Unit 10
FEMALE STERILISATION

Learning Objectives

- Define female sterilisation
- Describe the primary techniques of female sterilisation and how they work
- State the effectiveness of female sterilisation
- List the characteristics of female sterilisation
- List the potential complications of female sterilisation and how to manage them
- Correct misconceptions about female sterilisation
- Describe female sterilisation for HIV-positive clients
- Determine a client's medical eligibility for female sterilisation
- List the six points of informed consent for female sterilisation
- List the client assessment tasks required for female sterilisation
- Explain when women can undergo interval or postpartum minilaparotomy
- Describe the procedure for performing postpartum minilaparotomy
- Describe the procedure for performing interval minilaparotomy
- Demonstrate knowledge and skills in counselling clients to make an informed choice about female sterilisation
- Demonstrate competence in performing both postpartum minilaparotomy and interval minilaparotomy (for the cadres performing the procedure).

Teaching Resources in This Unit

Learning activities

Unit assessment

Unit 10: Female Sterilisation

Key Points

- **Highly effective and safe contraception**
- **Permanent.** Intended to provide life-long protection against pregnancy. Reversal is usually not possible.
- **Involves a physical examination and surgery.** A specifically trained provider is needed for the procedure.
- **No long-term side effects.**

10.1 Defining Female Sterilisation

Female sterilisation is a procedure for permanently occluding the fallopian tubes for clients who do not want more children.

Techniques of female sterilisation

Female sterilisation is also called tubal sterilisation, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, mini-lap and "the operation." This unit provides information and instruction primarily for postpartum and interval minilaparatomy procedures.

Two surgical approaches are most commonly used:

- **Minilaparatomy (minilap)** involves making a 2-5 cm incision in the abdomen. The fallopian tubes are brought to the incision and cut or blocked. Minilaparotomy can be performed up to 7 days after childbirth (**postpartum minilap)**, or 6 weeks or more after childbirth (**interval minilap)**.
- **Laparoscopy** involves inserting a long thin tube with a lens in it into the abdomen through a small incision. Laparoscopy enables the clinician to see and block or cut the fallopian tubes in the abdomen without making a large incision in the skin. In general, laparoscopy is not performed postpartum.

Other surgical approaches for female sterilisation include the **transcervical approach**, which involves the use of special equipment to implant blocking devices in the fallopian tubes by passing through the cervix and uterus. Sterilisation can also be performed at the time of a **caesarean section** if the woman was counselled, and she gave her consent prior to the procedure.

How female sterilisation works

Sterilisation procedures work by blocking or cutting the fallopian tubes, usually by tying and cutting or through electrocautery. Eggs released from the ovaries are thereby prevented from moving down the tubes and meeting the sperm.

10.2 Effectiveness

Female sterilisation is one of the most effective contraceptive methods, but it has a small risk of failure.

- Less than 1 pregnancy occurs per 100 clients over the first year after having the sterilisation procedure (5 per 1,000). This means that 995 of every 1,000 clients relying on female sterilisation will not become pregnant, or it is 99.5% effective.
- A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause.

Fertility does not return because sterilisation generally cannot be stopped or reversed. The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas.

10.3 Characteristics

Advantages

- Highly effective
- Has no lasting side effects
- Permanent, no need to think about contraception again
- Does not affect sexual function, menstruation or breastfeeding
- Is easy to use, nothing to do or to remember

Disadvantages

- Requires surgical procedure
- Does not provide protection from sexually transmitted infections (STIs), including HIV

Side effects

None, except short-term effects of surgery.

Health benefits

- May help protect against pelvic inflammatory disease (PID)
- May help protect against ovarian cancer

Health risks

Uncommon to extremely rare:

- Complications of surgery and anaesthesia (see Section 10.4)

10.4 Complications of Surgery

Complications of female sterilisation are uncommon, but include:

- Adverse reactions to anaesthesia
- Infection or abscess of the incision site
- Bleeding in the abdomen (from the cut fallopian tubes)

Female sterilisation is a safe method of contraception. It requires surgery and anaesthesia, however, which carry some risks. Serious complications are uncommon. Death due to the procedure or anaesthesia is extremely rare. The risk of complications with local anaesthesia is significantly lower than with general anaesthesia.

10.5 Correcting Misconceptions

Female sterilisation:

- Does not lead to loss of femininity or sexual desire
- Does not make the woman weak or cause lasting pain in the back, uterus or abdomen

- Does not require removal of uterus or lead to a need to have it removed
- Does not cause heavier bleeding or otherwise change the woman's menstrual cycle
- Does not cause weight gain, or changes in appetite or appearance
- Does not cause hormonal imbalances, and eggs do not build up in the body.

10.6 Women Who Can Have Female Sterilisation

With proper counselling and informed consent, any woman can have female sterilisation safely, including clients who:

- Have no children or few children
- Are not married
- Are young
- Just gave birth (within the last 7 days)
- Just had an uncomplicated abortion or miscarriage
- Are breastfeeding
- Are infected with HIV, whether or not on antiretroviral (ARV) therapy.

In some of these situations, especially careful counselling is important to make sure the client will not regret her decision. Women can have female sterilisation:

- Without any blood tests or routine laboratory tests
- Without cervical cancer screening
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant. (See the Pregnancy Checklist in Unit 4, Client FP Assessment and WHO MEC.)

10.7 Female Sterilisation for Women with HIV

- Clients who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo female sterilisation. Special arrangements are needed to perform female sterilisation on a woman with AIDS. (See Medical Eligibility, Section 10.8.)
- These clients should be encouraged to use condoms in addition to female sterilisation. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into having female sterilisation, and that includes clients with HIV/AIDS.

10.8

Medical Eligibility Criteria Screening Questions For Female Sterilisation

All women can have female sterilisation.

The WHO Medical Eligibility Criteria (MEC) categories for permanent contraception (vasectomy and female sterilisation) are different than those for other contraceptive methods. Instead of using Categories 1- 4, the categories for these methods are: **Accept**, **Caution**, **Delay**, and **Special**.

In the case of female sterilisation, no medical conditions prevent a woman from using this method, although some conditions require **caution**, **delay**, or making **special** arrangements.

These screening questions identify known medical conditions that may limit when, where, or how the female sterilisation procedure should be performed. Ask the client the questions below. If she answers "no" to all of the questions, then the female sterilisation procedure can be performed in a routine setting without delay. If no concerns are identified, the provider should perform a pelvic exam before scheduling the procedure. If she answers "yes" to a question, follow the instructions, which recommend caution, delay, or special arrangements.

In the set of screening questions below:

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- *Delay* means postpone female sterilisation. These conditions must be treated and resolved before female sterilisation can be performed. Give the client another method to use until the procedure can be performed.
- *Special* means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

1. Do you have any current or past female conditions or problems (gynaecologic or obstetric conditions or problems), such as infection or cancer? If so, what problems?

Action	Condition
If she has any of these, use **caution**	• Past pelvic inflammatory disease since last pregnancy • Uterine fibroids • Previous abdominal or pelvic surgery
If she has any of these, **delay** female sterilisation	• Current pregnancy • 7–42 days postpartum • Postpartum after a pregnancy with severe pre-eclampsia or eclampsia • Serious postpartum or postabortion complications (such as infection, hemorrhage, or trauma) except uterine rupture or

	perforation, which requires special arrangements (see below) • A large collection of blood in the uterus • Unexplained vaginal bleeding that suggests an underlying medical condition • Pelvic inflammatory disease • Purulent cervicitis, chlamydia, or gonorrhea • Pelvic cancers (treatment may make her sterile in any case) • Malignant trophoblast disease
If she has any of these, make **special arrangements**	• AIDS (see Female Sterilisation for Women With HIV, Section 10.7) • Fixed uterus due to previous surgery or infection • Endometriosis • Hernia (abdominal wall or umbilical) • Postpartum or postabortion uterine rupture or perforation

2. Do you have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or complications of diabetes? If so, what?

Action	Condition
If she has any of these, use **caution**	• Controlled high blood pressure • Mild high blood pressure (140/90 to 159/99 mm Hg) • Past stroke or heart disease without complications
If she has any of these, **delay** female sterilisation	• Heart disease due to blocked or narrowed arteries • Blood clots in deep veins of legs or lungs
If she has any of these, make **special arrangements**	• Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes • Moderately high or severely high blood pressure (160/100 mm Hg or higher) • Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes • Complicated valvular heart disease

3. Do you have any lingering, long-term diseases or any other conditions? If so, what?

Action	Condition
If she has any of these, use **caution**	• Epilepsy • Diabetes without damage to arteries, vision, kidneys, or nervous system

	• Hypothyroidism • Mild cirrhosis of the liver, liver tumours (Are her eyes or skin unusually yellow?), or schistosomiasis with liver fibrosis • Moderate iron-deficiency anaemia • Sickle cell disease • Inherited anaemia (thalassemia) • Kidney disease • Diaphragmatic hernia • Severe lack of nutrition (Is she extremely thin?) • Obesity (Is she extremely overweight?) • Elective abdominal surgery at time sterilisation is desired • Depression • Young age • Uncomplicated lupus
If she has any of these, **delay** female sterilisation	• Gallbladder disease with symptoms • Active viral hepatitis • Severe iron-deficiency anaemia (hemoglobin less than 7 g/dl) • Lung disease (bronchitis or pneumonia) • Systemic infection or significant gastroenteritis • Abdominal skin infection • Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization
If she has any of these, make **special arrangements**	• Severe cirrhosis of the liver • Hyperthyroidism • Coagulation disorders (blood does not clot) • Chronic lung disease (asthma, bronchitis, emphysema, lung infection) • Pelvic tuberculosis • Lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment

10.9 The 6 Points of Informed Consent

Female sterilisation counselling must cover all 6 points of informed consent. In some programs the client and the counsellor both sign an informed consent form. To give informed consent for female sterilisation, the client must understand the following points:

- Temporary contraceptives are also available to the client.
- Sterilisation is a surgical procedure.

- There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
- If successful, the procedure will prevent the client from having any more children.
- The procedure is considered permanent and probably cannot be reversed.
- The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

10.10 Timing: When to Provide Female Sterilisation

Important: If there is no medical reason to delay, a woman can have the female sterilisation procedure any time she wants, if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist. (See Unit 4: Client Family Planning Assessment and WHO MEC.)

Woman's Situation	When to Perform
Having menstrual cycles or switching from another method	**Any time of the month** • Any time within 7 days after the start of her monthly bleeding. There is no need to use another method before the procedure. • If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant. • If she is switching from oral contraceptives, she can continue taking pills until she has finished the pill pack to maintain her regular cycle. • If she is switching from an IUCD, she can have the procedure immediately.
No monthly bleeding	• Any time it is reasonably certain she is not pregnant
After childbirth	• Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance • Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant
After miscarriage or abortion	• Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance
After using emergency contraceptive pills (ECPs)	• The sterilisation procedure can be done within 7 days after the start of her next monthly bleeding or any other time it is reasonably certain she is not pregnant. Give her a backup method or oral contraceptives to start the day after she finishes the ECPs to use until she can have the sterilisation.

10.11 Client Instructions

Explaining the procedure

A client who has chosen female sterilisation needs to know what will happen during the procedure. The following description can help explain the procedure to her. Learning to perform female sterilisation takes training and practice under direct supervision. Therefore, this description is a summary and not detailed instructions.

Postpartum minilap

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination (cardiopulmonary, abdominal, and pelvic exam including bimanual). The pelvic examination is to assess the condition and mobility of the uterus and to be certain there are no signs of infection.
3. The client should not have anything to eat or drink prior to the procedure.
4. The provider usually gives the client local anaesthesia, which is injected at the lower edge of the navel to reduce pain. The client will feel a needle stick in her belly when the clinician injects the anaesthesia. The area around the injection will become numb.
5. The provider makes a small, horizontal incision 2-3 cm in the anesthetized area. The client will feel pressure, but it should not be painful.
6. The client stays awake throughout the procedure and feels little discomfort. She will probably feel some tugging, pulling, and slight cramping during the operation. The provider gives continual verbal feedback (verbal anaesthesia), explaining what he/she is doing, to reassure the client.
7. Each tube is cut and tied or cauterized.
8. The provider closes the incision with stitches and covers it with a sterile adhesive bandage.
9. The provider instructs the client what to do after she leaves the clinic or hospital.

Interval minilap

1. The provider uses proper infection prevention procedures at all times.
2. The provider performs a physical examination (cardiopulmonary, abdominal, and pelvic exam, including bimanual). The pelvic examination is to assess the condition and mobility of the uterus and to be certain there are no signs of infection.
3. The client should not have anything to eat or drink prior to the procedure.
4. The provider may give the client medication to relax her, usually through an I.V. line.
5. The provider usually gives the client local anaesthesia, which is injected above the pubic hair line to reduce pain. The client will feel a needle stick in this area when the clinician injects the anaesthesia. The area around the injection will become numb.
6. The provider inserts a uterine elevator into the vagina, through the cervix and into the uterus. This helps to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort but is not much different than having a regular pelvic exam with a speculum in the vagina.
7. The provider makes a transverse incision (2–3 cm) in the anaesthetized area.

8. The client stays awake throughout the procedure and feels little discomfort. She will probably feel some tugging, pulling, and slight cramping during the operation. The provider gives continual verbal feedback (verbal anaesthesia), explaining what he/she is doing, to reassure the client.
9. Each tube is tied and cut or cauterized.
10. The provider closes the incision with stitches and covers it with an adhesive bandage.
11. The provider instructs the client what to do after she leaves the clinic or hospital.

Preparing for the procedure

Tell the client the following:

- Use another contraceptive until the procedure (for interval minilap).
- Do not eat anything for 8 hours before surgery. It is okay to drink clear liquids until 2 hours before surgery.
- Do not take any medication for 24 hours before the surgery unless told to do so.
- Wear clean, loose-fitting clothing to the health facility if possible.
- Do not wear nail polish or jewellery.
- Bring a friend or relative, if possible, to accompany you home afterwards, as you may feel weak from the anaesthesia.

After the procedure

Give instructions orally and in writing, if appropriate. Ask client to repeat instructions.

- Rest for 2 days. Gradually resume normal activities as you feel able. You should be able to return to normal activities within 7 days.
- Keep the incision clean and dry for 2 days.
- Avoid heavy lifting and other strenuous physical activity for a week.
- Avoid rubbing the incision for 1 week.
- Do not have sex for at least 1 week and after resuming, stop if it is uncomfortable.
- It is normal to have some abdominal pain and local swelling after the procedure. It usually goes away within a few days. For pain relief take paracetamol (500–1000 mg) or ibuprofen every 4–6 hours.
- Return for follow-up 7 days after surgery.
- Return to the clinic immediately if you have any of the warning signs of possible complications. (See Section 10.12.)

10.12 Warning Signs of Complications

- Bleeding or fluid coming from the incision, or heat swelling, or redness of the incision area
- Persistent or increasing abdominal pain
- Fever (greater than 38° C/100° F)
- Fainting, persistent light-headedness, or extreme dizziness, especially in the first week
- Signs or symptoms of pregnancy.

10.13 Managing Complications

Problems can affect women's satisfaction with female sterilisation, and they deserve the provider's attention. If the client reports complications of female sterilisation, listen to her concerns and, if appropriate, treat.

Infection at the incision site (redness, heat, pain, pus)

- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return if the infection has not cleared after taking all antibiotics.

Abscess (a pocket of pus under the skin caused by infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess, and treat the wound.
- Give antibiotics for 7 to 10 days (may need intravenous antibiotics depending on the client's condition).
- Ask the client to return if she has heat, redness, pain, or drainage of the wound after taking all antibiotics.

Severe pain in lower abdomen, fainting with dizziness (suspected ectopic pregnancy)

- See Managing Ectopic Pregnancy, below.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.

Managing ectopic pregnancy

Ectopic pregnancy is any pregnancy that occurs outside the uterine cavity. Early diagnosis is important. Ectopic pregnancy is rare, but could be life-threatening and is more likely to happen after a woman has undergone sterilisation (see Question 11, Section 10.14).

- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually (usually by 6-8 weeks of pregnancy) they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness
  - Light-headedness or dizziness
  - Fainting.
- Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern
- Ruptured ectopic pregnancy: Sudden sharp or stabbing lower abdominal pain, sometimes on one side and sometimes throughout the body, suggests a ruptured ectopic pregnancy (when the fallopian tube breaks due to the pregnancy). Right shoulder pain may develop due to blood pressing on the diaphragm. Usually, within a few hours the abdomen becomes rigid, and the woman goes into shock.
- Care: Ectopic pregnancy is a life-threatening, emergency condition requiring immediate surgery. If ectopic pregnancy is suspected, perform a pelvic examination only if facilities

for immediate surgery are available. Otherwise, immediately refer and/or transport the woman to a facility where definitive diagnosis and surgical care can be provided.

10.14 Questions and Answers about Female Sterilisation

1. **Will sterilisation change a woman's monthly bleeding or make monthly bleeding stop?**

   No. Most research finds no major changes in bleeding patterns after female sterilisation. If a woman was using a hormonal method or IUCD before sterilisation, her bleeding pattern will return to the way it was before she used these methods. For example, women switching from COCs to female sterilisation may notice heavier bleeding as their monthly bleeding returns to usual patterns. Note, however, that a woman's monthly bleeding usually becomes less regular as she approaches menopause.

2. **Will sterilisation make a woman lose her sexual desire? Will it make her fat?**

   No. After sterilisation a woman will look and feel the same as before. She can have sex the same as before. She may find that she enjoys sex more because she does not have to worry about getting pregnant. She will not gain weight because of the sterilisation procedure.

3. **Should sterilisation be offered only to women who have had a certain number of children, who have reached a certain age, or who are married?**

   No. There is no justification for denying sterilisation to a woman just because of her age, the number of her living children, or her marital status. Health care providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each woman must be allowed to decide for herself whether or not she will want more children and whether or not to have sterilisation.

4. **Is it not easier for the woman and the health care provider to use general anaesthesia? Why use local anaesthesia?**

   Local anaesthesia is safer. General anaesthesia is more risky than the sterilisation procedure itself. Correct use of local anaesthesia removes the single greatest source of risk in female sterilisation procedures—general anaesthesia. Also, after general anaesthesia, women usually feel nauseous. This does not happen as often after local anaesthesia.

   When using local anaesthesia with sedation, however, providers must take care not to overdose the woman with the sedative. They also must handle the woman gently and talk with her throughout the procedure. This helps her to stay calm. With many clients, sedatives can be avoided, especially with good counselling and a skilled provider.

5. **Does a woman who has had a sterilisation procedure ever have to worry about getting pregnant again?**

   Generally, no. Female sterilisation is very effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however. Women who have been sterilized have a slight risk of becoming pregnant: About 5 of every 1,000 women become pregnant within a year after the procedure. The small risk of pregnancy remains beyond the first year and until the woman reaches menopause.

6. **Pregnancy after female sterilisation is rare, but why does it happen at all?**

   Most often it is because the woman was already pregnant at the time of sterilisation. In some cases an opening in the fallopian tube develops, permitting the egg to travel through

and meet the sperm. Pregnancy also can occur if the provider makes a cut in the wrong place instead of the fallopian tubes.

7. Can sterilisation be reversed if the woman decides she wants another child?

Generally, no. Sterilisation is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse sterilisation is possible for only some women, but, among these women, reversal often does not lead to pregnancy. The procedure is difficult and expensive, and providers who are able to perform such surgery are hard to find. When pregnancy does occur after reversal, the risk that the pregnancy will be ectopic is greater than usual. Thus, sterilisation should be considered irreversible.

8. Is it better for the woman to have female sterilisation or the man to have a vasectomy?

Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilisation.

9. Will the female sterilisation procedure hurt?

Yes, a little. Women receive local anaesthetic to stop pain, and, except in special cases, they remain awake. A woman can feel the health care provider moving her uterus and fallopian tubes. This can be uncomfortable. If a trained anaesthetist or anaesthesiologist and suitable equipment are available, general anaesthesia may be chosen for women who are very frightened of pain. A woman may feel sore and weak for several days or even a few weeks after surgery, but she will soon regain her strength.

10. How can health care providers help a woman decide about female sterilisation?

Provide clear, balanced information about female sterilisation and other family planning methods, and help a woman think through her decision fully. Thoroughly discuss her feelings about having children and ending her fertility. For example, a provider can help a woman think how she would feel about possible life changes such as a change of partner or a child's death. Review the 6 Points of Informed Consent (Section 10.9) to be sure the woman understands the sterilisation procedure.

11. Does female sterilisation increase the risk of ectopic pregnancy?

No. On the contrary, female sterilisation greatly reduces the risk of ectopic pregnancy. Ectopic pregnancies are very rare among women who have had a sterilisation procedure. The rate of ectopic pregnancy among women after female sterilisation is 6 per 10,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 65 per 10,000 women per year.

On the rare occasions that sterilisation fails and pregnancy occurs, 33 of every 100 (1 of every 3) of these pregnancies are ectopic. Thus, most pregnancies after sterilisation failure are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if sterilisation fails.

12. Where can female sterilisation be performed?

If no pre-existing medical conditions require special arrangements:

- Minilaparotomy can be provided in maternity centres and basic health facilities where surgery can be done. These include both permanent and temporary facilities that can refer the woman to a higher level of care in case of emergency.
- Laparoscopy requires a better equipped centre where the procedure is performed regularly, and where specialized equipment and an anaesthetist are available.

13. What are transcervical methods of sterilisation?

Transcervical methods involve new ways of reaching the fallopian tubes, through the vagina and uterus. A microcoil, Essure, is already available in some countries. Essure is a spring-like device that a specifically trained clinician using a viewing instrument (hysteroscope) inserts through the vagina into the uterus and then into each fallopian tube. Over the 3 months following the procedure, scar tissue grows into the device. The scar tissue permanently plugs the fallopian tubes so that sperm cannot pass through to fertilize an egg. Essure is unlikely to be introduced in low-resource settings soon, however, because of the high cost and complexity of the viewing instrument required for insertion.

Female Sterilisation Role Play

Participant Roles

Clinician: The clinician is an experienced family planning service provider. She/he is calm and knowledgeable when counselling clients.

Client: The client is a 33-year-old woman with 2 children. She has successfully used DMPA as her method of family planning for 6 years and is very happy with it. Her husband is now certain that he is too old to raise any more children and has suggested that she be sterilised; he says he is also concerned about her taking so many hormones for such a long time.

Situation

The client now comes to the clinic to get more information on sterilisation. She says that she too does not want to have any more children but is satisfied with DMPA and is not sure why she should change. She is also concerned, however, that she may be taking too much medication for too long a period of time. She repeatedly asks about the permanent nature of sterilisation.

Female Sterilisation Quiz Questions

Directions: Circle the best answer for each question

1. As compared to vasectomy, which of the following is an important issue to note with regard to female sterilisation?
    a. More effective
    b. Less expensive
    c. Safer
    d. All of the above
    e. None of the above
2. Possible complications of female sterilisation include all of the following except:
    a. Infection at incision site
    b. Loss of sexual function
    c. Abscess
    d. None of the above
3. Female sterilisation has an effectiveness rate of:
    a. 95%
    b. 97.5%
    c. 99.5%
    d. 100%
4. Types of female sterilisation procedures include:
    a. Minilaparotomy
    b. Laparascopy
    c. Vasectomy
    d. (a) and (b) above
    e. All of the above
5. Female sterilisation protects against pregnancy for an average of:
    a. 3-5 years
    b. 8-10 years
    c. 15 years
    d. Female sterilisation protects against pregnancy permanently.
6. Which of the following are true about female sterilisation? (Tick all that apply)
    a. Can be performed within 7 days after giving birth, if voluntary informed consent is given in advance
    b. Requires removal of the uterus
    c. Ends menstruation in women who undergo the procedure
    d. Should never be performed on a woman who has never had children
    e. Requires a pelvic exam
7. Essential points about informed consent for female sterilisation include: (Tick all that apply)
    a. Temporary contraceptives are also available.
    b. Sterilisation involves a surgical procedure.
    c. The sterilisation procedure involves no risks.
    d. The sterilisation procedure can be reversed whenever the woman desires pregnancy.
    e. All of the above

Questions 8–16: Indicate whether the following statements about female sterilisation are **true** or **false by writing a "T" for true or an "F" for false in the space provided before each statement.**

___8. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.

___9. The female sterilisation provider should verify a client's informed consent by talking with her before the procedure.

___10. During female sterilisation counselling the client should be assured that she can change her mind at any time before the procedure without losing the right to other medical services.

___11. A woman with uterine fibroids cannot undergo female sterilisation.

___12. A pre-female sterilisation evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.

___13. A client with chlamydia should delay female sterilisation until the infection is treated.

___14. A client whose female sterilisation needs to be delayed should be counselled about alternative methods of contraception to use in the meantime.

___15. After female sterilisation, a woman should use backup contraception for 3 weeks, until the sterilisation takes effect.

___16. Female sterilisation provides protection against pregnancy and sexually transmitted infections.

Female Sterilisation Quiz Questions Answer Key

1. As compared to vasectomy, which of the following is an important issue to note with regard to female sterilisation?
    e. None of the above
2. Possible complications of female sterilisation include all of the following except:
    b. Loss of sexual function
3. Female sterilisation has an effectiveness rate of:
    c. 99.5%
4. Types of female sterilisation procedures include:
    d. (a) and (b) above
5. Female sterilisation protects against pregnancy for an average of:
    d. Female sterilisation protects against pregnancy permanently.
6. Which of the following are true about female sterilisation? (Tick all that apply)
    a. Can be performed within 7 days after giving birth, if voluntary informed consent is given in advance
    e. Requires a pelvic exam
7. Essential points about informed consent for female sterilisation include: (Tick all that apply)
    a. Temporary contraceptives are also available.
    b. Sterilisation involves a surgical procedure.

Questions 8–16: Indicate whether the following statements are **true** or **false by writing a "T" for true or an "F" for false in the space provided before each statement.**

F___8. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.

T___9. The female sterilisation provider should verify a client's informed consent by talking with her before the procedure.

T___10. During female sterilisation counselling the client should be assured that she can change her mind at any time before the procedure without losing the right to other medical services.

F___11. A woman with uterine fibroids cannot undergo female sterilisation.

F___12. A pre-female sterilisation evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.

T___13. A client with chlamydia should delay female sterilisation until the infection is treated.

T___14. A client whose female sterilisation needs to be delayed should be counselled about alternative methods of contraception to use in the meantime.

F___15. After female sterilisation, a woman should use backup contraception for 3 weeks, until the sterilisation takes effect.

F___16. Female sterilisation provides protection against pregnancy and sexually transmitted infections.

Learning Guide for Minilaparotomy Counselling 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 not progressing from step to step efficiently

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

Participant_____ Course Dates_____

Learning Guide for Minilaparotomy Counselling Skills

Task/Activity	**Cases**				
BCS+ STEPS 1-6: SEE UNIT 5 FOR BCS+ LEARNING GUIDE					
STEP 7: DETERMINE CLIENT'S MEDICAL ELIGIBILITY FOR THE CHOSEN METHOD.					
1. Use the MEC Screening Questions for Female Sterilisation to determine if delay or special arrangements are indicated.					
2. Advise the client according to their answers to the screening questions.					
STEP 8: GIVE THE CLIENT COMPLETE INFORMATION ABOUT THE METHOD THAT SHE HAS CHOSEN					
1. Clearly discuss the benefits of minilap. Emphasize that it is a permanent method but there is a small chance of failure.					
2. Explain the importance of the spouse being involved in decision for MINILAP.					
3. (If woman has chosen Postpartum Minilap) Discuss whether the client's decision to have female sterilization might change if the baby were to die or suffer from health problems.					
4. Explain that minilap does not protect against STIs, including AIDS. (If the client is at risk, she may need to use a barrier contraceptive method also).					
5. Explain common complications of the surgical procedure and be sure they are fully understood.					
6. Explain the surgical procedure and what to expect during and afterwards.					
7. Discuss scheduling procedure and possible need for contraception prior to minilap.					
STEP 9: CHECK THE CLIENT'S COMPREHENSION AND REINFORCE KEY INFORMATION					
1. Check the client's comprehension and reinforce key information					
2. Obtain client's signature or mark on the informed consent form.					
STEP 9A: (FOR PERMANENT METHODS) CONDUCT REQUIRED SCREENING EXAMINATIONS					
1. Perform pelvic exam (speculum and bi-manual)					
2. Advise woman based on exam findings ,and schedule minilap procedure as indicated.					
STEP 10: MAKE SURE THE CLIENT HAS MADE A DEFINITE DECISION. GIVE HER/HIM					

Learning Guide for Minilaparotomy Counselling Skills					
Task/Activity	**Cases**				
THE SELECTED METHOD					
PRE-PROCEDURE (EXAMINATION/PROCEDURE AREA)					
1. Review client history and physical examination to assure proper client selection.					
2. Verify client's identity and check that informed consent was obtained.					
3. Explain that she will feel discomfort and a little pain during the procedure and she should inform a member of the surgical team if she feels significant pain at any time.					
POST PROCEDURE					
1. After sedation has worn off, give postoperative instructions, orally and in writing if appropriate. Ask client to repeat instructions.					
2. Discuss what to do if the client experiences any problems.					
3. Schedule a return visit within 7 days (according to local protocols).					
4. Discuss arrangements for discharge (e.g., person accompanying client home).					
5. Assure client she can return to the same clinic at any time to receive advice or medical attention.					
6. Answer client questions.					
7. Complete client record.					

Learning Guide for Postpartum Minilaparotomy Operating Provider 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 not progressing from step to step efficiently

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

Participant_____ Course Dates_____

Learning Guide for Postpartum Minilaparotomy Operating Provider Skills					
Task/Activity	**Cases**				
GETTING READY					
1. Change into surgical apparel (scrub suit or dress, cap and mask).					
2. Greet client respectfully and establish rapport.					
3. Review client history and physical examination.					
4. Verify client's identity and check that informed consent was obtained.					
5. Confirm that the client has not consumed solid foods for 6 hours and fluids for 2 hours before surgery.					
6. Check that client has thoroughly washed and rinsed abdominal and perineal areas.					
7. Check that client has recently emptied her bladder.					
PRE-OPERATIVE TASKS					
1. Help position client flat on her back on operating table.					
2. Determine that sterile or high-level disinfected instruments and emergency tray are present.					
3. Give IV medication, if needed (initial or maximum dose based on client's weight).					
4. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
5. Determine height of the uterine fundus.					
6. Perform surgical scrub (3 to 5 minutes) and put on sterile gown.					
7. Put sterile or high-level disinfected surgical gloves on both hands.					
8. Apply antiseptic solution to the incision area 2 times using a circular motion.					
9. Drape client for the procedure.					
10. Throughout procedure talk to client (verbal anaesthesia).					

Learning Guide for Postpartum Minilaparotomy Operating Provider Skills						
Task/Activity	**Cases**					
ML/LA PROCEDURE						
LOCAL ANAESTHESIA: SUBUMBILICAL INCISION						
1a. Raise a small skin wheal at centre of incision site using 1% local anaesthetic (e.g., lignocaine without epinephrine) in a 10 or 20 ml sterile or high-level disinfected syringe (maximum total dose for procedure of 4.5mg/kg).						
1b. Starting at the centre of the planned incision, administer local anaesthetic (about 3-5 ml) just under the skin along both sides of the incision line.						
1c. Again starting at the centre of the incision line, insert needle into the fascia with the needle directed along the upper half of incision line.						
1d. Aspirate to ensure the needle is not in a blood vessel; then withdraw the needle slowly while injecting additional 3-5 ml of lignocaine without epinephrine. (Repeat on other half of incision line).						
2. Withdraw needle and place in a safe area to prevent accidental needle sticks.						
3. Massage the skin to spread the anaesthetic within the tissues.						
4. Test incision site for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).						
ABDOMINAL ENTRY: TRANSVERSE SUBUMBILICAL INCISION						
5. Make a transverse skin incision, approximately 3 cm long, about 1 cm inferior to uterine fundus.						
6. Bluntly dissect subcutaneous tissues with scissor tips (use retractors as needed).						
7. Identify anterior rectus sheath, grasp sheath at 2 places with forceps and cut transversely with scissors.						
8. Separate rectus muscles in the midline (longitudinally) using blunt dissection with hemostat and clean off preperitoneal tissue, if needed.						
9. Use retractors to adequately expose the peritoneum and grasp it with forceps, (If client feels pain, provide more local anaesthesia).						
10. Confirm identification of peritoneum. Move bowel or other abdominal tissue away from planned entry site with fingers or a small retractor.						
11. While elevating the peritoneum with the forceps and watching carefully to avoid bowel, make a small incision in the peritoneum with scissors.						
12. Enlarge opening vertically with scissors, place hemostat on upper and lower (superior and inferior) cut edges of peritoneum and reposition retractors (longitudinally) within abdominal cavity. (Place client in slight head-down, Trendelenburg position, as needed).						
13. Use retractors to move abdominal contents away from operative site. If necessary, insert ribbon gauze to keep abdominal tissues from incision site.						
LOCATING FALLOPIAN TUBES						

Learning Guide for Postpartum Minilaparotomy Operating Provider Skills					
Task/Activity	**Cases**				
14. Visually confirm presence of uterine fundus underneath incision site.					
15. With the retractors in place, gently reposition the incision over the right or left adnexa by manipulating the uterus through the abdominal wall.					
16. Visually confirm presence of corneal portion of tube at incision site.					
GRASPING THE FALLOPIAN TUBES: FORCEPS METHOD (MODIFIED POMEROY)					
17. Identify midportion of tube and gently grasp it with the Babcock forceps.					
18. Gently bring the tube through incision. (Do not lock forceps and avoid grasping the cornu).					
19. Identify fimbriated end of the tube by “walking” the forceps laterally.					
TUBAL OCCLUSION					
20. While grasping the midportion (isthmus) of tube, place single free tie (absorbable suture) around a 1-2 cm loop of tube (about 3 cm from cornu) and tie square knot.					
21. Cut out a loop of tube with scissors and while still holding ligature, inspect the stump for hemostasis.					
22. Cut ligature 1 cm from stump and release tube allowing it to return to abdomen.					
23. Repeat procedure on opposite side for second tube.					
CLOSURE (WHEN HEMOSTASIS ASSURED, CLOSE WOUND IN LAYERS)					
24. Secure rectus fascial edges with interrupted sutures.					
25. Close skin with absorbable suture material.					
26. Dress the wound with a sterile dressing.					
POST-OPERATIVE TASKS					
1. Ensure that client is safely transferred to the recovery area.					
2. Fill syringe (with needle attached) with 0.5% chlorine solution and soak for 10 minutes. Process syringe and needle according to infection prevention guidelines for reuse.					
3. Place instruments in 0.5% chlorine solution for decontamination and soak for 10 minutes.					
4. Dispose of waste materials according to 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.					
6. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
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 any IV medications have been administered).					

Learning Guide for Interval Minilaparotomy Operating Provider Skills

(to be used by participants)

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

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

5 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently

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

Participant_____ Course Dates_____

Learning Guide for Interval Minilaparotomy Operating Provider Skills

Task/Activity	**Cases**				
GETTING READY					
1. Change into surgical apparel (scrub suit or dress, cap and mask).					
2. Greet client respectfully and with kindness, and establish rapport.					
3. Review client history and physical examination.					
4. Verify client's identity and check that informed consent was obtained.					
5. Check that client has thoroughly washed and rinsed abdominal and pelvic areas.					
6. Check that client has recently emptied her bladder.					
PRE-OPERATIVE TASKS					
1. Help position client flat on her back on operating table, in the "frog leg" position (or in stirrups if available).					
2. Determine that sterile or high-level disinfected instruments and emergency tray are present.					
3. Give IV medication, if needed (initial or maximum dose based on client's weight).					
4. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
5. Put new examination or high-level disinfected surgical gloves on both hands.					
6. Perform a gentle bimanual pelvic examination to assess uterine size, position, and mobility and presence of any pelvic abnormality.					
7. Insert vaginal speculum to see the cervix.					
8. Apply antiseptic solution 2 times to the cervix (especially the os) and vagina.					
9. Insert uterine elevator into the cervix without touching the vaginal walls.					
10. Remove the vaginal speculum and tenaculum without dislodging uterine elevator and place in 0.5% chlorine solution for decontamination.					

Learning Guide for Interval Minilaparotomy Operating Provider Skills					
Task/Activity	**Cases**				
11. Determine fundal height by gently pushing down on exposed end of uterine elevator and palpating abdominally.					
12. Select incision site.					
13. Position client's leg flat on the operating table with handle of elevator between her thighs.					
14. 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.					
15. Perform surgical scrub (3-5 minutes) and put on sterile gown.					
16. Put sterile surgical gloves on both hands.					
17. Apply antiseptic solution to the incision area 2 times using a circular motion.					
18. Drape client for the procedure.					
19. Throughout procedure talk to client (verbal anaesthesia).					
ML/LA PROCEDURE					
LOCAL ANAESTHESIA					
1. Raise a small skin wheal at centre of incision site using 1% local anaesthetic (e.g., lignocaine) in a 10 or 20 ml sterile or high-level disinfected syringe (maximum dose for entire procedure of 4.5 mg/kg).					
2. Starting at the centre 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 centre of the incision line, insert needle into the fascia at 45^{o} angle with the needle directed slightly above the incision line.					
4. Aspirate to ensure the needle is not in a blood vessel; then withdraw the needle slowly while injecting 3-5 ml of lignocaine without epinephrine. (Repeat at 45^{o} angle directly below incision line.)					
5. Insert the needle down through the rectus sheath to the perineum, aspirate and inject 1-2 ml into the peritoneal layer.					
6. Withdraw needle and place in a safe area to prevent accidental needle sticks.					
7. Massage the skin 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).					
ABDOMINAL ENTRY					
9. Make a 3 cm transverse incision in the skin about 3 cm above the pubic symphysis (usually 1 cm below the height of the uterine fundus). Do not incise subcutaneous tissue. Control small bleeding vessels, if any.					
10. Bluntly dissect subcutaneous tissues with scissor tips (use retractors as needed).					
11. Identify and grasp fascia with Kelly forceps and incise transversely with scissors until rectus muscle can be seen on either side of the sheath.					

Learning Guide for Interval Minilaparotomy Operating Provider Skills					
Task/Activity	**Cases**				
12. Separate rectus muscles in the midline (longitudinally) using blunt dissection with hemostat and clean off preperitoneal tissue.					
13. Use retractors to adequately expose the peritoneum and grasp it with forceps. (If client feels pain, provide more local anaesthesia).					
14. Confirm identification of peritoneum. Move bowel or other abdominal tissue away from planned entry site.					
15. While elevating the peritoneum with the forceps to avoid bowel, make a small incision in the peritoneum with scissors.					
16. Enlarge opening with scissors, place hemostat on upper and lower cut edges of peritoneum and reposition retractors (vertically) within abdominal cavity.					
17. Use retractors to move abdominal contents away from operative site.					
LOCATING FALLOPIAN TUBES					
18. Gently push down on handle of uterine elevator to bring uterine fundus toward incision. (Place client in head-down,Trendelenburg position, as needed).					
19. Visually confirm presence of uterine fundus underneath incision site.					
20. Rotate uterine elevator around its long axis to bring right or left cornu and fallopian tube under incision site.					
21. Visually confirm presence of corneal portion of tube at incision site.					
GRASPING THE FALLOPIAN TUBES: FORCEPS METHOD					
22a. Identify midportion of tube and gently grasp it with the Babcock forceps.					
22b. Gently bring the tube through incision. (Do not lock forceps and avoid grasping the cornu).					
22c. Identify fimbriated end of the tube by “walking” the forceps laterally.					
GRASPING THE FALLOPIAN TUBES: TUBAL HOOK METHOD					
22a. Insert tubal hook behind uterus and move one end of hook laterally until it is positioned behind the mesosalpinx.					
22b. Press the handle against the abdominal wall until parallel (flat) with it.					
22c. Visualize mid-portion of the tube held by tubal hook and bring it up to the incision.					
22d. Insert a Babcock forceps and gently grasp the tube.					
22e. With the Babcock forceps grasp the midportion of the tube gently and bring it through the incision. (Do not lock forceps and avoid grasping the cornu).					
22f. Identify the fimbriated end of the tube by “walking” the forceps laterally.					
TUBAL OCCLUSION					
23. While grasping the midportion (isthmus) of tube, place single free tie (absorbable suture) around a 1-2 cm loop of tube (about 3 cm from cornu) and tie square knot.					

Learning Guide for Interval Minilaparotomy Operating Provider Skills						
Task/Activity	**Cases**					
24. Cut out a loop of tube with scissors and while still holding ligature, inspect the stump for hemostasis.						
25. Cut ligature 1 cm from stump and release tube allowing it to return to abdomen.						
26. Repeat procedure on opposite side for second tube.						
CLOSURE (WHEN HEMOSTASIS ASSURED, CLOSE WOUND IN LAYERS)						
27. Secure fascial sheath edges with 2 interrupted sutures.						
28. Close skin with absorbable suture material.						
29. Apply a sterile dressing to the incision.						
POST-OPERATIVE TASKS						
1. Remove the uterine elevator and place in 0.5% chlorine solution.						
2. Ensure that client is safely transferred to the post-operative (recovery) area.						
3. Fill syringe (with needle attached) with 0.5% chlorine solution and soak for 10 minutes. Process syringe and needle according to infection prevention guidelines for reuse.						
4. Place instruments in 0.5% chlorine solution for decontamination and soak for 10 minutes.						
5. Dispose of waste materials according to 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.						
7. Wash hands thoroughly with soap and water and dry with clean, dry cloth or 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 (at least 2 hours after IV medications).						

Learning Guide for Minilaparotomy Circulating Nurse Skills

(to be used by **p**articipants)

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 not progressing from step to step efficiently

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

Participant_____ Course Dates_____

Learning Guide for Minilaparotomy Circulating Nurse Skills					
Task/Activity	**Cases**				
PRE-OPERATIVE					
1. Change into surgical apparel (scrub suit or dress, cap and mask).					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
3. Ensure that all supplies including sedatives and lignocaine without epinephrine are present and equipment for monitoring vital signs is available.					
4. Greet client, review record, and assure that informed consent was obtained by the provider performing the minilaparotomy.					
5. Bring client to operating room and assist her onto operating table.					
6. Position client flat on her back on operating table.					
7. Take and record vital signs.					
8. Assist operating provider in tying surgical gown when he/she has scrubbed.					
9. Give IV analgesia for pain management.					
10. Prepare vaginal instruments for operating provider for internal examination.					
11. Assist with vaginal exam, and preparation and insertion of uterine elevator when operating provider directs (interval procedure only).					
12. Assist surgical assistant in handling of local anaesthesia.					
DURING SURGERY					
1. Talk to the client and be supportive of client during procedure.					
2. Anticipate and respond to needs of surgical team: • Provide local anaesthetic to nursing assistant • Obtain extra/special instruments as required • Tie gowns of surgical team • Adjust lights.					

Learning Guide for Minilaparotomy Circulating Nurse Skills					
Task/Activity	**Cases**				
3. Monitor and record client's vital signs during procedure and report any deviation from accepted norms to operating provider.					
4. Report to the operating provider any increase in client's discomfort or stress regarding: • Pain level • Level of consciousness • Signs of reaction to medication including: itching, nausea/vomiting, difficulty breathing, or swelling of lips and tongue.					
POST-OPERATIVE					
1. Provide dressing to cover incision after the procedure.					
2. Record vital signs before leaving operating room.					
3. Keep appropriate records during procedure and ensure record is complete regarding: • Vital signs • Instrument and gauze counts after procedure is complete • Time of procedure (total and skin to skin).					
4. Assist client transfer to the post-operative (recovery) area.					
5. Introduce client to post-operative area personnel and brief them on her condition (vital signs and any complications or problems).					

Learning Guide for Minilaparotomy Surgical Assistant Skills

(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 proper sequence (if necessary) but participant not progressing from step to step efficiently

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

Participant_____ Course Dates_____

Learning Guide for Minilaparotomy Surgical Assistant Skills					
Task/Activity	**Cases**				
PRE-OPERATIVE					
1. Change into surgical apparel (scrub suit or dress, cap and mask)					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
3. Prepare instruments for procedure and: • Ensure that sterile or high-level disinfected instruments are available and ready • Ensure that emergency instruments, equipment, drugs are available • Place sterile or high-level disinfected packs on the table.					
4. Perform surgical scrub (3-5 minutes) and put on sterile gown.					
5. Put sterile or high-level disinfected surgical gloves on both hands.					
6. Arrange instruments on instrument table.					
7. Assist operating provider in draping the client.					
8. After verifying drug strength, withdraw local anaesthetic from vial held by circulating nurse.					
9. Note start time of surgery for circulator to record.					
DURING SURGERY					
1. Throughout the procedure, talk to the client.					
2. Assist during surgery, working as a team with operating provider.					
3. Take gauze and instrument counts and report findings to circulator.					
4. Record end time of surgery for circulator to record.					
5. 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 (interval procedure only).					
3. Ensure that client is transferred to the post-operative (recovery) area.					
4. Place instruments and other items in 0.5% chlorine solution for decontamination (in OR).					
5. Dispose of specimen of tube according to guidelines.					

Learning Guide for Minilaparotomy Surgical Assistant Skills						
Task/Activity	**Cases**					
6. 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.						
7. Wash hands with soap and water and dry with clean, dry cloth or air dry.						
8. Prepare instruments and operating room table for next case.						

Learning Guide for Verbal Anaesthesia

These guidelines apply to the entire surgical team: operating provider, circulating nurse, surgical assistant.

(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 not progressing from step to step efficiently

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Participant_____ Course Dates_____

Learning Guide for Verbal Anaesthesia						
Task/Activity	**Cases**					
GETTING READY						
1. Greet client respectfully and with kindness.						
2. Tell client what you are going to do and encourage her to ask questions.						
3. Tell client she may feel discomfort during some of the steps and you will tell her in advance.						
4. Assess need for additional pain medication or sedation.						
PROCEDURE						
1. Explain each step of the procedure prior to performing it.						
2. Wait after performing each step or task for client to prepare for next one.						
3. Move slowly, without jerky or quick motions.						
4. Use instruments with confidence.						
5. Avoid saying things like “This won’t hurt” when it will hurt; or “I’m almost done” when you’re not.						
6. Talk with the client clearly and gently throughout the procedure.						

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