

Appendix A

Minilaparotomy Equipment, Instruments, and Supplies

Equipment

Adjustable operating table

Step stool

Operating light (fixed, or portable with stand)

Instrument tray on a Mayo table

Auxiliary table

IV stand

Waste bucket

Plastic bucket (for instrument decontamination)

Sphygmomanometer (one in each area—operating theater, recovery, etc.)

Stethoscope (one in each area—operating theater, recovery, etc.)

Medicine cabinet

Stretcher with wheels and sides, or a wheelchair

Comprehensive Instrument List

1 antiseptic solution cup

1 dressing forceps, standard pattern, 5"

1 tissue forceps, delicate pattern, 5.5"

2 Kelly artery forceps, straight, 5.5"

2 mosquito forceps, delicate, curved, 5"

2 Allis intestinal forceps, delicate, 6", 3 × 4 teeth

2 baby Babcock intestinal forceps, 7.5"

1 Schroeder tenaculum forceps, 10"

1 Foerster sponge forceps, straight, 9.5"

1 Foerster sponge forceps, curved, 9.5"

1 Mayo-Hegar needle holder, 7"

- 2 Richardson-Eastman retractors, same small size (for suprapubic procedure)
- 2 Army-Navy retractors, double-ended (for subumbilical procedure)
- 1 Metzenbaum scissors, curved, 7"
- 1 Mayo operating scissors, curved, 6.75"
- 1 surgical handle, #3, graduated in cm
- 1 Graves speculum, medium

Specialized Instruments

- 1 Ramathobodi uterine elevator, 28 cm in length
- 1 Ramathobodi tubal hook

Optional Instruments

- 1 kidney tray

Alternative Instruments

- 1 Jackson vaginal retractor, 1.5 × 3" (deep blade)

Supplies

- Hypodermic syringes, 10-20 cc
- Hypodermic needles
- Scalpel blades
- Absorbable suture (if possible, on an atraumatic needle)
- Nonabsorbable suture (if possible, on an atraumatic needle)
- Suture needles
- Gauze sponges or cotton swabs
- Surgical adhesive tape
- IV solutions (normal saline or 5% dextrose in water)
- Infusion sets with large-caliber needles or catheters (14-16 gauge) and tubing
- Urethral catheter
- Linen tape
- Exam gloves
- Sterile or high-level decontaminated gloves
- Protective eyewear
- Lubricant for nasopharyngeal intubation

Appendix B

Informed Consent Form for Sterilization Clients

I, _____, the undersigned, request that a sterilization via
(client's name)

_____ be performed on my person.
(specify the procedure)

I make this request of my own free will, without having been forced, pressured, or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to my partner and me.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work 100% on all people. There is a small failure rate. If the procedure is successful, I will be unable to have any more children.
5. This surgical procedure will not protect me and my partner from sexually transmitted infections (STIs), including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

Signature or mark of the client

Date

Signature of attending physician or delegated assistant

Date

If the client cannot read, a witness of the client's choosing, of the same sex and speaking the same language, must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness

Date

Appendix C

Adapted from

World Health Organization (WHO) Screening Guidelines for Female Sterilization

Surgical Sterilization Procedures

Considering the irreversibility or permanence of sterilization procedures, special care must be taken to ensure that the client has made a voluntary informed choice to have the procedure. Particular attention must be given in the case of young people, nulliparous women, and male partners who have not yet been fathers, and in clients with mental health problems, including depressive conditions. All women should be counseled about the permanence of sterilization and the availability of alternative, long-term, highly effective methods; this is of extra concern for young people. The national laws and existing norms for the delivery of sterilization procedures must be considered in the decision-making process.

There is no medical condition that would absolutely restrict a person's eligibility for sterilization. Some conditions and circumstances indicate that certain precautions should be taken.

The classification of conditions into the different categories is based on an in-depth review of the epidemiological and clinical evidence relevant to medical eligibility. The programmatic implications of these updated medical criteria are still to be addressed, taking into account the various levels of service delivery. However, for the particular case of sterilization procedures, the following category definitions were developed.

Definitions

- A Accept:** There is no medical reason to deny sterilization to a person with this condition.
- C Caution:** The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
- D Delay:** The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
- S Special:** The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or if there is otherwise any delay.

Sterilization does not protect against sexually transmitted infections (STIs) or HIV; if there is risk for STIs or HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STIs and HIV.

Female Sterilization

Condition	Category	New Evidence/Comments
Personal Characteristics and Reproductive History		
Pregnancy	D	
Young age	C	<p>New evidence: Studies show that up to 20% of women sterilized at a young age later regret this decision, and that young age is the strongest predictor of regret that can be identified before sterilization (Hardy et al., 1996; Hillis et al., 1999).</p> <p>Comments: All women should be counseled about the permanence of sterilization and the availability of alternative, long-term, highly effective methods. This is of extra concern for young women.</p>
Parity		
(a) Nulliparous	A	Comments: Counseling requires special care to ensure that an informed choice is being made.
(b) Parous	A	
Breastfeeding	A	Comments: There is no impact on lactation if local anesthesia is used and separation of mother and child is minimized.
Postpartum		
(a) <7 days	A	Comments: Sterilization can be safely performed immediately postpartum.
7 up to 28 days	D	
≥28 days	A	
(b) Preeclampsia/eclampsia		Comments: There are increased anesthesia-related risks.
(i) Mild preeclampsia	A	
(ii) Severe preeclampsia/eclampsia	D	
(c) Prolonged rupture of membranes (≥24 hours)	D	Comments: There are increased risks of postoperative infection.
(d) Puerperal sepsis, intrapartum or puerperal fever	D	Comments: This may indicate systemic or local infection; there is an increased risk for postoperative infection.
(e) Severe antenatal or postpartum hemorrhage	D	Comments: The client may be anemic and unable to tolerate further blood loss (see section below).

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
(f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery	D	Comments: There may have been significant blood loss and anemia. The procedure may be very painful.
(g) Uterine rupture or perforation	S	Comments: There may have been significant blood loss or damage to abdominal contents, which may increase the infection risk. If exploratory surgery or laparoscopy is conducted and the client is stable, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
Postabortion		
(a) Uncomplicated	A	
(b) Postabortal sepsis or fever	D	Comments: This condition may substantially increase the poststerilization infection risk.
(c) Severe postabortal hemorrhage	D	Comments: The client may be anemic and unable to tolerate further blood loss.
(d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion	D	Comments: The client may be anemic and unable to tolerate further blood loss. The procedure may be more painful.
(e) Uterine perforation	S	Comments: There may have been significant blood loss or damage to abdominal contents, which may increase the infection risk. If exploratory surgery or laparoscopy is conducted and the client is stable, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
(f) Acute hematometra	D	Comments: The client may be anemic and unable to tolerate further blood loss.
Past Ectopic Pregnancy		
	A	
Smoking		
(a) Age <35 years	A	
(b) Age ≥35 years		
(i) <15 cigarettes/day	A	
(ii) ≥15 cigarettes/day	A	
Obesity ≥30 kg/m ² body mass index (BMI)	C	Comments: The procedure may be more difficult. There is an increased risk for wound infection and disruption. The condition may require general anesthesia and may limit respiratory function.
Cardiovascular Disease		
Multiple risk factors for arterial cardiovascular disease (such as older age, smoking, diabetes, and hypertension)	S	Comments: The client may be at high risk for complications associated with anesthesia and surgery.

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
<p>Hypertension</p> <p>(a) History of hypertension, where blood pressure <i>cannot</i> be evaluated (including hypertension during pregnancy)</p> <p>(b) Adequately controlled hypertension, where blood pressure <i>can</i> be evaluated</p> <p>(c) Elevated blood pressure levels (properly taken measurements)</p> <p>(i) Systolic 140 to 159 mm Hg or diastolic 90 to 99 mm Hg</p> <p>(ii) Systolic \geq160 mm Hg or diastolic \geq100 mm Hg</p> <p>(d) Vascular disease</p>	<p>C</p> <p>C</p> <p>C</p> <p>S</p> <p>S</p>	<p>Comments:</p> <ul style="list-style-type: none"> ▪ Blood pressure should be controlled before surgery. ▪ There are increased anesthesia-related risks and an increased risk for cardiac arrhythmia. Blood pressure may be very labile and difficult to control in the early postpartum period. Appropriate monitoring of blood pressure intraoperatively is necessary.
<p>History of high blood pressure during pregnancy (where current blood pressure is measurable and normal)</p>	A	
<p>Deep venous thrombosis (DVT)/pulmonary embolism (PE)</p> <p>(a) History of DVT/PE</p> <p>(b) Current DVT/PE</p> <p>(c) Family history of DVT/PE (first-degree relatives)</p> <p>(d) Major surgery</p> <p>(i) With prolonged immobilization</p> <p>(ii) Without prolonged immobilization</p> <p>(e) Minor surgery without immobilization</p>	<p>A</p> <p>D</p> <p>A</p> <p>D</p> <p>A</p> <p>A</p>	<p>Comments: To reduce the risk for DVT/PE, early ambulation is recommended.</p>
<p>Superficial venous thrombosis</p> <p>(a) Varicose veins</p> <p>(b) Superficial thrombophlebitis</p>	<p>A</p> <p>A</p>	
<p>Current and history of ischemic heart disease</p> <p>(a) Current ischemic heart disease</p> <p>(b) History of ischemic heart disease</p>	<p>D</p> <p>C</p>	<p>Comments: The client is at high risk for complications associated with anesthesia and surgery.</p>

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
Stroke (history of cerebrovascular accident)	C	
Known hyperlipidemias	A	Comments: Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. Some types of hyperlipidemias are risk factors for vascular disease. The category should be assessed according to the type and its severity.
Valvular heart disease		
(a) Uncomplicated	C	Comments: The client requires prophylactic antibiotics.
(b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	S	Comments: The client is at high risk for complications associated with anesthesia and surgery. If she has unstable atrial fibrillation or current subacute bacterial endocarditis, the procedure should be delayed.
Neurological Conditions		
Headaches		
(a) Nonmigrainous (mild or severe)	A	
(b) Migraine		
(i) Without focal neurologic symptoms		
Age <35	A	
Age ≥35	A	
(ii) With focal neurologic symptoms (at any age)	A	
Epilepsy	C	
Reproductive Tract Infections and Disorders		
Vaginal bleeding patterns		
(a) Irregular pattern <i>without</i> heavy bleeding	A	
(b) Heavy or prolonged bleeding (includes regular and irregular patterns)	A	
Unexplained vaginal bleeding (suspicious for serious condition)		Comments: The condition must be evaluated before the procedure is performed.
Before evaluation	D	
Endometriosis	S	
Benign ovarian tumors (including cysts)	A	
Severe dysmenorrhea	A	

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
Trophoblast disease		
(a) Benign gestational trophoblastic disease	A	
(b) Malignant gestational trophoblastic disease	D	
Cervical ectropion	A	
Cervical intraepithelial neoplasia	A	
Cervical cancer (awaiting treatment)	D	Comments: In general, the treatment renders a woman sterile.
Breast disease		
(a) Undiagnosed mass	A	
(b) Benign breast disease	A	
(c) Family history of cancer	A	
(d) Cancer		
(i) Current	C	
(ii) Past, and no evidence of current disease for five years	A	
Endometrial cancer	D	Comments: In general, the treatment renders a woman sterile.
Ovarian cancer	D	Comments: In general, the treatment renders a woman sterile.
Uterine fibroids		
(a) Without distortion of the uterine cavity	C	Comments: Depending on the size and location of the fibroids, it might be difficult to localize the tubes and mobilize the uterus.
(b) With distortion of the uterine cavity	C	
Pelvic inflammatory disease (PID)		
(a) Past PID (assuming no current risk factors for STIs)		Comments: A careful pelvic examination must be performed to rule out recurrent or persistent infection and to determine the mobility of the uterus.
(i) With subsequent pregnancy	A	
(ii) Without subsequent pregnancy	C	
(b) PID (current or within the last three months)	D	Comments: PID can lead to an increased risk for poststerilization infection or adhesions.
STIs		
(a) Current (including purulent cervicitis)	D	Comments: <ul style="list-style-type: none"> ▪ There is an increased risk for postoperative infection. ▪ If no symptoms persist following treatment, sterilization may be performed.

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
(b) Within the last three months	A	
(c) Vaginitis without purulent cervicitis	A	
(d) Increased risk for STIs	A	
HIV/AIDS		
High risk for HIV	A	Comments: No routine screening is needed. Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures. The use of condoms is recommended following sterilization.
HIV-positive	A	
AIDS	S	Comments: If the client is currently suffering an AIDS-related illness, the procedure should be delayed.
Other Infections		
Schistosomiasis		
(a) Uncomplicated	A	
(b) Fibrosis of liver	C	Comments: Liver function may need to be evaluated.
Tuberculosis		
(a) Nonpelvic	A	
(b) Known pelvic	S	
Malaria		
Endocrine Conditions		
Diabetes		
(a) History of gestational disease	A	Comments: If blood glucose is not well controlled, referral to a higher-level facility is recommended.
(b) Nonvascular disease:		Comments:
(i) Non-insulin-dependent	C	▪ If blood glucose is not well controlled, referral to a higher-level facility is recommended.
(ii) Insulin-dependent	C	▪ There is a possible decrease in healing and an increased risk for wound infection. Use of prophylactic antibiotics is recommended.
(c) Nephropathy/retinopathy/neuropathy	S	▪ There is a risk for hypoglycemia or ketoacidosis.
(d) Other vascular disease or diabetes of >20 years' duration	S	
Thyroid		
(a) Simple goiter	A	
(b) Hyperthyroid	S	Comments: The woman is at high risk for complications associated with anesthesia and surgery.
(c) Hypothyroid	C	

Female Sterilization (continued)

Condition	Category	New Evidence/Comments
Gastrointestinal Conditions		
Gall-bladder disease		
(a) Symptomatic		
(i) Treated by cholecystectomy	A	
(ii) Medically treated	A	
(iii) Current	D	
(b) Asymptomatic	A	
History of cholestasis		
(a) Pregnancy-related	A	
(b) Past oral contraceptive-related	A	
Viral hepatitis		
(a) Active	D	Comments: The client is at high risk for complications associated with anesthesia and surgery. Appropriate infection prevention procedures, including universal precautions, must be carefully observed.
(b) Carrier	A	
Cirrhosis		
(a) Mild (compensated)	C	Comments: Liver function and clotting might be altered. Liver function should be evaluated.
(b) Severe (decompensated)	S	
Liver tumors		
(a) Benign (adenoma)	C	Comments: Liver function and clotting might be altered. Liver function should be evaluated.
(b) Malignant (hepatoma)	C	
Anemias		
Thalassemia		
	C	
Sickle-cell disease		
	C	Comments: There is an increased risk for pulmonary, cardiac, or neurologic complications and possible increased risk for wound infection.
Iron deficiency anemia		
(a) Hb <7 g/dL	D	Comments: The underlying disease should be identified. Both preoperative hemoglobin level and operative blood loss are important factors in women with anemia. If peripheral perfusion is inadequate, this may decrease wound healing.
(b) Hb ≥7 to <10 g/dL	C	
Conditions Relevant Only for Female Surgical Sterilization		
Local infection		
Abdominal skin infection	D	Comments: There is an increased risk for postoperative infection.

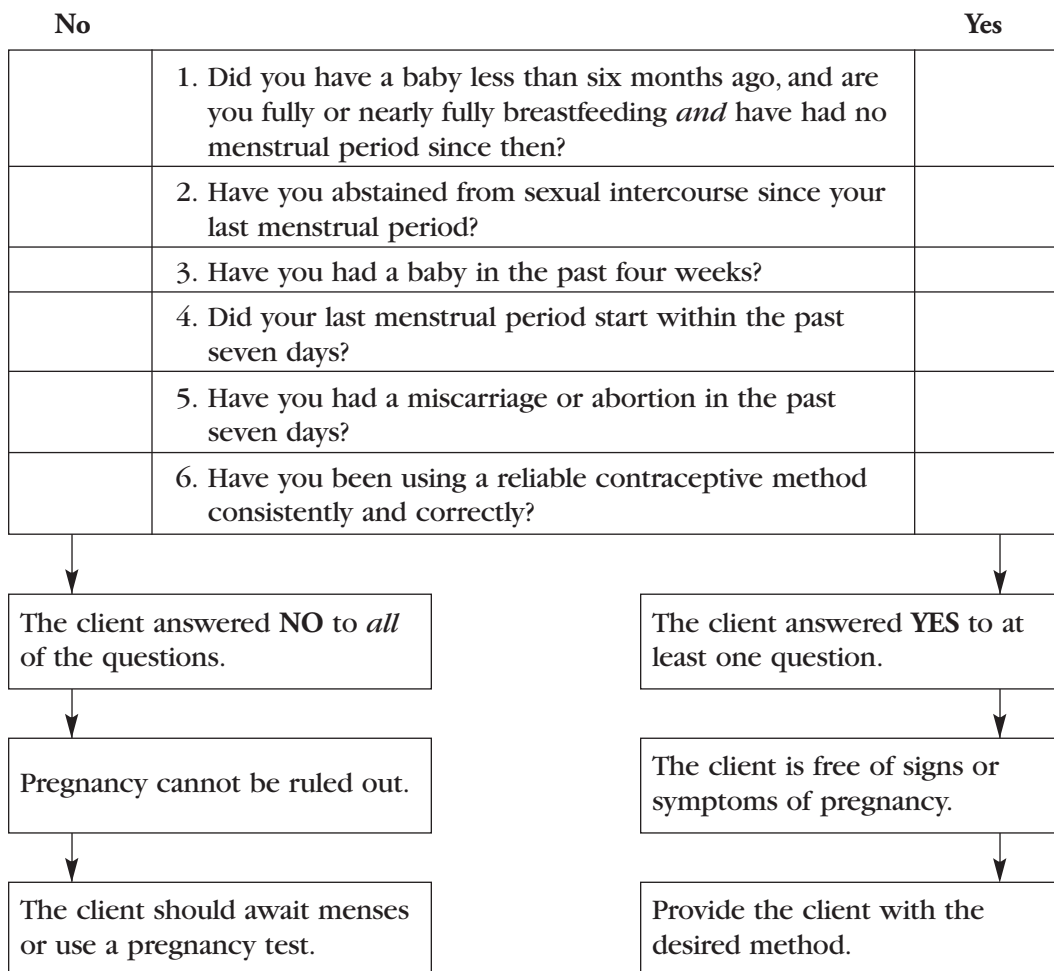
Female Sterilization (continued)

Condition	Category	New Evidence/Comments
Coagulation disorders	S	Comments: Women with coagulation disorders are at increased risk for hematologic complications of surgery.
Respiratory diseases		
(a) Acute (bronchitis, pneumonia)	D	Comments: The procedure should be delayed until the condition is corrected. There are increases in anesthesia-related and other perioperative risks.
(b) Chronic		Comments: For laparoscopy, the client may experience acute exacerbation of symptoms induced by the raising of the diaphragm by pneumoperitoneum, the Trendelenburg position, and a decrease in venous return from gaseous compression of the large vessels.
(i) Asthma	S	
(ii) Bronchitis	S	
(iii) Emphysema	S	
(iv) Lung infection	S	
Systemic infection or gastroenteritis	D	Comments: There are increased risks of postoperative infection, complications from dehydration, and anesthesia-related complications.
Fixed uterus due to previous surgery or infection	S	Comments: Decreased mobility of the uterus and bowels may make closed laparoscopy and minilaparotomy difficult and increase the risk for complications.
Abdominal wall or umbilical hernia	S	Comments: Hernia repair and tubal sterilization should be performed concurrently, if possible.
Diaphragmatic hernia	C	Comments: For laparoscopy, the client may experience acute exacerbation of symptoms induced by the raising of the diaphragm by pneumoperitoneum, the Trendelenburg position, and a decrease in venous return from gaseous compression of the large vessels.
Kidney disease	C	Comments: Blood clotting may be impaired. There may be an increased risk for infection and hypovolemic shock. May cause baseline anemia, electrolyte disturbances, peripheral neuropathy, and abnormalities in drug metabolism and excretion.
Severe nutritional deficiencies	C	Comments: There may be an increased risk for wound infection and delayed healing.
Sterilization concurrent with abdominal surgery		
(a) Elective	C	
(b) Emergency (without previous counseling)	D	
(c) Infectious condition	D	
Sterilization concurrent with cesarean section	A	Comments: Concurrent sterilization does not increase risk for complications in a surgically stable client.

Appendix D

Provider Checklist for Reproductive Health Services: How to Be Reasonably Sure a Client Is Not Pregnant

If the client answers YES to any question,
 proceed to the first box directly below the YES column.



Explanation of Checklist to Rule Out Pregnancy

Goal of the Checklist Tool

Family planning providers should always rule out pregnancy before providing hormonal methods, intrauterine devices (IUDs), or female sterilization. However, pregnancy tests may not be available at all clinics or affordable for all clients. In

such cases, this checklist serves as an easy-to-use tool for providers to help non-menstruating clients safely initiate their method of choice. The checklist is based on criteria for ruling out pregnancy recognized by the World Health Organization (WHO) (TG/CWG, 1997). Tests of the checklist's effectiveness in family planning clinics showed that the tool was more than 99% effective at ruling out pregnancy (Stanback, 1999).

Using the Checklist

The checklist is used to rule out pregnancy if no pregnancy tests are available. The provider simply asks the client each of the six questions (or includes them in history-taking). If the client answers "yes" to *any* one question, and has no signs or symptoms of pregnancy, then she can safely be provided with her method of choice. It is very important that the provider trust what the client says. For example, if the client says her menstrual period started within the past seven days, the provider should accept the client's word.

Pregnancy cannot always be ruled out. In these cases, the woman may go for a pregnancy test elsewhere, or may use a temporary barrier method while awaiting her menstrual period. If a client using the pill chooses to wait for her menstrual period, she should be given the option of carrying home a cycle of pills to initiate when her menstrual period returns.

Adapting the Checklist

Some programs may choose to adapt the checklist to their own unique situations. For example, since a provider does not need to continue asking questions once a client answers "yes," a program can reorder the checklist questions to reflect locally common reasons that exclude pregnancy. However, programs should take care to ensure that the meaning of the original questions remains unchanged when adapting or translating the checklist.

Note: Checklist and explanation are adapted from Family Health International, 2002.

Appendix E

Sample Preoperative and Postoperative Instructions to Clients (Oral and Written)

What You Should Know about Your Sterilization Operation

This leaflet contains important information that you need to know. It tells you how to prepare for your sterilization operation and how to take care of yourself afterwards.

Remember, sterilization is a surgical procedure. It is meant to be permanent. After sterilization, you will no longer be able to get pregnant. If you have any questions or doubts, talk to the clinic staff. We are here to help you.

Before going to the clinic:

1. Do not eat any solid food for at least six hours before surgery, but you may drink clear fluids up to two hours before the operation. You will be able to eat and drink after the operation.
2. Have a bath. Carefully wash your belly button, belly, and genital area using soap.
3. Wear clean, loose clothing.
4. Arrange for a family member or friend to come to the clinic to help you home after the operation.

When you return home:

1. Rest for one or two days at home. You will probably be able to resume most of your normal activities within three to five days. Avoid heavy work or lifting for one week. This will help the wound heal.
2. Do not let the bandage get wet for one to two days.
3. Take the medicine provided by the clinic.
4. You may have sex as soon as it is comfortable for you. This is usually about one week after the operation.
5. Avoid pulling, scratching, or irritating the wound.
6. It is important for you to know what is normal following your surgery. There will probably be some pain and swelling around the wound. This is normal and should not worry you.
7. Return to the clinic or notify the doctor or health worker if you have any of the following, or if you notice any unusual body changes:
 - Fever within one week of the operation
 - A pain in your belly that does not go away or that becomes worse

- Bleeding or pus coming from the wound
- Signs that you may be pregnant—a missed period, stomach pains, or dark or spotty bleeding between periods (Watch for these signs at any time after the operation. They may mean that the operation has failed and that you may be pregnant.)

For any of these problems, you should telephone or go to the following location for medical care without delay:

(add appropriate address)

Telephone number: _____

Adapted from: WHO, 1992.

Appendix F

Emergency Management Equipment and Drugs

Basic Equipment

Demand resuscitator *or* manual resuscitator (Ambu-bag)

Face mask

Oxygen tank with pressure-reducing valve, flow-meter tubing, oxygen nipple, and tubing

Suction machine with tubing and traps

Nonflexible (size 18 Fr) catheters

Flexible suction catheter

Oral airways (sizes 90 mm and 100 mm)

Nasopharyngeal airways (sizes 28 and 30)

Tourniquet

Foley bladder catheter (size 16 or 18) and drainage bag

Blood pressure apparatus

Stethoscope

Torch (flashlight)

Emesis basin

Blanket

Additional Equipment *(if personnel trained in the use of such equipment are available)*

Laryngoscope, with spare bulb and spare battery

Endotracheal tubes

Electrocardiogram (ECG) machine with leads

Defibrillator

Emergency Management Drugs

Adrenaline

Aminophylline

Diphenhydramine

Dopamine

Flumazenil

Hydrocortisone

Intravenous solutions (normal saline and 5% dextrose in water)

Naloxone

Physostigmine

Sodium bicarbonate