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Vasectomy Overview, with Trends and Programming Pearls

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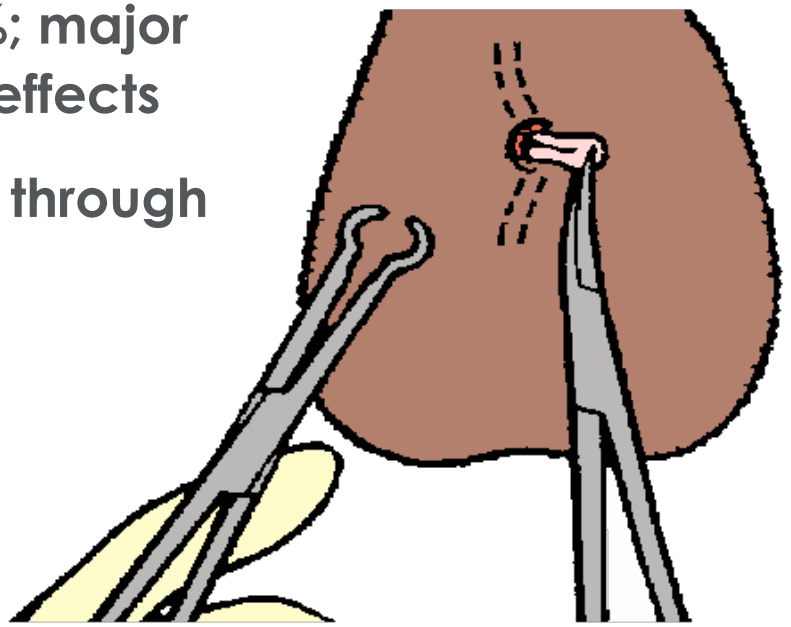
Context for Vasectomy: Demand to limit is increasing, everywhere

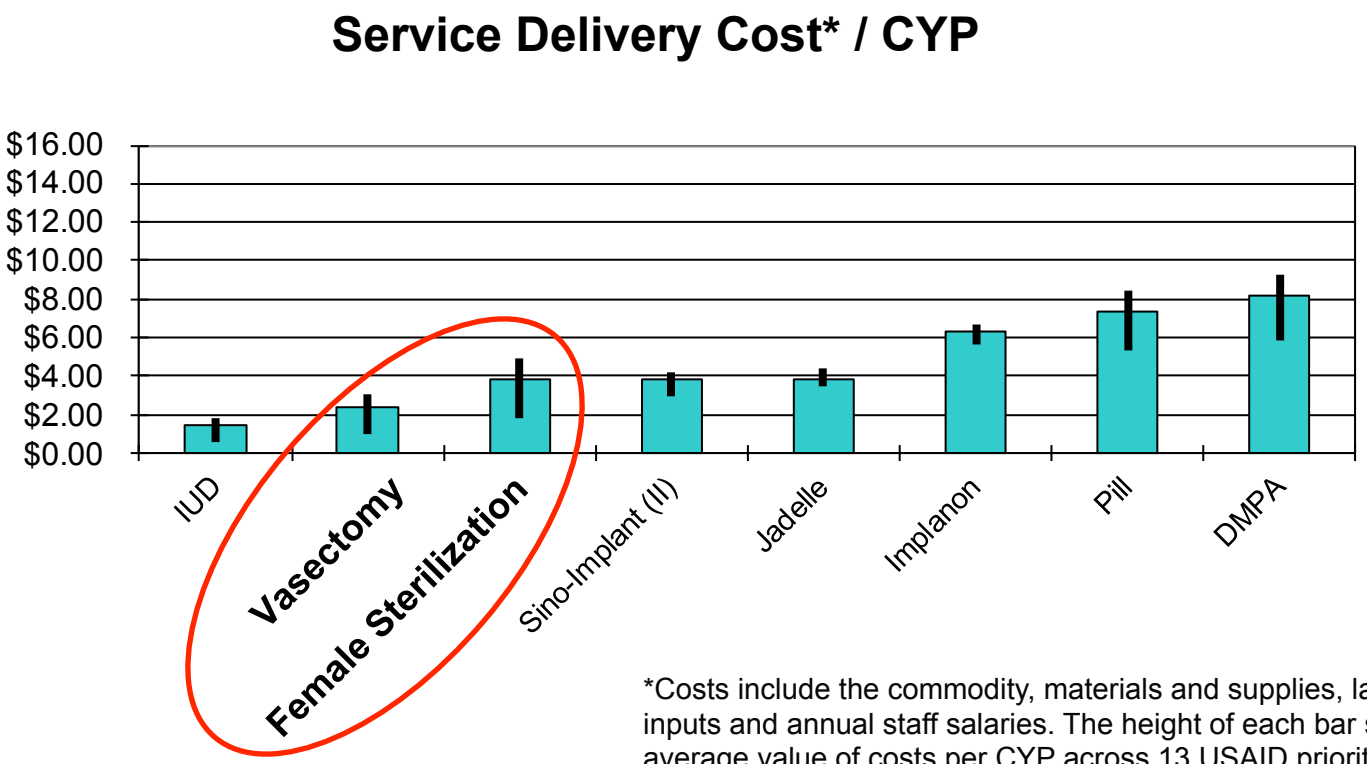
- Major global megatrends are driving smaller desired family size, i.e., the **small family norm is becoming universal.**
- Millions of women and couples are spending **½ to ⅔ of their 3-decade reproductive lives** having the **intention to limit**.
- **Demand to limit > demand to space** among women married or in union, **everywhere but West & Central Africa**.
- Average age at which demand to limit > demand to space ("crossover age") is falling: As **low as 23-24 in some countries.**
- **Does not mean all limiters want, need or will choose a PM** … but many men and women would and do choose them.

No-Scalpel Vasectomy (NSV): Method characteristics

- **Almost all men are eligible** (WHO MEC, 2015)
- **Very safe**: Minor complications, 5-10%; major morbidity rare; no adverse long-term effects
- Small puncture; *vas deferens* is pulled through skin, & ligated or cauterized
- **High effectiveness**, comparable to effectiveness of other LARCs/PMs
- Effective **only after 3 months**, i.e., not immediately
- **Low failure** (pregnancy) rate: 0.5% (1 in 200), but **depends on skill of operator & compliance of client and his partner** (Nepal study: 5% failure)



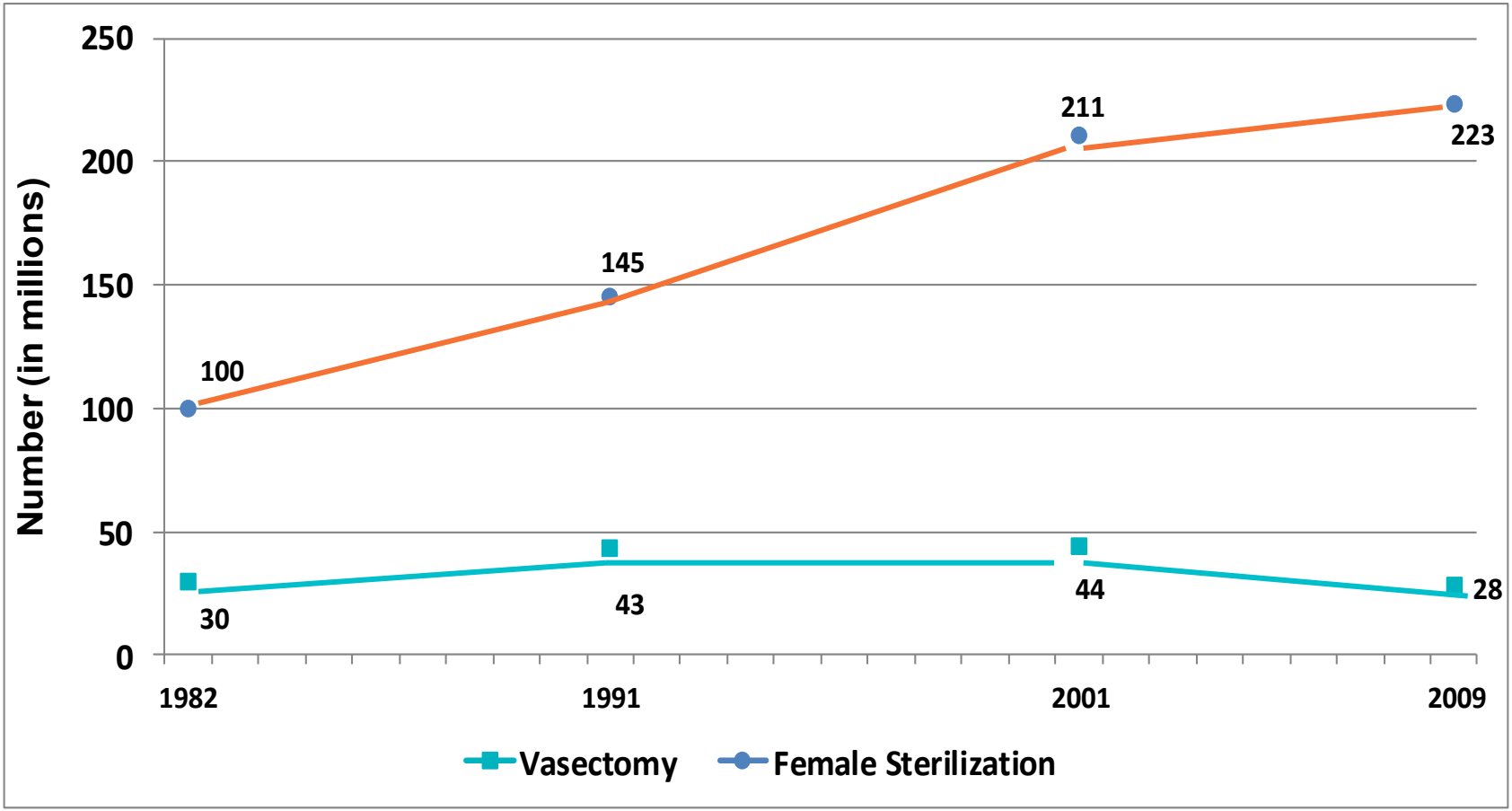
Compared to FS: Safer, simpler, equally highly effective, twice as cost effective



*Costs include the 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

Trends: Decline in use of vasectomy and in its relative share of permanent method use



Sources: *Contraceptive Sterilization: Global issues and trends*, EngenderHealth, 2002 and *World Contraceptive Use, 2011*, UNDESA 2012.

Notes: According to UNDESA 's *Trends in Contraceptive Use Worldwide 2015,* worldwide use of vasectomy is 2.4%, and female sterilization, the most widely used of any modern method, has a prevalence of 19.2%.

Vasectomy Use: Worldwide & regional

REGION	% of MWRA using (2007-08)*	# of users (millions, 2009)*	% of MWRA using (2015)**
Worldwide	**2.7%**	**32.8**	**2.4%**
Africa	**0.1%**	**0.1**	**0.0%**
Asia	**3.0%**	**22.5*** **	**2.2%**
Europe	**2.9%**	**2.8**	**3.3%**
Latin America & Car.	**1.3%**	**1.3**	**2.6%**
North/ern America	**10.3%**	**4.1**	**11.9%**
Oceania	**11.8%**	**0.5**	**6.3%**

***Source**: *Urol. Clinics of North America*, 2009, "Demographics of Vasectomy—USA and International," Pile, J.M. and Barone, M. Data for women married or in union, from UNDESA *World Contraceptive Use, 2008* and PRB *FP Worldwide, 2008*. China and India accounted for around 20 million users. In that study, Mexico is included in "North America."
****Source:** **UNDESA, *Trends in Contraceptive Use Worldwide, 2015.* Data for women married or in union; "Northern America" includes only Canada and USA. "Northern Europe" has an aggregate vasectomy prevalence of 16.4%; "Least Developed Countries" have an aggregate vasectomy prevalence of 0.4%.

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

Country	Vasectomy prevalence (CPR)	Share of modern method use
Canada	22%	31%
United Kingdom	21%	25%
New Zealand	20%	26%
Korea (South)	17%	21%
Bhutan	13%	19%
United States	11%	16%
Australia	9%	13%
Switzerland	8%	10%
Spain	8%	12%
Nepal	8%	18%
Netherlands	7%	10%
Brazil	5%	6%
Czech Republic	5%	7%
Denmark	5%	6%

Source: UNDESA, 2014. *World Contraceptive Patterns, 2013.. Data for women married or in union.*

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Very low awareness and negligible use in USAID priority countries (despite high demand to limit)

Country / (Year of DHS)	Demand to limit/ demand 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 (2014)	41% /35%	53.2	50%	0.0
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 in DHS]
DRC (2013-14)	14% / 34%	7.8	20%	0.1
Senegal (2014)	13% / 35%	20.3	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 Feb 20, 2016. Data for women currently married or in union

Reasons for low vasectomy use at the client level

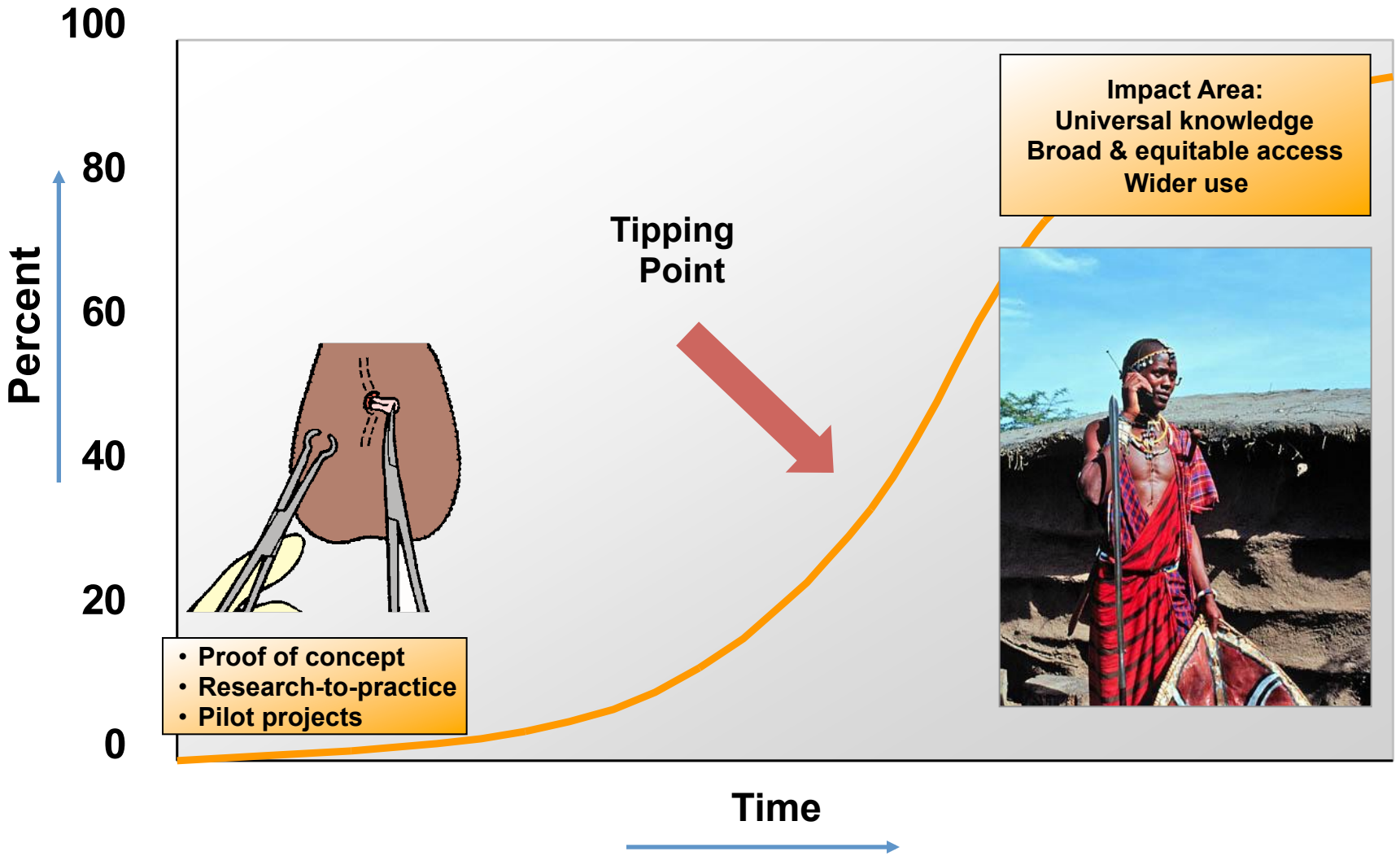
- **Lack of awareness:** Least "known" of all methods
- **Cultural and gender norms:**
  - "FP is a woman's duty"
  - Greater number of children = greater masculinity
- **Rumors and myths** (aka their "truths", & women as well as men)
  - Sexual function: "vasectomy = castration"
  - Subsequent health: "will make me (or him) 'weak' "
- **Anxiety** about undergoing a surgical procedure

Reasons for low vasectomy use at the program level

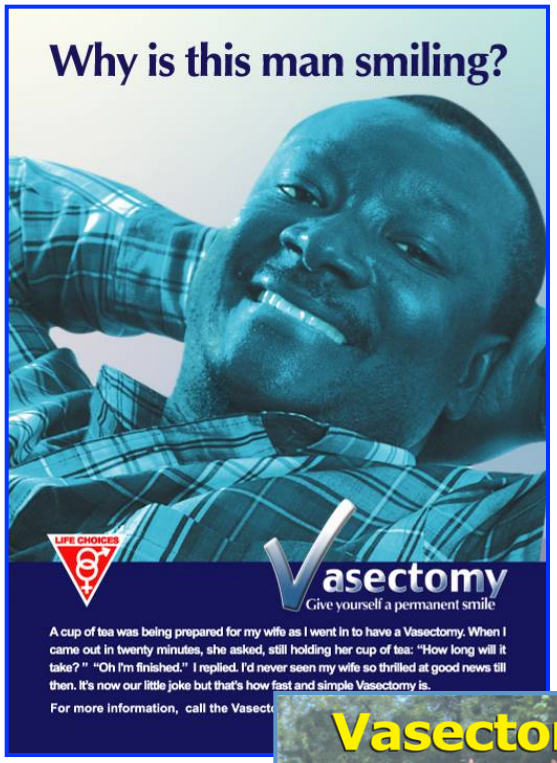
- Donor / provider / policy/ program factors:
  - **Neglected in CS**: Not a "commodity" or "contraceptive"
  - **Inadequate number of skilled & deployed providers**
    - "No provider, no program"
  - **Low donor priority / very limited funding**
    - "Small projects, small results"
  - **Too-short project time frames**
    - "There's no quick fix"

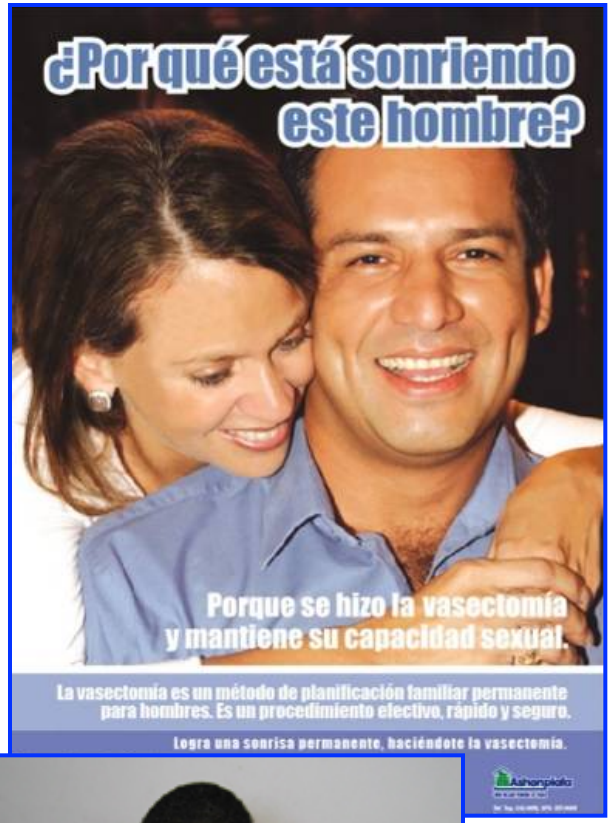
All adds up to limited vasectomy availability, diminished client choice, and very low use

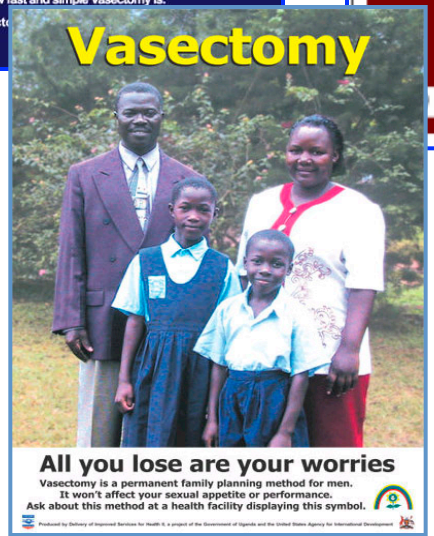
What we want to accomplish: Dynamics of introduction & scale-up of a "new" method



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







Strategies for greater male involvement (as clients for vasectomy)

- **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 and satisfied clients**

Some workforce and health system strategies for vasectomy services: "HIPs"

- Train **smaller cadre**, but support them **longer and "better"**
- Address **provider perspectives & rewards** (pay, recognition, workload)
- **Dedicated providers**
- **Male-friendly services**
- **Whole-site approach**: Engage all staff (inc. actual gatekeepers)
- Ensure services are **affordable**
- Focus on **quality** & client satisfaction

Conclusion

- Lack of vasectomy availability and access is
  - **A gender issue**
  - **A donor issue**
- Limiters are an **underserved** group
- The solution to having substantial male PM services:
  - **Vasectomy-specific** (or male RH-specific) **project**
  - **Adequately-resourced:** $$, attention, priority, time

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