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
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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 $\frac{1}{2}$ to $\frac{2}{3}$ 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

Number (in millions)

1982: 100
1991: 145
2001: 211
2009: 223

1982: 30
1991: 43
2001: 44
2009: 28

Vasectomy vs Female Sterilization
### Vasectomy use: Worldwide and regional

<table>
<thead>
<tr>
<th>REGION</th>
<th>% of MWRA using</th>
<th>Number of users (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worldwide</td>
<td>2.7%</td>
<td>32</td>
</tr>
<tr>
<td>Oceania</td>
<td>11.8%</td>
<td>0.5</td>
</tr>
<tr>
<td>North America</td>
<td>10.3%</td>
<td>4.1</td>
</tr>
<tr>
<td>Asia</td>
<td>3.0%</td>
<td>22.5</td>
</tr>
<tr>
<td>Europe</td>
<td></td>
<td>2.8</td>
</tr>
<tr>
<td>Latin America</td>
<td>1.3%</td>
<td>1.3</td>
</tr>
<tr>
<td>Africa</td>
<td>0.1%</td>
<td>0.1</td>
</tr>
</tbody>
</table>

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

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

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

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

**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

Mean knowledge of contraceptive methods, Sub-Saharan Africa countries

- Woman currently married:
  - Any modern method: 89%
  - Injectables: 75%
  - Vasectomy: 20%

- Men currently married:
  - Any modern method: 93%
  - Injectables: 74%
  - Vasectomy: 33%

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.

Service Delivery Cost*/CYP

*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.

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

**Supply**
Staff supported in delivering quality services that are accessible, acceptable, and accountable to clients and communities served

**Demand**
Individuals, families, and communities have knowledge and capacity to ensure SRH and seek care

**Meeting Clients’ Reproductive Intentions**

**Enabling Environment**
Policy, program, and community environment, coupled with social and gender norms, support functioning health systems and facilitate healthy behaviors

**Transformation of Social Norms**

**Systems Strengthening**

**Quality Client-Provider Interaction**
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—and “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

Impact Area:
Universal knowledge
Broad & equitable access
Wider use

- Research-to-practice
- Proof of concept
- Pilot projects -- all vasectomy projects have been pilots
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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Because Health Workers Save Lives.

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