Female contraceptive sterilization
FEMALE CONTRACEPTIVE STERILIZATION

Preamble

1. Female sterilization (tubal ligation) remains the leading method of contraception in India, being used by 37 per cent of Indian couples. A "cafeteria approach," whereby clients are provided with a choice of contraceptive methods, has been adopted by the Family Welfare Programme since the 1960s. However, emphasis of the programme remains skewed towards promoting nonreversible methods, particularly female sterilization, which accounts for 77 percent of modern contraceptive use in India. In some states such as Andhra Pradesh, as much as 94 per cent of all modern contraception is through female sterilization. Most women and men, particularly those who rely on the public sector [nearly 76 per cent of current users of modern methods] do not have access to a wide range of contraceptives.

2. Human rights include the right of individuals to control and decide on matters of their own sexuality and reproductive health, free from coercion, discrimination and violence. This includes the right to decide whether and when to have children. In order that this right may be realized, it is essential to offer men and women complete and accurate information about the various contraceptive methods, so that they may be able to select the one that best suits their needs.

3. Offering sterilization as the only contraceptive option to women does not address their needs at all and so a 'basket of choices' must be offered. Cognizance must be taken of the associated risks and long-term consequences of tubal ligation and the option of vasectomy must be discussed when sterilization is the contraception of choice.

4. Once an informed choice has been freely made, barriers to surgical sterilization should be minimised. Section 1.2 of FOGSI's 'Good Clinical Practice' guidelines also stresses that sterilization not be denied to any woman. In particular: a) sterilization should be made available to any person of adult age; b) no minimum or maximum number of children may be used as a criterion for access; c) a partner's consent must not be required, although women should be encouraged to include their partners in counseling, based on the woman's choice.

5. Only women themselves can give ethically valid consent to their own sterilization. Family members including husbands, parents, legal guardians, medical practitioners and, for instance, government or other public officers, cannot consent on the woman's or girl's behalf.

6. Women's consent to sterilization should not be made a condition of access to medical care, such as HIV/ AIDS treatment, natural or cesarean delivery, or abortion, or of any benefit such as medical insurance, social assistance, employment or release from an institution. When sterilization is to be performed concurrent with abortion, the woman should specifically be informed that abortion will be made available even if she declines consent for sterilization. In addition, consent to sterilization should not be requested when women may be, going into labor or in the immediate aftermath of delivery.

7. Further, it is unethical for medical practitioners to perform sterilization procedures within a government program or strategy that does not include voluntary consent to sterilization.

8. The U.N. Convention on the Rights of Persons with Disabilities includes recognition – that women and girls with disabilities are often at greater risk ... of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation. Accordingly, Article 23(1) imposes the duty – to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
a) The right of all persons with disabilities who are of marriageable age to marry and to found a family ... is recognized;
b) The rights...to decide freely and responsibly on the number and spacing of their children ...are recognized, and the means necessary to enable them to exercise these rights are provided;

c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

9. As in case of any surgical procedure, both tubectomy and vasectomy have risks involved. In order to minimize complications and failures related to these procedures it is of utmost importance that minimum quality standards as prescribed in the "Standards for Female and Male Sterilization Services" issued in 2006 by Ministry of Health and Family Welfare, Government of India be followed meticulously. The commitment to quality care and adherence to these guidelines has been the basis of the development of FOGSI's 'Good Clinical Practice Guidelines'. This includes guidelines related to counseling of clients prior to the procedure, clinical assessment and screening to determine eligibility, obtaining informed consent from the client, providing pre-operative instructions, choice of anaesthesia and surgical procedure, post-operative care and follow up. A robust mechanism for periodic review of the guidelines must be set up to address concerns arising out of field-level experiences.

10. Only those health professionals who have received adequate training and are considered eligible to perform the procedures as per the aforementioned guidelines may be allowed to do so, at a facility that fulfils all criteria for physical requirements for conducting the procedure. The eligibility criteria for health professionals, trainers and facilities must be clarified to avoid ambiguity. FOGSI's 'Good Clinical Practice Guidelines' on female sterilization, in Section 1.1, too underscore the importance of having trained personnel to conduct these examinations.

Recommendations

1. No woman may be sterilized without her own, previously-given informed consent, with no coercion, pressure or undue inducement by healthcare providers or institutions.

2. Women considering sterilization must be given information of their options in the language in which they communicate and understand, through translation if necessary, in an accessible format and plain, non-technical language appropriate to the individual woman's needs. Women should also be provided with information on non-permanent options for contraception. Misconceptions about prevention of sexually transmitted diseases (STDs) including HIV by sterilization need to be addressed with appropriate counseling about STDs. The physician performing sterilization has the responsibility of ensuring that the patient has been properly counseled regarding the risks and benefits of the procedure and its alternatives. Women must be advised about and offered follow-up examinations and care after any procedure they accept.

3. Sterilization for prevention of future pregnancy is not an emergency procedure. It does not justify departure from the general principles of free and informed consent. Therefore, the needs of each woman must be accommodated, including being given the time and support she needs, while not under pressure, in pain, or dependent on medical care, to consider the explanation she has received of what permanent sterilization entails and to make her choice known.

4. Consent to sterilization must not be made a condition of receipt of any other medical care, such as HIV/AIDS treatment, assistance in natural or cesarean delivery, medical termination of pregnancy, or of any benefit such as employment, release from an institution, public or private medical insurance, or social assistance.

5. Given that vasectomy is a simpler procedure with lower rates of complications, wherever possible, male sterilization or vasectomy must be offered as a valid option. Gynaecologists who usually perform tubectomies should also be trained to provide vasectomies. Public health facilities and teaching hospitals should be rearranged in order to facilitate this within Gynaecology departments.

6. Forced sterilization constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies. Healthcare providers have an ethical response in accordance with the guideline on Violence Against Women (2007).

7. It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.

8. At a public policy level, the medical profession has a duty to be a voice of reason and compassion, pointing out when legislative, regulatory or legal measures interfere with personal choice and appropriate medical care.

9. It is essential that minimum quality standards as laid down in Standard Guidelines for Male and Female Sterilization, issued by the Government of India Ministry of Health and Family Welfare, be followed. This includes guidelines related to informed consent, case selection, the technical aspects of the procedure, as well as follow up of patients. Each center must ensure that these guidelines are followed.

10. In the interest of continued quality assurance, it is important that routine audits be conducted, to ensure that prescribed standards are being followed. In case of reporting of failures, complications or deaths, a clear process for investigation must be laid down. Enquiries conducted should serve to support and enhance quality of care rather than be purely punitive in nature.

This statement has been modified from the 2011 FIGO Guidelines on Female Contraceptive Sterilization. It has been worked on and reviewed by the Working Group on Female Sterilization constituted by CEHAT, the Asia Regional Focal Point of IFHHRO. Members of the Working Group are as follows:

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