**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Tubal Sterilization – Counseling & Referral | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** January 2018, January 2019, **January 2021** |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 20th Ed |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; and Contraceptive Technology, 20th Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in understanding and accessing tubal sterilization.

Tubal sterilization is a permanent, safe, and highly effective method of contraception. There are 3 types of tubal sterilization performed in the U.S.: laparoscopic, abdominal, and hysteroscopic. They can be performed in an office setting or as an outpatient procedure.

Tubal sterilization is the process of blocking fertilization by cutting or occluding the fallopian tubes to prevent pregnancy. Fewer than 1 out of 100 people become pregnant in the first year after tubal sterilization. It is important to note that the risk of pregnancy is known to persist for 10 years after the sterilization procedure, and risk of pregnancy varies by occlusion technique and age of the client. The largest study in the U.S. on efficacy of tubal sterilization (the Collaborative Review of Sterilization) reported a 5-year cumulative probability of tubal sterilization failure to be 13 per 1,000 procedures (aggregated by all types of procedures and client ages). The failure rates of sterilization are comparable to those of IUD/IUS and implants.

Pregnancy after a sterilization procedure is uncommon; however, if a pregnancy does occur after sterilization, data found that roughly 30% of post-sterilization pregnancies were ectopic.

Tubal sterilization does not protect against sexually transmitted infections (STIs).

**STANDARD:**

(**insert AGENCY name**) MDs, NPs, PAs, DOs, NDs, and RNs may provide information and counseling to any client who requests tubal sterilization.

There are no medical conditions (category 4 risk conditions) that would absolutely restrict a person’s eligibility for sterilization (with the exception of known allergy or hypersensitivity to any materials used to complete the sterilization procedure) per the U.S. MEC, 2016.

Certain conditions place a client at high surgical risk (category 3 risk conditions); in these cases, careful consideration should be given to the risks and benefits of other acceptable alternatives, including long-acting, highly effective, reversible methods.

Clients who are uncertain about preventing pregnancy permanently should be advised that tubal sterilization is irreversible and should be counseled appropriately; provide information on alternative methods with similar efficacy that are reversible, such as long-acting reversible contraceptives (LARCs).

**PROCEDURE:**

1. Follow the [*Core Reproductive Health Services* *CPS*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx)

**PLAN:**

1. Provide the client with information on the different types of tubal sterilization and provide counseling regarding:
2. Permanent nature of the procedure;
3. Alternative methods of contraception which have similar efficacy rates but are reversible (such as IUD/IUS and implants);
4. Assess the client’s understanding of the procedure;
5. Reasons for choosing sterilization;
6. Risks and benefits; and
7. Screen for risk indicators for regret:
* Although age is not a contraindication to sterilization, age of clients <30 years is a risk factor for regret;
* Unstable relationship;
* Life stressors;
* Have no or very young children;
* During time of financial crisis; and/or
* Reasons related to a pregnancy.
1. Advise the client the hysteroscopic sterilization method will require a hysterosalpingogram (HSG) 3 months after the sterilization procedure to confirm bilateral tube occlusion.
2. Advise the client to abstain from sexual intercourse or use additional contraceptive protection until confirmation of tube occlusion.
3. Advise the client that they may rely on sterilization for contraception immediately after laparoscopic and abdominal procedures. No additional contraceptive protection is needed.
4. Offer referral assistance, call to schedule the appointment, fax pertinent medical records information, and obtain client signature on the Federal Sterilization Consent form.
5. Review the client’s history and access of recommended health screenings. Send a Release of Records for past health screenings, if performed elsewhere.
6. Offer and schedule a Reproductive Health Well Visit with the prescribing provider if the client has not had one within the past 12 months.
7. Offer an interim method of contraception and dispense supplies in a quantity to last up to the 180 day maximum.
8. Offer and dispense condoms for use as a back-up method and for STI protection.
9. The decision to offer and dispense future-use EC should be made on an individualized basis and should include shared decision making between the provider and the client. The practice of offering and dispensing future-use EC to *all* clients has had no impact on unintended pregnancy rates. Data shows that clients who had EC available at the time of unprotected intercourse either didn’t take it at all or took it incorrectly. Additionally, the practice of providing EC to all clients represents a significant cost to the agency. Clients *requesting* (those that self-identify that they need or want) EC for future use and those using less reliable methods of contraception (tier 3 methods) might benefit most from having future-use EC made available.

**CLIENT EDUCATION:**

1. Advise clients with government funded coverage that there is a 30-day waiting period from the time the consent is signed until the procedure can be performed. The tubal sterilization must be completed within 180 days from the time of signing the consent form.
2. Provide the client opportunity to ask questions.
3. Provide informed consent, if the client is ready.
4. Provide information regarding the provider performing the tubal sterilization procedure.
5. Advise the client they may change their mind at any time prior to the procedure.
6. Advise the client to use condoms for protection against STIs.
7. Advise the client to call the clinic if they have any questions or concerns regarding the tubal sterilization method.

**REFERENCES:**

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

Centers for Disease Control and Prevention. 2016. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

Roncari, D. & Hou, D. 2011. Female and Male Sterilization. In Deborah Kowal (Ed) *Contraceptive Technology*, 20th Ed. Pg 435-460. Ardent Media: Atlanta, GA