

INCREASING DEMAND FOR AND SUPPLY OF NON-SCALPEL VASECTOMIES BY BUILDING PROVIDER CAPACITY

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INTRODUCTION

Vasectomy is one of the most effective forms of contraception currently available, with a failure rate of 0.15 (typical use) as compared to 9.0 for oral contraceptive pills¹. Clinically, it is the safest and quickest form of long-acting and permanent method of contraception, with as few as 5 percent of the complications seen in tubal ligation². Unfortunately, compared to worldwide, men in developing countries have fewer vasectomies — about 0.1 percent in Sub-Saharan African, a rate mirrored in Rwanda³. Research has demonstrated that, to boost these rates, programs must increase vasectomy knowledge in men and their wives. In 2011, the government of Rwanda launched a campaign to encourage vasectomy as an inexpensive method to limit family size, thus enabling parents or guardians to better provide for existing children^{4,5}.



METHODS

From 2012–2014, the USAID-supported Rwanda Family Health Project (RFHP) worked closely with the Rwandan Ministry of Health to increase use of vasectomy by addressing issues related to demand for and access to the service.

To help build demand, the project supported nurses and midwives who provide family planning services to participate in health-related community outreach events near their facilities. During these events, the providers gave information and conducted sensitization activities for community leaders and the general population to increase demand for vasectomy. When community members expressed interest in the procedure, the providers referred them to the closest facility.

To increase access to vasectomy services, RFHP and the Ministry of Health worked with health-care facilities to ensure they had the right equipment and training. The program assessed facilities and providers in 14 of Rwanda's 30 districts to gauge the equipment, supplies, and human resources that facilities would need to provide high-quality vasectomies. Following this needs assessment, the project supplied vasectomy kits and other supplies to start and maintain the service. To address provider capacity, the Ministry of Health/RFHP team facilitated training sessions for 27 doctors and nurses in no-scalpel vasectomy and for 80 nurses in necessary lab skills, such as semen analysis. The classroom curriculum included:

- Counseling and informed consent
- Pre-vasectomy evaluation
- Prevention of infections
- Anesthetic techniques
- Surgical techniques
- Postoperative care

Practical sessions consisted of:

- Practicing vasectomy counseling role-playing. Each participant practiced counseling a fictitious client, including providing information and answering questions about benefits, possible side effects, level of discomfort, and healing time. The participants also role-played referring patients to nearby facilities where the service could be provided.
- Practicing on a pelvic model. Participants performed the no-scalpel vasectomy technique on a pelvic model several times until they mastered all steps.
- Practicing in a clinic on real patients. Under the direct supervision of mentors, each participant also practiced the technique on patients with their consent. Seventy-nine vasectomies were performed during these practical sessions in health facilities in Ruhango, Muhanga, Nyarugenge, and Rwamagana districts.

For each training session, RFHP staff administered pre- and post-tests to evaluate changes in knowledge. For the two training sessions on conducting vasectomies, pre- and post-test scores indicated that knowledge increased from 54 percent to 89 percent, on average. For the five training sessions on lab and support skills, knowledge scores increased from 54 percent to 86 percent, on average. The work took place in district (secondary) hospitals in 14 of the 30 districts in Rwanda during 2014. The beneficiaries were men and families that wished to limit births.

380

non-scalpel vasectomies performed from 2012 - 2014



0.1

percent of Rwandan men who have had a vasectomy

SUCCESS STORY

Kamanayo Octavian told this story: "I am now 37 years old and already have five children. I live in Bugurizo Village in Muhanga District. My wife and I got information about vasectomy from other men using this method and then sat in a counseling session on family planning methods given by health providers from Shyogwe Health Center. My wife and I chose vasectomy, and we were then informed that vasectomy was available from doctors at Kabgayi District Hospital, who had been trained by the Ministry of Health and RFHP. I got the vasectomy and since then have had no side effects, and the welfare of my family keeps improving because my wife can now work with me and contribute to the income of our family. I thank the Ministry of Health, Kabgayi District Hospital, and RFHP for making vasectomy available close to me. I continue to talk to other men about choosing vasectomy as a sure and safe method that doesn't have any negative impact on the intimacy between wife and husband, despite what rumors say."

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Kamanayo Octavian, a patient from Bugurizo Village



CONCLUSIONS

While the level of acceptance for vasectomy in developing countries is quite low, a comprehensive program of demand generation and capacity-building can significantly increase the number of vasectomies. Because of the high number of couple years of protection per procedure for long-acting and permanent method, the payoff for each procedure is relatively high compared to non-permanent methods. Thus, spending limited training funding on vasectomy can have a relatively larger payoff.

RESULTS

As a result of Ministry of Health's and RFHP's efforts to increase demand for and access to vasectomy services, providers in supported districts performed 380 non-scalpel vasectomies from 2012-2014, resulting in 3,800 couple years of protection. Services in these districts are ongoing; based on these results, the ministry is scaling up vasectomy capacity-building efforts to other districts.

CITATIONS

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³Roy Jacobstein and John M. Pile, "Vasectomy: The Unfinished Agenda" (New York: The ACQUIRE Project/EngenderHealth, 2007).

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