

GUIDELINES FOR TRAINING

in

Female Sterilization

for Programme Officers,
Training Coordinators and Trainers



Family Planning Division
Ministry of Health and Family Welfare
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Contents

<i>Preface</i>	v
Introduction	1
Minilap and Laparoscopic Female Sterilization	1
Capacity Building for Providers	3
Training Methodology: Clinical Training Approach	3
Planning for the Training	5
Annexures	9
Annexure 1: Calculation of the Training Load	11
Annexure 2: Road Map for Training	12
Annexure 3: Guidelines for Organising Training in Laparoscopic Tubal Sterilisation	14
Annexure 4: Guidelines for organising Training in Minilap Tubectomy	16
Annexure 5: Monitoring the Quality of Training	18
Annexure 6: Budget Provision	19
Annexure 7: Learning Guide/Checklist for Minilap Abdominal Tubectomy	20
Annexure 8: Learning Guide/check List for Laparoscopic Tubal Ligation	24
Annexure 9: Overview of the Revised Compensation Scheme	29
Annexure 10: Family Planning Insurance Scheme (Limit of Indemnity)	30



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Preface

Provision of quality contraception services is vital for stabilising population and also for improving maternal and child health. Female sterilisation which is one of the most accepted methods of contraception is being provided by two techniques - Minilap tubectomy and Laparoscopic tubal ligation. Ensuring the availability of skilled service providers for female sterilisation at every facility starting from PHCs up to district hospital is a vital component for providing quality sterilisation services. Keeping this in view, a skill based training for Minilap tubectomy and laparoscopic tubal ligation is designed which incorporates components of counselling, eligibility screening, anaesthesia, surgical technique, management of complications, follow up care and monitoring.

This handbook on “Guidelines for Training in Female sterilisation” is compiled to ensure the standards in training and to guide the State and District programme officers, trainers and clinical training centres in effective implementation of the training and utilisation of the trained service providers.

It is envisaged that all the stakeholders would make optimal use of this document for enhancing the skilled provider base for female sterilisation at every health facility.

(Dr.Kiran Ambwani)

Guidelines for Training in Female Sterilization

Introduction

Female Sterilization or Tubal ligation is the most accepted method of contraception in India. Although 5–6 million Sterilization procedures are done annually in India as per DLHS III data, the total unmet need in contraception for the country remains high at 21.5%, out of which 13.5% is for limiting methods. The architectural changes under National Rural Health Mission (NRHM) of Government of India have strengthened the health facilities for providing assured, fixed day Family planning services at FRUs, CHCs and 24×7 PHCs. In addition to this the increase in the number of institutional deliveries provides opportunity for post partum sterilization.

Minilaparotomy and laparoscopic tubal ligation are the two preferred procedures for female sterilization, since they are simple, safe, effective and can be made available in a variety of settings.

Minilap and Laparoscopic Female Sterilization

To ensure broad access to female sterilization, the method offered at a service site should be safe, simple, highly effective, and relatively pain-free, affect only fertility, inexpensive, suitable to be performed as an ambulatory procedure and cause minimal tubal damage in order to facilitate reversibility (WHO, 1992). Minilaparotomy and laparoscopy both fit these criteria and are acceptable procedures for reaching the fallopian tubes (WHO, 1992).

In large-scale studies and service settings, both methods have proven to be equally safe and effective. The two techniques are compared in Table I.

Table No. 1: Comparison of minilaparotomy and laparoscopy for female sterilization

Consideration	Minilaparotomy	Laparoscopy
Surgical skills and expertise	The procedure can be performed by MBBS graduate (after training & certification in minilap).	The procedure is to be performed by trained and certified surgeons and gynaecologists.
Instruments and equipments	Requires few inexpensive surgical instruments.	Requires delicate and expensive endoscopic equipment.
Timing	Can be performed postpartum, post abortion or at any time (interval procedure)	Laparoscopy is appropriate only for interval and first-trimester post-abortion procedures.
Postoperative pain	Mild Postoperative abdominal pain.	Mild Postoperative abdominal pain. Chest and shoulder pain may also result due to abdominal insufflations.
Postoperative complications	Associated with a risk of minor complication such as wound infection.	Carries a risk of major complication such as bowel or vascular injury that may require additional surgery
Recovery time	Recovery time is 4-6 hours.	Recovery time is 4-6 hours.

Objectives

- To standardise the trainings in female sterilisation at the state and district levels.
- To help Programme officers, Training centres, state and district trainers for planning, conducting and evaluating the trainings.

Target audience

- State and district programme officers
- State and district training coordinators.
- State and district trainers.

Capacity Building for Providers

To provide sterilization services as per standards it is essential to build the capacity of the service providers at all levels of service delivery.

Training is essential to empower service providers with the knowledge, attitudes and skills for competent delivery of services. Efficiently managed training can have a substantial impact on performance. The following important steps will help programme managers to effectively plan, design, deliver and evaluate training.

Training Methodology: Clinical Training Approach

The goal of clinical training is to assist health professionals in learning to provide safe high quality reproductive health services through improved work performance. To achieve this goal the clinical training is based **on mastery learning approach**.

The **mastery learning** approach to clinical training assumes that all participants can master (learn) the required **knowledge, attitudes or skills**, provided sufficient time is allowed and appropriate training methods are used.

KEY FEATURES OF MASTERY LEARNING

- adult learning principles
- behaviour modelling
- competency-based
- humanistic training techniques

Adult Learning principles

- Learning should be participatory, relevant, and practical
- Build upon the knowledge and experience of the participants
- Use variety of training methods.
- More opportunities for hands on practices- at least 50% of the session time
- Participants should be aware of what they need to learn.
- Repetition is necessary for competency development.
- Realistic learning situations are more effective.
- Feedback should be immediate, positive and non-judgmental.
- Warm-up exercises and good planning establishes a **positive climate for learning**.

Behaviour Modelling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modeling to be successful, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them.

A trainer who is enthusiastic, energetic and genuinely interested in both the subject and getting it across will evoke the greatest response from the trainees. Success of the training which produces the desired results lies entirely in the hands of the trainer. Qualities of a good trainer include:

- Communication skills- verbal and non-verbal
- Knowledge about the subject
- Interactive Presentation skills- arrange and present subject logically.
- Sound convincing and sincere.
- Problem solving skills
- Clinical decision making and higher order thinking skills
- Use competency-based assessment instruments
- Coaching skills
- Provide supportive supervisions focused on guiding trainees towards competency.

“How something is said is just as important as what is said”.

Competency-based Training

- Learning by doing is the basic principle behind acquisition of any skill. How the participant performs (i.e. a combination of knowledge, attitudes and skills) is emphasized rather than just what information the participant has acquired.
- CBT requires that the clinical trainer facilitate, guide and encourage learning rather than serve in the more traditional role of instructor or lecturer.

Humanistic Training Techniques

- Effective use of models is an important factor in improving the quality of clinical training.
- By using anatomic models initially, participants can practice more easily without the fear of hurting the clients to acquire the skills
- Clinical training is possible even when the client caseload is low because fewer cases are needed for participants to attain skill competency.
- Training time is reduced, resulting in: lower costs for training **and less disruption of services due to provider absence.**

Planning for the Training

Performance needs Assessment (Training need Assessment)

There are many factors that affect the performance of healthcare workers. A performance needs assessment (PNA) will identify performance gaps or problems and determine the most appropriate interventions to improve performance.

Selecting Appropriate Participants

Select participants from the facilities where there is a need for the service. Participants selected for training must have basic knowledge and skills needed to master the specific training objectives.

The District Chief Medical Officer needs to identify the gap in the availability of service providers required for providing regular sterilization services in all hospitals, CHCs, and 24*7 PHCs. **The table in Annexure -I can be used for assessment of the number of Medical officers to be trained.**

Organising Clinical Training

Effective training involves advanced attention to details. The team responsible for training must plan and budget for the following key components of training: (Training road map Annexure-2) and Budget guidelines (Annexure- 6).

- Facilities – Facilities for instruction and clinical practice are equally important to successful clinical training.
 - *Instructional facilities* - may take place in a classroom, meeting room or conference facility.
 - *Clinical facilities* - Hospitals/ CHCs with enough caseload of clients so that each participant gets at least 5 clients to do Minilap tubectomy/laparoscopy independently under supervision for acquiring competency.
 - *Accommodation* - for the participants and sometimes for the trainers to be arranged in the hostel or nearby hotels as per budget allocation.

(Detailed guidelines for organizing Minilap and laparoscopic sterilization given in Annexure 3

Conducting Clinical Training (Coaching)

The technique of developing the clinical skill is known as coaching. It is done on a one to one basis and involves the following stages.-

- Explain and demonstrate the clinical skill by the trainer, step by step
- Practice by the participant under the supervision of the trainer, first on models (if available) and then with clients. More than 70% of the time to be given for practice.
- Evaluation of the participant's skill competency by the trainer

LEVELS OF DEVELOPING THE CLINICAL SKILLS-

Skill Acquisition:

Knows the steps and their sequence to perform the required skill or activity but needs assistance.

Skill Competency:

Knows the steps and their sequence and can perform the required skill or activity independently.

Skill Proficiency:

Knows the steps and their sequence and performs the skill or activity efficiently.

Feedback Session

Feedback given to the trainees during coaching on client is important to motivate them to become competent in the skills without compromising client's rights.

- Feedback should be timely, specific, descriptive and not judgmental. Keep the feedback restrained and low key. Often a look or hand gesture can be as effective as words and less worrisome to the client
- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner

Be prepared to calmly step in and take over the critical procedure at a moment's notice.

Coaching tools

- Learning Guide (Annexures- 7 and 8)
- Check lists
- Anatomical models (When available, the model should be treated gently and with the same respect given to an actual client)

Measuring Competency

Competency is the ability to master a set of knowledge, skills and attitudes obtained during training and transfer them to the care of clients in the clinical practice setting.

Before issuing a Competency certificate, the trainer should observe and rate the performance for each step of the procedure as per the checklist. (Annexure- 7 & 8).

Evaluation of Training

At the end of the course, evaluation of the quality of training is done by getting a feedback from the participants regarding the content and process of training and by assessing the clinical skills of the trainees.

Performance Measurement

Evaluation of the training involves monitoring of the trained personnel after they are back on their jobs, to assess the improvement in performance. This requires follow up visits to the job sites of the trainees. Ideally, the trainer/Supervisor/Programme manager who delivered the course conducts these visits within 2 to 3 months of training as per the guidelines.

Evaluation Dissemination

It is important to document the overall value of investments in training. Evaluation information will show whether training addressed the performance gap identified by the Performance need assessment. Policymakers and program planners can use this evaluation information to assess the value of training as an intervention to improve workers' performance.

ANNEXURES

Calculation of the Training Load

	Technique of female sterilisation	DH / SDH			CHC/BPHC			24*7 PHCs		
		R	A	G	R	A	G	R	A	G
1	Minilap									
2	Laproscopy									

R- Required A- Available G - Gap

Based on the gap analysis from table above the trainings to be organised as per the guidelines

1. MBBS doctor can be selected for Minilap trainings.
2. Gynaecologist or surgeon to be selected for laparoscopy training.

Annexure 2

Road Map for Training

The training strategy is to start with orientation of trainers and programme managers at the national level and state level followed by clinical training of service providers at district/ sub district level .This process would ultimately build a sustainable self-renewing system of DH/CHC based trainers responsible for developing the capacity of medical officers to competently provide sterilisation services.

National Level Orientation of State Training Team

Responsible Agency	FP Division, MOHFW and National Institute of Health and Family Welfare, N.Delhi
Target Participants	<ul style="list-style-type: none">- State FW /RCH Director,- Gynaecologist from Medical college/ District hospital- SIHFW Director
Training Team	<ul style="list-style-type: none">- FP Division officials, and NIHFW faculty.
Capacity, Venue & Duration	3 participants from each state. Total 20- 25 participants per batch Duration- 2 days Venue- NIHFW, New Delhi.
Objectives	<ul style="list-style-type: none">- Standardize Knowledge Skills & Attitudes in accordance with GOI National guidelines "Standards on Female and Male sterilisation services" and Quality assurance Manual"- Standardize training competencies needed to lead state level training activities.- Introduce GOI Operational Guidelines in order to support implementation of the Fixed Day Static sterilisation services within the state.

State Level Orientation for District Trainers

Responsible Agency	State Directorate of health service , State Institute of Health and Family Welfare
Target Participants per District	<ul style="list-style-type: none"> - District FW /RCH officer - Gynaecologist or senior medical officer from District/Sub div. Hospitals/CHC – (2-3 per district)
Training Team	- State Trainers from Directorate, SIHFW /medical college or District hospital trained at NIHFW.
Capacity, Venue & Duration	No. of participants- 20-25 Venue-SIHFW Duration - 2 days
Training Objectives	<ul style="list-style-type: none"> - Standardize Knowledge Skills & Attitudes in accordance with GOI guidelines on “Standards on Female and Male sterilisation services “ - Standardize training competencies needed to lead district level training activities. - Introduce GOI Operational Guidelines on FDS in order to support implementation of Fixed day services for sterilisation at the facilities by capacity building of Medical officers.

District Level Training of Service Providers

Responsible Agency	District Family Welfare Officer/District RCH officer
Target Participants	2- 3 Medical Officers
Training Team	District Gynaecologists mentored during state level training
Capacity, Venue & Duration	No of participants-2-3 Venue-District hospital/ Sub. District hospital./CHC Duration- 12 days
Training Objectives	<ul style="list-style-type: none"> - Standardize Knowledge Skills & Attitudes in accordance with GOI National guidelines” Standards on Female and Male sterilisation services “. - Skill competency for performing minilap /Laparoscopy tubectomy as per standards.

Annexure 3

Guidelines for organising Training in Laparoscopic tubal sterilisation

Introduction	Laparoscopic sterilisation is a method of tubal ligation using a tubal ring and done as an interval method.
Objectives	To update the participants with the knowledge and develop skills needed to perform the procedure. To develop the skills for managing surgical complications and routine follow -up care To develop communication and counselling skills To develop managerial skills for provision of quality services
Selection criteria Trainees/Participants	Post Graduate Medical Doctors in gynaecology or surgery
Selection of Training Centres	The states should aim at developing at least 1 'clinical training centre' (based in District/ Sub-district Hospital providing reproductive health services) per district. 1. Only those facilities with sufficient case load (more than 50 cases per month for training 23 trainees per batch should be identified and designated as "training centres". 2. In addition, the training centres should be well equipped for training with facilities like a training room and audio-visual learning aids.
Selection of Trainers	Gynaecologists /surgeons who has undergone ToT (Training of Trainer) at National /State Level and certified as Laparoscopic Trainer. The state should maintain an updated list of certified trainers.
Duration of Training	Two weeks: 12 working days
Number of Trainees	2-3 teams (each team consisting of a Surgeon/gynaecologist, staff nurse and an OT technician) according to the case load in the training centre. (States/districts may plan for intensive IEC activities coinciding with training days to increase the number of clients.)
Key Contents	Overview of family planning services Pre and Post procedure counselling Clinical assessment and selection of clients Clinical Procedures as per standards: Infection Prevention, Surgical procedure, Post procedure follow -up Post surgical case management including early recognition and management of complications Other program Management components like Information, Education and Communication (IEC)/ Behavioural Change Communication (BCC) activities, Record keeping, Compensation scheme, Family Planning Insurance scheme, quality assurance and audit

Training/Learning Methods	Guided clinical practice on clients Illustrated lectures and group discussions
Training Materials For Trainers	Facilitator's Guide
For Participants	Workshop schedule and learning guides. Copy of "Standards for female and male sterilization", and "Quality assurance manual " by GOI.
Evaluation of the participants / Competency Certification	<p>Designated trainer In-Charge (I/C) for each training facility should ensure that each trainee is issued competency certificate after assessing the competencies (Knowledge and Skills) as per the following tools:</p> <ol style="list-style-type: none"> 1. Knowledge <ol style="list-style-type: none"> a. Pre- and mid-course questionnaire 2. Skills <ol style="list-style-type: none"> a. Checklist for Lap Clinical Skills for Doctors (completed by clinical trainer) 3. Each participant should be given opportunity to: <ol style="list-style-type: none"> a. Assist 5 cases b. Perform at least 10 cases (under the supervision of the trainer) <p>It is suggested that each trainee will maintain a record of all the cases he has assisted and performed.</p> <p>NOTE for trainers:</p> <ol style="list-style-type: none"> 1. The trainers should issue 'competency certificate' based on clinical competency of the trainee to perform the procedure systematically and without mistakes rather than basing on the number of procedures the trainee has performed. 2. If the trainee does not meet the certification criteria, he/she may be called back to undergo further training. No TA/DA will be paid for this additional training.

Annexure 4

Guidelines for organising Training in Minilap Tubectomy

Introduction	Minilap abdominal tubectomy, generally referred to as “Minilap,” is an abdominal surgical approach to the fallopian tubes by means of an incision 2-3 cm in length. It is also known as tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, Minilap, and “PPS’ if done just after delivery”.
Objectives	To update the participants with the knowledge and develop skills needed to perform the procedure. To develop communication and counselling skills. To develop the skills for managing surgical complications and routine follow-up care To develop managerial skills for provision of quality services.
Selection criteria Trainees/Participants Facility profile	Medical officers (MBBS) from identified facilities (including PHC) where the services can be provided. Facility should be equipped with Operation theatre for conducting minilap tubectomy as per Government of India Guidelines on “Standards for Male & Female Sterilisation
Selection of Training Centres Selection of Trainers	The states should aim at developing at least 1 ‘clinical training centre’ (based in District/ Sub-district Hospital) per district. Only those facilities with sufficient case load (more than 50 cases per month for training 2-3 trainees in minilap) should be identified and designated as “training centres”. In addition, the training centres should be well equipped for training with facilities like a training room and audio-visual learning aids. Medical officer (MBBS or MBBS with PG degree) who has undergone ToT (Training of Trainer) at National / State Level or certified as Minilap Trainer. The state should maintain an updated list of certified trainers.
Duration of Training	Two weeks: 12 working days
Number of Trainees	2-3 medical officers in a batch according to the case load in the training centre. (The states/districts may plan for intensive IEC activities coinciding with training days to increase the number of clients.)

Key Contents	<p>Overview of family planning services Pre and Post procedure counseling Clinical assessment and selection of clients Clinical Procedures as per standards: Infection Prevention, Surgical procedure, Post procedure follow -up Post surgical case management including early recognition and management of complications</p> <p>Other program Management components like Information, Education and Communication (IEC)/ Behavioral Change Communication (BCC) activities, Record keeping, Compensation scheme, Family Planning Insurance scheme, Quality assurance and audit</p>
Training/Learning Methods	<p>Guided clinical practice on clients Illustrated lectures and group discussions</p>
Training Materials For Trainers For Participants	<p>Facilitator's Guide Workshop schedule and learning guides.</p> <p>Reference manual on Minilap Abdominal tubectomy. Copy of "Standards for female and male sterilization" and "Quality assurance manual" by GOI.</p>
Evaluation of the participants / Competency Certification	<p>Designated trainer In-Charge (I/C) for each training facility should ensure that each trainee is issued competency certificate after assessing the competencies (Knowledge and Skills) as per the following tools:</p> <ol style="list-style-type: none"> 1. Knowledge <ol style="list-style-type: none"> a. Pre- and mid-course questionnaire 2. Skills <ol style="list-style-type: none"> a. Checklist for Minilap Clinical Skills for Doctors 3. Each participant should be given opportunity to: <ol style="list-style-type: none"> a. Assist 5 cases b. Perform 10 cases (under the supervision of the trainer) <p>It is suggested that each trainee will maintain a record of all the cases he has assisted and performed.</p> <p>NOTE for trainers:</p> <ol style="list-style-type: none"> 1. The trainers should issue 'competency certificate' based on clinical competency of the trainee to perform the procedure systematically and without mistakes rather than basing on the number of procedures the trainee has performed. 2. If the trainee does not meet the certification criteria, he/she may be called back to undergo further training. No TA/DA will be paid for this additional training.

Annexure 5

Monitoring the Quality of Training

The activities and the agencies responsible:

Activities	Responsible agency
Identification and designation of state trainers and training centres	State Family Welfare Director / RCH Project Director
Identification and designation of training coordinator, district trainers and training centres	District CMHO (I/C of RCH)
Assessing training load	District CMHO & Training Coordinator
Drawing up training calendar	District CMHO & Training Coordinator
Selection and nomination of trainees for training	District CMHO & Training Coordinator
Organization and management of trainings	District Training Coordinator
Certification of successful trainees	Clinical Trainer
Quality assurance of trainings	District Training Coordinator and Trainer
Post training support and follow-up	District Training Coordinator/ District CMHO

Budget Provision

Sl. No.	Budget Head	Rate per day per person (Rs.)
1	a)DA to MOs b) DA to SN/Technician	700 400
2	Honorarium to trainer	600
3	Working Lunch	150
4	Tea & Snacks	50
5	Incidental expenditure	250
		Subtotal
6	Institutional overheads	15% Of total exp
7	TA	as per state Government norms
	Grand Total	

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Annexure 7

Learning Guide/Checklist for Minilap Abdominal Tubectomy

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

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted.
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently.
3. **Proficiently Performed:** Step or task performed efficiently and precisely in proper sequence (if necessary).

STEPS/ TASKS		CASES				
GETTING READY AND ASSESSMENT OF CLIENT						
1.	Greet client respectfully and establish rapport.					
2.	Review client history, physical examination and haemoglobin and urine report.					
3.	Check that informed consent was obtained and verify client's identity.					
4.	Ensure that client has thoroughly washed abdominal and pelvic areas.					
5.	Ensure that client has recently voided.					
6.	Help position client flat on her back on operating table.					
7.	Determine that sterile or high level disinfected instruments and emergency tray are present.					
8.	Take and record vital signs.					
9.	Wash hands thoroughly with soap and water and air dry or dry with a clean cloth.					
10.	Place client in a lithotomy position.					
11.	Put new examination or high level disinfected surgical gloves on both hands.					
12.	Perform a per speculum examination to rule out any lesion in the cervix.					

13.	Perform a gentle bimanual pelvic examination.					
14.	Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.					
15.	Give IV medication, if needed (initial or maximum dose based on client's weight). If IM premedication is to be used, give it 25-30 minutes before the procedure.					
16.	Change into surgical apparel.					
17.	Perform surgical scrub (3-5 minutes) and put on clean or sterile gown.					
18.	Put sterile or high level disinfected surgical gloves on both hands.					
19.	Select incision site about 1-2 cm inferior to uterine fundus.					
20.	Apply antiseptic solution to the incision area two times using a circular motion.					
21.	Drape client for the procedure.					
22.	Throughout procedure communicate to the client					
LOCAL ANAESTHESIA						
1.	Raise a small skin wheal at the centre of incision site using 1% lignocaine (or equivalent) in a 10 or 20 ml sterile or high level disinfected syringe (dose 5mg/kg).					
2.	Starting at the centre of the planned incision, administer local anaesthesia (about 3-5 ml) just under the skin along both sides of the incision line.					
3.	Without withdrawing the needle again starting at the centre of the incision line, insert needle into the fascia at a 45° angle with the needle directed slightly superior 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 upto the subcutaneous level and repeat on the other side of incision line.					
5.	Insert the needle down through the rectus sheath to the peritoneum, aspirate and inject 1-2 ml into the peritoneal layer.					
6.	Withdraw needle and place in a safe area to prevent accidental needle pricks.					

7.	Test incision site with forceps tip for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).					
ABDOMINAL ENTRY						
8.	Make transverse/vertical, subumbilical skin incision, approximately 3 cm long at the preselected incision site (about 1-2 cm below uterine fundus).					
9.	Bluntly dissect subcutaneous tissues with scissor tips or fingers.					
10.	Identify and grasp fascia at two places with the Allis forceps and cut with scissors.					
11.	Separate rectus muscles in the midline (longitudinally) using blunt dissection with artery forceps.					
12.	Confirm identification of peritoneum.					
13.	While elevating the peritoneum with the forceps, make a small nick in the peritoneum with knife/scissors after confirming that there is no underlying bowel or abdominal viscera.					
14.	Enlarge opening vertically with scissors/ fingers, place artery forceps on upper and lower cut edges of peritoneum. (Place client in head-down, Trendelenburg position, if needed.)					
Locating Fallopian Tubes						
15.	Insert index finger/index finger and middle finger of one hand inside the incision and feel for the fundus of the uterus.					
16.	Slide the finger/s along the fundus laterally and a little posteriorly and feel for the Fallopian tube.					
17.	Trace the tube laterally with the fingers and roll it between them to confirm that it is the fallopian tube. If using one finger, hook the tube, lift it and roll it against the anterior abdominal wall. [Fallopian tube will be soft and mobile.]					
Grasping the Fallopian Tubes						
18.	Holding the tube between the two fingers or hooking over one finger gently bring it out through the abdominal incision.					
19.	Gently grasp the mid portion of the tube with the Babcock's forceps.					
20.	Identify the tube by tracing the tube laterally till the fimbrial end.					
Tubal Occlusion						
21.	While grasping the midportion of tube, transfix the tube with chromic catgut 1-0 making a loop of about 2-3 cms.					

22.	Tie the knots on both the sides of the tube.					
23.	Cut out one end of the loop and then the other with scissors ensuring that at least one cm. of the tubal stump above the ligature has been left behind.					
24.	While still holding the ligature inspect the stump for haemostasis and then release the tube, allowing it to return to the abdomen.					
25.	Repeat procedure on opposite side for the second tube.					
Closure (When haemostasis assured, close wound in layers)						
26	The closure of peritoneum is optional.					
27.	Secure the rectus sheath edges with interrupted/ continuous sutures.					
28.	Close skin with the same absorbable /non absorbable suture material.					
29.	Dress the wound.					
POST-OPERATIVE TASKS						
1.	Ensure that client is safely transferred to the post-operative (Recovery) area.					
2.	Ensure that the assistant disposes of disposable needles and syringes in a puncture-proof container <u>or</u> fill re-usable needles and syringes with 0.5% chlorine solution and soaks for decontamination for 10 minutes.					
3.	Ensure that assistant decontaminates instruments by soaking in 0.5% chlorine solution for 10 minutes.					
4.	Check that assistant disposes of waste materials according to infection prevention guidelines.					
5.	Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.					
6.	Wash hands thoroughly with soap and water and air dry or dry with clean cloth.					
7.	Ensure that client is monitored at regular intervals and that vital signs are taken.					
8.	Determine that client is ready for discharge (at least 2 hours after IV medication).					
9.	Ensure that post-operative instructions and follow-up schedule are given					

Annexure 8

Learning Guide/check List for Laparoscopic Tubal Ligation

STEP/TASK	CASES				
GETTING READY					
1. Change into surgical apparel.					
2. Greet client respectfully and establish rapport.					
3. Review client history, physical examination and haemoglobin and urine reports.					
4. Check that informed consent was obtained and verify client's identity.					
5. Check that client has thoroughly washed and rinsed abdominal and pelvic areas and dried them with a clean, dry cloth.					
6. Check that client has recently passed urine .					
7. Check that the client has been premedicated.					
PRE-OPERATIVE TASKS					
1. Help position client flat on her back on operating table.					
2. Determine that sterile or high-level disinfected laparoscopic instruments, fiber-optic cable, insufflator tubing and emergency tray are present and in working order.					
3. Check that insufflator apparatus and light source units are working.					
4. Record vital signs.					
5. Give IV medication.					
6. Wash hands thoroughly with soap and water and air dry.					
7. Put examination gloves on both hands.					
8. Place client in a Lithotomy position.					
9. Perform a gentle bimanual pelvic examination to assess uterine size, position and mobility and presence of any pelvic abnormality.					
10. Perform surgical scrub (3-5 minutes) and put on sterile gown.					
11. Put sterile or high-level disinfected surgical gloves on both hands.					

12. Apply antiseptic solution to the incision area two times using a circular motion.					
13. Drape client for the procedure.					
14. Check Laprocator system and trocar assembly unit.					
15. Throughout procedure communicate to client.					
LAPAROSCOPIC 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 gently to spread the anaesthetic within the tissues.					
8. Test incision site with tissue forceps for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site.)					
Creating Pneumoperitoneum either through veress needle or trocar directly					
9. Place client in a head down (Trendelenburg) position of not more than 20 degrees.					

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.					
11. Make a 1.5-2 cm incision along the rim of the lower umbilical margin.					
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.					
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.)					
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.					
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.					
16. Percuss the hypogastric area and listen for a drum-like sound, which will indicate pneumoperitoneum.					
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.					
18. Tell assistant to load rings.					
Abdominal Access					
19. Recheck trumpet valve and rubber seal of trocar sleeve to assure airtightness.					
20. Assemble the trocar unit by inserting the obturator into the trocar sleeve.					
21. Manually grasp and raise the anterior abdominal wall directly beneath the umbilicus.					
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.					
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.					

24. Slightly retract obturator and advance trocar sleeve 1-2 cm into the abdominal cavity. Completely remove obturator.					
25. Connect the insufflator tubing to the trocar stop cock. Insufflate air as needed.					
26. Connect the fiber-optic light cable to the Laprocator and ask the assistant to switch on the light source.					
27. Hold trocar trumpet valve mechanism between middle finger and thenar eminence of the non-dominant hand in palms down position.					
28. Hold the hand grip assembly of the Laprocator using the thumb, middle and ring fingers of the dominant hand. Allow the index finger to remain free.					
29. Insert Laprocator slowly under direct vision. Manoeuvres Laprocator-trocar unit towards pelvic cavity.					
30. Inspect and identify pelvic cavity structures. Elevate the uterus by depressing handle of the uterine elevator/manipulator.					
Laparoscopically Guided Tubal Ligation					
31. Locate and verify the tube by identifying anatomical landmarks such as the cornu and fimbria.					
32. Extend forceps prongs fully by pushing the trigger operating slide away from the handgrip.					
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.					
34. Slowly retract the tongs by pulling the trigger operating slide toward the hand grip. Move the Laprocator forward during tong retraction to reduce risk of lacerating or injuring the tube. Continue retracting until spring tension is felt.					
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.					
36. Slowly push away the operating slide to extend the forceps tongs and release the occluded fallopian tube.					
37. Inspect for adequacy of occlusion and for any active bleeding. Completely retract forceps tongs prior to inspection.					

38. Locate and verify the other tube.					
39. Place two ring adaptor in #2 position. Repeat steps 33-38 to occlude the other tube.					
40. Inspect pelvic cavity for bleeding and other organ injuries.					
41. Remove Laproscator from abdominal cavity and disconnect external light source.					
42. Keep open the trocar trumpet valve to desufflate the abdomen.					
43. Remove trocar after inserting the obturator in trocar sleeve. Bring the operating table from trendelenburg position to the horizontal position.					
44. Close incision with a single, simple stitch using absorbable or non-absorbable suture material.					
45. Dress the wound.					
POST-OPERATIVE TASKS					
1. Ensure that client is safely transferred to the post-operative (recovery) area.					
2. Ensure that the assistant disposes of disposable needles and syringes in a puncture-proof container or fill re-usable needles and syringes with 0.5% chlorine solution and soaks for decontamination for 10 minutes.					
3. Ensure that the assistant places instruments in 0.5% chlorine solution for decontamination and soaks for 10 minutes.					
4. Check that assistant disposes of waste materials according to infection prevention guidelines.					
5. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak 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.					

Overview of the Revised Compensation Scheme

A. High Focus States

Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chattisgarh, Uttrakhand, Orissa, Jammu & Kashmir, Himachal Pradesh, Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Tripura, Sikkim.

I. Public Facilities

Procedure	Acceptor	Motivator	Drugs & dressings	Surgeons' charges	Anesthetist charges	Staff nurse	OT technician	Refreshments	Camp management	Total (in Rs.)
Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
Tubectomy (ALL)	600	150	100	75	25	15	15	10	10	1000

2. Accredited Private/NGO Facilities

Procedure	Facility	Motivator	Total (in Rs.)
Vasectomy (ALL)	1300	200	1500
Tubectomy (ALL)	1350	150	1500

B. Non High Focus State

Karnataka, Kerala, Tamil Nadu, Andhra Pradesh, Maharashtra, Goa, Gujarat, Punjab, Haryana, West Bengal, Delhi, Chandigarh, Puducherry, Andaman and Nicobar Islands, Lakshadweep Islands, Dadra and Nagar Haveli, Daman and Diu.

I. Public Facilities

Procedure	Acceptor	Motivator	Drugs & dressings	Surgeons' charges	Anesthetist charges	Staff nurse	OT technician	Refreshments	Camp management	Total (in Rs.)
Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
Tubectomy (BPL/SC/ST only)	600	150	100	75	25	15	15	10	10	1000
Tubectomy (APL only)	250	150	100	75	25	15	15	10	10	650

Annexure 10

Family Planning Insurance Scheme (limit of indemnity)

Claims arising out of Sterilization Operation	Amount
A <i>Death at hospital/ within seven days of discharge</i>	Rs. 2,00,000/-
B <i>Death following sterilization (8th 30th day from the date of discharge)</i>	Rs. 50,000/-
C <i>Expenses for treatment of Medical Complications</i>	Rs. 25,000/-
D <i>Failure of Sterilization</i>	Rs. 30,000/-
E <i>Doctors/ Facilities covered for litigations up to 4 cases per year including defence cost</i>	Rs. 2,00,000/-

