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Vasectomy Overview

"If Vasectomy Is Such a Good Method—and It Is—Why Has It Fared So Poorly in Our Family Planning Programs the Past 30 Years?"

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Long-Acting and Permanent Methods
Community of Practice Meeting on Vasectomy
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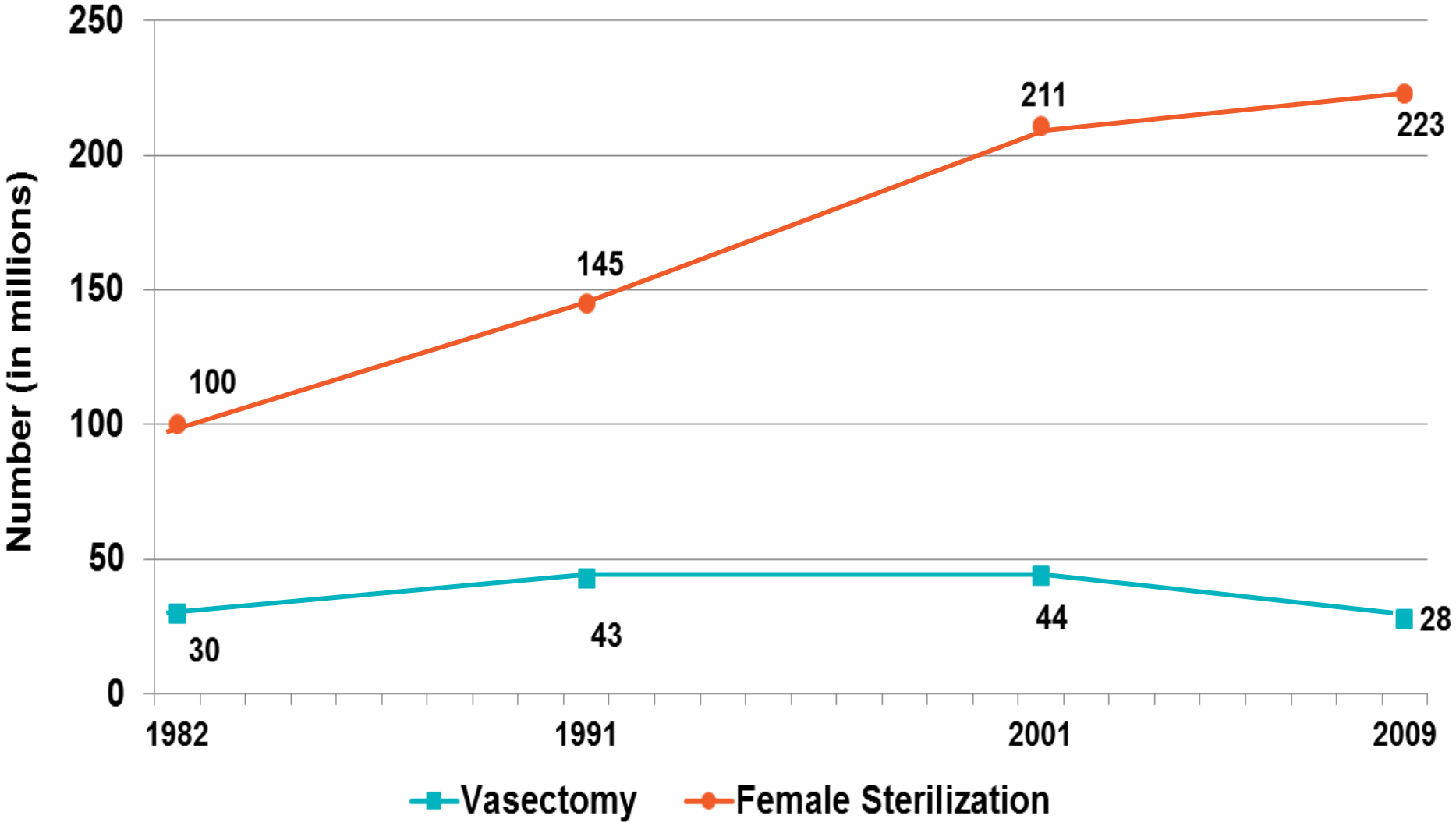
Outline of presentation

- **Context for vasectomy**
  - Reproductive intentions / rising demand to limit
  - Global, regional, and country data regarding use
- **Method characteristics**
- **Why has vasectomy use been so low?**
- **What should we do to increase vasectomy access?**

Context for vasectomy: Demand to limit is increasing everywhere

- **Major global megatrends are driving smaller desired family size**: small family norm is becoming universal; millions of women & couples now spending ½ to ⅔ of their 3-decade reproductive lives with intention to limit
- **Demand to limit > demand to space** among women in union, in every region except West Africa & Central Africa
- **Average age at which demand to limit exceeds demand to space ("crossover age") is falling** & as low as 23-24 in some countries *(Van Lith, Yahner & Bakamjian, GHSP, 2013)*
- **Does not mean all limiters want, need or will choose a permanent method** … but **many men and women would** & do choose them

Trends: Decline in use of vasectomy and in its relative share of PM use



Vasectomy use: Worldwide and regional

REGION	% of MWRA using	Number of users (in millions)
Worldwide	2.7%	32
Oceania	**11.8%**	0.5
North America	**10.3%**	4.1
Asia	3.0%	**22.5**
Europe		2.8
Latin America	1.3%	1.3
Africa	**0.1%**	0.1

Source: *Urologic Clinics of North America*, Aug 2009, 38/3, "Demographics of Vasectomy—USA and International," Pile, J.M. and Barone, M. Data for women married or in union Europe 2.5%; Northern Europe: 12.5%: *World Contraceptive Use, 2011*

High V use in countries with high knowledge, universal access to FP and high gender equity

Country	Vasectomy prevalence (CPR)	Share of method mix
Canada	22%	31%
United Kingdom	21%	25%
New Zealand	20%	26%
Korea (South)	17%	21%
Australia	14%	19%
Bhutan	14%	44%
United States	13%	16%
Switzerland	8%	10%
Spain	8%	12%
Netherlands	7%	10%
Nepal	6%	13%
Brazil	5%	6%
Czech Republic	5%	7%
Denmark	5%	6%

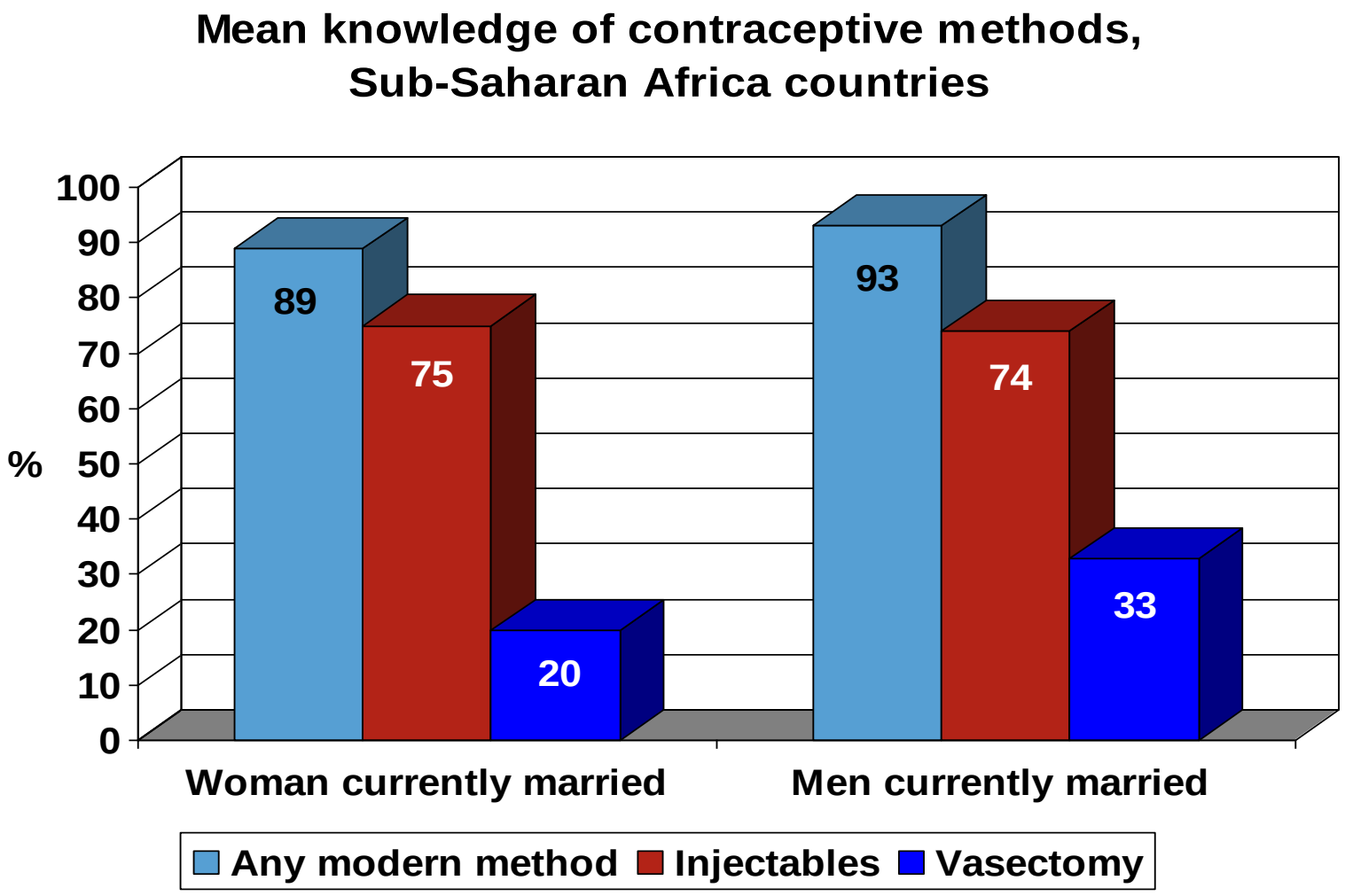
Source: UNDESA, *World Contraceptive Patterns, 2013.. Data for women married or in union*

Vasectomy use in USAID priority countries in Africa and Asia: Low to negligible

Country / (Year of DHS)	Demand to limit/ to space (%)	MCPR (%)	Awareness ("knowledge")	Vasectomy use (CPR)
India (2005-06)	58/11	48.5	83%	1.0
Bangladesh (2011)	53/22	52.1	"universal" (FP)	1.2
Pakistan (2012-13)	37/18	26.1	51%	0.3
South Africa (2003)	55/19	59.8	36%	0.7
Kenya (2008-09)	41/30	39.4	42%	0 [not listed]
Rwanda (2010)	39/33	40.3	71%	0.0
Malawi (2010)	38/35	42.2	73%	0.1
Uganda (2011)	29/36	26.0	58%	0.1
Tanzania (2010)	23/37	27.4	40%	0.0
Ethiopia (2011)	21/33	27.3	16%	0 [not listed]
DRC (2013-14)	14/34	7.8	20%	0.1
Senegal (2012-13)	13/34	16.1	Not given	0 [not listed]
Mali (2012-13)	11/26	9.9	20%	0.0
Nigeria (2013)	11/20	9.8	16%	0 [not listed]

Source: Latest DHS available, as of Jan 29, 2015. Data for women currently married or in union.

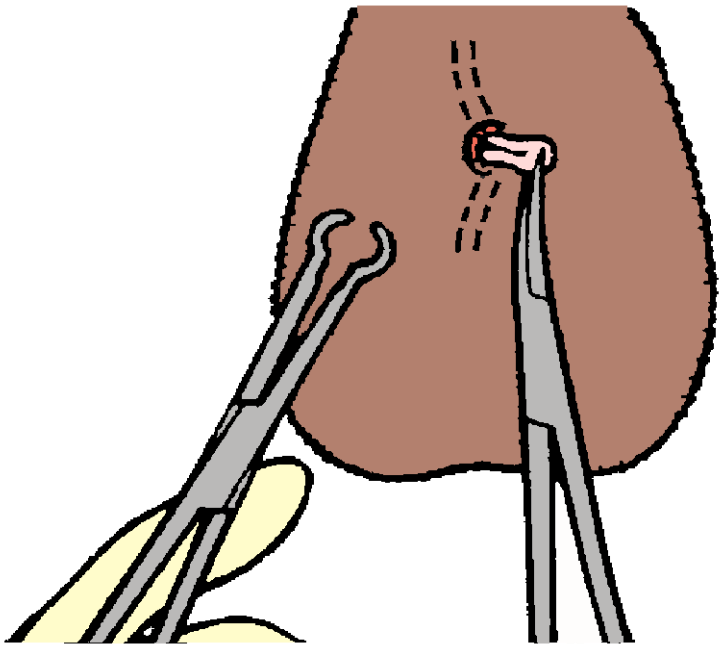
"Knowledge" (really: awareness) of vasectomy: Very low compared to knowledge of other methods



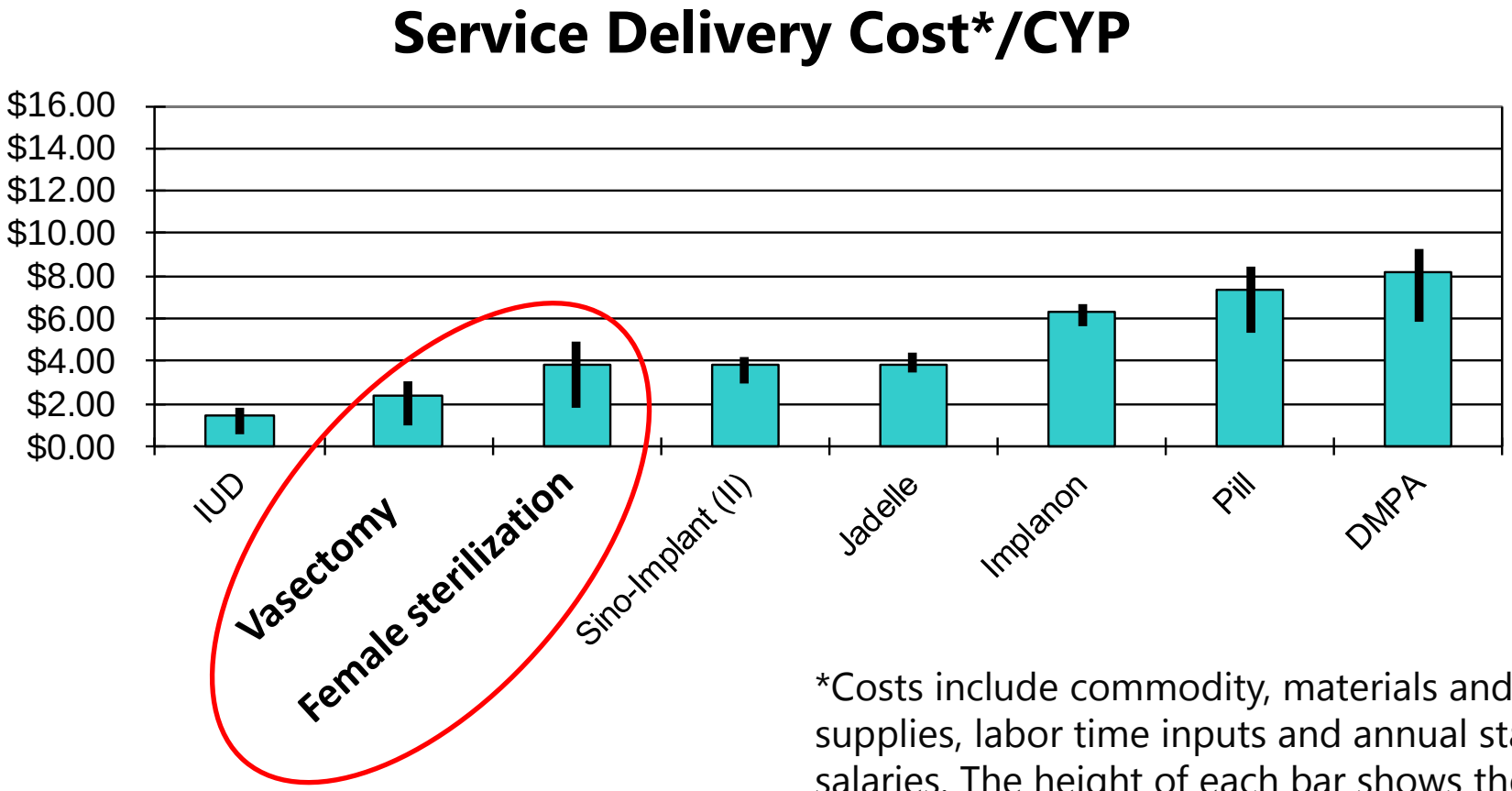
Source: Select DHS Country Reports

No-scalpel vasectomy (NSV): Method characteristics

- **Fewer complications with NSV** than with incisional technique
- **Small puncture**; vas deferens is pulled through skin & ligated or cauterized
- **Effectiveness comparable to other LA/PMs** (effective after 3 months)
- **Low failure rate (pregnancy): 0.5%,** but **depends on skill of operator & on compliance** of client & partner **(Nepal study: 5% failure)**
- **Almost all men are eligible to receive it** (WHO's MEC 2010)
- **Very safe:** Minor complications 5-10%; major morbidity rare; no adverse long-term effects



Compared to female sterilization: Safer, simpler, equally highly effective, twice as cost-effective



*Costs include commodity, materials and supplies, labor time inputs and annual staff salaries. The height of each bar shows the average value of costs per CYP across 13 USAID priority countries.

Adapted from: Tumlinson, et. al., The promise of affordable implants: Is cost recovery possible in Kenya? *Contraception*, 2011. Includes 2/3 lower commodity cost of implants

So if vasectomy is such a good method, why is its use so low? At the client level:

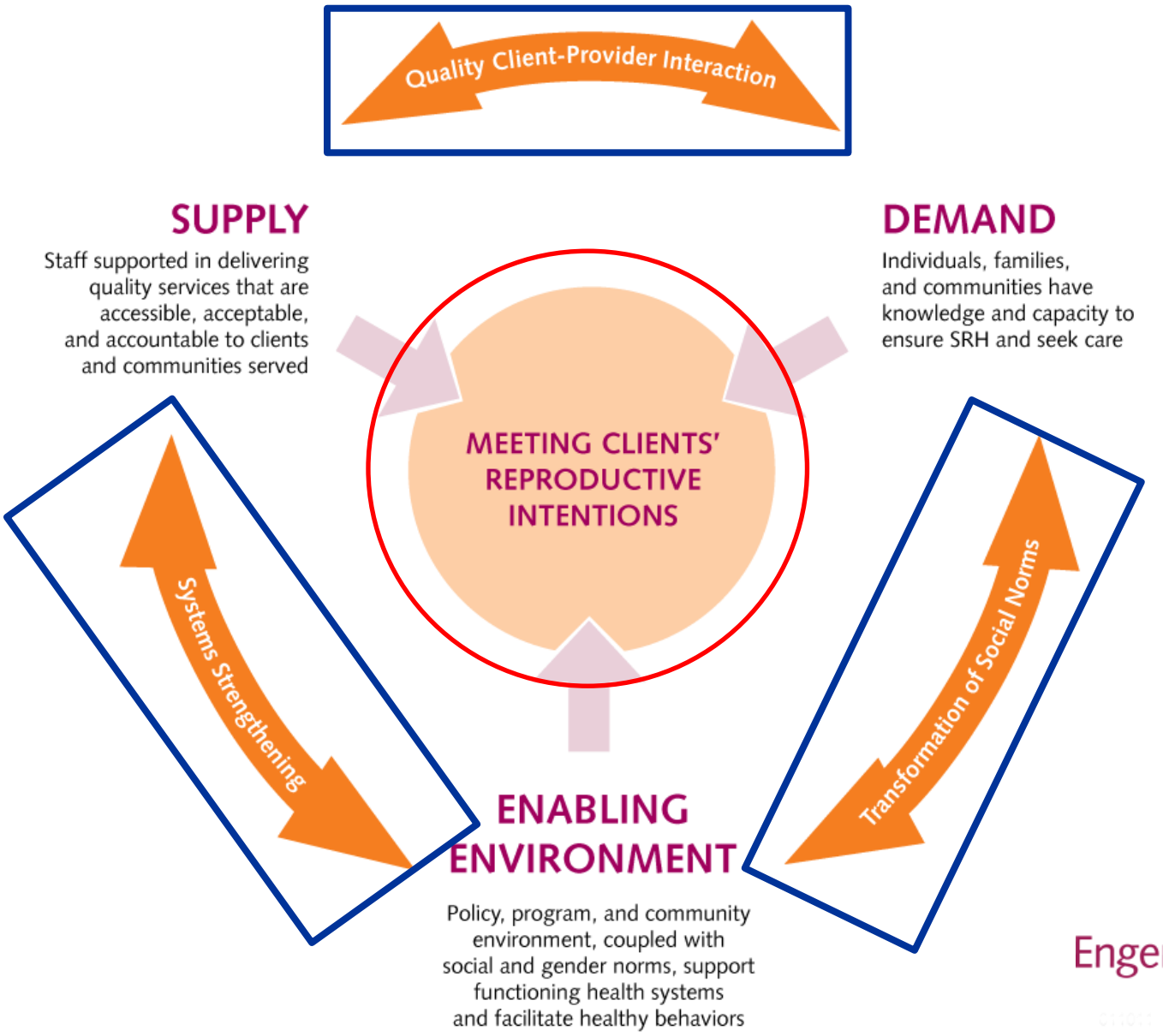
- **Lack of awareness**: least "known" of all methods
- **Cultural & gender norms**: "FP is a woman's duty; greater number of children = greater masculinity
- **"Rumors & myths"** -- i.e., their "**truths**"
  - Sexual function: "vasectomy = castration"
  - Health impact: "will make me (or him) 'weak' "
- **Anxiety** about undergoing a surgical procedure

So if vasectomy is such a good method, why is its use so low? At the program level:

Donor/provider/policy/program bias, reflected in:

- **Low priority/very limited funding**
  "Small projects, small results" (Duff G.)
- **Unrealistic time frames**
  "There's no quick fix" (Lynn B.)
- **Inadequate human resources**
  "No provider, no program" (Roy J)
- **Neglected in contraceptive security**
  Not a "commodity" or "contraceptive"
- **Limited access to services**
  FP services geared to women; FP providers mainly female; only a few vasectomy providers

So, what to do? Think, plan, and program holistically: S-EE-D; & heed blue boxes



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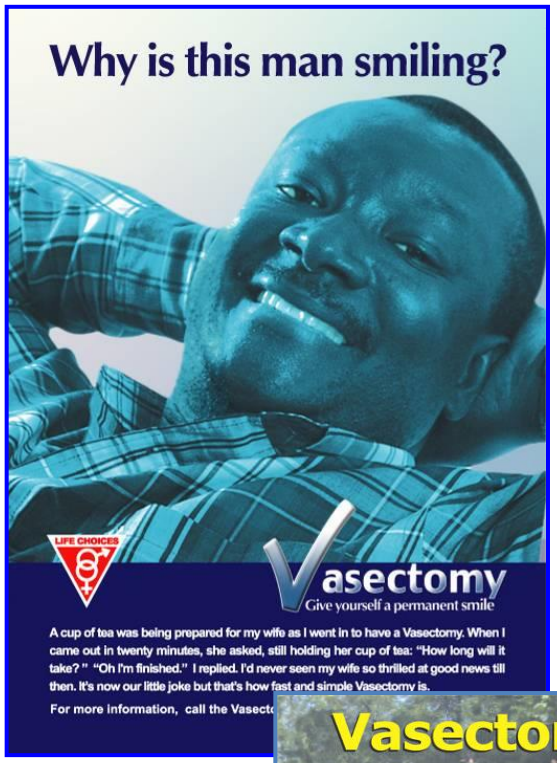
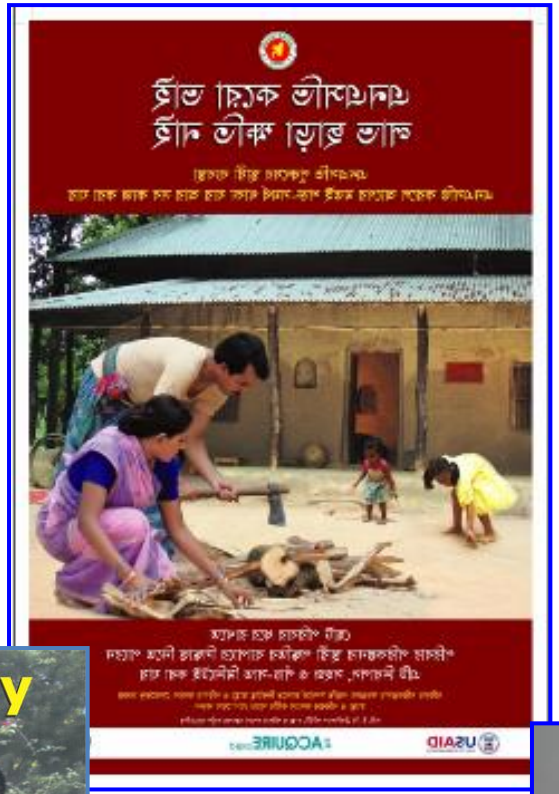
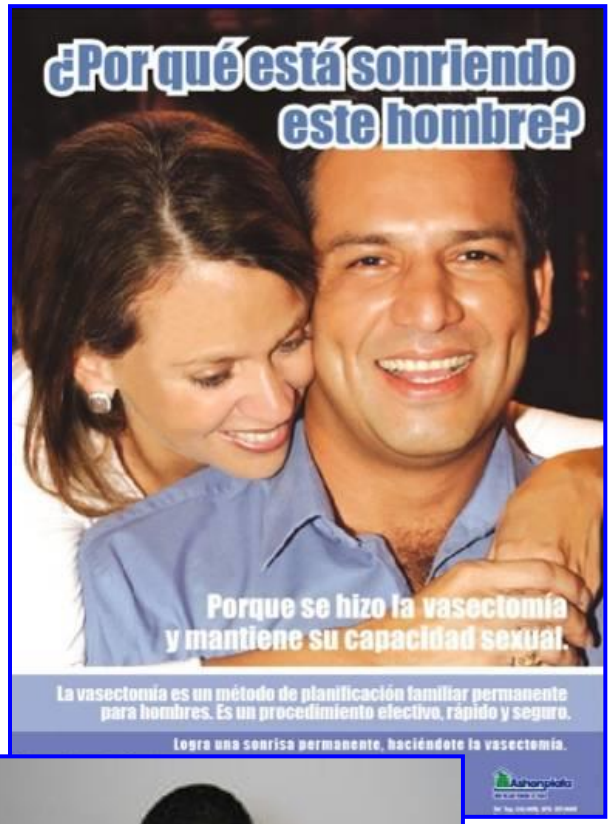
Demand: Lessons learned

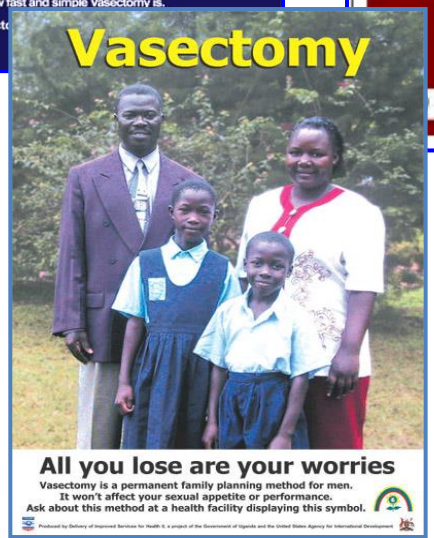
- **Use multiple communication channels**
  - Mass media, print, interpersonal, hotlines, & mHealth
- **Address women as well as men**
- **Emphasize benefits**
  - Provide for your family / love & concern for your wife
  - Advantages: one act; permanent; simpler than FS
  - Sexual satisfaction / retention of strength
- **Use champion providers & satisfied clients**
- **Repetition** is key to learning & behavior change.

Vasectomy is a communication "operation" as much as it is a surgical operation









Enabling environment: Champions are essential at all levels: "Nurture" them

At the head of almost all energetic / successful vasectomy programs is **a director personally interested** in involving men in FP and is **committed** to the program's success

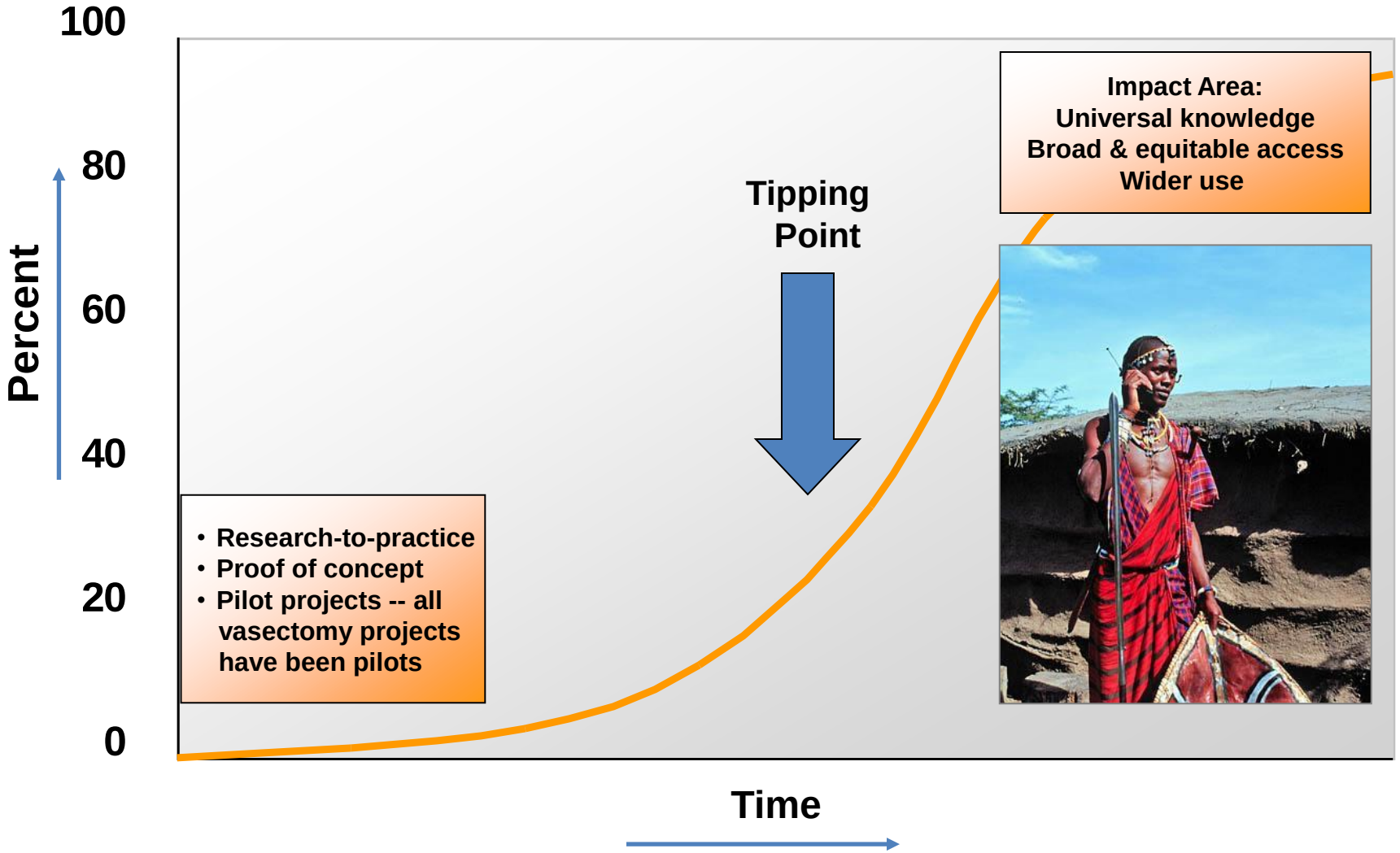
- At every clinic where vasectomy is regularly provided is **a trained provider who strongly believes in the method**—& **"walks the talk"**

- How to find & "nurture" them:
  - Follow an **"activity" bias**
  - Find among **early adopters**
  - Make their activity **visible**
  - **Sustain your engagement** (not a one-time/brief encounter)
  - **Reward** them

Supply: Lessons learned

- Train a **smaller cadre**, but support them **longer & "better"**
- Consider **provider perspectives & rewards**: adequate & reliable pay, recognition; reduced other workload
- Use **dedicated providers**
- Create "**male-friendly**" services
- Engage **all staff** in contact with clients, including "gatekeepers"
- Focus on **client satisfaction**
- Ensure that services are **affordable**

What we want to accomplish: Dynamics of introduction & scale-up of a new method



Conclusions

- Ensure **rights & choice**
- Recognize **limiters are an underserved group**
- Lack of access to vasectomy is a **gender issue**
- **Vasectomy-specific/male RH-specific projects needed** (focused holistically on S-EE-D; draw lessons from male circumcision programs)
- **Follow rules of good pilots**:
  Visible to policymakers; urban-based; funding adequate & sustained; scale-up planned from start
- "Change takes [a lot of] time": at least ten years
  — but if not now, when?"
- **What will be different this time?**

Thank you!

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