

Policy for Sterilisation Reversal in Males and Females

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Document control:		
Date:	Version Number:	Section and Description of Change
March 2019	V1.0	Policy ratified by Healthier Lancashire and South Cumbria's Joint Committee of Clinical Commissioning Groups
July 2022	V1.1	Policy adopted by Lancashire and South Cumbria ICB – references to CCG replaced by ICB where relevant
November 2025	V2.0	The revised policy explicitly states that sterilisation reversal is not routinely commissioned. Jan 2026: Minor criteria/terminology/pathway clarification following evidence review and template migration. No change to commissioning intent or expected activity.

1. Policy

1.1 Reversal of sterilisation in males and females is not routinely commissioned.

2. Scope and definitions

2.1 This policy is based on the ICB's Statement of Principles for Commissioning of Healthcare (19 January 2016).

2.2 Reversal of sterilisation is a surgical procedure involving the reconstruction of the vas deferens in males (vasovasostomy, vasoepididymostomy) and the reconstruction of the fallopian tubes or removal of clips from the fallopian tubes in females with the main aim of restoring fertility after a voluntary surgical sterilisation.

2.3 In some instances, vasectomy reversal is carried out in males to relieve post-vasectomy pain after failure of conservative management, while removal of clips may be done to relieve post tubal ligation syndrome (PTLS) in females.

2.4 The scope of this policy includes requests for sterilisation reversal following voluntary sterilisation as a permanent contraceptive method, in people of either gender.

2.5 The ICB recognises that a patient may have certain features, such as:

- Having sterility after voluntary sterilisation as a permanent method of contraception
- Wishing to have a service provided for restoring fertility due to non-medical reasons e.g. loss of an only child, being in a new relationship.
- Being advised that they are clinically suitable for reversal of sterilisation, and
- Be distressed by their sterility, post-vasectomy pain or post tubal ligation syndrome, and by the fact that they may not meet the criteria specified in this commissioning policy.

Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.

2.6 For the purpose of this policy, the ICB defines males and female sterilisation reversal as any surgical procedure in people who have had voluntary sterilisation as a permanent contraception method to restore patency of the vas deferens or the fallopian tubes, with the aim of restoring fertility, or managing post-vasectomy pain or post tubal ligation syndrome.

3. Appropriate Healthcare

3.1 The purpose of sterilisation reversal is normally to restore fertility after voluntary sterilisation in either gender.

3.2 This policy relies on the criterion of appropriateness in that the ICB considers that sterility following voluntary sterilisation performed as a permanent contraception method is not a medical condition and treatment for it does not otherwise accord with the criteria for appropriateness in the Statement of Principles.

4. Effective Healthcare

4.1 This policy relies on the criterion of effectiveness in relation to commissioning sterilisation reversal for the management of post-vasectomy pain or post tubal ligation syndrome as the ICB considers there is insufficient evidence that sterilisation reversal for these purposes can achieve the intended outcomes.

5. Cost Effectiveness

5.1 The ICB does not call into question the cost-effectiveness of sterilisation reversal and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether the treatment is likely to be Cost Effective in this patient before confirming a decision to provide funding.

6. Ethics

6.1 The ICB does not call into question the ethics of sterilisation reversal and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.

7. Affordability

7.1 The ICB does not call into question the affordability of sterilisation reversal and therefore this policy does not rely on the Principle of Affordability. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.

8. Exceptions

8.1 The ICB will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.

8.2 Inadequate or improper counselling will not be considered as a basis for exceptionality.

8.3 The Faculty of Sexual & Reproductive Healthcare (2014) and the Royal College of Obstetricians and Gynaecologists (2016) recommend counselling and advice on sterilisation procedures should be provided to women and men and should include information on the advantages, disadvantages and relative failure rates of each method. The Royal College of Obstetricians and Gynaecologists (2016) further emphasised it is crucial the permanent nature of the procedure is reiterated to patients intending to undergo sterilisation and should include ascertainment of patients' wishes not to have any more children in the future.

8.4 In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this ICB. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.

9. Force

9.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.

9.2 In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then:

- If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory.
- If the new NICE guidance does not have mandatory status, then the ICB will aspire to review and update this policy accordingly. However, until the ICB adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this ICB are concerned.

10. References

- Weisberg E, Fraser IS. Fertility following reversal of male and female sterilization. Contraception 1982;26:361-71. doi: [https://dx.doi.org/10.1016/0010-7824\(82\)90103-2](https://dx.doi.org/10.1016/0010-7824(82)90103-2)
- Faculty of sexual and reproductive healthcare clinical guidance: Male and female sterilisation. London: Clinical effectiveness unit, Faculty of sexual and reproductive healthcare, 2014.
- Male and female sterilisation: Evidence-based clinical guideline number 4. London: Royal College of obstetricians and gynaecologists, 2004.
- Vasectomy: AUA guideline. American Urological Association 2012
- Schmidt JE, Hillis SD, Marchbanks PA, et al. Requesting information about and obtaining reversal after tubal sterilization: Findings from the U.S. collaborative review of sterilization. Fertility and Sterility 2000;74:892-98. doi: <https://dx.doi.org/10.1016/S0015-0282%2800%2901558-2>
- Cohen MA, Chang PL, Uhler M, et al. Reproductive outcome after sterilization reversal in women of advanced reproductive age. Journal of Assisted Reproduction and Genetics 1999;16:402-04. doi: <https://dx.doi.org/10.1023/A:1020509323039>
- Prabha S, Burnett Lunan C, Hill R. Experience of reversal of sterilisation at Glasgow Royal Infirmary. The journal of family planning and reproductive health care 2003;29:32-3. doi: <https://dx.doi.org/10.1783/147118903101196882>
- Premalatha R, Tripathi MS. A Study on the reversal of sterilisation in women over two decades. Journal of Obstetrics and Gynecology of India 2012;62:62-67. doi: <https://dx.doi.org/10.1007/s13224-012-0144-x>

11. Associated OPCS/ICD codes

OPCS codes
Q291, Q292, Q298, Q299, Q371, Q378, Q379 - Reversal of female sterilisation N181, N182, N188, N189 - Reversal of male sterilisation