

IS KENYA READY TO ADD VASECTOMY TO ITS METHOD MIX?

A QUALITATIVE STUDY OF VASECTOMY USERS, PROVIDERS, AND STAKEHOLDERS IN FOUR COUNTIES

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BACKGROUND

Vasectomy Use Worldwide and in Africa

Vasectomy (male sterilization) is one of two methods of permanent contraception and one of only two male methods of modern contraception. The other permanent method, female sterilization (tubal ligation), is the most commonly used form of contraception worldwide, chosen by 19% of women of reproductive age who are married or in a union (MWRA).¹ Conversely, male sterilization (vasectomy) lags far behind most other available short-term or long-acting methods, with a prevalence of only 2.4% globally but with substantial regional variation: from highs of 11.9% in Northern America (Canada and the United States), 6.3% in Oceania, and 2% in Latin America and the Caribbean to a low of 0.0% in Africa overall.¹ In Canada, the United Kingdom, New Zealand, and the Republic of Korea, vasectomy prevalence ranges from 17-22%, comprising 24-31% of modern contraceptive use.

Despite vasectomy's high effectiveness and surgical simplicity, it has very low use in almost all African countries. Awareness of vasectomy—i.e., having heard of the method (but not necessarily having accurate knowledge)—is the lowest among all modern methods, often to a sizeable degree.² Gender inequality regarding contraception,^{2,6} myths and misconceptions about vasectomy,^{3,4,5} and men's and women's negative attitudes toward vasectomy are other major reasons for low client demand for and use of vasectomy. On the supply side, lack of skilled and motivated vasectomy providers and/or the providers' own negative attitudes and biases result in limited vasectomy availability.^{2,6} Of 54 African countries, 10 report measurable vasectomy use in their population-based survey reports, with only Swaziland (0.3%), Botswana (0.4%), and South Africa (0.7%) reporting levels exceeding 0.2% prevalence.⁷

Nonetheless, in all African countries at least some men have chosen vasectomy. Also, demand to limit births among MWRA is rising in many African countries, and the average age at which the demand to limit births exceeds the demand to space births can be surprisingly low—e.g., 29 in Malawi, 28 in Namibia, 24 in Lesotho, and 23 in Swaziland.⁸ (Demand for limiting exists when

women say they do not desire any more children in the future; it consists of both “met need,” i.e., current use of contraception, and unmet need.)

Kenyan Context

Under the FP2020 global partnership, the Government of Kenya has committed to broadening family planning (FP) access and method choice, in part through wider availability of long-acting and permanent methods. The Government has also committed to scaling up its efforts to equip new and existing health workers with adequate practical training for provision of a full range of FP methods, and to empower community health workers to provide counselling and referral services for long-acting reversible and permanent methods, as well as short-acting resupply methods.⁹ As part of this effort Kenya seeks to ensure that vasectomy is more widely available and accessible.¹⁰

While Kenya has one of the highest levels of contraceptive use in sub-Saharan Africa, with a modern contraceptive prevalence rate (mCPR) of 59.0% among MWRA and a fairly well-diversified method mix, vasectomy use is negligible: 0.12% in 2017¹¹ and 0.0% in 2014.¹² The assumption is that if vasectomy were more widely known, accurately understood, and available/accessible, its use might increase, as the demand to limit births among MWRA (41%) exceeds their demand to space births (35%) in Kenya.¹²

The possibility of nascent interest in vasectomy in Kenya was further suggested during the events of World Vasectomy Day (WVD), which IntraHealth International helped to support in Nairobi on November 18, 2016. Leading up to the day, mass and social media were used to publicize the event and mobilize men and their partners to consider participating. The day's activities included a men's health fair, expert panel discussions, and speeches and videos on the importance of male engagement in FP. Men also had the opportunity to be counseled on and receive vasectomy at no cost on that day.¹³ County ministries of health supported WVD through community mobilization using community health workers and field staff. This day-long, government-sponsored event, essentially a “proof of concept,” revealed noteworthy, if still

modest, interest in vasectomy. In a country where vasectomy services and acceptors are uncommon, 74 men from four Kenyan counties—Nairobi, Busia, Kakamega, and Kisumu—chose to have a vasectomy that day. In addition, five Kenyan FP service providers were trained by visiting international vasectomy experts.

Another subsequent vasectomy event led by some of the WVD partners during the week of April 24-27, 2018, provided no-scalpel vasectomies (NSV) to 71 new users in Nairobi only.¹⁴ While this event occurred after this study's data collection was completed, it further suggests that, given the opportunity to undergo a vasectomy at no cost, a considerable number of Kenyan men will choose the procedure when it is made readily available and affordable.

Purpose of the Study

Considering that 74 men recently came to get a vasectomy on a single day in a country where vasectomy prevalence is close to zero, we wanted to learn more about: 1) demand—i.e., the decision-making dynamics of recent early adopters of vasectomy (those who had a vasectomy between 2015 and 2018); 2) the experience of vasectomy providers in the four counties in Kenya that participated in WVD; and 3) the perspectives of other stakeholders. This might illuminate ways in which Kenya could increase vasectomy knowledge, availability, and access, so that the method could become a wider and more regular part of the available method mix.

METHODS

We based this qualitative study on a phenomenological approach, where we sought to describe the “lived experience” of recent vasectomy users and providers. We used a cross-sectional survey design, in which respondents from four Kenyan counties were interviewed by five trained data collectors between January and April 2018. Our sample consisted of 35 people: 19 vasectomy users, 7 vasectomy providers, and 9 stakeholders selected through a purposive sampling method. The study team conducted semi-structured interviews with participants to assess the prevalence of certain characteristics and experiences of vasectomy users, and the

attitudes and perspectives of vasectomy providers and stakeholders. Verbal consent was obtained from all respondents, and human subjects protection measures were respected. The Kenyatta University Ethics Review Committee approved this study for data collection. All study respondents provided oral informed consent, which was witnessed by trained data collectors. All interview guides and informed verbal consent were translated into the local language.

Selection of Study Respondents

Vasectomy users

The study team, with the assistance of Ministry of Health (MOH) reproductive health (RH) coordinators, recruited adult males who received a vasectomy between 2015 and 2018 at either public or private health facilities located in one of the four counties. Purposive sampling and referral sampling led to the participation of 19 respondents. The RH coordinators shared with the study coordinator the names and contact details of men who had indicated willingness to participate in the study.

Vasectomy providers and other stakeholders

We used purposive sampling to recruit vasectomy providers and stakeholders. Key stakeholders included directors of health and RH coordinators from each of the four counties. Stakeholders also represented other implementing partners involved in vasectomy provision and programming in Kenya. Both providers and stakeholders were contacted directly by the study coordinator to determine their interest in participating and to arrange interview times.

Table 1. Study Participants by Group/Location and Selection Criteria (N=35)

Population	Criteria for Participation in Study	Recruited
Vasectomy users	<ul style="list-style-type: none"> • Adult male • Had vasectomy 2015-2018 • Had procedure in one of the four counties • Gave consent to participate 	<p>19 participants:</p> <ul style="list-style-type: none"> • 8 from Busia • 7 from Nairobi • 3 from Kakamega • 1 from Kisumu

Vasectomy providers	<ul style="list-style-type: none"> • Trained in vasectomy at WVD 2016, or works in facilities with highest vasectomy procedure provision in 2016-17 • Gave consent to participate 	7 participants: <ul style="list-style-type: none"> • 3 from Nairobi • 2 from Kakamega • 2 from Kisumu
Stakeholders	<ul style="list-style-type: none"> • Currently involved in vasectomy provision and/or advocacy in one of the four counties • Gave consent to participate 	9 participants: <ul style="list-style-type: none"> • 3 from Busia • 2 from Nairobi • 2 from Kakamega • 2 from Kisumu

Data Collection and Analysis

We conducted data collection using semi-structured interview guides, customized for users, providers, and stakeholders. The interview guides and informed consent forms for vasectomy users were field-tested, finalized, and translated into Swahili to ensure that all respondents could easily understand the questions. Individual key informant interviews were conducted among vasectomy users, providers, and stakeholders.

The study coordinator regularly submitted annotated field notes, in English, with quotes illustrating key thematic areas, to the study team, who interpreted, synthesized, and analyzed findings. Emerging themes were identified by reading data collector field notes from these 34 interviews. The study team also incorporated the feedback of MOH staff and NGOs for the discussion section.

Study Limitations

This study was not representative of Kenya and focused on a small sample size from four counties. Data collectors wrote up annotated field notes in English during the interviews, therefore nuances and meaning may have been altered in the process of distilling interviews to short responses, and in translations from Swahili to English. Interviews were not recorded to verify the respondents' answers. Unfortunately, the study was not able to include the partners of the vasectomy users, whose input was often cited as an important part of men's decision-making process.

FINDINGS

Vasectomy in Nairobi, Kakamega, Busia, and Kisumu Counties

Vasectomy users

The average age of the 19 users was 42 years old. Education among the men varied widely; seven men (37%) had a primary school education, four (21%) had completed secondary school, and eight (42%) had their diploma or higher. All men were married, with an average of five children, with an additional average of two other dependents in their households.

Table 2. Demographic Characteristics of Vasectomy Users (N=19)

Variable	Disaggregation	Frequency	Percentage
Age group (years)	30-39	8	42%
	40-49	9	47%
	50-59	0	0%
	60-69	2	11%
Educational Status	Primary	7	37%
	Secondary	4	21%
	College	5	26%
	Post-college	3	16%
Number of children	1-2 children	3	16%
	3-5 children	9	47%
	6-9 children	5	26%
	10+ children	2	11%
Marital status	Married	19	100%

Participants from Busia were on average 10 years older (46) than participants from Nairobi (36); the average age of Kakamega participants was 41, while the single participant from Kisumu was 49 years old. Participants from Busia had an average of eight children, Kakamega men had an average of four children, while their counterparts in Nairobi had an average of three children. The Kisumu participant had four children.

When asked how the vasectomy has affected their life, these 19 men had only positive things to say. They felt no changes post-procedure physically or sexually. Most men described having peace of mind in being able to continue their sexual relations with their partners, and not worry about more pregnancies and their partners' birth control-related side effects.

"I don't see any side effect, I am a free man especially with my partner. I don't have any worries of impregnating my wife during sexual intercourse. My wife is very healthy and psychologically stable unlike before where she got worried about excessive bleeding and irregular monthly periods [while on contraceptive pills and injectables]." – Vasectomy user from Busia County

" Wasiwasi imeisha. (The worry is over)." – Vasectomy user from Kakamega County

"There is confidence of not having another baby. Now I feel that I can plan with what I already have." – Vasectomy user from Nairobi County

Vasectomy providers

Seven vasectomy providers were interviewed: three from Nairobi County, two from Kakamega County, and two from Kisumu County. No providers from Busia County were interviewed. Six of the respondents are physicians (two are OB/GYNs), and one a nurse. Three providers work at NGO health facilities, three work in the public sector, one runs his own private practice, and one is not currently working in service delivery. The providers averaged 24 years of medical practice, and 14 years of experience in vasectomy provision. One provider is female while the rest are male.

As providers of primary care and reproductive health services, respondents had either been trained in vasectomy to fulfill work duties or spoke of their passion for reproductive health and saw the opportunity to satisfy client needs. Two providers also shared that they themselves had undergone vasectomies and were satisfied users of the method.

"I used to work in a busy maternity unit in Kisumu County where I experienced the difficulties women underwent during childbirth. Maternal death was high due to excessive bleeding, hypertension, and infection. I also used to attend to women with different family planning methods' side effects, which included vaginal bleeding and vaginal discharge. Some men started inquiring about vasectomy and no doctor was trained in the area hence

the decision to be trained in performing vasectomy procedure." – Vasectomy NGO provider in Nairobi County

Since being trained, five of the seven providers noted that they were currently performing fewer vasectomies than they initially expected or had hoped.

"[I am performing fewer vasectomies than expected] because comparing the number of counseling we do versus those who turn out or make up their mind for the procedure which is very few. I believe there are a lot of people out there who [might] take up the procedure, but few consider it." – Vasectomy MOH provider in Kisumu County

"Limitations have been [in] getting clients, but in the past years [the number of] clients have increased. We mostly get referred clients from satisfied clients. It is not easy to do publicity unless it is World Vasectomy Day. Vasectomy is not well taken as much as tubal ligation, because the demand has not been created." – Vasectomy NGO provider in Nairobi County

All three public facility providers and one NGO provider reported that almost all clients returned for their scheduled follow-up appointments three months later. However, two NGO providers and the private provider had difficulty getting men to return for their appointments. Overall, most providers said their clients were satisfied with the procedure, based on follow-up or inferred by the fact that clients did not contact them with complaints.

Vasectomy stakeholders

Nine stakeholders were interviewed: three from Busia, two from Nairobi, two from Kakamega, and two from Kisumu. All stakeholders worked in county government. Four are RH coordinators involved in the coordination and monitoring of all RH activities for both men and women. One is a director of curative and rehabilitative services who coordinates vasectomy services provided by partner organizations and acts as the link between the partners and communities. Two are county directors of preventive and promotive health who coordinate and supervise health workers, including capacity-building. Two are county directors of health supporting all health activities, including FP.

Stakeholders reported that no funds are allocated directly for vasectomy and also that vasectomy is considered very low priority when compared to more popular FP methods. One

Kakamega stakeholder noted that “no special attention has been accorded to vasectomy within the family planning program due to the negative attitude of the community.” One county RH coordinator said that, as a practice, they are not allowed to advocate for any single method because FP is meant to be voluntary and the government cannot be seen as encouraging one method over another.

Instead of funding vasectomy directly, the county governments partner closely with Marie Stopes Kenya (MSK, the local affiliate of Marie Stopes International) and Family Health Options Kenya (FHOK), an affiliate of IPPF, which are both active in promoting and providing vasectomy services. MSK and FHOK collaborate with the counties to conduct outreach, support community health volunteers to sensitize communities, and to provide all methods including vasectomy. There is no formal existing vasectomy network; instead counties partner with MSK and/or FHOK in varying degrees to meet demand.

Vasectomy Demand

Barriers to getting a vasectomy

Although the men interviewed ultimately chose to have a vasectomy, they had to overcome a number of impediments to accessing the service. Myths and misconceptions about vasectomy are still pervasive in their communities, most stemming from a widespread lack of accurate information and/or understanding. Many men also pointed to “culture” as a further barrier to vasectomy adoption, describing the procedure as taboo, as against the belief that “children are a blessing,” or that “family planning is a ‘woman’s issue,’” all of which were preventing men from setting foot in FP clinics and engaging in FP conversations.

“There [are] cultural, mental barriers where vasectomy is viewed not as an African thing. Some of these things are viewed as Western... and in Africa family planning is seen as a woman's thing.” – Vasectomy user from Nairobi County

At the community level, there is high stigmatization against those who undergo a vasectomy, as though they will no longer be “full men” and their status among peers will decrease. Some users

also worried that current and future partners would not approve. Respondents spoke of the fear that their partners might leave for a more virile man, or that if they were to remarry, they could not have children with a new partner. One respondent admitted that at the time of the interview, his wife still did not know about the vasectomy he underwent the year prior. Another man waited until after the procedure to tell his wife, for fear that she would not allow him to go for the vasectomy. Vasectomy users also described having to overcome their own personal barriers to vasectomy—e.g., exposing their genitals to the health worker and allowing him or her to manipulate them during the procedure. Lastly, some men complained about the cost of the procedure (which varies by county and type of health facility) as an additional hurdle.

Facilitators to getting a vasectomy

Primary points of contact to first learn about vasectomy differed between men with a primary school education and those with more than a primary school education. Six of the seven men with primary school educations cited community health volunteers who conduct house visits as their main source for vasectomy information. The 12 men with more than a primary school education cited several sources of information: family members who had vasectomy and openly shared their experience, community health volunteers visiting to discuss FP, and World Vasectomy Day awareness campaigns. The four men with a university education were distinct in that they also learned about vasectomy through their formal education and/or self-initiated research.

Reasons for ultimately choosing a vasectomy were consistent among vasectomy users: families had reached the desired number of children; economic constraints with raising children and affording routine contraceptives; dissatisfaction (side effects) with other contraceptive methods; concern for their partner's health; and assumption of joint responsibility for achieving reproductive intentions.

"After seeing the problems my wife had undergone, the cesarean-birth and...the number of children we had given birth to, we thought of vasectomy. I must also say [I] like doing things unique, hence I wanted to explore to some extent. I had been told it would be 98.9% success rate hence I considered it to be the best method so that whenever we had an

intercourse, I would not be bothered." – Vasectomy user from Kisumu County

A man's responsibility to his family came up often in the interviews; to be successful meant to be able to provide the basic needs to his children.

"Whether people got to know about it or not, I would have taken care of my family."
– Vasectomy user from Kakamega County

One vasectomy user from Busia County believed his actions would not only benefit his family but also make a positive impact on his country.

Vasectomy Supply

Barriers to vasectomy service delivery

All four counties reported low—and varied—vasectomy uptake. NGO providers in Nairobi County report an average of 100 vasectomies a year while one county government stakeholder guessed at 50 a year and the other could not say how many vasectomies took place in a year. The public-sector vasectomy provider in Kakamega County reported conducting an average of three vasectomies per year and the private practitioner estimated nine per year, while the county government stakeholders reported one or two a year. In Kisumu County, the public-sector vasectomy providers and county government stakeholder all reported fewer than one vasectomy being conducted per year on average. Estimates varied among Busia County government stakeholders at between 20 and 100 vasectomies a year.

County government stakeholders say that the challenges regarding reporting vasectomies come from the fact that most vasectomies are not performed by the public health system itself, but rather by NGOs (and private facilities), who may or may not report up to the county or national district health information system (DHIS2) service delivery database.

"Nationally for the country we have 700 clients, but we can only account for 100 meaning there are a lot of unreported vasectomies out there." – NGO vasectomy provider in Nairobi County

Stakeholders and providers interviewed reported substantial challenges within the supply chain system. Without adequate medical equipment and supplies to support vasectomies, efforts have been outsourced to partners (MSK and FHOK).

The cost of the procedure can prohibit some men from choosing vasectomies. Generally private insurance companies do not cover FP methods. While the new National Hospital Insurance Fund (NHIF) does offer FP services to its members, one provider respondent reported NHIF does not yet cover those services. Four of the vasectomy users listed financial constraints as a barrier; one man recalled that an NGO charged 25,000 KSH (about 250 USD) and another recounted that a private hospital was charging over 1,000 USD. A private provider reported that private facilities charge between 5,000-10,000 KSH (50-100 USD), depending on the county.

Health worker biases also present a major barrier to vasectomy uptake in all four counties. Three providers (an OB/GYN, a private physician, and a nurse from a referral hospital) and two stakeholders expressed concern that the attitudes of some providers may discourage clients from considering vasectomy. As one stakeholder admitted, there was a need to “destigmatize health workers on the issues pertaining to vasectomy, including [myself]. I cannot allow my husband to go for it.” One county RH coordinator pointed out that even when couples do attend antenatal/postnatal care clinics together, they are often not informed about vasectomy and/or are steered towards contraceptives for women.

One vasectomy user in Busia shared a story that highlights how health workers can create an inhospitable environment for a person’s free decision to undergo vasectomy. While he and other men were waiting their turn for the vasectomy procedure, female students from the Kenya Medical Training College attached to the hospital came and teased them about wanting to “cut themselves so that they would no longer have children.”

Facilitators to vasectomy service delivery

Good counseling facilitates service delivery. In one-on-one counseling, Nairobi providers talk to more people about vasectomy than those from the other counties; one respondent from FHOK speaks to an average of 100 people a month about vasectomy and uses social media to create awareness and demand. One Kakamega provider previously (but no longer) led a group of men who had vasectomy to assist in recruitment and advocacy. Nairobi providers use social media to mobilize interested men.

Besides individual counseling, FHOK and MSK have implemented several different demand creation activities, including social media ads and taking advantage of World Contraception Day and World Vasectomy Day for health promotion activities. FHOK occasionally offers no-cost procedures for low-income clients, financially supported by No-Scalpel Vasectomy International. MSK also sometimes offers subsidized procedure costs and can negotiate with clients on the cost—i.e., they have a sliding scale. A Kisumu provider at a public facility reports that they talk about reproductive health during morning health education talks to reach out to the larger population.

The FHOK provider leads his own separate organization that links FHOK with No-Scalpel Vasectomy International to provide a physical space for post-vasectomy couples to share their experiences and encourage other men to consider vasectomies. MSK conducts outreach with MOH facilities and other private facilities, including MSK's social franchise arm, AMUA. Sub-county teams partner on awareness creation, and MOH, UNFPA, and other providers collaborate on trainings. Amref Health Africa, Christian Health Association of Kenya (CHAK), and EngenderHealth are also partners in these efforts.

Seven of the vasectomy users had been in large part introduced to vasectomy by one of Busia's community health workers. This particularly effective intervention was implemented by a seven-member consortium to improve sexual and reproductive health outcomes.¹⁵ In the five-year intervention, Busia County collaborated with MSK to use community health volunteers as part of

the county's Community Health Strategy to educate and mobilize community members on FP, including vasectomy.

Fostering an Enabling Environment for Vasectomy in Kenya

Increasing vasectomy demand

Of the 19 men who had vasectomy, 17 felt comfortable and empowered to speak about vasectomy with community members and even family and friends. These vasectomy users observed that other men are struggling with similar challenges that they and their partners had faced and felt they could share their experience and offer advice. Even the respondent who had not yet disclosed his vasectomy to his partner was open to speaking about vasectomies anonymously. One suggestion made by two of the respondents was to have vasectomy champions speak in other counties, to add a level of privacy when the subjects may still be met with criticism in their own counties.

"I can be willing to talk about it and share my story. There is need to demystify the myths and misconceptions about vasectomy as one of the best contraceptive methods. I would be willing to be a champion anonymously, since they say, 'a prophet is not accepted in his own town'." – Vasectomy user from Kisumu County

The two men who said they were unwilling to talk to others about the benefits of vasectomy were pastors. Both felt unable to publicly advocate for one specific contraceptive method but remained open to the possibility of encouraging men to participate in FP discussions.

The three groups of respondents were asked which mode of communication would be most appropriate for the topic. For each group, the most popular method was the use of radio and other mass media channels. For example, a few of the vasectomy users recalled hearing a well-known radio personality speaking about his vasectomy procedure on air. Respondents noted that the choice of communication mode depended on whether the message was for awareness raising (large group settings, radio) or a more focused and specific conversation (one-on-one counseling). Table 3 lists study respondents' top six preferred modes of disseminating vasectomy information, by frequency of the response.

Table 3. Study Respondents' Preferred Modes of Information Dissemination, by Group (N=35)

Users	Providers	Stakeholders
Mass media (radio)	Mass media (radio)	Mass media (radio)
One-on-one counselling	Social media	Social media
Men's forums/ <i>chamas</i>	Health education/outreach	Community health workers
Chief's <i>Barazas</i>	IEC materials	Health education/outreach
Health education/outreach	One-to-one counselling	IEC materials
IEC materials	Chief's <i>Barazas</i>	Health workers

The main factors that respondents believed were important to consider when talking about vasectomy are a man's age and the current size of his family, since the method is permanent. Messages should also include the facts that one's sex drive and strength remain intact after the procedure, the importance of having men involved in FP, the personal economic benefits of FP, and where and how the service can (at times) be obtained at low cost or free of charge. Language regarding vasectomy is important. There may be the necessity to make sure a suitable term for vasectomy is used in the local languages. For example, in Kakamega, "the word they use for vasectomy is castration."

One Nairobi vasectomy user respondent had a more population-focused view for encouraging fellow Kenyan men to consider a vasectomy: "As men we need to help our wives by sharing the burden. Every person has a duty to self, family, and society."

Improving vasectomy services

Providers and stakeholders identified the need for dedicated resources to highlight vasectomy as a necessary part of the contraceptive method mix; develop awareness campaign materials; provide surgical equipment including NSV kits; and train additional providers in NSV. Providers and stakeholders felt it was important to foster high-level leadership from the MOH so that vasectomy can be offered in MOH health facilities as part of standard FP options, similar to tubal ligation. They also felt that dependency on NGOs and donor funding to provide vasectomy services limits the scope of service provision and access.

DISCUSSION AND RECOMMENDATIONS

The findings gleaned from our in-depth qualitative interviews lead us to a number of demand-side and supply/service-side observations and recommendations, as follows.

Increasing Vasectomy Demand

Demand generation should be a first priority over working to increase vasectomy service availability (e.g., by widespread provider training). The well-known myths, misconceptions, and biases about vasectomy that this study confirmed indicate a need for accurate and correct information to not only be provided but understood in order spur demand for vasectomy. Community input regarding effective and positive messaging is important when building successful awareness campaigns. Simple messages in local languages that better explain vasectomy need to be developed first.

1. **Policy.** MOH units should prepare by updating their FP communication and demand creation strategies, policies, and procedures to ensure that vasectomy is part of a wide range of methods about which people are counseled and offered as an option.
2. **Information, Communication, and Technology.** To convey appropriate information and messages, mass media (newspapers and radio in particular) is still ubiquitous and trusted, while social media is gaining popularity among younger segments of the Kenyan population. Both mass and social media allow for repetitive messaging, which is key—and cost-effective—in increasing knowledge and demand and facilitating honest and open discussion about vasectomy.
3. **Community Health Volunteers.** The results from community health volunteers recruiting vasectomy clients among less-educated men in Busia County demonstrate the success of Busia's Community Health Strategy. A scale-up of similar efforts in other more rural counties could help to reach an underserved population of men. This would include community dialogue meetings and routine home visits by community health volunteers who have received training on key messages about vasectomy. These one-on-one

conversations are important for replacing myths with facts, correcting misunderstandings, and addressing any general concerns.

Extending Vasectomy Services

Even as work is necessarily being done to increase demand for vasectomy (as described above), several aspects of service delivery should also be addressed, perhaps with the national and county governments partnering to a greater extent with private service delivery organizations (e.g., MSK and FHOK) to ensure that vasectomy services are available (and affordable) to those men who want them now.

1. **Service Delivery Guidelines.** National and county service delivery guidelines should be updated to ensure that vasectomy is a meaningful part of the FP method mix.
2. **Strategic Capacity Building.** To ensure that vasectomy is available and accessible within a reasonable distance, there should be at least one trained and active NSV provider in each county.
3. **Health Worker Behavior.** Addressing health worker bias against vasectomy as a method, or more generally against men participating in FP, would likely lead to more men feeling encouraged to participate in their family's contraceptive decision-making. Additionally, all facility health workers should be informed and supportive regarding vasectomy to create a positive "whole site" atmosphere and to ensure that people interested in vasectomy are not turned away or discouraged from choosing the procedure.
4. **Technical Working Groups.** Collaboration should be nurtured within and across counties and counties encouraged to bring in other reproductive health stakeholders like civil society (e.g., Kenya Organization of Obstetricians and Gynecologists), in addition to vasectomy users and providers. Vasectomy champions should also participate in other FP working groups, to not only advocate for vasectomy as a method option but to encourage increased male engagement in FP.

5. **Program Cost Considerations.** We applaud the Kenya Government’s FP2020 and Costed Implementation Plan commitments to include a wide range of contraceptive choices and increase access to those methods. The national and county level ministries of health should go further by ensuring that vasectomy receives appropriate attention to enable it to become a meaningful part of the FP method mix.
6. **Ensuring Affordability.** As noted in our in-depth interviews, cost can be a major impediment for many clients. World Vasectomy Day 2016 provided vasectomy free of charge and 74 men came for vasectomy. No-Scalpel Vasectomy International’s repeat event in April 2018 provided free vasectomies to an additional 71 men just in Nairobi. In Malawi, a neighboring country facing similar socioeconomic and programmatic constraints, the other permanent method, tubal ligation (female sterilization) has been provided largely free of charge by the MSI affiliate, which has led to widespread, equitable, and substantial uptake of the method.¹⁶

CONCLUSION

Is Kenya ready to add vasectomy to its method mix? Our answer, based on the findings of this limited study, is a qualified yes. The country already has a high mCPR, diversified method mix, and high demand for limiting births. In that context, the willingness of study respondents to share in their family’s contraceptive responsibilities and to champion the benefits of vasectomy—and the relatively large numbers of men who chose to have a vasectomy as part of promoted events—offer encouraging signs that now is the right time to capitalize on nascent interest in the method. However, a concerted focus on demand-side interventions is needed as a next step—in particular, to dispel the deep-rooted myths and misconceptions about vasectomy that persist among both the general population and the health workers who are meant to support free and informed choice from a wide range of contraceptive methods. Such demand creation should be coupled with thoughtful (i.e., modest) capacity enhancement, titrated to the counties’ basic needs for vasectomy availability, as well as the (hopefully) growing demand for vasectomy services there. “Payoff” in terms of substantial vasectomy uptake, with

vasectomy prevalence in Kenya reaching levels attained globally, will not be immediate or even realized in the short-term—but if it is to happen at all, the recommendations made above should be instituted now.

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