infection prevention practice</td>
<td>Presentation and discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>50 minutes</td>
<td>Video</td>
<td>Audio-visual presentation</td>
<td>VCR, video photo-set &amp; TV set</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.

- Describe recommended infection prevention practices in the provision of Abdominal Tubectomy sterilisation that minimise the risk of post-operative infections including Hepatitis B, Hepatitis C and HIV/AIDS.
- Describe recommended infection prevention practices in the decontamination, cleaning and high-level disinfection and sterilisation of instruments.
- View video cassette on infection prevention.

INFECTION PREVENTION PRACTICE

Open a short discussion (5 minutes) on how the participants prepare the O.T. and instruments for an Abdominal Tubectomy sterilisation under local anaesthesia. 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, sterilisation and high-level disinfection. Provide clarifications as you proceed.

SUMMARY

Briefly summarise the content covered in the session and address any questions the participants may have.
Session Title: ANAESTHESIA

ADVANCE PREPARATION

- Read the facilitator's notes and Chapter 7 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>50 minutes</td>
<td>Abdominal Tubectomy under Local Anaesthesia</td>
<td>Demonstration &amp; discussion Practice on ZOE model</td>
<td>ZOE, 20cc syringe with needle, kidney tray, 2% xylocaine vial, distilled water/normal saline, sponge holder, Betadine, cotton swabs, ss small bowl, gauze piece.</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.

- Describe the principles of and requirements for the use of local anaesthesia.
- Explain the importance of emotional preparation of the client and continual communication during surgery.
- Practice of steps of Local Anaesthesia & Abdominal Tubectomy on ZOE model.

GOAL OF ANAESTHESIA
Ask participants what is the goal of administering anaesthesia. Having ascertained that the goal of anaesthesia is to prevent pain, discomfort and anxiety, the operating team uses a three pronged approach to allay anxiety, discomfort and pain with the use of sedatives, verbal anaesthesia and local anaesthesia. Ask participants what they would do for each of these, including the drug and the dosage used for sedation and local anaesthesia. Then present what is verbal anaesthesia, how and when is it used; what is local anaesthesia, 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 anaesthesia 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 conducted by you, using the standard technique of administering local anaesthesia.

Explain each step as you proceed slowly.

SUMMARY
Briefly summarize what you had covered in the session, emphasizing the importance of constant verbal communication with the client, use of the appropriate drugs and dosage for sedation and local anaesthesia and the importance of how the right technique while administering local anaesthesia, increases the effectiveness. Let the participants practice steps of Local Anaesthesia & Abdominal Tubectomy on ZOE by using learning guides.

Facilitator's Session Guide
Session Title: FUNDAMENTALS OF ABDOMINAL TUBECTOMY UNDER LOCAL ANAESTHESIA

ADVANCE PREPARATION

- Read the facilitator’s notes and ensure you have the TV, video photoset and VCR/VCP 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>25 minutes</td>
<td>Video film</td>
<td>Audio-visual presentation</td>
<td>VCR, video photoset &amp; TV</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Fundamental features of Abdominal Tubectomy</td>
<td>Demonstration and discussion</td>
<td>Flip chart, ZOE model and Abdominal Tubectomy kit</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Discussion summary</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVE

☐ To demonstrate and discuss the fundamentals of Abdominal Tubectomy under local anaesthesia.
☐ Viewing of video film.

Tell the participants that they will now view a video photoset on the standard technique of performing an Abdominal Tubectomy. Discussions can be conducted after having viewed the entire procedure. After the tape has been viewed, let the participants air their comments and discuss their queries. Demonstrate on the ZOE, the standard technique of performing Abdominal Tubectomy.
Session Title: DEMONSTRATION IN O.T.

ADVANCE PREPARATION

☐ Read the facilitator’s notes and ensure with CMO/CMS that you have clients to demonstrate the Abdominal Tubectomy procedure.
☐ Inform the O.T. in advance about the practical session.

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 minutes</td>
<td>Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>50 minutes</td>
<td>Demonstration in O.T.</td>
<td>Demonstration in O.T.</td>
<td>Client and Abdominal Tubectomy kit</td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

☐ To demonstrate the standard technique of performance of Abdominal Tubectomy on a client.

☐ Practical in the O.T. will depend on the participants observation of the number of clients on whom you have conducted Abdominal Tubectomy. Then you should assist the participant to perform the procedure.

DISCUSSION

All discussions should be done outside the O.T. Refrain from passing comments during the procedure keeping in mind that the client is conscious and your comments may disturb her.
Session Title: REVIEW OF O.T. ACTIVITY

ADVANCE PREPARATION

<table>
<thead>
<tr>
<th>Estimated time</th>
<th>Content</th>
<th>Training techniques</th>
<th>Materials required</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>O.T. Activity</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

FACILITATOR’S NOTES

OBJECTIVES

- Discussion on the O.T. activity just observed.

- Come back to the classroom for the discussions. First, give a chance to the operating team to express how they felt using the standard technique of Abdominal Tubectomy, what difficulties they encountered and what steps they performed well. Then ask the other participants for their comments. Then provide feedback on their performance and encourage them on good performance. Highlight the areas that need improvement.

SUMMARY

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

- Read the facilitator's notes and Chapter 10 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>10 minutes</td>
<td>Post-operative recovery</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>8 minutes</td>
<td>Discharge</td>
<td>Discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>8 minutes</td>
<td>Follow-up</td>
<td>Discussion</td>
<td>Flip chart</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.

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

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 10), clarify and fill gaps as necessary.

POST-OPERATIVE INSTRUCTIONS

Ask participants what instructions they give the clients, whether written or oral and in what language. Ask them also whether these instructions are also given during pre-procedure counselling. Write their responses on the flip chart and review the responses (refer Chapter 10), clarify and fill gaps as necessary.
DISCHARGE

Ask participants when they discharge a client after an Abdominal Tubectomy under local anaesthesia. Write the responses and discuss them with the group. Fill gaps.

Ask the participants what the criteria are for discharge. Write the responses on the flip chart and seek clarifications as you proceed (refer Chapter 10). Fill gaps where necessary.

FOLLOW-UP

State that follow-up for clients of Abdominal Tubectomy sterilisation after surgery is of two kinds—a) routine follow-up and b) emergency follow-up. Ask participants when the first follow-up should be conducted and where and when the client should go for the follow-up. Write the responses and discuss them with the group. Fill gaps in their knowledge.

Ask participants, "Under what conditions should a client seek emergency medical attention and where?" Write the responses and discuss them with the group. Fill gaps in their knowledge.

SUMMARY

Briefly summarise the content covered in the session and address any questions the participants may have.
Session Title: COMPLICATIONS AND THEIR MANAGEMENT

ADVANCE PREPARATION
- Read the facilitator's notes and Chapter 11 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>25 minutes</td>
<td>Anaesthesia-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 for participants to use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Large group discussions</td>
<td></td>
</tr>
<tr>
<td>25 minutes</td>
<td>Surgical 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 for participants to use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Large group discussions</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 objective of the session to the participants.

Explain how to recognise and manage Surgical and Anaesthesia-related complications.

MANAGEMENT OF COMPLICATIONS

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

Tell participants that they will now be called to do a small exercise—to list out on a grid the symptoms presented, the possible cause of the complication and the management for each of
the complications that they had listed out under Anaesthesia-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.

Now repeat the same pattern for the Surgery-related complications as was done for Anaesthesia-related complications. Allow 10 minutes for the small group exercise and follow it up with 5 minutes for the review of the filled grids and discussion.

**SUMMARY**

Ask one of the participants to summarize what was covered in this session.

**Anaesthesia-related complications**

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

**Surgery-related complications**

<table>
<thead>
<tr>
<th>Complication</th>
<th>Cause</th>
<th>Symptom</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session Title: QUALITY ASSURANCE IN FAMILY PLANNING PRACTICES

ADVANCE PREPARATION

- Read the facilitator's notes and Chapter 12 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 &amp; Introduction</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Elements of quality care</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Rights of clients</td>
<td>Brainstorming/discussion</td>
<td>Flip chart</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

OBJECTIVES

☐ To provide the participant with the knowledge and skills needed to organize and manage a quality Abdominal Tubectomy service.
☐ To enumerate elements of quality care.

FACILITATOR'S NOTES

Brainstorm the participants for rights of the clients and write their responses on a flip chart. Fill in the gaps.

SUMMARY

Briefly summarise the content covered in the session and address any questions the participants may have.
ABDOMINAL TUBECTOMY
COURSE EVALUATION
(To be completed by Participant)

Please rate your opinion of the following course components using the following scale:

5-Strongly Agree  4-Agree  3-No Opinion  2-Disagree  1-Strongly Disagree

<table>
<thead>
<tr>
<th>COURSE COMPONENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Pre-test helped me to study more effectively.</td>
<td></td>
</tr>
<tr>
<td>2. The training video/photoset helped me to get a better understanding of</td>
<td></td>
</tr>
<tr>
<td>standardised Abdominal Tubectomy procedure.</td>
<td></td>
</tr>
<tr>
<td>3. The practice sessions with the pelvic model made it easier for me to do</td>
<td></td>
</tr>
<tr>
<td>perform the Abdominal Tubectomy procedure on clients.</td>
<td></td>
</tr>
<tr>
<td>4. There was sufficient time scheduled for performing Abdominal Tubectomy</td>
<td></td>
</tr>
<tr>
<td>under Local Anaesthesia on clients.</td>
<td></td>
</tr>
<tr>
<td>5. I am now confident in performing Abdominal Tubectomy under Local Anaesthesia.</td>
<td></td>
</tr>
<tr>
<td>6. I am now able to use the infection prevention practices recommended for</td>
<td></td>
</tr>
<tr>
<td>Abdominal Tubectomy.</td>
<td></td>
</tr>
<tr>
<td>7. The interactive training approach used in this course made it easier for</td>
<td></td>
</tr>
<tr>
<td>me to learn how to provide Abdominal Tubectomy services.</td>
<td></td>
</tr>
<tr>
<td>8. Three days were adequate for learning how to provide quality Abdominal</td>
<td></td>
</tr>
<tr>
<td>Tubectomy services.</td>
<td></td>
</tr>
<tr>
<td>9. I feel confident in managing the complications of Abdominal Tubectomy that</td>
<td></td>
</tr>
<tr>
<td>might occur.</td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL COMMENTS

1. What topics (if any) should be added (and why) to improve the course?

2. What topics (if any) should be deleted (and why) to improve the course?
3. If three days were not adequate for the course, how many days should the course be?

4. Do facilities at your workplace exist which will allow you to provide quality Abdominal Tubectomy services? If not, what changes are needed?

5. Will you be able to implement the standardised Abdominal Tubectomy procedure you learned during the course? If not, why not?

6. To whom would you bring up your frustrations of not being able to provide these services?
Session Title: FUTURE PLAN

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>5 minutes</td>
<td>Introduction</td>
<td>Presentation</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>5 minutes</td>
<td>Summary</td>
<td>Presentation</td>
<td>Flip chart</td>
</tr>
</tbody>
</table>

FACILITATOR'S NOTES

OBJECTIVE

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

FOLLOW-UP

Explain that all participants will be followed-up at their work sites within three months after 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.
Appendices
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 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 uteri
- Vaginal speculum examination
- Visual recognition of normal cervices and cervical abnormalities
- Uterine sounding
- IUCD insertion and removal
- Diaphragm sizing and fitting
- Laparoscopic inspection and occlusion of Fallopian tubes (Falope rings or other clips)
- Abdominal Tubectomy (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>6–8 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>10–12 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 Abdominal Tubectomy.</td>
<td>1</td>
</tr>
<tr>
<td>Cervices (nonpatent) for use in visual recognition:</td>
<td></td>
</tr>
<tr>
<td>- Normal cervix</td>
<td>2</td>
</tr>
<tr>
<td>- Cervix with proliferation of columnar epithelium (ectropion)</td>
<td>1</td>
</tr>
<tr>
<td>- Cervix with inclusion (nabothian) cyst and endocervical polyp</td>
<td>1</td>
</tr>
<tr>
<td>- Cervix with lesion (cancer)</td>
<td>1</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 cervices with patent os for IUCD insertion/removal</td>
<td>4</td>
</tr>
<tr>
<td>Extra cervices for 6–8 week and 10–12 week uteri (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 3 cm incision (reinforced at each end) located just below the umbilicus can be used to insert a laparoscopic to look at the uterus, round ligaments, ovaries and Fallopian tubes and practice laparoscopic occlusion. This incision also can be used for practicing postpartum tubal ligation by Abdominal Tubectomy.

The 3 cm incision located a few centimetres above the symphysis pubis is used for practicing interval Abdominal Tubectomy. This incision also is reinforced which allows the skin to be retracted to facilitate demonstration of the Abdominal Tubectomy 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 counter-clockwise until the cervix and uterine body are separated.

To remove the cervix, turn the thin grey ring counter-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 ZOE’s anatomical parts fit together, we suggest you change them through the opening at the top of the model. This helps to preserve ZOE’s outer shell 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 **counter-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 Tubectomy: use either the normal (non-pregnant) anteverted or retroverted uterus with a cervix having a patent os.

Postpartum Abdominal Tubectomy (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 6–8 or 10–12 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's 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 questions 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 audiovisual 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
• Recognising 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 instructions.

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 adds to, rather than subtracts from, the participant's self-esteem and sense of competence
  • 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. Repetition 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 thought, 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 clinical trainer to know basic information about participants:

  How many participants will be attending the course. For the clinical 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 clinical 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 clinical 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 sociocultural 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 customise or localise the course must be developed in advance of training.
Even if most of the training activities and methods (e.g., case studies, group discussions, brainstorming, 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 up-to-date
  ♦ Prepare and personalise a set of trainer’s notes. Use coloured pens or markers 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 also can be written directly on the manual pages.

- The clinical trainer must consider the physical resources at the training site:
  ♦ Is the size of the space appropriate for the size of the participant group? Is there a need for smaller ‘breakout’ rooms for participants? 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 chords 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 needs of participants is essential. Some of the questions that must be addressed include:
  ◆ Are there physical barriers?
  ◆ 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?
  ◆ Are telephones accessible and working? Can emergency messages be taken?
  ◆ What arrangements have been made for emergencies, such as accidents or sudden illnesses?

Establishing and maintaining a positive training climate during training depends on how the clinical trainer delivers information because the trainer sets the tone of 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 clinical trainer 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 WITH 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 counselling, 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 counselling 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 counselling, 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 case 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

Participants’ Handout: PRINCIPLES OF LEARNING

Learning is a life long process in which experience leads to changes within the individual. It has also been defined as self-development through self-activity. Learning is a relatively permanent change in behaviour resulting from experience. In brief, learning means change!

Purpose of this chapter is to look at the field of adult learning in a very basic way and presented to you in a practical manner, the way we learn.

1. PRINCIPLES OF ADULT LEARNING ARE:

The need to know

Once adults are convinced about why learning the new skill, knowledge or attitude is important, the motivation to learn follows. Without this knowledge, resistance may develop. The more adults can understand the importance of the “need to know”, the more effective and positive will be the learning experience.

Readiness to learn

Adults must be ready to learn. This means that our participants must be ready, able and willing to learn before we can ever hope to teach them. Unless there is an inner motivation and an acknowledged mental and physical readiness on the part of the learner, even the most articulate, eloquent presentation will not fulfil its goal. This further pinpoints the importance of the practicality in the training programmes. Your participants have every right to be told why this particular topic or session is included and why they are expected to learn this skill, knowledge or attitude. Without this information, it may be difficult for some trainees to recognise the value of a session or to prepare themselves for learning.

The need to be self-directing

Most participants in any training programme want to be self-directing, responsible for their actions and activities and involved in directing them. We have a strong need to take responsibility for our own lives. Participants come to our programmes with the experience, they are a keen resource for the astute trainer. Correctly used, these areas of background and expertise can enrich the training effort.

Experience

Adults have experience. Adults can help each other learn. In fact, this type of supportive learning can be very effective. If we can search for this experience and make it an integral part of the learning process, then we are indeed learning from each other.

Orientation to learning

While there may be some training sessions where the memorisation of facts and figures is critical, certainly the majority of training situations call for “real world” attitudes and values. Case studies or role-play techniques allow the participants to “plug in” to realistic problems.
Learning is the best when this closeness to the actual job or task is apparent. Transfer of learning, likewise will also be easier when this ready application to real problems can be shown to the learner. Remember, children are usually "taught" with a teacher-centred approach; adults are best "taught" with a real-world approach.

2. HOW DO ADULTS LEARN?

(i) Adults are voluntary learners.

They are self-motivated. They perform best when they have decided to attend the training for a particular reason. They have a right to know why a topic or session or the whole learning activity is important to them.

Help motivate them by:

- Explaining to them the objectives of this training.
- Explaining to them the Jobs and Tasks of MHW and MHS in the performance of quality FP services.
- Explaining to them the objectives of each session in the training.

(ii) When the learning is relevant, adults learn better.

People learn fast when it is clear that the context of the training is close to their own tasks or jobs. They are best taught with a real-world approach.

People also learn fast when the new information or skill is related to what they already know or can do.

Make learning relevant by:

- Explaining how the knowledge and skills acquired during the training will be useful to them in their future work.
- Find out what the trainees already know.
- Ask yourself 'What do they need to learn?'
- Make the connections between the existing knowledge and the new knowledge, e.g., if one already knows the principles and techniques used in DPT immunisation, then one can learn about measles immunisation faster. Often, a major part of training is not so much giving new information, but drawing out, organising and building on what the trainees already know.
(iii) Adults have experience and can help each other learn.
Encourage the sharing of that experience and build on it. Your sessions will become more effective.

Help them to share their experience by:

- Understand the background of your trainees from their completed biodatas.
- Put questions to them that draw out their experience and build on it to get your message across, e.g. "Do you know of anyone who had a baby before she was 18 years old? Were there any complications?" Then generate a discussion on malnutrition and the dangers on adolescent pregnancies. Add demographic data.
- Organise group activities which require them to share their experiences, e.g., divide the trainees into three groups and ask each group to discuss and list rumours associated with the use of condoms, oral pills and sterilisations.

(iv) Adults learn best in an atmosphere of active involvement and participation.
This may be using a variety of learning methods including discussions, games, individual/group activities, questioning and feedback, role-plays, and audio-visual aids. As they are ‘doing’, self-confidence increases and trainees will be better able to adapt what they are learning to their own circumstances.

Develop positive learning atmosphere by:

- Never talk longer than the average age of your group.
- Active bodies equal active brains. Get trainees moving out of their chairs or talking or writing at regular intervals.

(v) Adults have usually come with an intention to learn.
If this motivation is not supported, they may switch off or stop coming.

Remember:

- Keep the trainee motivation alive by following all these principles of learning and maintaining a positive learning climate.
TIPS FOR TRAINERS

Trainers should remember to apply —

**Principles of Adult Learning Programme**

- Adult learners have many individual differences.
- A good training programme does not rely much on lectures and other such didactic methods of training. A combination of many methods is highly desirable to allow the learners to learn knowledge and skills and develop the right kind of attitudes.
- Positive environment in a training programme enhances learning.
- Adults learn better if the training is relevant to the actual work to be done by them on the job.
- A good trainer always utilises the experiences of the trainees to make the training more meaningful.
- Practice is valuable. It reinforces skills. Practice should always be built into the training programme.
BASIC TRAINING SKILLS

Learners learn best when they participate in the training process. When you use facilitation skills, you encourage involvement by showing interest in the learners and allowing them to feel free to comment and ask questions. Facilitation skills also help you to obtain feedback from the learners about how the training is being received. This enables you to respond to learners’ needs most appropriately.

Facilitation is an approach to communication that employs techniques of listening questioning, sharing problem-solving, resolving conflict, using a participatory style, accepting others, empathising and leading.

Four basic types of facilitation skills are used when conducting training. They are:

A. Attending
B. Observing
C. Listening
D. Questioning

A. ATTENDING SKILLS

‘Attending’ means presenting yourself physically in a manner that shows you are paying attention to your learners. You are communicating that you value them as individuals and are interested in their learning.

Attending helps you gather information from learners. Your physical positioning enables you to observe learner behaviour—important sources of information in assessing how the training is being received. It also encourages the learners to interact verbally with you.

<table>
<thead>
<tr>
<th>DO</th>
<th>DON'T</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Position your body so you face all the learners.</td>
<td>- Talk to visual aids (e.g. the board or flip chart).</td>
</tr>
<tr>
<td>- Continually scan the group with your eyes.</td>
<td>- Turn your back to part of the group.</td>
</tr>
<tr>
<td>- Walk toward learners.</td>
<td>- Stare at individuals.</td>
</tr>
<tr>
<td>- Smile at individuals.</td>
<td>- Avoid eye contact or scan the group too frequently or too rapidly.</td>
</tr>
<tr>
<td>- Nod affirmatively.</td>
<td>- Put too much distance between you and your learners.</td>
</tr>
<tr>
<td>- Circle the room during exercises to check learner’s progress.</td>
<td>- Stand in fixed positions.</td>
</tr>
<tr>
<td>- Use natural facial expressions in talking with learners.</td>
<td>- Shuffle papers or look at your watch while learners are talking.</td>
</tr>
</tbody>
</table>

Facilitator’s Session Guide
B. OBSERVING SKILLS

Observing skills help you assess how the training is being received. Based on your observations, you can make decisions to continue the learning process as planned or to modify it in response to learner needs.

The following table provides a list of non-verbal behaviours and some inferences you might make about the learner’s feeling when you observe them.

**LEARNERS’ NON-VERBAL BEHAVIOUR AND THEIR POSSIBLE FEELINGS**

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Possible Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiling</td>
<td>Enthusiasm/Understanding</td>
</tr>
<tr>
<td>Nodding affirmatively</td>
<td></td>
</tr>
<tr>
<td>Leaning forward</td>
<td></td>
</tr>
<tr>
<td>Eye contact</td>
<td></td>
</tr>
<tr>
<td>Yawning</td>
<td>Boredom</td>
</tr>
<tr>
<td>Vacant stare</td>
<td></td>
</tr>
<tr>
<td>Shuffling feet</td>
<td></td>
</tr>
<tr>
<td>Leaning back in chair</td>
<td></td>
</tr>
<tr>
<td>Looking at the clock/wrist watch</td>
<td></td>
</tr>
<tr>
<td>Frowning</td>
<td>Confusion</td>
</tr>
<tr>
<td>Scratching head</td>
<td></td>
</tr>
<tr>
<td>Pursing lips</td>
<td></td>
</tr>
<tr>
<td>Vacant stare</td>
<td></td>
</tr>
<tr>
<td>Avoiding eye contact</td>
<td></td>
</tr>
</tbody>
</table>

You can add a few more to the list that best match the behaviour and feelings as per the local culture.

Although a single behaviour can serve as an indicator of a feeling, your inferences will be based on all your observations. Whether you decide to take action or not will depend on the situation as you view it—how many learners are experiencing the feeling. The depth and the possible duration of it, the impact it will have on present and future learning, etc. If the situation warrants action, in your judgement, consider the following possible actions:
## RESPONSE OF TRAINERS TO TRAINEES'

<table>
<thead>
<tr>
<th>If the inference you have drawn is</th>
<th>And...</th>
<th>Then...</th>
</tr>
</thead>
</table>
| Enthusiasm/Understanding           | - Several learners display the behaviour.  
   - One learner displays the behaviour | - Continue, and make a mental note that the training is being well received.  
   - Continue and make a mental note to check again later. |
| Boredom                           | - Several learners display the behaviour.  
   - Only one learner displays the behaviour | - Try taking a break, or checking your training method to be sure that the learners are involved in the training process.  
   - Continue, but make a mental note to reassess later. |
| Confusion                         | - Several learners display the behaviour.  
   - One learner displays the behaviour | - Ask learners about areas of confusion, and provide clarification by giving examples or re-phrasing information.  
   - Ask learner about areas of confusion and provide clarification. If time is limited, talk with learner at next break. |

## C. LISTENING SKILLS

Listening as we define it, means obtaining verbal information and verifying that you understand the information. Listening skills enable you to demonstrate your understanding of learners’ perspective. They also provide you with feedback about how the training is being received. You can use this feedback in considering how you need to proceed in conducting your training.

Listening involves two key steps. They are:

1. Listening to the words being expressed, which means maintaining concentration on what the learner is saying (accompanying body language provides additional clues).
2. Paraphrasing what was said to demonstrate understanding, which means interacting with the learner to ensure accurate understanding of the learner information.

Each step is discussed in more detail below:

### Step 1

Listen to the words being expressed, try to grasp both the content and the meaning of the words from the learner’s perspective. While this may sound simple, you will find that the major roadblocks to listening to the learner’s words are the internal and external distractions that compete with good listening habits.
Internal distractions are the competing thoughts that develop inside you while the learner is talking. Sometimes they are related to what the learner is saying; sometimes they are mental excursions to unrelated topics. You must eliminate these internal distractions that keep you from focusing on what the learner is saying.

External distractions are things that happen in the learning environment that compete with your attention on the learner. They can be sights or sounds. Exclude them or at least put them out of your mind until the learner has finished speaking.

Once you have focussed on the learner’s message, you can then proceed to the next step—demonstrating your understanding of what the learner said.

Step 2
Paraphrase what was said to demonstrate understanding. Paraphrasing to demonstrate understanding requires you to verbally interact with the learner. The interaction is either to:

- Get additional information you’re missing, or to
- Verify with the learner what you think was said.

Use a phrase such as "You’re saying ...." or "As I understand it ...." before paraphrasing what the learner said. If you then paraphrase the information accurately, the learner can confirm that you have demonstrated understanding. If you paraphrase inaccurately or miss important details, the learner can add the information needed for you to understand.

D. QUESTIONING SKILLS

Questions play a major role in training. Questions can:

- Help you determine what the learners already know about a topic, so you can focus your training on what they need to learn.
- Invite learner participation and involvement in the training process.
- Provide you with feedback about how the training is being received.
- Enable your learners to evaluate what they know don’t know and fill in the gaps.

There are three skills associated with the questioning process. They are:
1. Asking questions
2. Handling answers to questions
3. Responding to questions

1. Asking questions
Asking effective questions is one of the most important skills you can develop. Asking effective questions means selecting the right type of question, phrasing it so it elicits the response you are after and then directing the question appropriately.
There are two basic types of questions from which to choose—open questions and closed questions.

<table>
<thead>
<tr>
<th>Type of Question</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
</table>
| Open             | - Requires more than a ‘yes’ or ‘no’ or one word answer.  
|                  | - Stimulates thinking.  
|                  | - Elicits discussion.  
|                  | - Usually begins with ‘what,’ ‘how,’ ‘when,’ ‘why’.  | "What ideas do you have for explaining the changes to our clients?" |
| Closed           | - Requires a one-word answer.  
|                  | - Closes off discussion.  
|                  | - Usually begins with ‘is,’ ‘can,’ ‘how many,’ ‘does’.  | "Does everyone understand the changes we’ve discussed?" |

2. Phrasing Questions

There are important considerations in phrasing questions so that the learner is focussed on the precise information you are trying to obtain.

GUIDELINES FOR PHRASING QUESTIONS

<table>
<thead>
<tr>
<th>DO</th>
<th>DON’T</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ask clear concise questions covering a single issue.</td>
<td>• Ask rambling, ambiguous questions covering multiple issues.</td>
</tr>
<tr>
<td>• Ask reasonable questions based on what the learners can be expected to know at this point in the training.</td>
<td>• Ask questions that are too difficult for the majority of the learners to answer.</td>
</tr>
<tr>
<td>• Ask challenging questions that require thought.</td>
<td>• Ask questions that are too easy and provide no opportunity for thinking.</td>
</tr>
<tr>
<td>• Ask honest, relevant questions that direct the learners to logical answers.</td>
<td>• Ask 'trick' questions designed to fool the learners.</td>
</tr>
</tbody>
</table>

Directing Questions

The final consideration in asking effective questions is how to direct your question. During training there are two ways to direct questions:

- To the group.
- To the individual.
CHOOSING HOW TO DIRECT QUESTIONS

<table>
<thead>
<tr>
<th>If you want to</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulate all your learners to think, allow learners to respond voluntarily.</td>
<td>Direct the question to the group.</td>
</tr>
<tr>
<td>Avoid putting an individual learner on the spot.</td>
<td>Example:</td>
</tr>
<tr>
<td></td>
<td>&quot;What experience have you had on this issue?&quot;</td>
</tr>
<tr>
<td>Stimulate one learner to think and respond.</td>
<td>Direct the question to an individual.</td>
</tr>
<tr>
<td>Tap the known resource of an 'expert' in the class.</td>
<td>Example:</td>
</tr>
<tr>
<td></td>
<td>&quot;Sharma, you have had a lot of experience in applying these regulations with clients. What would you do in this case?&quot;</td>
</tr>
</tbody>
</table>

Handling Answers to Questions

The second skill associated with the questioning process involves the way in which you handle responses to your questions. To ensure maximum learning, you need maximum participation by your learners. The way in which you respond to a learner’s answer has an impact not only on the individual learner but also on the amount of future participation you will receive from all learners.

Some ways to handle responses and still maintain a high level of learner participation are to:

- Use positive reinforcement for correct answers.
- Acknowledge the effort of the respondent, regardless of whether the answer is right or wrong.
- Minimize potential learner embarrassment for wrong or incomplete answers.
### TIPS FOR HANDLING RESPONSES

If the learner's response is:

<table>
<thead>
<tr>
<th>Correct</th>
<th>Incorrect</th>
<th>Partly correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Positive reinforcement</td>
<td>• Acknowledge the effort.</td>
<td>• Reinforce the correct portion.</td>
</tr>
<tr>
<td>Then</td>
<td>• Redirect the question to others or answer it</td>
<td>• Redirect the question to the same learner or to another learner or address it yourself.</td>
</tr>
<tr>
<td>yourself.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Examples:**

- "Yes"
- "Good Point"
- "That's right"

**Examples:**

- "I can see how you might come up with that. Who else has an idea?"
- "That's not exactly what I was looking for. What I was looking for was..."

**Examples:**

- "You're on the right track. What other ideas do you have?"
- "That's one good point, Gupta. Who else has some idea?"

### 3. Responding to Questions

The third skill associated with the questioning process involves responding to questions from the group. Questions provide an opportunity to enhance the entire group's learning, as well as that of the individual asking the question. The way in which you respond to learners' questions also affects whether learners feel free to ask future questions during training.

There are three acceptable ways to respond to questions. They are:

1. Provide the answer yourself.
2. Redirect the question to a learner.
3. Defer the question.
RESPONDING TO QUESTIONS

<table>
<thead>
<tr>
<th>Choose the following way to respond:</th>
<th>When...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the answer yourself.</td>
<td>You are the only person who can provide the answer.</td>
</tr>
<tr>
<td>Redirect the question back to the same learner or to another learner.</td>
<td>There is a high probability that the person will be able to come up with the correct answer.</td>
</tr>
<tr>
<td>Defer the question.</td>
<td>• The question is beyond the scope of the course.</td>
</tr>
<tr>
<td></td>
<td>• The question cannot be handled in the allotted time frame.</td>
</tr>
<tr>
<td></td>
<td>• The answer will be provided by material covered later in the course.</td>
</tr>
<tr>
<td></td>
<td>• You need time to get the correct answer and get back to the learner.</td>
</tr>
</tbody>
</table>

USING FLIP CHARTS

Flip charts consist of an easel and blank pages that can be written on. The information can be prepared ahead or recorded during training.

Filling out the chart in advance is neater and more efficient. Recording during training allows you to respond to the immediate learning situation.

There are certain guidelines that should make your flip charts readable and appealing to learners such as:

- Use as few words as possible.
- Leave two or more spaces between the lines.
- Make letters at least 1-1/2 inches high.
- Check readability by going to various parts of the room.
- If the pages are very thin, then leave a blank page between each pre-prepared page, so that the writing on the next page does not show through and distract learners.
## FLIP CHART TIPS

<table>
<thead>
<tr>
<th>IF</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are recording learner input.</td>
<td>Record words quickly.</td>
</tr>
<tr>
<td>You wish to have learners compare and contrast data.</td>
<td>Check with learners to be sure you are reflecting their ideas accurately.</td>
</tr>
<tr>
<td>You want to display information for a period of time.</td>
<td>Alternate colours when listing the group’s ideas.</td>
</tr>
</tbody>
</table>
| You want to look especially professional in the front of the group. | • Use two flip charts  
• Hang pages on wall  
• Lightly write memory joggers in pencil in margin of flipchart page and use presentation notes.  
• Practice tearing out pages neatly, before trying it on front of the group.  
• Tab specific pages ahead of time.  
• Cover errors with paste-on-labels, then write correct information on the labels. |

## WAYS TO DEAL WITH NERVES


2. There is no need to become defensive in your preparation. The audience will read it and react by becoming hostile.

3. Start talking to participants as soon as they begin to arrive. Smile and be relaxed. Get to know a few names and faces and if possible do an introduction game soon. This sets an informal tone for the entire session. Mingle with the trainees outside the training sessions during lunch breaks.

4. A good way to calm yourself and slow your heartbeat is by inhaling and exhaling deeply several times. You can do this whenever you get a spare minute during the session. Get your spare minutes by making the participants talk.

5. Rest assured. Even experienced trainers feel nervous before beginning a training course.
APPENDIX F

TRAINING METHODS

METHODS OF INSTRUCTION:

By exploring several of the more commonly used techniques and methods of training, you will be able to decide which method may be best for a given lesson. While several techniques are listed, it is important to recognise that you as a trainer should have a working knowledge of all of them. In some cases, one or two techniques will be preferable, depending upon the objectives of the session and the background and interest of the people involved.

What is the most effective method?
There is no simple answer. To help you make your decision, though, let’s discuss the pros and cons of each. Certainly, good trainers will have a variety of techniques in their repertoires. As trainers gain experience, they tend to favour one or two methods and then continue to use only those. “Because this one is easier,” is a weak reason to select a method. Unfortunately, however, even senior trainers have fallen into that trap.

There are some important items to consider in choosing a particular method.

Obviously, there is merit in picking one with which we feel comfortable. We should, of course, consider first the objectives of that particular session. How about cost? Time, of course, is also important. For example, while we know that discussion may be better for learning, it may be that we simply cannot afford the extra time and must settle instead for the lecture method. The size of the group and type of room are also relevant considerations in choosing appropriate methods.

Here, then, are some commonly used methods.

(i) LECTURE

Without question, the lecture methods is both the most widely used and the most abused technique of training. It is primarily a one-way communication: one person presents a prepared talk or a series of facts or information of a particular subject. The lecture is very economical in that little time is wasted with discussion. If it is properly prepared, the meaning of a message can be clearly stated and illustrated.

Advantages:
* Time saving
When there is a lot of material to present to a group, the lecture is often the best choice since it allows the entire group to be given the information in a relatively short period of time.

* Control of topic
The trainer is in complete control of the session since all of the information is presented with little, if any, time for questions or feedback. This enable trainers with well prepared lesson plans to gauge accurately the time elements of their presentations.
* Repetition
Because the trainer is in such control of the meeting, points can easily be repeated for emphasis and clarification.

* Economy
As suggested previously, the trainer can present a lot of new material to almost any size group, thus saving time and talent. Assuming that the trainees are listening to the material being presented, it is easy to see that giving large groups the same information is an economical training method.

* Flexible group size
The lecture is applicable to any size group. With appropriate audio and visual aids, the lecture can be used with large groups.

Disadvantages:

* One-way communication
Without some method of testing or evaluation, the trainer has little assurance that the message is really being understood or received properly. Because of a lack of participation, there is no feedback or no real reinforcement of the learning process.

* Boredom
Too many trainers or teachers forget that a lack of variety of voice style and methodologies will undercut the effectiveness of the session. A dull, dreary monotone makes it extremely difficult for the trainees to listen to what is being presented.

* Attention span
Most people listening to a lecture have an extremely limited span of attention. Studies indicate that immediately after hearing something, the average person will have forgotten 50 percent of that material! The lecturer must repeat and summarise frequently to overcome this drawback.

* Lower retention rate
Because of the lack of involvement or participation, the lecture has a much lower rate of learning as measured by long and short-term retention.

* The "canned" talk.
Too many trainers forget the individualisation of their trainees and are too prone to "pull" a session out of the file drawer and merely redo it for that "new group". The canned talk is inherently boring and contribute to lack of attention on the part of the trainees. Listeners can quickly see through canned talks and hence they lose any value for the individual.

* Feedback
Because of the one-way communication of the lecture, the speakers or trainers have no way of knowing whether they are staying on track or going completely afield in regard to the interests of the group. They may be expanding on a point that is of no interest whatever. To avoid this disadvantage of the lecture, trainers must be assured that their content and presentation are such as to overcome this negative point.
(ii) LECTURE DISCUSSION

The lecture discussion is a modified version of the lecture, combining the content session with some discussion on the part of the trainees. This easy modification helps to overcome some of the earlier disadvantages of the lecture technique used by itself.

A lecture can be improved by asking questions that make the audience think about your ideas or concepts. The following questions can be adapted to this purpose:

How does this compare with what you used to do?
What do you think is the reason for this?
What do you think will be the outcome?
What are the alternative methods that can be used?

A discussion allows individual participation even with large training programmes. As implied by the term, discussion involves the people in either large or small group sessions to further comment on the training session at hand.

Discussion brings many views into plays and brings out details required for understanding. By promoting a free exchange of ideas, the members take responsibility for learning. The purpose is to explore a subject and permit questioning that will bring out the unclear areas so they can be cleared up. The advantage of discussion is that you get immediate feedback and can, therefore, immediately correct any misunderstanding. One of the disadvantages is that the group may stray away from the intended topic. More time is required than for the lecture.

Discussion can be made more effective by careful preparation. Prepare questions and statements in advance to guide trainees in case they get off-track. Watch the time each participant takes and don’t let one person monopolise the conversation. Be prepared to redirect the conversation to the intended topic.

(iii) BUZZ GROUPS

Large group discussions often used to allow for questions and feedback but a far preferable approach is the used of what is termed the buzz group. Buzz groups are subdivisions of a large group—they are small groups of five to ten people formed for the purpose of discussing a chosen or selected topic. A variation of the buzz group method is the “66” technique, wherein six people are given six minutes to discuss the topic at hand.

Advantage:

* Involvement for everyone
Whereas in a large group session or large discussion, only a few voices may be heard, the small group session allows almost everyone to express his or her opinion or thinking on the topic.

* Reduced peer pressure
People are often hesitant or reluctant to express their opinion in a large group because of fear of what their fellow trainees may think. In a small group session, of course, this pressure is far less apparent and individuals may be much more willing to express their opinions.
* Variety of experience
The small group session allows for a tremendous variety of experience, knowledge and backround to come to the fore. Whereas in large groups only a few voice are heard, the use of buzz groups in a training session allows a large number of ideas to come forward. This greater volume of ideas, comments, and opinions is of real value to learning process.

* Exchange of ideas
Visualise two people seated across the room from one another. One person walks over to the other and hands that person a rupee note. Before leaving, however, she takes from that person a different rupee note and then returns to her place. The net result of this, of course, is that each person started with a rupee and while it is a different rupee, each person also finished with a rupee. Contrast that scene with the exchange of an idea rather than a rupee. The net result, of course, is that the person has two ideas instead of the one that he or she had initially. This is one of the most important advantages of the discussion technique because it does allow for a free flow of ideas, thus enhancing the totality of all ideas. A far greater volume of ideas can be gathered in a short period of time.

Disadvantages:
* Unfamiliarity
Depending upon the time constraints of the programme, it may take some time for the trainee to become acclimatised to this technique. For some people, it may be a brand new method and may take some getting used to.

* Volume participation
While it is felt that most people will contribute to the small group discussion, there is no rule that they must do so and some individuals may still feel no desire to participate. While this is a limited drawback, it should be recognised as a possibility.

* Lack of leadership
Unless the buzz group leaders completely understand their responsibility, the buzz group is nothing more than the proverbial “blind leading blind.” The discussion leader must have been oriented to the situation and should be given some hints as to how to best use the group for participation. Sometimes the buzz group is both leaderless and without direction. The net result is a large waste of time.

* Lack of organisation
Without proper coaching, the individual participant may feel both lost and disorganised. This, of course, hampers the entire training effort.

(iv) ROLE-PLAY
The role-play technique allows participants to “play” the role of one or more individuals in a real life situation.

Advantages:
* Participation
By definition, role-play directly involves the individuals in the training session. It is usually best to ask volunteers from the group to take part; at times, however, it may be necessary for
all the members to participate. Rather than select two or three volunteers, form triads and have each person rotate roles, with the third person acting as an observer who assists in the critique.

* Increased self-confidence
When the role play involves situations that individuals are likely to encounter, the methods can build self-confidence in training situations. When the real case occurs, individuals can be more confident knowing they have met and conquered similar situations and are better prepared to deal with such incidents.

* Empathy
Since role-play involves case studies, individuals have a chance to put themselves in the other person’s position. By so doing, they can empathise with both sides of the role.

* Variety of solutions
Although there may be a “school solution” as such for the role-play method being used, it is far preferable to let the individuals work out the actual solution. Often a variety of possible answers will evolve that can be used in this and future training programmes.

* Real world solutions
The end result of the exercise is typically a practical usable answer.

Disadvantages :
Like other methods, role-play is not without its disadvantages as well. Some of the more important items to consider are these:

* Artificiality of situation
Since role-play is done in an unreal or artificial atmosphere, some participants may have difficulty imagining themselves in the real situation. A classroom or training situation is not the same as a customer’s office or other place where the situations being portrayed really will take place.

* Discomfit of participants
There may be trainees who feel very uncomfortable portraying any type of a role. If the role-play involves other trainees acting as observers, some participants may simply go through the motions and the result is far from ideal. If participants are forced to play roles, the play many times overtake the real work of the programme.

* Lack of productivity
Without proper counselling in advance, role-play is nothing more than a game. If the participants are not convinced that this is a viable and important technique for training, role-play loses all value.

* Time-consuming
Since this method takes much more time than other types of training, the cost-conscious trainer must be certain that the time is worth the effort. If role-play is given too much time, the participants may lose interest and again all value is lost. Within specified time periods, however, role-play performs a functions. Role-play may be made more effective if the
participants are given time to prepare with the help of other group members. They practice before their own group prior to playing before the larger group. Make it a team effort rather than an individual one.

(v) CASE STUDY

The case study is another important technique that trainers should become familiar with and know how to use properly. The case study is an actual presentation, either written or verbal, of an incident that either did or could happen in a related area. Some schools of business administration rely primarily on the case study as a method of instruction. As with all the other techniques, we should consider both its pros and its cons.

Advantages:
* Participation
After having read or being given the case, small groups typically spend a prescribed period of time discussing it and its possible solutions fully.

* Applicability
Since the case should be an incident of relevance to the training situation, its “real world” application is obvious. Often the trainee may encounter a similar type of situation after the training programme has been concluded.

* Specificity of case
Since the case should be directly related to the training situation, the training administrator can select or write those cases that are of real relevance and concern to the group at hand.

Disadvantages:
* Artificiality
If the case study does not reflect a real-life situation, trainees may view the case as too theatrical and not recognise its applicability to their situation.

* Time consuming
Depending on the length and scope of the case presented, the time spent in discussion may be far more than is warranted by whatever point is being made. It must be recognised that the case study is a very time-consuming tool.

* Cost
If commercially prepared cases are not available for or adaptable to particular training situations, the training administrators may be forced to prepare cases themselves. If such is the case, a well-prepared case study becomes very expensive in terms of time and preparation.

* Lack of information
Too many cases do not give a sufficient number of facts or enough information for the trainees to take action.

* Identifiability
While the case study should be realistic, if some participants can identify the case as one in
which they may have been involved, this will materially stifle their participation. Cases, of course, should be identified as general examples of situations and not identifiable with a specific department or individual in the organisation.

(vi) DEMONSTRATION
An excellent way to practice the “show and tell” technique is to use the demonstration to illustrate your points. By simulating the actual job situations, the trainer gives the learner a “hands on” experience. It follows a step-by-step procedure so that every process to be taught can be followed.

Because the demonstration method is best with small groups, there is a cost-benefit factor to consider. For some training situations, it may well be prohibitive on a cost basis. Before discarding it, however, you will want to be certain that its substitute will fulfill your objectives satisfactorily in terms of cost and results.

(vii) BRAINSTORMING
A method that merges the discussion technique with a creative twist is a group ideation process called brainstorming. Its purpose is simply to elicit a number of new ideas and responses to a problem. Unlike a typical discussion or buzz group method, brainstorming is based on four basic rules:
  • Judicial judgement is ruled out.
  • “Free-wheeling” is welcomed.
  • Quantity is wanted.
  • Combination and improvement are sought.

The first rule is the most important. In most business meetings, someone is always ready to throw “cold water” on what we may think of as a “hot idea.” Not so in brainstorming. Criticism is not allowed.

In an open, “free-wheeling” system, we are looking for a concept that indicated “the wilder, the better.” It may take some training to convince the participants you are, indeed, looking for what some may feel are crazy, outlandish ideas. In fact, as outlined by rule three, the more the better. Don’t even concern yourself with quality—only quantity.

The last rule prompts us to keep building or “hitch hiking” on previous ideas.

Proponents of brainstorming declare it an excellent way to bring forth new ideas in a creative atmosphere. Critics cite the time-consuming element as wasteful of time and money.

Let’s return to our earlier question. Which method is best? There is no one best method. It depends on the objectives, size of group, time frame, and comfort zone of both trainer and learner.

The preceding list of methods is not intended to be a complete list of methodologies. In fact, there are probably dozens of different methods and techniques available. Our intent was to enumerate some of the more commonly used methods and provide our readers with some pros and cons to consider. Whatever your choice, don’t rely only on one!
<table>
<thead>
<tr>
<th>Training Method</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASE STUDY</td>
<td>Learners given hypothetical situation and asked to make a decision</td>
<td>Involves learners actively</td>
<td>Precision needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simulates “real world”</td>
<td>Can over-focus on content</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Can observe learning</td>
<td></td>
</tr>
<tr>
<td>DEMONSTRATION</td>
<td>Learners shown correct steps in completing task.</td>
<td>Aids understanding</td>
<td>Needs accuracy and preparation time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adds interest</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provides model</td>
<td></td>
</tr>
<tr>
<td>GROUP DISCUSSION</td>
<td>Trainer leads the group in discussing a topic</td>
<td>Involves learners</td>
<td>Can be confusing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiences are shared</td>
<td>Domination by one person possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Can observe learning</td>
<td></td>
</tr>
<tr>
<td>ROLE-PLAY</td>
<td>Learners ‘act out’ situations</td>
<td>Involves learners</td>
<td>Can ‘overact’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Can practice real situations</td>
<td>May be resistance to method</td>
</tr>
<tr>
<td>STRUCTURED EXERCISE</td>
<td>Learners take part in exercise using new skills</td>
<td>Aids retention</td>
<td>Needs preparation time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involves learners</td>
<td>Time consuming during training</td>
</tr>
<tr>
<td>TRAINER PRESENTATION (LECTURE)</td>
<td>Trainer orally presents new information</td>
<td>Keeps group together</td>
<td>Can be dull</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time control</td>
<td>Limited retention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Can use with large group</td>
<td></td>
</tr>
</tbody>
</table>
Training Method: PRESENTATION

DESCRIPTION
A presentation is an activity conducted by a resource specialist to convey information, theories or principles. Forms of presentations can range from simple lecture to involvement of the trainer for content than does any other training technique.

USES
- To introduce participants to a new subject
- To provide an overview
- To convey facts, statistics
- To address a large group

ADVANTAGES
- Covers a lot of material in a short time
- Useful for large groups
- Can be adapted to any kind of learner
- Can precede more practical training techniques
- The trainer has more control than in other situations

THINGS TO BE AWARE OF BEFORE DECIDING TO USE A LECTURE/PRESENTATION
- Emphasises one way communication
- Is not experimental in approach
- Learner’s role is passive
- Trainer needs skills to be an effective presenter
- Inappropriate for changing behaviour or for learning skills
- Learner retention is not as great unless it is followed up with a more practical technique
- A presentation is common in more formal situations

PROCESS
- Introduce the topic - tell the participants what you are going to tell them
- Tell the participants what you want to tell them – present the material/information using flip charts or visual aids
- Summarise the key points you have made – tell the participants what you have told them
- Invite the participants to ask questions
Training Method: DEMONSTRATION

DESCRIPTION
A demonstration is a presentation of a method for doing something.

USES
- To teach a specific skill or technique
- To model a step-by-step approach

ADVANTAGES
- Easy to focus learner's attention
- Shows practical applications of a method
- Involves learners when they try the method themselves

THINGS TO BE AWARE OF BEFORE DECIDING TO USE A DEMONSTRATION
- Requires planning and practice ahead of time
- Demonstrator needs to have enough materials for everyone to try the method
- Not useful in large groups
- Requires giving feedback to learners when they try themselves

PROCESS (REFER TO THE CHECKLIST ON DEMONSTRATION FOR PRACTICE)
- Introduce the demonstration – what is the purpose?
- Present the material the trainer is going to use
- Demonstrate – ensure that the participants can observe each step clearly or arrange to demonstrate in smaller groups
- Demonstrate again, explaining the purpose of each step and the relationship of some steps to each other
- Invite the learners to ask questions
- Have the learners practice themselves
- Provide supportive feedback and correct the participants if wrong by explaining and demonstrating again (or have another participant demonstrate who has done the procedure correctly)
- Discuss how easy/difficult it was for them
- Summarise
Training Method: ROLE-PLAY

DESCRIPTION
In a role-play, two or more individuals enact parts in a scenario related to a training topic.

USES
- Helps to change participant’s attitude
- Enables participants to see the consequences of their actions on others
- Provides an opportunity for learners to see how others might feel/behave in a given situation
- Provides a safe environment, in which participants can explore problems they may feel uncomfortable about discussing in real life
- Enables learners to explore alternative approaches to deal with situations

ADVANTAGES
- Stimulating and fun
- Engages the group’s attention
- Simulates the real world

THINGS TO BE AWARE OF BEFORE DECIDING TO USE A ROLE PLAY
- A role play is spontaneous – there is no script to follow
- Actors must have a good understanding of their role for a role play to succeed
- Actors might get carried away with their roles

PROCESS (REFER TO THE CHECKLIST OF ROLE-PLAY FOR PRACTICE)
- Prepare the actors so that they understand their roles and the situation. To have an ad hoc response of the service provider during a FP Counselling skills role-play, the situation may not be told to serve provider and only the client in briefed regarding his role and situation.
- Set the climate to let the observers know what the situation involves
- Arrange the stage so that everyone can see clearly. Ensure that the actors speak loudly and clearly enough for everyone to hear clearly
- Observe the role-play (checklists) to manage role-play and Counselling/clinical skills that can be used
- Thank the actors and ask them how they felt about the role-play – be sure that they get out of their roles and back to their real selves
- Share the reactions and observations of the other participants (observers)
- Discuss different reactions regarding what happened
- Ask the learners what they have learned and develop principles
- Ask the learners how the situation relates to their own lives or job experience
- Summarise
Training Method: SMALL GROUP-WORK

DESCRIPTION

A small group-work is an activity that allows learners to share their experiences and ideas or to solve a problem.

USES
- Enhances problem-solving skills
- Helps participants learn from each other
- Gives participants a greater sense of responsibility in the learning process
- Promotes team work
- Clarifies personal values

ADVANTAGES
- Learners develop greater control over their learning
- Participation is encouraged
- Allows for reinforcement and clarification of lesson through discussion

THINGS TO BE AWARE OF BEFORE DECIDING TO USE A SMALL GROUP WORK
- The task given to a group needs to be very clear
- The group should be aware of time limits for the group-work
- Participants should be able to listen to each other, even if they do not agree
- Group work should not be dominated by any one or two people
- Everyone should be encouraged to participate

PROCESS
- Arrange the learners in groups of three or four
- Introduce the task that describes what should be discussed
- Ask each group to designate a facilitator and a person to present the result to the larger group
- Check to make sure that each group understands the task
- Give groups time to work – this should not require the trainer’s involvement unless the learners have questions for the trainer
- Have one participant from each summarise the result of the group work (this could be a solution to a problem, answers to a question or a summary of ideas)
- Identify common themes that were apparent in the groups’ presentations
- Ask the participants what they have learned from the exercise
- Ask the participants how they might use what they have learned
Training Method: CASE STUDY

DESCRIPTION
A case study is a written description of a hypothetical situation that is used for analysis and discussion.

USES
- To discuss common problems in a typical situation
- Provides a safe opportunity to develop problem-solving skills
- To promote group discussion and group problem-solving

ADVANTAGES
- Learner can relate to the situation
- Involves an element of mystery
- The hypothetical situation does not involve personal risks
- Learners are involved

THINGS TO BE AWARE OF BEFORE DECIDING TO USE A CASE STUDY
- The case must be closely related to the learners’ experience
- Problems are often complex and multi-faceted
- There is not always just one right solution
- Requires a lot of planning time if the trainer wants to write the case herself/himself
- Discussion questions need to be carefully designated

PROCESS
- Introduce the case
- Give the participants time to familiarise themselves with the case
- Present questions for the discussion or the problem to be solved
- Give participants time to solve the problem/s
- Have some participants present their solutions/answers
- Ask the participants what they have learned from the exercise
- Ask them how the case might be relevant to their own environments to their job experience
- Summarise
APPENDIX - G

USING THE LEARNING GUIDE

The Learning Guides for Abdominal Tubectomy Counselling and Clinical Skills are designed to help the participants learn the tasks involved in performing Abdominal Tubectomy under Local Anaesthesia. There are three learning guides:

- Learning Guide for Interval Abdominal Tubectomy Clinical Skills Checklist for Doctors
- Learning Guide for Postpartum Abdominal Tubectomy Clinical Skills for Doctors
- Learning Guide for Interval Abdominal Tubectomy Clinical Skills Checklist for Nurse Assistants

Each learning guide contains in sequence the tasks performed by the respective clinician when performing a Abdominal Tubectomy procedure under local anaesthesia. These tasks correspond to the information presented in relevant chapters of the reference manual as well as the training video photo-set. This facilitates participant’s review of essential information.

The participant is not expected to perform all the activities/tasks correctly the first time s/he practices them. Instead the learning guides are intended to:

- Assist the participant in learning the correct steps and sequence in which the task/activity should be performed (skill acquisition), and
- Measure progressive learning in small steps as the participant gains confidence and skill (skill competency)

Prior to using the learning guides, you will review the entire pre-operative assessment and Abdominal Tubectomy procedure with the participants using the training video photo-set. In addition, each participant will have the opportunity to witness the steps of the Abdominal Tubectomy procedure using an anatomic/pelvic model and with a client. Thus, by the time the group breaks up into teams to begin practising and rating each others’ performance, each participant should be familiar with the process for performing Abdominal Tubectomy under local anaesthesia, including the use of verbal anaesthesia.

Used consistently, the learning guides enable each participant to chart her/his progress and to pinpoint areas for improvement. Furthermore, they are designed to make communication (coaching and feedback) between you and the participant easier and more helpful. When using the learning guide, it is important that you and the participant work together as a team. For example, before the participants attempts the skill or activity the first time, you should briefly review the steps involved and discuss the expected outcome. In addition, immediately after the skill or activity has been completed you should debrief the participant. The purpose of the debriefing is to provide positive feedback regarding the learning progress and to define the areas where improvement (knowledge, attitude and practice) is needed in subsequent practice sessions.

Because the learning guides are used to assist in developing skills, it is important that the
rating (scoring) be done carefully and as objectively as possible. The participant’s performance of each step is rated on a three-point scale as follows:
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.
3. Proficiently performed: Step or task efficiently and precisely performed correctly in the proper sequence (if necessary).

Using the Learning Guides for Abdominal Tubectomy Clinical Skills for Doctors and Nursing Assistants: These guides are to be used primarily during practice sessions with anatomic (pelvic) models and during observation and assisting sessions in the operating room.

Examples of how the learning guides can be used at different stages of the course include:
- Initially, participants can use the learning guides to follow the steps as you role play pre-operative assessment of a client or demonstrate steps of the Abdominal Tubectomy procedure using the pelvic model.
- Subsequently, during the classroom sessions where participants are paired, one ‘service provider’ participant performs skill or activity while the other participant uses the learning guide to prompt the ‘service-provider’ on each step. You should circulate, move to each group of participants to see how the learning is progressing and check to see that the participants are following the steps outlined in the learning guides.
- Once participants become confident in performing the procedure using models, participants can use the learning guide to rate each others performance. This exercise can serve as a point of discussion during a clinical conference before the participants provide services to clients.
- Prior to the first clinic sessions, participants are again paired. Here, one ‘service-provider’ participant performs the procedure while the other observes and uses the learning guide to remind the ‘service-provider’ of any missed steps. You should coach the participants as they perform the activities or tasks.

Remember: It is the goal of this training that every participant performs every task or activity correctly with clients by the end of the course.
LEARNING GUIDE FOR INTERVAL ABDOMINAL TUBEECTOMY 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)

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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>
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<td>8. Take and record vital signs.</td>
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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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<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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<tr>
<td>13. Perform a gentle bimanual pelvic examination to assess uterine size, position and mobility and presence of any pelvic abnormality.</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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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.

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 ANAESTHESIA**

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 anaesthesia (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 anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).
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<td>9.</td>
<td>Make transverse/vertical, suprapubic skin incision, approximately 3 cm long at the preselected incision site 3 cm above symphysis pubis</td>
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<td>Bluntly dissect subcutaneous tissues with scissor tips or fingers.</td>
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<td>11.</td>
<td>Identify and grasp fascia at two places with the Allis forceps and cut with scissors.</td>
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<td>Separate rectus muscles in the midline (longitudinally) using blunt dissection with artery forceps and clean off preperitoneal tissue if needed.</td>
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<td>13.</td>
<td>Confirm identification of peritoneum.</td>
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<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>
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<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>
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**Locating Fallopian Tubes**

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<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>
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<td>17.</td>
<td>Slide the finger/s along the fundus laterally and a little posteriorly and feel for the Fallopian tube.</td>
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<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>
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**Grasping the Fallopian Tubes**

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<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>
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<td>20.</td>
<td>Gently grasp the mid portion of the tube with the Babcock's forceps</td>
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<td>Identify fimbriated end of the tube by tracing the tube till the fimbrial end.</td>
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**Tubal Occlusion**

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

24. 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.

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

26. Repeat procedure on opposite side for second tube.

**Closure (When haemostasis assured, close wound in layers)**

27. The closure of peritoneum is optional.


29. Close skin with 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
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:

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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 anaesthesia).

**LOCAL ANAESTHESIA**

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 anaesthesia (about 3-5 ml) just under the skin along both sides of the incision line.

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4. Aspirate to ensure the needle is not in a blood vessel; then, while injecting 3-5 ml of lignocaine, withdraw the needle slowly up to 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 anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).

**ABDOMINAL ENTRY**

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

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<td>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.</td>
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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 reusable 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.