## CONTENTS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>Learning Guide For Laparoscopy Tubal Ligation Counseling Skills</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Learning Guide For Laparoscopy Tubal Ligation Clinical Skills For Operating Doctors</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Learning Guide For Laparoscopy Tubal Ligation Clinical Skills For Nurse Assistants</td>
<td>9</td>
</tr>
<tr>
<td>5.</td>
<td>Follow-Up Assessment - Interview For Medical Officers Who Attended Lap Induction Training</td>
<td>12</td>
</tr>
<tr>
<td>6.</td>
<td>Laparoscopic Tubal Ligation Checklist For Operating Doctors</td>
<td>14</td>
</tr>
<tr>
<td>7.</td>
<td>Laparoscopy Tubal Ligation Induction Checklist For Nurse Assistants</td>
<td>17</td>
</tr>
<tr>
<td>8.</td>
<td>Laparoscopic Tubal Ligation Checklist For Nurse Assistants</td>
<td>18</td>
</tr>
<tr>
<td>9.</td>
<td>Session 1 - Introduction To Quality Improvement</td>
<td>21</td>
</tr>
<tr>
<td>10.</td>
<td>Session 2 - Facilitative Supervision</td>
<td>25</td>
</tr>
<tr>
<td>11.</td>
<td>Session 3 - Leadership</td>
<td>31</td>
</tr>
<tr>
<td>12.</td>
<td>Session 4 - Team Building</td>
<td>35</td>
</tr>
<tr>
<td>13.</td>
<td>Session 5 - Coaching</td>
<td>41</td>
</tr>
<tr>
<td>14.</td>
<td>Session 6 - Planning A Meeting</td>
<td>47</td>
</tr>
<tr>
<td>15.</td>
<td>Session 7 - Communication</td>
<td>58</td>
</tr>
<tr>
<td>16.</td>
<td>Bibliography</td>
<td>63</td>
</tr>
</tbody>
</table>
INTRODUCTION

Female sterilization remains a common method for a large number of family planning acceptors. Laparoscopy tubal ligation is a popular method of sterilization in U.P.

As a part of their work in strengthening training, Government of India, Government of Uttar Pradesh and USAID have collaborated with EngenderHealth to strengthen the service delivery skills of family planning service providers. Under this activity a twelve day laparoscopic induction training is being given to medical officers and surgeons from all districts of Uttar Pradesh.

In order to bring about sustainability to the efforts of training and follow-up activities in laparoscopic ligation, it has been decided to utilize the skills of experienced laparoscopists after providing them the six day ToT in laparoscopic tubal ligation and on procedures on how to carry out the follow up of the newly trained providers within the district. In this endeavour SIFPSA has planned to provide ToT to the experienced laparoscopists from all districts of U.P. at the Meerut and Lucknow Medical Colleges respectively.

The role of the district trainer after receiving the ToT would be to act as a mentor to new inductees (doctors and nurses) who will work under their supervision unless and until they are declared performing to standard, to conduct follow-up at the site of the new inductees, to do facilitative supervision and to act as a district resource or expert for laparoscopic tubal ligation.

Follow-up plan:

The follow-up visit will be done by the district trainer at the working site of the newly trained service providers (laparoscopists and nurse assistant), ideally at an interval of 6 weeks and 3 months following the training. Soon after the training the newly inducted laparoscopists would work under the supervision of the district trainer at the district women hospital and RCH camps. During this period the district trainer will mentor and guide the laparoscopists in performing the procedure as per the standard. Once the district trainer is satisfied with the performance of the new laparoscopist, he/she will conduct the first follow-up at the working site of the new laparoscopist.

During the second follow-up visit the district trainer will finally assess the new laparoscopists for competency and confidence in performing the procedure independently at RCH camps, as per the standard. The end result of the second assessment is either the newly trained doctor is declared as competent and performing to standard (PTS) or not performing to standard (NPTS). In either case the CMO should be informed. If the doctor is PTS he/she can be allowed to perform the procedure independently, while if NPTS the CMO is requested to make sure that the doctor is assigned duties to perform laparoscopic ligation under supervision until he/she performs the procedure to standard.
LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION COUNSELING SKILLS
(To be used by Participants)

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

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted.
2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently.
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<thead>
<tr>
<th>PARTICIPANT</th>
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<table>
<thead>
<tr>
<th>LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION COUNSELING SKILLS</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL INTERVIEW (Client Reception Area)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greet woman respectfully and with kindness.</td>
<td></td>
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<tr>
<td>2. Establish purpose of the visit and answer questions.</td>
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<tr>
<td>3. Provide general information about family planning.</td>
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<tr>
<td>4. Give the woman information about the contraceptive choices available and the risks and benefits for each. Explain the difference between reversible and permanent contraception. Correct false rumours or misinformation about all methods.</td>
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<tr>
<td>5. Explain what to expect during the clinic visit.</td>
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<tr>
<td><strong>METHOD-SPECIFIC (Counseling Area)</strong></td>
<td></td>
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<tr>
<td>1. Assure necessary privacy.</td>
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<tr>
<td>2. Obtain demographic information (name, address, etc.).</td>
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<tr>
<td>3. Ask the client about her reproductive goals (Does she want to space or limit births?) and need for protection against RTIs and other STDs.</td>
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<tr>
<td>4. Discuss the client's needs, concerns and fears in a thorough and sympathetic manner.</td>
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<tr>
<td>5. Help the client begin to choose an appropriate method.</td>
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<tr>
<td><strong>If Client Chooses Laparoscopy tubal ligation:</strong></td>
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<tr>
<td>6. Screen the client carefully to make sure there is no medical condition that would be a problem. (Complete Client Screening Checklist.)</td>
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<tr>
<td>7. Clearly discuss the benefits of Laparoscopy tubal ligation. Emphasize that it is a permanent method but there is a small risk of failure.</td>
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## LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION COUNSELING SKILLS

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<tr>
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<tr>
<td>8. Explain the importance of the spouse being involved in decision for VS.</td>
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<tr>
<td>9. Explain that Laparoscopy tubal ligation does not protect against RTI/STIs. (If the client is at risk, she may need to use a barrier contraceptive method also)</td>
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<tr>
<td>10. Explain common complications of the surgical procedure and be sure they are fully understood.</td>
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<tr>
<td>11. Explain the surgical procedure and what to expect during and afterwards.</td>
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<tr>
<td>12. Discuss surgical procedure and possible need for contraception prior to VS.</td>
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<tr>
<td>13. Obtain client’s signature or thumb print on the informed consent form.</td>
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### PRE-PROCEDURE (Examination/Procedure Area)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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<tbody>
<tr>
<td>1. Review client history and physical examination to assure proper client selection.</td>
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</tr>
<tr>
<td>2. Verify client’s identity and check that informed consent was obtained.</td>
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<tr>
<td>3. Explain that she will feel a little pain during the procedure and she should inform a member of the surgical team if she feels any discomfort at any time.</td>
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### POST-PROCEDURE

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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<tbody>
<tr>
<td>1. After sedation has worn off give postoperative instructions, verbally and in writing. Ask client to repeat instructions.</td>
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</tr>
<tr>
<td>2. Discuss what to do if the client experiences any problems.</td>
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</tr>
<tr>
<td>3. Schedule a return visit within 7 days.</td>
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<tr>
<td>4. Discuss arrangements for discharge (e.g., person accompanying client home).</td>
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<tr>
<td>5. Assure client she can return to the same clinic at any time to receive advice or medical attention.</td>
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<tr>
<td>6. Answer the client’s questions.</td>
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<tr>
<td>7. Complete client record.</td>
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</table>
LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION
CLINICAL SKILLS FOR OPERATING DOCTORS
(To be used by Participants)

Rate the performance of each step or task observed using the following rating scale:
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2. **Competently Performed**: Step or task performed correctly in the proper sequence (if necessary) but participant does not progress from step to step efficiently.
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<tr>
<th><strong>GETTING READY</strong></th>
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<tbody>
<tr>
<td>1. Change into surgical apparel.</td>
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<tr>
<td>2. Greet client respectfully and establish rapport.</td>
<td></td>
</tr>
<tr>
<td>3. Review client history, physical examination and haemoglobin and urine reports.</td>
<td></td>
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<tr>
<td>4. Check that informed consent was obtained and verify client's identity.</td>
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<tr>
<td>5. Check that client has thoroughly washed and rinsed abdominal and pelvic areas and dried them with a clean, dry cloth.</td>
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<tr>
<td>6. Check that client has recently voided.</td>
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<tr>
<td>7. Check that the client has been premedicated.</td>
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<thead>
<tr>
<th><strong>PRE-OPERATIVE TASKS</strong></th>
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<tbody>
<tr>
<td>1. Help position client flat on her back on operating table.</td>
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<tr>
<td>2. Determine that sterile or high-level disinfected laparoscopy instruments, fiber-optic cable, insufflator tubing and emergency tray are present and in working order.</td>
<td></td>
</tr>
<tr>
<td>3. Check that insufflator apparatus and light source units are working.</td>
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<tr>
<td>4. Take and record vital signs.</td>
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<tr>
<td>5. Ensure IM medication is given if required (initial or maximum dose based on client's weight).</td>
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<tr>
<td>6. Wash hands thoroughly with soap and water and air dry.</td>
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<tr>
<td>7. Put examination gloves on both hands.</td>
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<tr>
<td>8. Place client in a Lithotomy position.</td>
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<tr>
<td>9. Perform a gentle bimanual pelvic examination to assess uterine size, position and mobility and presence of any pelvic abnormality.</td>
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<tr>
<td>10. Insert vaginal speculum to expose the cervix.</td>
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</tbody>
</table>
### LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION

#### CLINICAL SKILLS FOR OPERATING DOCTORS

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Apply antiseptic solution two times to the cervix and vagina and hold cervix with vulsellum.</td>
<td></td>
</tr>
<tr>
<td>12. Insert uterine elevator/manipulator without touching the tip to the vaginal walls</td>
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<tr>
<td>13. Carefully remove the vaginal speculum without dislodging uterine elevator/manipulator and place in 0.5% chlorine solution for decontamination.</td>
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<tr>
<td>14. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leakproof container or plastic bag. If reusing gloves, soak gloves in chlorine solution for 10 minutes for decontamination.</td>
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<tr>
<td>15. Perform surgical scrub (3-5 minutes) and put on sterile gown.</td>
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<tr>
<td>16. Put sterile or high-level disinfected surgical gloves on both hands.</td>
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<tr>
<td>17. Apply antiseptic solution to the incision area two times using a circular motion.</td>
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<tr>
<td>18. Drape client for the procedure.</td>
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<tr>
<td>19. Check Laprocator/Laparoscope system and trocar assembly unit.</td>
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<tr>
<td>20. Throughout procedure talk to client (verbal anaesthesia).</td>
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</table>

#### LAPAROSCOPY TUBAL LIGATION PROCEDURE

##### Local Anaesthesia

1. Raise a small skin wheal at center of incision site using 1% lignocaine (or equivalent) in a 10 or 20 ml sterile or high-level disinfected syringe (dose 5 mg/kg). **CAUTION:** When passing sharps, have them placed in a sterile or high-level disinfected kidney basin.

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

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

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.
<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Test incision site with tissue forceps for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site.)</td>
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<tr>
<td><strong>Creating Pneumoperitoneum through Veress needle</strong></td>
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<tr>
<td>9. Place client in a head down (Trendelenburg) position of not more than 20 degrees.</td>
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<tr>
<td>10. Immobilize the inferior margin of the umbilical ring by gently pinching the inferior border of the umbilicus between the thumb and the forefinger of the non-dominant hand and lift the abdominal wall away from the intestines.</td>
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<tr>
<td>11. Make a 1.5-2 cm incision along the rim of the inferior umbilical margin.</td>
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<tr>
<td>12. Grasp the shaft of the Veress needle and insert at a 45° caudal angle to the abdominal wall. Two distinct gives will be felt as the fascia is penetrated and the peritoneum is entered.</td>
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</tr>
<tr>
<td>13. Check for correct abdominal entry by placing a drop of anaesthetic on the Veress needle Luer Lok opening and observing its ingress when the abdominal wall is lifted manually. (Alternatively, use the pressure gauge of the insufflator apparatus to check for negative intra-abdominal pressure.)</td>
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</tr>
<tr>
<td>14. Connect the sterile or high-level disinfected insufflator tubing to the Veress needle stop cock. Ask the assistant to connect the other end to the insufflator or rubber hand pump.</td>
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<tr>
<td>15. Start insufflating by pumping room air using the rubber hand bulb. Alternatively, use the high flow switch of the insufflator to introduce carbon dioxide at the rate of 1 litre per minute.</td>
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<tr>
<td>16. Percuss the hypogastric area and listen for a drum-like sound, which will indicate pneumoperitoneum.</td>
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<tr>
<td>17. Remove Veress needle after insufflating 1.5-2.0 litres of room air or carbon dioxide, or when the hypogastrium attains a 20-week or 5-month gestation size.</td>
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<tr>
<td>18. Tell assistant to load rings. (See ASSISTANT’S LEARNING GUIDE FOR FALOPE RING BAND LOADING.)</td>
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<tr>
<td><strong>Abdominal Access</strong></td>
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<tr>
<td>19. Recheck trumpet valve and rubber seal of trocar sleeve to assure airtightness.</td>
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<tr>
<td>20. Assemble the trocar unit by inserting the obturator into the trocar sleeve.</td>
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<tr>
<td>21. Manually grasp and raise the anterior abdominal wall directly beneath the umbilicus.</td>
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**LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION**

**CLINICAL SKILLS FOR OPERATING DOCTORS**

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<tr>
<td>22. Hold the fully assembled trocar on the palm of the dominant hand, making sure that the thenar eminence is resting on the superior end of the obturator.</td>
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<tr>
<td>23. Tilt handle of trocar cephaloid to a 60-70° angle, directing the tip of the obturator to an imaginary point where the Pouch of Douglas is located. Apply downward and twisting force to traverse the fascia and peritoneum. Stop after the second give is felt.</td>
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<tr>
<td>24. Slightly retract obturator and advance trocar sleeve 1-2 cm into the abdominal cavity. Completely remove obturator.</td>
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<tr>
<td>25. Connect the insufflator tubing to the trocar stop cock. Insufflate air as needed.</td>
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<tr>
<td>26. Connect the fiber-optic light cable to the Laprocator/Laparoscope and ask the assistant to switch on the light source.</td>
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<tr>
<td>27. Hold trocar trumpet valve mechanism between middle finger and thenar eminence of the non-dominant hand in palms down position.</td>
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<tr>
<td>28. Hold the hand grip assembly of the Laprocator/Laparoscope using the thumb, middle and ring fingers of the dominant hand. Allow the index finger to remain free.</td>
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<tr>
<td>29. Insert Laprocator/Laparoscope slowly under direct vision. Manoeuvre Laprocator/Laparoscope - trocar unit towards pelvic cavity.</td>
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<td>30. Inspect and identify pelvic cavity structures. Elevate the uterus by depressing handle of the uterine elevator/manipulator.</td>
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**Laparoscopically Guided Tubal Ligation**

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<tr>
<td>31. Locate and verify the tube by identifying anatomical landmarks such as the cornu and fimbria.</td>
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<tr>
<td>32. Extend forceps tongs fully by pushing the trigger operating slide away from the handgrip.</td>
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<tr>
<td>33. Place the posterior tong under the inferior aspect of the tube, about 4 cm away from the cornu. Slightly lift it toward the anterior abdominal wall to allow excess mesosalpinx to fall off.</td>
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<tr>
<td>34. Slowly retract the tongs by pulling the trigger operating slide toward the hand grip. Move the Laprocator/Laparoscope forward during tong retraction to reduce risk of lacerating or injuring the tube. Continue retracting until spring tension is felt.</td>
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<tr>
<td>35. Using index finger, check that ring adaptor is in position #1. Apply additional pressure to the operating slide to overcome the spring tension and to release the Falope ring.</td>
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<tr>
<td>36. Slowly push away the operating slide to extend the forceps tongs and release the occluded fallopian tube.</td>
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<tr>
<td>37. Inspect for adequacy of occlusion and for any active bleeding. Completely retract forceps tongs prior to inspection.</td>
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<tr>
<td>38. Locate and verify the other tube.</td>
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<tr>
<td>39. Place two ring adaptor in #2 position. Repeat steps 32-37 to occlude the other tube.</td>
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</tr>
<tr>
<td>40. Inspect pelvic cavity for bleeding and other organ injuries.</td>
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<tr>
<td>41. Remove Laproca tor/Laparoscope from abdominal cavity and disconnect external light source.</td>
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<tr>
<td>42. Keep open the trocar trumpet valve to desufflate the abdomen.</td>
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<tr>
<td>43. Remove trocar after inserting the obturator in trocar sleeve.</td>
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<tr>
<td>44. Close incision with a single, simple stitch using absorbable or non-absorbable suture material.</td>
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<td>45. Dress the wound.</td>
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**POST-OPERATIVE TASKS**

1. Remove the uterine elevator/manipulator (and vulsellum, if used) and place in 0.5% chlorine solution.

2. Ensure that client is safely transferred to the post-operative (recovery) area.

3. 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.

4. Ensure that the assistant places instruments in 0.5% chlorine solution for decontamination and soaks for 10 minutes.

5. Check that assistant disposes of waste materials according to infection prevention guidelines.

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

7. Wash hands thoroughly with soap and water and air dry.

8. Ensure that client is monitored at regular intervals and that vital signs are taken.

9. Determine that client is ready for discharge 4-6 hours after operation.

10. Ensure that post-operative instructions and follow-up schedule are given.
LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION CLINICAL SKILLS FOR NURSE ASSISTANTS

(To be used by Participants)

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<td><strong>PRE-OPERATIVE</strong></td>
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<tr>
<td>1. Change into surgical apparel (scrub suit or dress).</td>
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<tr>
<td>2. Wash hands thoroughly with soap and water and dry with a clean cloth or air dry.</td>
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</tr>
<tr>
<td>3. Ensure that all supplies including narcotic and sedatives are present and equipment for monitoring vital signs is available.</td>
<td></td>
</tr>
<tr>
<td>4. Check that insufflator and light source are working.</td>
<td></td>
</tr>
<tr>
<td>5. Prepare instruments for procedure:</td>
<td></td>
</tr>
<tr>
<td>• Ensure that instruments are sterile or high-level disinfected.</td>
<td></td>
</tr>
<tr>
<td>• Ensure that emergency instruments, equipment and drugs are available.</td>
<td></td>
</tr>
<tr>
<td>• Place sterile or high-level disinfected packs on the table.</td>
<td></td>
</tr>
<tr>
<td>6. Arrange instruments on instrument table.</td>
<td></td>
</tr>
<tr>
<td>7. Greet client and help to make her comfortable.</td>
<td></td>
</tr>
<tr>
<td>8. Take and record vital signs.</td>
<td></td>
</tr>
<tr>
<td>9. Give IV medication (initial or maximum dose based on client's weight).</td>
<td></td>
</tr>
<tr>
<td>11. Assist with vaginal exam and application of vullscellum and/or insertion of uterine elevator.</td>
<td></td>
</tr>
<tr>
<td>12. Perform surgical scrub (3-5 minutes) and put on sterile gown.</td>
<td></td>
</tr>
<tr>
<td>13. Put sterile surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>14. Assist operating doctor in preparing the skin.</td>
<td></td>
</tr>
</tbody>
</table>
**LEARNING GUIDE FOR LAPAROSCOPY TUBAL LIGATION CLINICAL SKILLS FOR NURSE ASSISTANTS**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Assist operating doctor in draping the client.</td>
<td></td>
</tr>
<tr>
<td>16. After verifying drug strength, withdraw local anaesthetic from vial held by the attendant, as advised by the operating doctor.</td>
<td></td>
</tr>
</tbody>
</table>

**DURING SURGERY**

1. Throughout the procedure, talk to the client.
2. Anticipate and respond to needs of the operating doctor:
   - Provide additional local anaesthetic to the operating doctor if required.
3. Load Falope rings:
   - Lubricate Falope ring with sterile water or remaining local anaesthetic.
   - Insert tip of dilator into Falope ring and pick it up.
   - Place the base of the dilator with the loaded Falope ring into the inner tube of the applicator.
   - Grasp the Laprocator/Laparoscope at the middle bar area just above the trigger operating slide and stand vertically on the operating side table.
   - Place the end of the guide against the tip of the dilator and in a steady motion, slowly push the band along the dilator until it rests on the inner tube. Remove guide and dilator.
   - Repeat to load the second ring.
4. Report to the operating doctor any increase in client’s discomfort or stress regarding allergic reactions.
5. Assist in manipulating the uterine elevator
6. Record end time of surgery on client record.
7. Place dressing on wound at end of procedure.

**POST-OPERATIVE**

1. Remove drape when wound is dressed.
2. Check that uterine elevator has been removed and placed in 0.5% chlorine solution for decontamination.
3. Record final vital signs before leaving operating theatre.
4. Keep appropriate records during procedure and ensure that record is complete regarding:
   - Vital signs
   - Instrument and gauze counts
   - Time of procedure (total and skin to skin)
<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Brief the operating theatre attendant on the client's condition (vital signs and any complications or problems).</td>
<td></td>
</tr>
<tr>
<td>6. Place instruments and other items in 0.5% chlorine solution for decontamination (in OT).</td>
<td></td>
</tr>
<tr>
<td>7. Dispose of disposable needles and syringes in a puncture proof container or fill reusable needles and syringes with 0.5% chlorine solution and soak to decontaminate for 10 minutes.</td>
<td></td>
</tr>
<tr>
<td>8. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.</td>
<td></td>
</tr>
<tr>
<td>10. Wash hands thoroughly with soap and water and dry with clean cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>11. Prepare instruments and OT table for next case.</td>
<td></td>
</tr>
</tbody>
</table>
FOLLOW-UP ASSESSMENT
Interview for Medical Officers who attended LAP Induction Training

FIRST FOLLOW-UP DATE ________________

Remarks ____________________________________________________________

_________________________________________________________________

_________________________________________________________________

SECOND FOLLOW-UP DATE ________________

Remarks ____________________________________________________________

_________________________________________________________________

_________________________________________________________________

Note: Please emphasize that all information will be kept confidential

1. Name of Provider:________________________ Date:________ Qualification______
   Site: __________________________ District: __________________________

2. When did you attend the SIFPSA 12 day Laparoscopy Induction training?
   ___________ (date) _____________ (where)

3. How many Laparoscopy cases have you done (at any/all sites) since your SIFPSA
   Lap Induction training? ______________________________

4. How many Laparoscopy cases have you done (at any/all sites) in the past month?
   ______

5. Do you have any comment on the Lap Induction Training that you received?
   ________________________________________________________________
6. Assessor’s Comments on any of the following issues:
   A. Explain the reason if there is no follow-up assessment for this provider,
   B. Any problems for you as an assessor, in performing the follow up,
   C. Any problems at the site with regard to the provider performing the procedure, or
   D. Any additional observations about the provider’s technical performance.
# LAPAROSCOPIC TUBAL LIGATION CHECKLIST FOR OPERATING DOCTORS

<table>
<thead>
<tr>
<th>TASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessor:</strong> When rating tasks for assessment, use the following codes:</td>
</tr>
<tr>
<td><strong>S</strong> = Satisfactory:</td>
</tr>
<tr>
<td><strong>U</strong> = Unsatisfactory:</td>
</tr>
<tr>
<td><strong>N/O</strong> = Not Observed:</td>
</tr>
<tr>
<td><strong>All critical steps must be performed satisfactorily for the participant to be assessed as performing to standard (PTS) during follow-up</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please write any comment, or any extra explanation of what occurred for any step in that space (and continue on reverse if needed.)</td>
</tr>
</tbody>
</table>

## GETTING READY

<table>
<thead>
<tr>
<th>Code</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Greets client respectfully.</td>
</tr>
<tr>
<td>2.</td>
<td>Reviews medical records.</td>
</tr>
<tr>
<td>3.</td>
<td>Checks that informed consent was obtained and verifies client’s identity.</td>
</tr>
<tr>
<td>4.</td>
<td>Ensures that client has voided.</td>
</tr>
<tr>
<td>5.</td>
<td>Ensures client’s abdominal and pelvic areas are clean.</td>
</tr>
</tbody>
</table>

## PRE-OPERATIVE TASKS

<table>
<thead>
<tr>
<th>Code</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Ensures that sterile or high level disinfected laparoscopic instruments, fiber-optic cable, insufflator tubing and emergency tray are present and in working order.</td>
</tr>
<tr>
<td>7.</td>
<td>Ensures that insufflator and light source are working.</td>
</tr>
<tr>
<td>8.</td>
<td>Ensures that vital signs are taken.</td>
</tr>
<tr>
<td>9.</td>
<td>Ensures sedation has been given.</td>
</tr>
<tr>
<td>10.</td>
<td>Washes hands thoroughly with soap and water and air dries or dries with clean cloth.</td>
</tr>
<tr>
<td>11.</td>
<td>Puts examination gloves on both hands.</td>
</tr>
<tr>
<td>12.</td>
<td>Performs a bimanual pelvic examination. (Record as “S” if done now, or earlier in the day by the person being assessed, or by another examiner if the doctor being assessed is a male doctor.)</td>
</tr>
<tr>
<td>13.</td>
<td>After applying antiseptic solution to the cervix and vagina (two times), inserts uterine manipulator.</td>
</tr>
<tr>
<td>14.</td>
<td>Immerces both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out.</td>
</tr>
<tr>
<td></td>
<td>• If disposing of gloves, places in leakproof container or plastic bag.</td>
</tr>
</tbody>
</table>
GETTING READY

- If reusing surgical gloves, submerges in 0.5% chlorine solution for decontamination.

15. Performs surgical scrub, puts on surgical attire and sterile surgical gloves.

16. Ensures Laparoscope system and trocar assembly unit are ready

17. Applies antiseptic two or more times to incision area and drapes client for procedure.

18. Throughout procedure talks to client.

PROCEDURE

LOCAL ANAESTHESIA

1. *After raising a small skin wheal, administer local anaesthetic just under the skin along both sides of the incision line.

2. Massages the skin to spread the anaesthetic within the tissue.

CREATING PNEUMOPERITONEUM

3. *Places client in a head down (Trendelenburg) position of not more than 20 degrees.

4. *Immobilize the inferior margin of the umbilical ring and makes a 1.5-2 cm incision.

5. *Inserts Veress needle at a 45 degree caudal angle to the abdominal wall

6. Check for correct abdominal entry by placing a drop of anaesthetic on the Veress needle Luer Lok opening and observing its ingress when the abdominal wall is lifted manually. (Alternatively, use the pressure gauge of the insufflator apparatus to check for negative intra-abdominal pressure)

7. *Connects the disinfected insufflator tubing to the Veress needle stop cock. Asks the assistant to connect the other end of the insufflator.

8. Withdraws Veress needle after pneumoperitoneum is achieved.


ABDOMINAL ACCESS

10. *Inserts trocar at 60°-70° angle and traverses the fascia and peritoneum.

11. Connects light cable to Laparoscope and asks OT attendant to switch on light source

12. Inserts Laparoscope slowly under direct vision and manoeuvres towards pelvic cavity.

13. *Identifies pelvic cavity structures. Ensures uterine manipulator is used to elevate uterus as needed.

LAPAROSCOPICALLY GUIDED TUBAL LIGATION

14. *Locates the first tube and grasps it about 3-4 cm away from cornu.

15. *Slowly retracts the tongs and applies additional pressure to release the Falope ring.

16. *Releases the occluded fallopian tube and inspects for adequacy of occlusion and for active bleeding.
### GETTING READY

<table>
<thead>
<tr>
<th>Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>*When haemostasis and occlusion are assured, removes Laparoscope.</td>
</tr>
<tr>
<td>19.</td>
<td>Removes trocar after desufflating abdomen.</td>
</tr>
<tr>
<td>20.</td>
<td>Dresses the wound</td>
</tr>
</tbody>
</table>

### POST-OPERATIVE TASKS

<table>
<thead>
<tr>
<th>Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Removes the uterine manipulator and places in 0.5% chlorine solution for decontamination</td>
</tr>
</tbody>
</table>
| 2.   | *Ensures that the assistant  
      - Disposes of disposable needles and syringes in a puncture proof container  
        or  
      - Fills re-usable needles and syringes with 0.5% chlorine solution and soaks for decontamination. |
| 3.*  | Ensures that assistant decontaminates instruments by soaking in 0.5% chlorine solution for 10 minutes. |
| 4.   | Ensures that assistant disposes of waste material according to 1P guidelines. |
| 5.*  | Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out.  
      - If disposing of gloves, places in leakproof container or plastic bag.  
      - If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination. |
| 6.   | Washes hands thoroughly with soap and water and air dries or dries with clean cloth.  
      \[\checkmark\] one -- air dries -- clean cloth |
| 7.   | Ensures that vital signs are taken regularly. |
| 8.   | Instructs client on wound care and return visit. |

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

**Assessment for_________________________**

(Provider’s name)

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

The provider

_____ performed to standard (PTS)

_____ did not perform to standard (NPTS)

Assessor’s name:__________________________________________

Assessor’s Signature______________________________________ Date__________________

_Lap. Ligation Facilitator’s Session Guide_
FOLLOW-UP DATE: ________

Remarks

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Note: Please emphasize that all information will be kept confidential

1 Name of Provider: ______________________________ Qualification: __________________________
   Site: __________________________________ District: ______________________________

2 When did you attend the SIFPSA 6 day Laparoscopy Induction training?
   _________________________ (date) _________________________ (where)

3 How many Laparoscopy cases have you assisted (at any/all sites) since your SIFPSA
   Lap Induction training? ______________

4 How many Laparoscopy cases have you assisted (at any/all sites) in the past month?
   ______________

5 Do you have any comment on the Lap Induction Training that you received?
   __________________________________________________________________________

6 Assessor’s Comments on any of the following issues:
   A. Explain the reason if there is no follow-up assessment for this provider,
   B. Any problems for you as an assessor, in performing the follow up,
   C. Any problems at the site with regard to the provider performing the procedure,
   or
   D. Any additional observations about the provider’s technical performance.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
# LAPAROSCOPIC TUBAL LIGATION CHECKLIST FOR NURSE ASSISTANTS

<table>
<thead>
<tr>
<th>TASKS</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S= Satisfactory: Performs the step or task according to the standard guideline.</td>
<td></td>
</tr>
<tr>
<td>U= Unsatisfactory: Unable to perform the step or task according to the standard guideline.</td>
<td></td>
</tr>
<tr>
<td>N/O= Not Observed: Step, task or skill not performed by participant during an assessment</td>
<td></td>
</tr>
<tr>
<td>All critical steps must be performed satisfactorily for the participant to be assessed as performing to standard (PTS) during follow-up</td>
<td></td>
</tr>
<tr>
<td>Please write any comment, or any extra explanation of what occurred for any step in that space (and continue on reverse if needed.)</td>
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</tbody>
</table>

## STEPS/TASKS

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRE-OPERATIVE</strong></td>
<td></td>
</tr>
<tr>
<td>1. Changes into surgical apparel (scrub suit or dress).</td>
<td></td>
</tr>
<tr>
<td>2. *Washes hands thoroughly with soap and water and air dries or dries with clean cloth. [✓ one --- air dries --- clean cloth --- sterile cloth]</td>
<td></td>
</tr>
<tr>
<td>3. Ensure that all supplies including narcotic and sedatives are present and equipment for monitoring vital signs is available.</td>
<td></td>
</tr>
<tr>
<td>4. *Checks that insufflator and light source are working.</td>
<td></td>
</tr>
<tr>
<td>5. *Prepares instruments for procedure:</td>
<td></td>
</tr>
<tr>
<td>- Ensures that instruments are sterile or high-level disinfected.</td>
<td></td>
</tr>
<tr>
<td>- Ensures that emergency instruments, equipment and drugs required are available.</td>
<td></td>
</tr>
<tr>
<td>- Places sterile or high-level disinfected packs on the table.</td>
<td></td>
</tr>
<tr>
<td>7. Greets client and helps to make her comfortable.</td>
<td></td>
</tr>
<tr>
<td>8. Takes and records vital signs.</td>
<td></td>
</tr>
<tr>
<td>9. Gives IV/IM medication (initial or maximum dose based on client's weight).</td>
<td></td>
</tr>
<tr>
<td>11. Assists with vaginal exam and application of vellum and/or insertion of uterine elevator.</td>
<td></td>
</tr>
<tr>
<td>12. *Performs surgical scrub (3-5 minutes and put on sterile gown.</td>
<td></td>
</tr>
<tr>
<td>13. *Puts on sterile surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>14. Assists operating doctor in preparing the skin.</td>
<td></td>
</tr>
<tr>
<td>15. Assists operating doctor in draping the client.</td>
<td></td>
</tr>
<tr>
<td>16. After verifying drug strength, withdraws local anaesthetic from vital held by the attendant, as advised by the operating doctor.</td>
<td></td>
</tr>
</tbody>
</table>
### DURING SURGERY

1. Throughout the procedure, talks to the client.

2. Anticipates and responds to needs of the operating doctor:
   - Provides additional local anaesthetic to the operating doctor if required.

3. *Loading of Falope rings:
   - Lubricates Falope ring with sterile water or remaining local anaesthetic.
   - Inserts tip of dilator into Falope ring and picks it up.
   - Places the base of the dilator with the loaded Falope ring into the inner tube of the applicator.
   - Grasps the Laprocat/Laparoscope at the middle bar area just above the trigger operating slide and stand vertically on the operating side table.
   - Places the end of the guide against the tip of the dilator and in a steady motion, slowly push the band along the dilator until it rests on the inner tube. Removes guide and dilator.
   - Repeats to load the second ring.

4. Reports to the operating doctor any increase in client's discomfort or stress or allergic reactions.

5. Assists in manipulating the uterine elevator.

6. Record end time of surgery on client record.

7. Places dressing on wound at the end of the procedure.

### POST-OPERATIVE

1. Removes drape when wound is dressed.

2. *Ensures that uterine elevator has been removed and placed in 0.5% chlorine solution for decontamination.

3. Records vital signs before leaving operating theatre.

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

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

6. *Places instruments and other items in 0.5% chlorine solution for decontamination (in OT).

7. *Disposes of disposable needles and syringes in a puncture proof container or fills re-usable needles and syringes with 0.5% chlorine solution and soaks for 10 minutes to decontaminate.

8. *Briefly immerses gloved hands in chlorine solution. If disposing of gloves, places in leak-proof container or plastic bag. If reusing gloves, soaks in chlorine solution for 10 minutes.
<table>
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<th>STEP/TASK</th>
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<tbody>
<tr>
<td>9. *Washes hands thoroughly with soap and water and air dries or dries with clean cloth.</td>
<td></td>
</tr>
<tr>
<td>10. Prepares instruments and OT table for next case</td>
<td></td>
</tr>
</tbody>
</table>

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

Assessment for ________________________________

(Provider's name)

The provider

_____ performed to standard (PTS)

_____ did not perform to standard (NPTS)

Assessor's name: ______________________________

Assessor's Signature ___________________________ Date ________________
FACILITATIVE SUPERVISION
Session 1

INTRODUCTION TO QUALITY IMPROVEMENT

"Quality is a race without a finish line.... We know we'll never be as good as we can be because we'll always try to be better."

-David T Kearns

The most important objective of supervision is quality improvement. In the past, the potential of supervision to influence quality was largely ignored. However, there is a growing trend to position the supervisor not only as an evaluator of performance, but also as a catalyst for quality improvement. Fulfilling the role of an agent of change takes time and attention. Therefore, instead of focusing on the number of sites to be visited, the facilitative supervisor needs the institutional support to supervise fewer sites and spend more time at each site. During site visits, the supervisors aim is to provide the staff with quality improvement tools and train them in their use.

UNDERSTANDING THE CUSTOMER MINDSET

Organizations that make quality a priority are successful because they focus on meeting and exceeding their customers (clients) expectations. To do that, they need to understand the customer mindset.

There are two types of customers: external and internal. An external customer is outside the work process; an internal customer is within the work process. Generally, clients and the community are considered external customers, while other healthcare workers are considered internal customers.

WHAT IS QUALITY?

In a health care setting, quality consists of the proper performance of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability and malnutrition. (WHO)

WHY FOCUS ON QUALITY?

Studies show that the quality of reproductive health services is an important determinant of acceptance and continuation of reproductive health services and, therefore a major contributor to the level of contraceptive prevalence and increased utilization of other reproductive health services.
**Impacts of quality are:**
- Improved performance of staff and institutions.
- Increased client satisfaction.
- Better health.

**WHAT ARE THE NEEDS AND EXPECTATIONS OF CLIENTS?**

Although each staff member has one or more customers, the ultimate customer for everyone is the client. Consequently, it is important to use the following philosophy as a basis for all supervision and quality improvement.

**Clients have the right to:**
- Information.
- Access to services.
- Informed choice.
- Safe services.
- Privacy and confidentiality.
- Dignity, comfort and expression of opinion.
- Continuity of care.

**To meet the needs of the client, health care staff have a need for:**
- Facilitative supervision and management.
- Information, training and development.
- Supplies, equipment and infrastructure.

**Following are some of the features clients might say they expect to find at a quality reproductive health service site:**
- Information about all services.
- Availability of a range of services.
- Signs that show services, hours, costs etc.
- Educational sessions.
- Brochures, pamphlets, posters, flipcharts, models, method samples about the services / methods.
- Adequate time and space for counseling.
- Answers to specific questions.
- Affordable services.
- Convenient hours and location.
- Clean facility in good condition.
• Availability of essential laboratory tests.
• Availability of medicines and contraceptive methods.
• Staff that speaks their language.
• Information about risks and benefits of treatments or contraceptive methods.
• Efficient referral system.
• Respect for infection prevention protocols.
• Respectful treatment.
• Private areas for services and counseling.
• Confidentiality.
• Short waiting time for services.
• Equipment in good working condition.

Almost every site can improve something in order to better meet these client expectations.

ROLE OF FACILITATIVE SUPERVISION IN QUALITY IMPROVEMENT

• Addresses staff's needs for:
  - Mentoring.
  - Information, training and development.
  - Supplies, equipment and infrastructure.

• Considers staff as team members.
• Promotes joint problem-solving.
• Engages in two-way communication.
• Provides technical updates.
• Delegates problem-solving related to day-to-day problems.
• Enables staff to continuously improve quality and meet clients' needs.
• Serves as liaison between site-staff and institution.

QUALITY IMPROVEMENT: APPROACHES AND TOOLS

• Facilitative supervision.
• Medical monitoring.
• Whole site training.
• Quality measuring tools (QMT).
• Cost analysis tools.
• COPE.
• Informed choice.
Quality Improvement Approaches and Tools

1. Facilitative Supervision
2. Medical Monitoring
3. Whole-Site Training & Research

COPE
Cost Analysis
Community COPE
Quality Measuring Tool

THE QUALITY IMPROVEMENT PROCESS

The QI Process

1. Gather Information
2. Develop Action Plan
3. Implement Interventions
4. Evaluate

Actual Practice

BEST PRACTICE
Session 2

FACILITATIVE SUPERVISION
(A New Approach to Supervision)

"Before facilitative supervision, the staff were angry when we came to supervise them. Now they get angry when we don’t come"

-A regional supervisor

LOOKING FOR A NEW APPROACH TO SUPERVISION?

The fact that you have picked up this manual indicates that you suspect there is a better way to carry out your supervisory duties. Do any of the following describe your situation?

- You face the same problems at many of the sites you supervise.
- The problems keep recurring.
- The sites are not meeting their objectives and you don’t know how to help them.
- You are overwhelmed by the number and complexity of the problems to be solved.
- You are tired of listening to complaints about the lack of support from the headquarters or regional organization.
- Too many people depend on you to solve their problems for them.
- You don’t get enough cooperation at the sites or at higher levels.
- You don’t have enough time to devote to the staff and their issues.
- You can’t provide all the resources that the staff need.
- You feel exhausted and demoralized.

If you supervise other supervisors, are they also experiencing the above difficulties? If so, the reason could be the way you are approaching supervision.

WEAKNESSES OF TRADITIONAL SUPERVISION

We at EngenderHealth believe that traditional supervision isn’t delivering the desired results because of the following weaknesses:

- It is superficial
  The supervisor isn’t able to spend enough time at the site to become familiar with its problems or to be helpful in solving them. We call this “hello supervision” in which the supervisor arrives, collects statistics, and then rushes off to another site.
It is often punitive, faultfinding, and critical. Traditional supervisors often come and go without any staff interaction. Because they don't have enough time or the facilitative tools, supervisors often can only look for deficiencies, point them out to the staff, and report them to headquarters.

**TRADITIONAL SUPERVISION**

**"HELLO SUPERVISION"**
• It focuses on individuals rather than on processes
  Supervisors look at why an individual hasn’t done a good job, rather than considering
  that the workings of the overall system, or the process, may be preventing staff
  members from performing well.

• It emphasizes the past rather than the future
  Because the focus is on individual performance, the result is a report on what
  happened rather than a plan to improve things for the future.

• It is not continuous
  Too often, supervision is sporadic and does not build on past experience.

WHAT IS FACILITATIVE SUPERVISION?

Facilitative supervision is a system of management, whereby supervisors, at all levels in an
institution, focus on the needs of the staff they oversee. Supervisors who use the facilitative
approach consider staff as their customers. The most important part of the facilitative
supervisor’s role is to enable staff to manage the quality-improvement process, to meet the
needs of their clients, and to implement institutional goals. This approach emphasizes
monitoring, joint problem solving, and two-way communication between the supervisor
and those being supervised.

Facilitative supervision is different from traditional supervision because it:

• focuses on helping staff solve problems through the use of quality
  improvement tools.
• focuses on processes rather than on individuals.
• assists staff in planning for future quality improvement goals.
• is continuous and builds on past gains while setting higher quality
  improvement goals.

BENEFITS OF FACILITATIVE SUPERVISION

Facilitative supervision may seem to you like a lot more work than traditional supervision.
While this approach does require an initial investment of extra time, after using facilitative
supervision techniques, you will find that they benefit you and may actually allow more
free time to devote to other, more appropriate responsibilities.
• As staff learn to solve their own problems, you will have fewer routine, low-level
  problems to solve by yourself.
• As other supervisors under your authority learn to supervise in a facilitative manner,
  you will need to provide them with less technical assistance.
• You will gain a reputation as a leader, an effective supervisor, and an enabler.
• You will be more welcome at sites because you help staff solve their problems, rather
  than criticize them for their faults.
• You will have the satisfaction of working as a team member, watching staff learn and
  grow and watching quality improve.
Your job will become more fulfilling as your staff's motivation and commitment increase.

Thus, facilitative supervision is just as good for you, the supervisor, as it is for the people you supervise. In addition, the impact of facilitative supervision is much stronger than that of traditional supervision.

FOCUS ON PROCESSES

The facilitative supervisor emphasises leading the staff in the effort to improve processes, rather than focusing on individuals.

Often traditional supervisors limit their activity to reporting problems and assigning blame. Their theory is, that once those responsible for the problem are identified and corrected, the problem will be solved. The facilitative approach, however, recognises that over 75% of problems are due to overly complex or faulty processes or systems, not due to the people who try to implement them.

For example, if improper processing of instruments results in a high infection rate at a site, the cause may actually be faulty autoclaves or staff who haven’t been adequately trained in their use. In this case, the lack of systems for equipment maintenance and lack of regular staff training are to blame, not the individuals who process the equipment. The facilitative supervisor helps staff look for the causes of problems and find solutions that will have the greatest positive impact on overall quality.

STAFF INVOLVEMENT AND OWNERSHIP

Traditionally, supervisors get feedback only from high level staff. The facilitative supervisor, on the other hand involves all staff in the quality improvement process and tries to foster a spirit of ownership and team work by emphasizing that quality is every ones business and every one can contribute to better quality. The quality improvement tools that are used in this process therefore involve every level of staff.

In traditional supervision the focus is on noticing and repeating problems but not on investing much effort in solving them. The facilitative supervisor’s main objective is to improve quality through joint problem-solving with staff. By involving all level of staff in the identification of problems, through a self-assessment process, the supervisor also involves all levels of staff in the solutions. It often happens that the lower level staff know the root cause of all problems and how to solve them.

CONTINUOUS LEARNING, DEVELOPMENT, AND CAPACITY BUILDING

Facilitative supervisors serve as catalysts for staff development and capacity building much more than do traditional supervisors, by:

- Transferring the knowledge and skills needed to implement the quality-improvement process. Thus, staff learns to conduct their own quality-improvement exercises without external facilitation. This empowerment of staff not only increases their sense of ownership and involvement (they can do it themselves), but also increases the likelihood that the site's quality-improvement process will become continuous (they don't have to wait for an outsider).

Lap. Ligation Facilitator's Session Guide
Ensuring necessary training opportunities for staff. Although not all quality problems can be solved by training, it is sometimes the case that quality problems arise because refresher training and training in new processes and procedures are neglected. The facilitative supervisor not only enables staff to identify training needs, but also assists staff in identifying training mechanisms or opportunities to meet those needs.

The facilitative supervisor fosters change and helps staff implement the quality improvement process by providing good management and supervision and, most importantly, by working with the staff to plan, implement and evaluate their quality improvement objectives. Because providers cannot deliver quality services without proper supplies, infrastructure and training, the facilitative supervisor works to ensure that these elements are available to the staff.

TRAITS OF A FACILITATIVE SUPERVISOR

Some training is required to develop the leadership skills necessary to become a facilitative supervisor. Although facilitative supervision is easier for people who have certain characteristics, with experience, anyone can learn to supervise in a facilitative manner.

EngenderHealth has found that supervisors who possess the following characteristics and experience are better equipped to become successful facilitative supervisors:

- Leadership qualities (ability to inspire others, establish trust, promote teamwork).
- Good communication skills, especially active listening and constructive feedback.
- Desire to empower others and provide opportunities for growth.
- Ability to work in team.
- Experience in delivering RH services.
- Technical knowledge.
- Flexibility.
- Openness to new ideas.
- Ability to train or convey information to others.
- Empathy.
Self-assessment: Do You Need to Change Your Approach?

Please take a few minutes to assess how you approach your supervisory visits.

- I visit the sites under my jurisdiction frequently. □ Yes □ No
- I see myself as part of their team. □ Yes □ No
- My primary objective is to improve service quality, not to collect data. □ Yes □ No
- I believe in empowerment rather than criticism. □ Yes □ No
- I take enough time to understand the site's problems. □ Yes □ No
- I speak to all levels of staff during my visits. □ Yes □ No
- I regularly observe the day-to-day operations of the clinic. □ Yes □ No
- I try to help the staff identify and solve their problems. □ Yes □ No
- I practice active listening and other communication skills when supervising. □ Yes □ No
- I provide the staff with the information they need to perform their jobs well. □ Yes □ No
- I provide or arrange training that staff need to provide high-quality services. □ Yes □ No
- I try to create partnerships between the staff and outside resources to help improve service quality. □ Yes □ No

If you answered “no” to two or more of these questions, you may be ready to try a different approach.
LEADERSHIP

WHO IS A LEADER?

A leader is someone who influences and guides others toward the accomplishment of a goal.

The facilitative supervisor's immediate goal is to teach others how to undertake the quality-improvement process, with the ultimate goal of enabling them to provide high-quality services that meet their client's needs. However, there are different styles of leadership, and the facilitative supervisor must know which style to use in different situations.

LEADERSHIP STYLES

<table>
<thead>
<tr>
<th>Leadership Style</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarian</td>
<td>The leader makes the decisions and announces them to staff.</td>
<td>• Saves time.</td>
<td>• Other, better options may not be considered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Decision is usually clear and final.</td>
<td>• Staff may lack commitment to the decision.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leader is in control.</td>
<td>• Staff may be resentful or uncooperative.</td>
</tr>
<tr>
<td>Authoritarian, with some</td>
<td>The leader makes the decisions and announces them after having received input</td>
<td>• Increased information for decision making.</td>
<td>• Staff not asked for input may lack commitment or be</td>
</tr>
<tr>
<td>input</td>
<td>from one or more staff members</td>
<td>• Relatively quick.</td>
<td>uncooperative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Decision is usually clear and final.</td>
<td>• Other, better options may not be considered.</td>
</tr>
<tr>
<td>Consensus</td>
<td>Entire group discusses and agrees to support group decisions. Leader</td>
<td>• Staff feels more involved and committed.</td>
<td>• Time-consuming; may require long meetings or multiple</td>
</tr>
<tr>
<td></td>
<td>maintains authority.</td>
<td>• Staff support for decisions may be greater.</td>
<td>meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Good chance of implementation.</td>
<td>• Compromise decisions may be unclear.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Consensus may not always be possible.</td>
</tr>
</tbody>
</table>
| Democratic                  | All members of the group vote for their preferred decision. | Staff feel involved.  
  High level of support for decisions.  
  Good chance of implementation. | May take more time.  
  Most popular decision may not be best option available.  
  Those on the “losing” side may feel resentful. |
|----------------------------|----------------------------------------------------------|-------------------------------------------------|------------------------------------------------|
| Delegation                 | The leader assigns the task of decisions making to another person, or to a group. | Opportunity for developing leadership qualities in others.  
  High chance of implementation. | Leader sacrifices control.  
  May take more time.  
  Group may not have the skills and knowledge to make a good decision. |

**TIPS FOR LEADING STAFF**

How can you lead staff and colleagues toward the goal of quality improvement? The following tips will help you guide staff decision-making and foster commitment.

- **Share the vision of high-quality services**
  One of the best ways to motivate people is to share an inspiring vision. If you are excited about what the future could be for the site, if you are optimistic about the staff’s ability to achieve that future, and if you are able to articulate it, you will inspire them to follow you toward that goal. A staff that is excited about the goal will be more willing to go through a process of change in order to achieve it. A leader could enable staff to envision what their service would be like if it were a model that everyone came to see and learn from. Or, if infection prevention is deficient, a leader can conjure up for the staff a vision of “high-quality infection prevention”, sparkling tables, floors and instruments; all staff co-operating in the effort to keep the site clean and disinfected; and an infection rate that plummets over time.

- **Build commitment and confidence**
  Emphasize the importance of quality improvement. Use recognition, praise, and positive reinforcement to build confidence. At the outset, guide the group toward solving small problems in order to build the confidence and expertise needed to tackle larger problems.

- **Be well informed and prepared**
  You can’t expect people to follow you if you are not sure where you’re going or what you are doing. Become expert in the skills, quality-improvement tools, and problem solving methodologies that you will be transferring to your colleagues. Always be prepared for meetings and interventions.

- **Use facilitation skills**
  Show leadership in group meetings by using facilitation skills to keep the group on track and manage interpersonal and power-related conflict.
• Do real work
  Be an active participant in the endeavor by modeling facilitative behavior, taking part in problem-solving activities, and serving as a liaison between the site and external resources. When your colleagues see your active participation, they will be convinced of your commitment to the process and to them, and they will be more willing to follow you.

• Be ethical
  Be honest in your communications. Support your colleagues as they implement the quality-improvement methodologies that you are suggesting and as they co-operate in facilitative supervision.

**MOTIVATING STAFF BY RECOGNIZING AND REWARDING GOOD WORK**

"The deepest need in all human beings is the need to be appreciated"

-William James

Throughout the world, poor-quality services are a direct result of staff feeling unmotivated or unrecognized for their efforts in service provision.

To show staff how important quality services are, it is critical to find an appropriate way to recognize and reward good work.

Many people associate motivation with increased salary, but there are a number of other ways to help motivate staff. For example:

- Post pictures or stories about “star” employees.
- Tell personal stories of staff members who treated their customers well by doing simple things.
- Allow employees of all levels to participate in conferences, meetings and workshops.
- Celebrate successes (especially those of groups).
- Make sure that a variety of individuals or teams are recognized, and do it often.

**Caution:** Staff needs to see that the criteria for recognizing “stars” are applied fairly to everyone. As much as possible, make sure that groups are recognized, as well as individual employees.

**FOSTERING TRUST**

Another very important role for a leader is to foster trust. You are trying to encourage other supervisors or site staff (your “customers”) to adopt new behaviors and attitudes in the way they interact with one another, in the way they identify and solve problems, and in the way they deal with clients. Change is difficult for most people and they will avoid it unless they have a certain level of trust in the outcome and in the person leading them to change.

Fear of the unknown, fear of failure, and fear of loss of control play a part in the unwillingness to change. Consequently, you will need to allay these fears, and establish and maintain trust throughout the process of introducing facilitative supervision.
WHAT IS TRUST?

In the work context, trust is the knowledge that another will not take advantage of you, which allows you to feel safe, putting your self-esteem and position in that person’s hands.

Trust is not automatically given; it must be earned. How can you earn the trust of your customers – the clinic managers, other supervisors, or site staff with whom you work?

- Create and maintain a non-threatening environment.
- Pay careful attention to communication.
- Model correct behavior by showing trust in others and being reliable yourself.
- Practice appropriate self-disclosure.
Session 4

TEAM BUILDING

"Coming together is a beginning; keeping together is progress; working together is success"
-Henry Ford, American industrialist

INTRODUCTION

The sheer complexity of the health care sector today means that no one person can know or do it all. Obviously, there are situations where, in the more isolated health posts, there are few human and material resources available. Therefore, many health care providers have to "wear a variety of hats" to ensure that their clients receive the best service possible. But whether working in a large tertiary health care facility with a large staff (and many types of teams) or a local health center with few providers, the concept of group work or team is still relevant. The types of teams will vary, the membership will vary but the ultimate goal is still that of providing the client or user with the best attention possible.

WHY TEAM WORK IS IMPORTANT?

The literature shows that companies/organizations/institutions benefit from people working together because it results in:

- greater productivity.
- effective use of resources.
- better problem solving.
- better quality products and services.
- creativity and innovation.
- higher quality decisions.

Perhaps the saying "Two heads are better than one" is an important reminder that each of us has a different contribution to make in the work setting. What one person may see another may not. From one good idea may come another, or an even better idea.

HOW CAN A GROUP OR TEAM BECOME EFFECTIVE?

Teams are not born, they are made. And each time a different set of individuals come together, the team takes on a different composition.

It is important to understand that teams go through a growth process. In 1977, Tuckman and Jensen, in Group and Organization Studies (1977), proposed the "Team Maturing Model". They said that teams begin at a stage where people are questioning their role and participation and they look to the leader for guidance and direction (FORMING). When the
team begins to try to find a way to achieve the task for which it has come together it enters the next stage (STORMING) during which there may be a great deal of conflict and competition. Once the purpose of the team's task is agreed to by the team members and the team acknowledges individual members' contributions, team competence and pride develop (NORMING). At this point the team has both task and people oriented players and the team becomes much more innovative and creative (PERFORMING). Not all teams make it through to the performing stage. For those that do, once the reason for their team has been accomplished the team ADJOURNS.

It is important to keep in mind that all team members go through these stages individually, with each other and in relation to the total team. Each member moves at his/her own pace. If one member is not ready to move to the next stage, the team cannot move ahead fully. The team will usually try to find ways to bring that member along.

Defining the roles and responsibilities of each team member is the greatest challenge. Each member is different in terms of interests, skills and abilities. Different members will take on different roles related to the tasks of the team and the process the team will go through to complete the tasks. Unfortunately, not all team members take on a positive role to ensure the team accomplishes what it has to. Non-functional roles include BLOCKING the progress of the team, DIGRESSING from the task at hand and COMPETING in ways that lead to the team's destruction.

When the team reaches a level of effectiveness, it will be characterized in part by:

- appropriate leadership.
- clear and shared image of its goals.
- concern for the welfare and growth of team members.
- use of resources of all team members.
- members with the needed abilities to accomplish the tasks.
- appropriate decision-making procedures and authority.
- appropriate problem solving techniques.
- operation on a definite time schedule.
- evaluation of results and team processes periodically.
THE FOUR STAGES OF TEAM DEVELOPMENT

1. Forming

2. Storming

3. Norming

4. Performing

TEAM-MATURING MODEL

One familiar team-maturing model is that proposed by B.W. Tuckman and M.A.C. Jenson in Group and Organization Studies in 1977. According to Tuckman and Jenson, team progress through the following stages:

- **Forming**
  This stage is characterized by the reliance of team members on past behavior. Players may be uncertain why they are there, and they will avoid serious topics and expression of their feelings. Players look to the team leader for guidance and direction and try to avoid controversy and keep things safe. Team output at this stage of development is low.

- **Storming**
  In this stage, conflict and competition surface within the team. Some players may be hostile or defensive. The team is trying to find a way to achieve the task it was assembled to accomplish, although there may be serious disagreement about its goals and objectives. Conflict results from some players’ attempts to dominate the team, while others remain silent. In order to leave the storming phase, the team needs to acquire a problem solving mentality. Output in this stage is low.

- **Norming**
  During this stage, the team comes together. The goals and objectives are agreed to and “owned” by players. This phase is typified by acknowledgement of individual members’ contributions, community building, and cohesion. Players share feelings, solicit and give feedback, and maintain the safe atmosphere already created. Team competence and pride develop. The major task of this stage is data flow between members and exploration of possible solutions. Output in this stage is moderate to high.

- **Performing**
  At this point, the team identity is complete and player morale is high. Players are both task and people oriented. Team members organize themselves in highly flexible ways and innovate and experiment with solutions. If teams reach this stage—and not all do—their capacity, range, and depth of personal interactions make them truly dependent. Output at this level is very high.

Source: INFO-LINE Issue 9212, “How to Build a Successful Team”, ASTD, December 1992, page 2. All rights reserved, used with permission.
LEADER’S ROLE IN THE TEAM-MATURING MODEL

• Forming
The leader’s role during the formation of the team includes:
   - clarifying direction.
   - getting members acquainted.
   - creating a positive atmosphere.
   - providing the opportunity for early success by seeking out straightforward, quick results that the team can accomplish.

During this phase, the leader often acts as both supervisor and leader.

• Storming
The leader’s role includes:
   - opening up conflict.
   - moving toward negotiation and consensus.
   - getting players to assume more task responsibility.
   - negotiating ground rules with the team.

The leader in this phase is often acting as teacher, coach, and mentor.

• Norming
During this phase, the leader’s role becomes much less directive. The leader:
   - lets the team provide its own task direction.
   - helps build solid working relationships and trust.
   - encourages the team to evaluate progress and establish its own goals.

The leader continues to act as mentor and moves into consulting.

• Performing
The leader:
   - begins to consult and mediate.
   - participates on an equal footing with other team members, becoming involved in tasks, as required.
   - may also consult and inspire players to higher levels of productivity.
   - as a mediator, keeps communication and information pertinent to the task flowing into the team, as well as drawing out necessary information from team members.

The leader also reinforces performance by celebrating team achievements and provides new vision for the team.

Source: INFO-LINE Issue 9212, “How to Build a Successful Team”, ASTD, December 1992, page 4-5. All rights reserved, used with permission.
HOW CAN A WORK TEAM STAY EFFECTIVE?

This is no easy task. The manager or leader has an important, if not essential, role to play. He/she may have to look at the team from both the outside, as the supervisor, and from the inside, if he/she is a part of the team. The manager's role is to assist in diagnosing problems and conflicts and in supporting the resolution of those issues.

Sometimes, it is necessary to change the composition of the team membership in order to accomplish the task at hand. Once again, the management skills of the leader is the key.

Any time there is a team of individuals trying to work together there will be conflicts as the individuals work through the stages of development. However, there will also be rewards. The accomplishments which result from the team's efforts should be recognized and help to create a motivating work environment which will stimulate future team participation.


When the team reaches a level of effectiveness, it will be characterized in part by:

- Appropriate leadership.
- Clear and shared image of its goals.
- Concern for the welfare and growth of team members.
- Use of resources of all team members.
- Members with the needed abilities to accomplish the task.
- Appropriate decision making procedures and authority.
- Appropriate problem solving techniques.
- Operation on a definite time schedule.
- Evaluation of results and team processes periodically.
Session 5

COACHING

"Tell me, and I will forget. Show me, and I may not remember.
Involve me, and I will understand."
-Native American Proverb

As a facilitative supervisor, you will want to supervise your staff in the most supportive manner possible. However, you may also have the additional task of coaching other supervisors in the art of facilitative supervision.

What you want to achieve is a gradual hand-off of skills from you as a facilitative supervisor to the other supervisors under your management, and from them to clinic managers. Remember that your customer is anyone who needs something from you and what other supervisors need from you is practical assistance in developing facilitative supervision skills. To impart skills of facilitative supervision to other managers the facilitative supervisor must have coaching skills.

WHAT IS COACHING?

Coaching is a training approach that seeks to achieve continuous improvement in the performance through motivation, modeling, practice, constructive feedback and gradual transfer of skills.

(Adapted from Landsberg 1997)

CHARACTERISTICS OF COACHING

- It is balanced
  There is give and take, mutual questioning, sharing of ideas and information. It is not one-sided.

- It is concrete
  It focuses on objective aspects of performance.

- It is respectful
  The coach uses behaviors that convey that the other person is a valued and fully accepted counterpart and avoids behaviors that convey that the other person is ignorant or inferior in any way.
Motivation
Motivation is about gaining the staff's commitment to acquire the new behavior. This involves mutual understanding of the problem and of the benefits of the new behavior, and mutual belief that the trainee is competent to learn it. Praise is an important element of motivation.

Modeling
Modeling involves the trainer's competent demonstration and explanation of the new behavior, with the opportunity for the trainee to ask questions.

Practice
Practice is an opportunity for the trainees to demonstrate their ability to perform the new behavior under the supervision of the trainer.

Constructive feedback
Constructive feedback is the sharing of the trainer's evaluation of the trainee in a concrete, respectful, two-way interchange of ideas.

THE ESSENTIAL ELEMENTS OF THE COACHING STRATEGY

The essential elements of the coaching strategy can be described in five concepts that form the acronym coach, which are described below:

C Clear performance mode (behavior modeling). Participants should be shown in a clear and effective manner the skills they are expected to learn.

O Openness to learning. The clinical coach should include activities designed to create readiness to learn and use new skills.

A Assessment of performance. Clinical training should include measures for both assessing competence in the skills being taught and providing feedback on progress toward a satisfactory standard of performance.

C Communication. Effective two-way communication between the coach and participant is essential to skill acquisition and attaining skill competency.

H Help and follow-up. Clinical training should include planning for application of the new skills and help in overcoming obstacles to utilization of the skills.

Provide feedback. Be a Coach. A coach criticizes with a helpful attitude to help improve the performance of the athlete.
TEN COMMANDMENTS OF GIVING FEEDBACK

- Offer feedback on observed behavior, not on perceived attitude.
- Offer description rather than judgment.
- Focus on behavior that can be changed.
- Choose an important aspect of job performance that is important and limit comment.
- Ask questions rather than make statements.
- Set the ground rules in advance.
- Comment on the things that everyone did as well as areas for improvement.
- Relate all your feedback to specific items of behavior, do not make statements about general feelings.
- Observe personal limits, do not give too much feedback at once.
- Before feedback, consider its value to the trainee.

ADVANTAGES OF COACHING

- Aids understanding
- Provides feedback
- Provides scope for guidance in activity

DISADVANTAGES OF COACHING

- Labor intensive
- Depends on availability of coach

AN EFFECTIVE COACH

- Is proficient.
- Promotes open two-way communication.
- Encourages participant in learning new skill.
- Provides immediate positive feedback.
- Does not allow any skill to be performed incorrectly.
- Avoids negative feedback and instead offers specific suggestion for improvement.
THE ODOBOCKO NUMBER SYSTEM

Your boss has just given you a card (printed below) which explains the Odobocko number system - a system which assigns a specific symbol to each of the numbers 1 (one) through 9 (nine). (A zero can be represented by diagonally crossed sticks - X). You must teach this system to employees before your company can use it as a code for certain billing data that should not be read by customers or others outside the organization.

Your abilities, both as an organizer and a coach, will be measured on the basis of how well your trainee remembers and is able to convert, any Arabic number from 1 (one) to 50 (fifty) into its Odobocko equivalent. For example, if you asked your trainee for the number 26, s/he must be able to write:

Now take five minutes to analyze the system and decide how you are going to teach it.

1 = □  4 = □  7 = □

2 = □  5 = □  8 = □

3 = □  6 = □  9 = □

Created by: Bill Berg, Team Technologies, Inc. 620 Herndon Parkway, Suite 350 Herndon, Virginia 22070
THE WORRABURRA NUMBER SYSTEM

Your boss has just given you a card (printed below) which explains the Worraburra number system - a system which uses symbols for numbers. You must teach this system to employees before your company can use it as a code for certain billing data that should not be read by customers or others outside the organization.

Your abilities, both as an organizer and a coach, will be measured on the basis on how well your trainee remembers and is able to convert any Arabic number from 1 (one) to 50 (fifty) into its Worraburra equivalent. For example, if you asked your trainee for the number 26, s/he must be able to write:

```
1

---

2

---

3

---

4

---
```

Now take five minutes to analyze the system and decide how you are going to teach it.

```
1 = ||  5 =  9 = —

2 = ||  6 =  10 = —

3 = |||  7 =  11 = —

4 = —  8 =  12 = —
```

Created by: Bill Berg, Team Technologies, Inc. 620 Herndon Parkway, Suite 350 Herndon, Virginia 22070
THE TEACHER LEARNER GAME

ODOBOCKO NUMBER SYSTEM

WORRABURRA NUMBER SYSTEM

THE TEACHER-LEARNER GAME

14
9
27
22
46
31
18
6
15
19

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Session 6

PLANNING A MEETING

WHAT IS A MEETING?

A meeting can be defined as a gathering of three or more people sharing common objectives, where communication (verbal and/or written), is the primary means of achieving those objectives.

WHEN IS A MEETING EFFECTIVE?

A meeting is effective when it achieves its objectives in a minimum amount of time to the satisfaction of the participants.

BEING A PRODUCTIVE PARTICIPANT

Everyone is a meeting participant at one time or another. An effective meeting depends on productive participants. As a participant, you are in a position to make a significant contribution to the success of meetings you attend. All you need is a tactful way to ask questions and offer suggestions.

Being a productive participant includes being on time, not carrying on side conversations, being willing to ask questions, paying attention, listening, and staying involved. Other helpful things you can do as a participant include:

- Supporting useful ideas from the leader or other participants.
- Judging the merit of ideas presented and not being distracted by delivery styles.
- Delaying any judgment until the full idea has been presented.
- Not allowing environmental conditions to distract you; such as noise or uncomfortable conditions.
- Taking well-organized notes.

A GOOD MEETING PARTICIPANT

- Prepares for the meeting.
- Contributes ideas to the discussion.
- Listens to the ideas of others.
- Considers the problem objectively.
- Contributes to the orderly conduct of the meeting.
- Provides feedback to the meeting leader.
- Carries out agreed upon action.
FACILITATING AND PLANNING MEETINGS

In order for staff to work together on improving quality, they must agree on the nature and causes of quality-related problems and, more importantly, on their solutions. As a facilitative supervisor, one of your most important functions is to enable staff to come to an agreement when there are divergent opinions. In order to do so, you may take advantage of certain facilitation tools. These tools may be used in any meeting that requires agreement.

STAGES OF DISCUSSIONS

- **Opening**: Participants generate ideas for discussions.
- **Narrowing**: The information is considered and prioritized.
- **Closing**: Participants agree on the issues to be addressed.

*(Interaction Associates 1997)*

Different facilitation tools are appropriate for each stage of the process.

- **Opening tools** are used to begin discussion. During this stage:
  - **Make a suggestion**
    Offer a proposal to get the discussion flowing. For example, the facilitator may say, “We’ve noticed that the wound infection rate has increased lately. Can someone identify the cause for us?” Or, “Mr. Ramesh, you’ve had some experience on the issue of cost-sharing. Please suggest a course of action for the group.”

  - **Make a list**
    Record several ideas for possible discussion topics. For example, the facilitator may say, “Mohandas has suggested two possible donor agencies to approach for our construction project. Let’s try to think of two or three more and then begin to consider which one would be most likely to finance our expansion plans.

  - **Brainstorm**
    Ask the group to generate as many ideas as possible in a short period of time. In brainstorming, all ideas are acceptable, no criticism is allowed, ideas are not judged, and participants are encouraged to be creative and use their imagination. It is a good idea to have two people alternately writing the ideas on a flipchart, so that the group’s thought processes will keep flowing. For example, the facilitator may say, “Let’s suggest as many topics for refresher training as we can now. We can prioritize them later.”

    *(Interaction Associates 1997)*

- **Narrowing tools** are used to organize and evaluate information
  - **Avoid redundancy**
    Ask the group to look through the discussion topics and eliminate any that are duplicates or are very similar.
Assign priorities
Make sure agreement is reached on the most important/feasible ideas. There are a number of ways to prioritize, such as.

- **N/3 method**: Divide the number of topics by three; the answer will give you the number of items each participant should choose as his or her favorites.
- **Nominal Group Technique**: Give each participant three pieces of paper or three cards and a writing implement, preferably a marker. Ask participants to write an idea on each piece of paper. This technique also ensures that all participants have the opportunity to contribute ideas to the discussion. Post all the ideas on a wall, eliminate duplicates, and ask participants to vote for three. Record the number of votes each idea receives.

- **Closing tools** are used to reach agreement.

  - **Use negative polling**
    Help the group narrow their choices by asking them what they do not want to eliminate from the list. For example, the facilitator asks, “Is anyone unwilling to delete item number five?”

  - **Negotiate by building up/eliminating**
    This helps the group choose between alternatives by adding or eliminating aspects. For example, the facilitator says, “What can we add to or eliminate from alternative number one to make it acceptable to you?”

  - **Consider both**
    Suggest accepting two alternatives when there is a failure to agree.

  *(Interaction Associates 1997)*
THE ESSENTIAL ELEMENTS OF AN EFFECTIVE MEETING

- Objectives
- Participants
- Organization
- Leadership
- Information
- Meeting Time
- Meeting Place

MEETING
RATE YOURSELF AS A MEETING PARTICIPANT

Instructions: Check yes or no to each of the following questions based on how you participate in meetings. Be honest.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Do I typically know the purpose of the meetings I attend?</td>
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<td></td>
<td>2. Do I have a clear understanding of my role in meetings attended?</td>
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<td>3. Do I confirm my attendance in advance for the meeting?</td>
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<td>4. Do I complete required “homework” such as looking up information or studying proposals?</td>
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<td>5. Do I arrive at meetings before they are scheduled to begin?</td>
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<td>6. Do I engage in side conversations while the meeting is in progress?</td>
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<td>7. Do I leave meetings for reasons such as non-emergency telephone calls?</td>
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<td>8. Do I ask questions when I am not sure about something?</td>
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<td></td>
<td>9. Am I typically open to the ideas of others?</td>
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<td></td>
<td>10. Am I a good listener?</td>
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<td></td>
<td>11. Do I actively participate in discussions when there is something worthwhile to contribute?</td>
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<td></td>
<td>12. Do I help others stay on the subject?</td>
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<td></td>
<td>13. Following meetings, do I take agreed upon action?</td>
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<td></td>
<td>14. Do I contribute to improving meetings by giving feedback to the people who conduct them, either by a note, phone call or visit?</td>
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<tr>
<td></td>
<td>15. Following meetings, do I inform appropriate people who did not attend about what was discussed, and the outcome?</td>
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</table>
RATE YOURSELF AS A MEETING LEADER

Instructions: Check yes or no to each of the following questions based on how you act (or would act) as a meeting leader. Be honest.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<td></td>
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</tr>
<tr>
<td>1.</td>
<td>Do I have clear objectives for the meetings?</td>
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<td>2.</td>
<td>Am I selective about the invited participants?</td>
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<td>3.</td>
<td>Do I prepare an agenda and distribute it in advance of the meeting?</td>
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<td>4.</td>
<td>Do I arrive early enough to check the arrangements?</td>
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<td>5.</td>
<td>Do I start the meeting promptly regardless of who is present?</td>
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<td>6.</td>
<td>Do I follow the agenda?</td>
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<td>7.</td>
<td>Do I manage time and conclude the meeting as scheduled?</td>
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<td>8.</td>
<td>Do I elicit everyone's participation?</td>
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<td>9.</td>
<td>Do I help in the resolution of conflict?</td>
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<td>10.</td>
<td>Do I maintain proper control of the discussion?</td>
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<td>11.</td>
<td>Do I summarize accomplishments at the end of the meeting and clarify any action to be taken?</td>
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<td>12.</td>
<td>Do I prepare and distribute a memorandum of discussion?</td>
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<td>13.</td>
<td>Do I request evaluative feedback from participants?</td>
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<td>14.</td>
<td>Do I take agreed upon action?</td>
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<tr>
<td>15.</td>
<td>Do I follow up on action to be taken by others?</td>
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</tbody>
</table>
WORKSHEET FOR PLANNING A MEETING

1. **Objective**: What key results do you want to achieve?

2. **Timing**: How long should the meeting last? When is the best time to hold it?

3. **Participants**: Who should attend? Be sure to include those with the authority to decide, those whose commitment is needed, and those who need to know.

4. **Agenda**: What items should be dealt with? Who is responsible for preparing and distributing the agenda? How will participants help in developing the agenda?
5. **Physical Arrangements:** What facilities and equipment are required? How should the meeting room be arranged?


Exercise

Planning a Meeting

Think of a meeting that you need to hold soon. Plan the meeting following the process described above and fill in the spaces.

Date:
Time:
Place:
Purpose:
Desired Outcome:

Topics:
1. Review of purpose, desired outcome, and ground rules of meeting:
   Content presenter:
   Time:
   Process:
   Opening / narrowing / closing technique:

2. Content to be covered:
   Content presenter:
   Time:
   Process:
   Opening / narrowing / closing technique:

3. Content to be covered:
   Content presenter:
   Time:
   Process:
   Opening / narrowing / closing technique:

4. Content to be covered:
   Content presenter:
   Time:
   Process:
   Opening / narrowing / closing technique:
EVALUATE A MEETING

Instructions: Consider the typical meeting you attend whether in business, at church, in a club, etc., Compare your meeting to the following characteristics of an effective meeting. Check those statements that apply to meetings you normally conduct or attend:

☐ 1. An agenda is prepared prior to the meeting.
☐ 2. Meeting participants have an opportunity to contribute to the agenda.
☐ 3. Advance notice of meeting time and place is provided to those invited.
☐ 4. Meeting facilities are comfortable and adequate for the number of participants.
☐ 5. The meeting begins on time.
☐ 6. The meeting has a scheduled ending time.
☐ 7. The use of time is monitored throughout the meeting.
☐ 8. Everyone has an opportunity to present his or her point of view.
☐ 9. Participants listen attentively to each other.
☐ 10. There are periodic summaries as the meeting progresses.
☐ 11. No one tends to dominate the discussion.
☐ 12. Everyone has a voice in decisions made at the meeting.
☐ 13. The meeting typically ends with a summary of accomplishments.
☐ 14. The meeting is periodically evaluated by participants.
☐ 15. People can be depended upon to carry out any action agreed to during the meeting.
☐ 16. A memorandum of discussion or minutes of the meeting is provided to each participant following the meeting.
☐ 17. The meeting leader follows up with participants on action agreed to during the meeting.
☐ 18. The appropriate and necessary people can be counted on to attend each meeting.
☐ 19. The decision process used is appropriate for the size of the group.
☐ 20. When used, audiovisual equipment is in good working condition and does not detract from the meeting.

Number of Statements Checked ______ x 5 = _______ Meeting Score

A score of 80 or more indicates you attend a high percentage of quality meetings. A score below 60 suggests work is required to improve the quality of meetings you attend.
SUMMARY CHECKLIST FOR CONDUCTING EFFECTIVE MEETINGS

1. Clarify the purpose of the meeting.

2. Select appropriate physical setting and room arrangement.

3. Use an appropriate leadership style.

4. Secure group agreement on expectations about agenda, time, objective, and ground rules.

5. Don't allow the group to jump to conclusions. Suspend judgment and explore alternatives.

6. Use conflict to differentiate ideas and feelings before attempting to integrate them.

7. Work for group consensus where knowledge is fragmented and decisions must be supported.

8. Examine interaction whenever feelings and behavior are not congruent, opinions are not readily offered, or the meeting seems ineffective.

9. Insist on action commitments which are specific in terms of what is to be done, follow-up, and responsibility.

10. Evaluate each meeting with the intent of soliciting positive improvement steps for future meetings.
COMMUNICATION

In order to transform traditional supervision into facilitative supervision, supervisors have to approach the people they manage by using certain communication skills. These skills are similar to the ones used in counseling clients because facilitative supervision and counseling have some common goals: the creation of an environment of trust and the establishment of a spirit of cooperation.

THE FACILITATIVE SUPERVISOR USES THE FOLLOWING COMMUNICATION SKILLS:

- Active listening.
- Positive body language.
- Verbal and nonverbal encouragement.
- Paraphrasing.
- Clarification.
- Appropriate questioning techniques.
- Constructive feedback.

ACTIVE LISTENING

Active listening is not the same as hearing. It is not a natural process, but rather requires energy, skill, and commitment. Although listening is considered in many cultures to be passive and less important than speaking, active listening is a powerful tool because it can make the speaker feel important, acknowledged, and empowered.

What Is Active Listening?

Active listening is listening to another person in a way that communicates understanding, empathy, and interest.

Active Listening Do’s and Don’ts

<table>
<thead>
<tr>
<th>Do</th>
<th>Do Not</th>
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</thead>
<tbody>
<tr>
<td>Concentrate on what the speaker is saying.</td>
<td>Do other things (e.g., look through papers) when the speaker is talking.</td>
</tr>
<tr>
<td>Allow the speaker to express himself or herself.</td>
<td>Daydream or get distracted by surrounding events.</td>
</tr>
<tr>
<td>Allow the speaker to control the conversation.</td>
<td>Interrupt. Finish the speaker’s sentences.</td>
</tr>
<tr>
<td>Accept the speaker’s opinion as valid for himself or herself.</td>
<td>Ask questions that change the subject.</td>
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<tr>
<td></td>
<td>Rebut, criticize or judge.</td>
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</tbody>
</table>
Pay attention not only to the words, but also to gestures and behavior.
Anticipate what the speaker is going to say next.

Prevent emotions from inhibiting active listening, no matter what the speaker is saying.
Ignore the emotional context.

Become angry, defensive or upset.

POSITIVE BODY LANGUAGE

Body language includes the posture of the body, the position of different parts of the body (arms, legs, eyes), gestures, space, and seating. Active listeners use positive body language to indicate respect, interest and empathy. However, body language means different things in different cultures. In many Western cultures, looking people in the eye and leaning toward them with an open posture (arms and legs uncrossed) indicates attention to what they are saying, but such actions are considered impolite in other cultures. Also, body language may have a different meaning depending on whether one is in a group or communicating one-on-one.

VERBAL AND NONVERBAL ENCOURAGEMENT

Facilitative supervisors want staff and colleagues to feel free to discuss any issue or problem so that they may work together to find solutions. One of the ways to encourage people to continue speaking is through verbal and nonverbal encouragement.

What Are Verbal and Nonverbal Encouragement?

Verbal and nonverbal encouragement involve using words, phrases and gestures that indicate attention and the wish for the person to continue speaking.

PARAPHRASING

As a facilitative supervisor, you will always want to convey to your colleagues, especially those whom you supervise, that you attach importance to what they are telling you. You also want to encourage them to give you all the information you need so that you may be better equipped to help them solve their problems. A technique that can be used for this purpose is paraphrasing.

What Is Paraphrasing?

Paraphrasing is restating what the speaker said in different words in order to demonstrate attention and encourage the speaker to continue.

When paraphrasing, follow these simple guidelines:

- Listen for the speaker’s basic message.
- Give the speaker a simple summary of what you believe is the message. Do not add any new ideas.
Observe a cue or ask for a response that confirms or denies the accuracy of the paraphrase.

- Do not restate negative statements that people may have made about themselves in a way that confirms this perception. If someone says, “I really acted foolishly in this situation,” it is not appropriate to say, “So, you feel foolish.”

- Use paraphrasing sparingly. Your objective is to encourage the person to continue speaking and constant interruption may be counterproductive. Typically, you will use paraphrasing when the speaker hesitates or stops speaking.

CLARIFICATION

The facilitative supervisor makes every effort to understand what other supervisors or site staff are trying to convey. Sometimes the message is vague or contradictory, and the supervisor must attempt to understand it better. A technique to improve understanding is called clarification.

What Is Clarification?

Clarification is asking questions in order to better understand what the speaker said. It is somewhat like paraphrasing, but its purpose is to ensure understanding rather than to motivate the person to continue speaking. Clarifying is more polite and respectful than merely saying, “I didn’t understand you.” In addition, using clarifying questions shows that you are genuinely interested in what you are being told because you take the trouble to restate the speaker’s point in order to increase understanding.

Some guidelines on clarification:

- Admit that you don’t understand exactly what the person is telling you.
- Restate the message as you understand it, asking if your interpretation is correct. Use phrases such as “Do you mean that . . . ?” or “Are you saying that . . . ?”
- Do not use clarification excessively. People may resent being interrupted if it happens too frequently.

APPROPRIATE QUESTIONING TECHNIQUES: OPEN-ENDED VERSUS CLOSED QUESTIONS

It is important for you as a facilitative supervisor to know how to ask questions in such a way that your customers (other supervisors or site staff) are encouraged to provide maximum information. Staff who are uncomfortable or reticent may tend to respond with one-word answers that do not convey enough information for you to understand what’s going on. Using open-ended questions helps to avoid these one-word answers and to get the staff to open up more in their conversations with you.

What are Open-ended and Closed Questions?

Open-ended questions are those that cannot be answered with yes or no. They usually begin with the interrogatives: who, what, where, when, why, and how. Closed questions are those that can be answered with yes or no.
Because closed questions require only a yes or no answer, they don’t always draw out sufficient information. Open-ended questions cannot be answered with one word, so staff will be encouraged to explain the situation in more detail. In this way, you, as a supervisor, will have a better understanding and be able to assist more effectively. Another problem is that closed questions sometimes hint at the desired answer (for example, within the question “Are you going to meet with that troublesome employee?” is implicit the idea that the manager should have a meeting with the employee). If the objective is to obtain accurate information, you should not convey the desired answer in your question.

**Examples of closed questions and open-ended questions**

<table>
<thead>
<tr>
<th><strong>Examples: Closed questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Did you solve the problem of the stock out of bleaching powder?</td>
</tr>
<tr>
<td>• Are you going to meet with that troublesome employee?</td>
</tr>
<tr>
<td>• Did you organize the training course?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Examples: Open-ended questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What has been done about the stock-out of bleaching powder?</td>
</tr>
<tr>
<td>• How will you handle that troublesome employee?</td>
</tr>
<tr>
<td>• What have you done to organize the training course?</td>
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</tbody>
</table>

**CONSTRUCTIVE FEEDBACK**

As a supervisor, you are called upon to evaluate the performance of the staff and the quality of the services they provide. As part of this evaluation, you need to discuss your findings with the staff. This is called *feedback*. Feedback can be:

- Negative – Overly critical, causing hurt feelings.
- Positive – Supportive, causing good feelings.
- Punitive – Focusing on assigning blame.
- Constructive – Focusing on the solutions to the problem.

When performance is good and the quality of services is high, the facilitative supervisor never fails to acknowledge and praise. Congratulations on a job well done are always in order.

However, there will be circumstances when performance and quality need to be improved. Facilitative supervisors keep in mind that the people they supervise are their customers and must always be treated with respect. Therefore, facilitative supervisors always give positive feedback. In addition, facilitative supervisors understand that their job is to help their customers solve problems. Therefore, facilitative supervisors always give constructive feedback and ensure two-way communication.
COMMUNICATION SKILLS

VERBAL COMMUNICATION

How something is said to capture and maintain participants’ interest

- Vary the pitch, tone and volume of the voice.
- Give a strong introduction.
- Communicate on a personal level.
- Incorporate participants’ ideas and examples.
- Avoid repeating words or phrases such as “Do you know what I mean?”
- Vary the pace and delivery.
- Make important points slowly and less important quickly.
- Make logical and smooth transitions between topics.
- Give clear directions.

Remember:

- Reproductive Health involves consideration of intimate issues.
- Sexual matters may be difficult to talk.
- Consider strongly held views, taboos and religious beliefs.
- Use words, which are acceptable to participants, will encourage them to do the same when they work with clients.

NON-VERBAL COMMUNICATION

Non-verbal communication is as important as verbal communication. Such things as dress, eye contact, body language and movement about the room, as well as other factors, can have a significant impact on establishing and maintaining a positive training climate. To use non-verbal 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 workshop.
- 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.
- Avoid gestures or body language, such as fidgeting, excessive pacing, jiggling 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.
BIBLIOGRAPHY


