Policy Category:
CBA+PA
Who usually applies for funding?
GP

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

Female Sterilisation Policy

Commissioning decision	**The ICB will fund female sterilisation for women who meet the criteria defined within this policy. Funding approval for eligible patients must be sought from the ICB via the Prior Approval process prior to treatment.**

Policy statement:

Funding approval for surgical treatment will only be funded by the ICB as a standalone procedure or during a caesarean section in women who meet all of the following criteria:

The patient has received counselling about all other forms of contraceptives. Long-acting reversible contraception has been discussed, tried, refused or deemed unsuitable.

AND

She is certain her family is complete

AND

a) Vasectomy of the male partner is the preferred option and has been discussed but is unwanted or impractical.
OR
b) The female does not have a permanent partner

AND

She understands that the sterilisation procedure is irreversible, and the reversal of sterilisation operation would not be routinely funded by the ICB

AND

She understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections.

NOTE: Female sterilisation will be routinely funded in women who have a medical condition making pregnancy dangerous and where LARC is contra-indicated or inappropriate.

Clinicians should be aware that some patients maybe under coercion from partners and / or family members for this procedure to be undertaken.

Rationale:

Effectiveness and Risks of Female Sterilisation (NHS Choices)
Female sterilisation is as effective as other methods of female contraception with a success rate of around 99% - One in 200 female patients who have undergone sterilisation will become pregnant.

However, Vasectomy is around ten times more successful with only one in 2000 patients becoming fertile again after their procedure (once confirmation of the absence of spermatazoan are confirmed in 2 post procedure samples).

In addition, the risks in carrying out a female sterilisation are significantly greater than that of Vasectomy:

- Female sterilisation is usually carried out under general anaesthetic and all such procedures carry risks including a small risk of death

- With tubal occlusion, there is a very small risk of complications, including internal bleeding and infection or damage to other organs

- With hysteroscopic sterilisation, there is a small risk of pregnancy even after your tubes have been blocked. Research collected by NICE has shown that possible complications after fallopian implants can include:
  - pain after the operation – in one study, nearly eight out of 10 women reported pain afterwards and a 2015 US study found that around 1 in 50 women who had a hysteroscopic sterilisation required further surgery due to complications such as persistent pain
  - the implants being inserted incorrectly – this affected two out of 100 women
  - bleeding after the operation – many women had light bleeding after the operation, and nearly a third had bleeding for three days

- There is an increased risk that a pregnancy in the event of failure of the procedure will mean that the patient suffers an ectopic pregnancy

Plain English Summary:

Sterilisation is a procedure that permanently removes an individual’s fertility. Sterilisation can be carried out on a male (vasectomy) or female (normally by tubal occlusion) (NHS Choices)

This policy is intended to ensure sterilisation is only carried out after appropriate discussion of alternatives. Sterilisation should only be considered after full counselling on complications, failure rates and all alternative contraceptive methods.

Patients must be well informed about the permanent nature of the procedure and that reversals will not be routinely funded on the NHS. Patients must be advised that Long-Acting Reversible Contraception [LARC] or Vasectomy are the routinely commissioned treatment for patients seeking contraception advice.

Vasectomy has a low failure rate, is a less invasive procedure and has fewer complications compared to procedures for female sterilisation.

Clinicians should ensure sterilisation is discussed with both partners whenever possible. This is a best practice recommendation but legally only the patient's consent is required.

Evidence base:

This policy has been developed with the aid of the following references:

Faculty of Sexual and Reproductive Healthcare. (2014). FSRH Clinical Guidance: Male and Female Sterilisation Summary of Recommendations. Retrieved from FSRH.org: www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/

Loof S., D. B. (2014). Perioperative complications in smokers and the impact of smoking cessation interventions [Dutch]. Tijdschrift voor Geneeskunde, vol./is. 70/4(187-192.

NHS Choices. (n.d.). Female sterilisation. Retrieved 09 16, 2016, from Female sterilisation NHS Choices: http://www.nhs.uk/Conditions/contraception- guide/Pages/female-sterilisation.aspx

NHS Choices. (n.d.). Vasectomy (male sterilisation). Retrieved 09 19, 2016, from Vasectomy NHS Choices : Vasectomy (male sterilisation) - NHS (www.nhs.uk)

Thelwall, S. P. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases, , vol. 21, no. 11, p. 1008.e1.

British Association for Sexual Health and HIV guidance for responding to domestic abuse in sexual health settings:https://www.bashhguidelines.org/media/1085/responding-to-domestic-abuse-in-sexual-health-settings-feb-2016-final.pdf P.22 lists "Perpetrator asserting contraceptive control" as a risk factor for domestic abuse.

For further information please contact Glicb.ifr@nhs.net

Date of publication	8 December 2017
Policy review date	March 2026

Policy sign-off:

Reviewing Body	**Date of review**
Effective Clinical Commissioning Policy Group	30.11.2017
Integrated Governance and Quality Committee	07.12.2017

Version Control:

Version No	Type of Change	Date	Description of Change
1		08.12.2017	
2	Minor word adjustment; review date	01.02.2020	Minor word adjustment; 'single' removed before permanent partner. [3b]. Review date changed to January 2023
3	Minor wording adjustment to Note box; link added to Evidence Base box; review date.	21.03.2023	Wording added to Note box regarding coercion from family/friends. Link to British Association for Sexual Health and HIV guidance for responding to domestic abuse in sexual health settings in the Evidence Base box. Ratified by Executive Directors 30.03.23 Review date changed to March 2026