



**SPOTLIGHT ON
VASECTOMY
ACCESS AND
UPTAKE IN
SOUTH AFRICA**

R E P O R T



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**SONKE
GENDER
JUSTICE**

HIV/AIDS • GENDER EQUALITY • HUMAN RIGHTS

**SETTING THE NATIONAL AGENDA AND SHARING
CONTRACEPTIVE RESPONSIBILITIES:
SPOTLIGHT ON VASECTOMY ACCESS AND UPTAKE IN SOUTH AFRICA**

A report on a 2014 National Consultation, Stakeholder Interviews and what the latest vasectomy research science means for Sexual & Reproductive Health and Rights Advocacy in South Africa and the region.



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ABBREVIATIONS

AAI	AIDS Accountability International
AIDS	Acquired Immuno Deficiency Syndrome
AVSSA	Association for Voluntary Sterilisation in South Africa
BTL	Bilateral Tubal Ligation
DNA	Deoxyribonucleic Acid
HIV	Human Immunodeficiency Virus
LARC	Long-Acting Reversible Contraceptive
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MSI	Marie Stopes International
MMC	Medical Male Circumcision
NACOSA	Networking HIV and AIDS Community of South Africa
SACC	South African Council of Churches
Sonke	The Sonke Gender Justice
SRHR	Sexual and Reproductive Health Rights
SRC	Student Representative Council
TAC	Treatment Action Campaign
ToP	Termination of Pregnancy
WHO	World Health Organisation (WHO)
WISPIVAS	Winam Safe Parenthood Initiative

[Responsibility is the price of freedom]

Elbert Hubbard



PREFACE

AIDS ACCOUNTABILITY INTERNATIONAL

AIDS Accountability International is a small think tank and research and advocacy unit which believes that strong and accountable leadership is necessary to ensure effective responses to health needs.

We do this by increasing transparency, promoting dialogue and supporting action to improve the health response. Our interest in vasectomy is a natural one, given that our work across Africa focuses on sexual and reproductive health and rights. As data and policy analysts and activists, we witness women carrying the burden of reproduction responsibility and struggling with the consequences of their decisions, usually compounded by socio-economic circumstances. Policies are seldom in place which allow for access to vasectomy as a form of male contraception, thereby limiting opportunities for men to play an important role in sharing this responsibility.

Sharing contraceptive responsibilities, creating true equality and providing equal access to quality health care, are the ideals upheld by AAI as we work towards encouraging accountability and transparency. We hope that by lifting the silence on vasectomy and what a positive role it can play in South Africa, by putting it up for discussion and then supporting whatever actionable outcomes develop, that we are able in a small way, to improve SRHR for all in Africa.



Phillipa Tucker
Co-Founder & Research & Communications Director
AIDS Accountability International



REFLECTION

Sonke's vision is a world in which men, women and children can enjoy equitable, healthy and happy relationships that contribute to the development of just and democratic societies. Established in 2006, Sonke works in all of South Africa's nine provinces and in fifteen countries across Southern, East, Central and West Africa to prevent domestic and sexual violence, reduce the spread and impact of HIV and AIDS and promote gender equality and human rights.

With a broad mix of social change strategies, Sonke reaches nearly 25,000 men each year through workshops and community dialogues, nearly ten million listeners a week via community radio shows, and millions more as a result of media coverage of our high profile advocacy work, to effect change in government policies and practices. Sonke's work brings about meaningful change on all these levels.

Through its commitment to research, and its role as co-chair of the Global MenEngage Alliance, and as a regular partner with UN agencies and other multilateral organisations, Sonke plays a critical role in building and shaping gender equality work with men and boys across the globe. Sonke's work in local communities, its high profile advocacy work, and its significant media reach across South Africa ensures that Sonke is also well known and trusted at the community level.

This report represents exploratory consultative work in the area of vasectomy awareness, uptake and provision in South Africa and seeks to strengthen a regional discussion on shared contraceptive responsibility as a gender transformative approach.

In response to the need to further explore vasectomy as a viable contraceptive option for South African men and their partners, Sonke Gender Justice (Sonke) in partnership with AIDS Accountability International (AAI), held two think thank meetings in May 2014 in Cape Town and Johannesburg to discuss and debate the national agenda on vasectomy. Participants consisted of service providers, research and advocacy networks and various stakeholders affiliated with the policy and practice of vasectomy. Both Sonke and AAI chose to follow an open plan approach to the consultation process in order to ensure that it had no pre-determined outcome. We assumed a largely facilitative role that in the end enabled the representatives of the various invited organisations to freely express their views and share their own experiences with regards to issues on vasectomy in South Africa and the work being done in the region.

Vasectomy is widely accepted as a safe and effective method of birth control, with an estimated 31 million couples worldwide currently relying on vasectomy for contraception. Uptake in sub-Saharan Africa is less than 0.1%, with South Africa reporting the highest rate of 0.7% in the region (United Nations, 2011) and other parts of the world reporting rates as high as 20%.

Society ascribes **family planning**¹ and contraception as being inherently the woman's domain. Women often carry the burden of contraceptive decision-making and the consequences of unintended pregnancies alone. Aside from male condoms, which are readily available but fraught with complexities related to use, vasectomy is the only other male-focused contraceptive method currently on the market. The nominal uptake of vasectomies has been attributed to a range of barriers including inadequate resources, limited policy, the patriarchal nature of socio-cultural and religious beliefs, and lack of information and misconceptions regarding vasectomy (Ebeigbe et al., 2011; Xinhua, 2013; Kakimba, 2013; Steinfeld et al., 2013). Increasing access to vasectomy and proactively engaging men in the contraception discussion will foster shared responsibilities between women and their partners, thereby unburdening women as the sole proprietors of contraception decision making.

1. A problematic term in and of itself, often replacing terms such as reproductive health, reproductive rights, sexual and reproductive health and rights, and reproductive justice. The use of this term assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choice; it also assumes a very heteronormative version of a nuclear family and procreative path. Therefore the concept is best placed within a broader SRHR framework that is founded in the understanding of choice. The use of the term family planning also specifically does not include access to safe and legal abortion and yet family planning is often used as the term for all pregnancy prevention.

The overarching consensus across both meetings was the vast potential that South Africa has to promote the use of vasectomy. Given an opportunity to explore more male-focused contraceptive options, participants concurred that men could be more amenable to taking on shared contraceptive responsibility. Securing adequate resources, improving public awareness, and addressing sociocultural barriers were identified as essential elements for building a steady yet systematic vasectomy campaign aimed at increasing the uptake of and access to vasectomy services in the country.

The current low rate of vasectomy uptake can be partially attributed to an inadequate policy framework that is funded and whose progress is tracked, this should therefore be prioritised as key obstacle to overcome when developing a campaign strategy. Participants cited the prohibitive costs of vasectomy as a

major factor leading to low uptake of vasectomy services, which was corroborated by two local NGOs, Association for Voluntary Sterilisation in South Africa (AVSSA) and Marie Stopes. The concept of “task shifting,” which would enable less specialised staff to provide vasectomy services rather than expensive specialists, has been previously shown as successful elsewhere in the health sector and was proposed by participants as a way to reduce costs. In addition, limited medical aid coverage was identified (within the various scheme packages and levels of membership) as another contributing barrier to uptake, which could be ameliorated by streamlining the vasectomy procedure and reducing overnight hospital stays which has proven to be a deterrent to full medical aid coverage of the procedure. However, there is a limit to how much cost-cutting can feasibly be done while still preserving the service's integrity, and therefore, the importance of lobbying the provincial and national governments to invest more in funding vasectomy services was also highlighted.

While lack of funding and resources has hampered vasectomy uptake, low levels of acceptability and demand among men remains the crux of the matter. This is perpetuated by widespread lack of awareness about vasectomy as a viable contraceptive option and misconceptions regarding the procedure, which could be addressed via improved educational and community engagement programs. Furthermore, deep-rooted social issues such as gender inequality, perceptions of masculinity, manhood, fatherhood and the patriarchal nature of most local culture, traditions and religion were identified as factors leading to poor male involvement in decisions relating to contraception use. To grapple with these issues, participants believed that initiatives should engage men in positive SRHR and gender discourse and work toward transforming traditional gender roles and expectations. Participants also highlighted the need to not only consider men's perspectives but also healthcare professionals' perspectives, whose assumptions or biases may also affect uptake of vasectomy – as is the case with a range of public health interventions, especially those linked to sexual and reproductive health and rights. Efforts to engage and include men in SRHR matters, through public campaigning about pertinent topics such as vasectomy, represent a unique opportunity to influence public health, gender equity and development.

An individual rights approach supported by informed consent and autonomy to choose a suitable contraceptive method are two fundamental aspects of reproductive justice. Another consideration is medical conditions that may preclude certain individuals from a safe vasectomy. While vasectomy is a safe, highly effective and viable option for most men, it is also important to recognise that it may not be for everyone. The viability of vasectomy within certain groups was highlighted during the meetings. It has been suggested that vasectomy may be less effective if clients have more white cells developed to fight a sexually transmitted infection (STI), which may explain why Medical Eligibility Criteria suggests delaying the procedure until the STI is resolved (National Department of Health, 2012). In regards to whether vasectomy is a viable option for HIV prevention, participants remained skeptical given the inconclusive evidence about the role of spermatozoa and seminal fluid in HIV transmission.

Another key group discussed was the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community. While participants remained unclear about the relevance of vasectomy for LGBTI, they acknowledged the challenges related to stigma about and access to contraception that should not be neglected. It was therefore concluded that a vasectomy campaign should remain separate from mainstream issues around HIV prevention and LGBTI and focus its energy on reaching all individuals that may benefit from vasectomy.

While the prospect of a ground swell of support for universal access to vasectomy may be on the horizon, it is also important to draw attention to a recent study conducted in the United States that found an association between vasectomy and prostate cancer risk, amidst other conflicting findings. These data showed that vasectomy was not associated with an increased risk of low-grade or localised disease, but men who had had a vasectomy were approximately 20% more likely to develop high-grade or lethal disease compared to men who had not had a vasectomy (Siddiqui, M., 2013). The risk ratio was higher among men who underwent more regular screening than among those who were screened less often (RR1.56; 95%CI 1.03-2.36) (Siddiqui, M., 2013). Conjecture has been made about underlying mechanisms but also the potential of bias, which warrants the need for further research. While it is important to consider highlighting the potential risk to prospective vasectomy patients, it does not yet necessitate a change in guidelines. We have included in this report an overview and commentary related to the findings of this study by the American Society of Clinical Oncology as well as the American Urological Association. The Associations guidelines on vasectomy can be found at auanet.org.

The think tank meetings generated rich discussion that indicated a clear need for a public awareness campaign to promote improved uptake and access to male contraception such as vasectomy. The next proposed step is to develop a “National Roadmap for Vasectomy” in South Africa, influenced by the work being undertaken in the region. It is proposed that this roadmap will provide strategies for intense policy and advocacy action that promotes vasectomy as a viable option within the contraceptive method mix, galvanised by strong civil society leadership in conjunction with multi-sectorial stakeholder commitment.

The on-going, broad-reaching Medical Male Circumcision (MMC) campaign, which has similar goals but within the context of MMC, should be unpacked for lessons learnt to inform the roadmap development. An integral part of this roadmap development will be a linked monitoring and evaluation framework and costed operational plan. We hope that by lifting the silence on vasectomy and what role it can play in South Africa, that we can nurture gender equality and improved sexual and reproductive health rights (SRHR) for all, never detracting from the essential need to support women's right to a range of accessible and supported contraceptive options, but to add vasectomy to the basket of SRHR tools.



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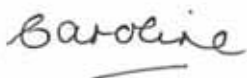
FORWARD

Contraception, family planning, birth control: these ideas, even the words themselves, are too often associated with women alone. Women bear both the major burden of contraception and consequences of unintended pregnancies. Encouragingly, there are opportunities for men to be more involved and in an increasing number of families and couples, men are doing their share. But more work is required. Efforts to engage and include men in sexual and reproductive health (both theirs and their partners) represent a unique opportunity to influence public health, gender equity and development.

With this in mind I was excited to learn that colleagues at AIDS Accountability International and Sonke Gender Justice were bringing stakeholders together to discuss male sterilisation, or vasectomy. It marks an amazing opportunity to consider the possibilities of this highly effective yet underused permanent contraceptive method. Vasectomy not only allows couples to plan their families and prevents unintended pregnancies but reduces maternal and child mortality. The noninvasive procedure (which takes between 10 and 20 minutes to perform and requires a simple checkup after 3 months to ensure it was effective) provides men with the opportunity to share the responsibilities of family planning in a way that presents virtually no side effects.

At present our national uptake of vasectomy is negligible, at an estimated 0.7%, so significant progress is needed to increase awareness and access. As the largest non-profit provider of sexual and reproductive healthcare in the country we at Marie Stopes South Africa have significant work to do in regards to our own provision of vasectomy. At present, the service is not offered across our entire centre network but efforts are underway to recruit the specialists required to deliver.

The ideal, of course, is a South Africa in which every woman, family and couple can choose from a healthy contraceptive method mix that includes short-term methods (i.e., oral contraceptive pills and injectables), long-acting methods: implants and intrauterine devices and permanent methods: female sterilisation and vasectomy. The fruitful findings of this report will be instrumental in determining a way forward on this important issue. Thank you to all involved and let us continue to come together to improve sexual and reproductive health and rights, including contraceptive access for all.



Caroline Mitchell
Country Director
Marie Stopes South Africa



BACKGROUND CONTEXT

Vasectomy is widely accepted as a safe and effective method of birth control, with an estimated 31 million couples currently relying on vasectomy for contraception (United Nations, 2011). It is considered a form of permanent contraception, even though the procedure can be reversed. It is a surgical procedure which involves the severing, clamping or otherwise sealing of the man's vasa deferentia which prevents sperm from entering into the seminal fluid.

Normally it is performed as an outpatient procedure (taking 10 -20 minutes), with a short recovery period and is relatively inexpensive, highly effective and safe. There is a wide variety of techniques used; including ligation, excision, clips, cauterisation, open-ended, fold-back, fascia interposition, irrigation, etc. Physicians often use a combination of these methods in a single vasectomy, indicating a lack of evidence around the superiority of any one method in particular. There is, however, also a no-scalpel option, whereby the skin is punctured with a sharp-pointed instrument. This method shortens operating time, does not require sutures and reduces side effects such as pain, bleeding, bruising, hematoma and infection (Cook et al., 2007; Xiaozhang, 2008).

As already alluded to, vasectomy access and uptake remains largely minimal in South Africa, and indeed in the rest of Africa. There is thus a real need to further explore vasectomy as a viable option in the context of sexual and reproductive health issues in the country.

As such the overall objective of this initiative is to provide a public consultative platform to discuss and debate on vasectomy as a potential option for not just South Africa but also the rest of Africa. It is thus hoped that this initiative will as one of its intended outcomes, unearth the available evidence for and against the procedure, based on scientific data, case study analysis and questions raised in the literature. This initiative will also identify challenges and opportunities around vasectomy in Africa, fostering further dialogue around its potential value for roll-out and scale-up on the continent.

NB: The authors would like to note at this stage that one of the highlights of the national meetings was learning about the progressive, community based and human rights aware work of the Association for Voluntary Sterilization of South Africa. This work stands out as a possible model for upscale and certainly one to highlight to the global community and our SRHR allies and networks that are keen to support the discussion and action around upscaling vasectomy services not only in South Africa, but in the region as well. Unfortunately, under the direction of the AVSSA board, Director Coleen Marco declined to share any information beyond what was shared at the meeting for inclusion in this report. This included information about the services and support AVSSA offers and perhaps more importantly, the cost of providing that service - this information was intended to give the broader community as much information as possible around the provision of vasectomy and to allow advocates to have all of relevant information, as cost is an essential component to any advocacy campaign - in this case to advocate for upscaled services.

THE KEY ISSUES FOR CONSIDERATION

In both meetings, the participants were asked to discuss a number of key issues for consideration.

The issues include the following among others:

- Is Vasectomy a Viable Option for Contraception in Africa?
- Is Vasectomy a Viable Option for HIV Prevention in Africa?
- Does Vasectomy Have Implications for Women's Sexual and Reproductive Health and Rights?
- How Might Vasectomy Contribute to Gender Equality and Male and Female Empowerment?
- Is There a Role for Vasectomy in the LGBTI Community?
- What work is currently being done that can be built on?

The consultative meetings provided some answers to the above questions and the summary is provided herein.

VASECTOMY: A VIABLE OPTION FOR CONTRACEPTION IN AFRICA

Key opinion leaders have found that vasectomy is a highly effective method of permanent contraception (WHO, 2008). For example pregnancy rates associated with vasectomy are around 0-2%, but in most cases it is less than 1% (Royal College of Obstetricians and Gynaecologists, 2004).

However, there are also issues to consider when discussing the efficacy and viability of vasectomy as contraception in Africa. Globally, 2.4% of men (of reproductive age) have had a vasectomy, but the procedure is not equally popular in all regions. Developed countries such as the US, UK and Australia, all have rates higher than 12% whereas less than 0.1 percent of married women rely on a partner's vasectomy in sub-Saharan Africa (United Nations, 2011). The highest rates of vasectomy in Africa are South Africa (0.7%) and Namibia (0.4%) but this is still much lower than the global average. Recent evidence shows that misinformation, coupled with cultural barriers were the biggest inhibitors for uptake among men in Rwanda (see case study below) (Xinhua, 2013, October 25).

When discussing and debating acceptability of vasectomy it is not just the perspectives of the client that need to be considered in various African contexts, but also the perspectives of physicians. A recent survey conducted in Nigeria revealed that more than 80% of doctors were convinced that the average Nigerian male would not accept vasectomy when offered (Ebeigbe, Igberase, & Eigbefoh, 2011). In addition, more than 60% of physicians surveyed considered Bilateral Tubal Ligation (BTL) to be a more appropriate option than vasectomy for permanent contraception. Some of the reasons given for opposition to vasectomy were socio-cultural (21.3%), religious (13.1%) and psychological (41.0%).

Further, it is critical that this procedure be performed in line with existing clinical standards (see annexures) in order to be effective. Is this a reality for most contexts on the continent? In addition, a large proportion of vasectomy method failure is attributed to client behaviour (having unprotected sex during the waiting period – the first three months after surgery). It is therefore worthwhile for us to discuss the impact that low levels of knowledge may have on behavioural aspects during this waiting period.

Third, it has also been suggested that vasectomy might be less effective if clients have many more white cells developed to fight another sexually transmitted disease, so this is also a factor to consider when assessing the viability of the procedure for contraception in Africa.

In general, both the meetings in Cape Town and Johannesburg had broad discussions on the viability of vasectomy as a credible contraceptive option not just in South Africa but also in Africa as a whole. In both meetings, the participants were clearly in favour of broadening the scope of contraceptive options to fully include the option of vasectomy.

The participants were of the strong view that if given a fair chance in terms of funding and policy support, vasectomy was most likely to be well received by more men in the country as a viable contraceptive option.

Instead, most participants were in favour of a steady but systematic progress in terms of increasing both the uptake and access to vasectomy services in the country. As such, there is sufficient goodwill in the country to enable one to consider the fuller promotion of vasectomy as a viable contraceptive in South Africa, and indeed in the rest of Africa.

IS VASECTOMY A VIABLE OPTION FOR HIV PREVENTION IN AFRICA?

Another crucial issue was on whether vasectomy was a viable option for HIV prevention in Africa?

While there is consensus that semen represents the main vector of HIV dissemination (Deleage et al., 2011; Le Tortorec & Dejuq-Rainsford, 2010), the origin of HIV in semen remains unclear and there is some debate around the extent to which vasectomy may or may not play a role in reducing transmission of HIV.

First, there are those who find that vasectomy may have an impact on the infectiousness of HIV seropositive men on sexual partners (Krieger et al., 1998). These results have been replicated by others in the field (Baccetti et al., 1998; Dulioust et al., 1998; Barboza et al., 2004; Muciaccia et al., 2007). A study conducted in Thailand found that HIV was found in 26% of semen samples taken from HIV positive men who had not had vasectomies, but that the virus could not be found in 7 emission samples from four infected men who had vasectomies (Krieger et al., 1991).



However, researcher Dr. Robert Coombs said they are certainly not yet advocating vasectomies for people living with HIV. More recent research also finds similar results, showing that far from being a passive carrier, spermatozoa might affect the early course of sexual transmission of HIV-1 infection (Ceballos et al., 2009). However, the use of vasectomy among HIV positive men, either for contraception or for prevention of HIV transmission, has not been documented (Delvaux & Nostlinger, 2007).

There is, however, a notable lack of agreement in the literature around whether or not vasectomy does indeed have a potential role to play in HIV prevention. There have been scientific studies which debate the role of spermatozoa in HIV transmission, with several studies reaching conclusions that HIV was not found in the DNA of spermatozoa from men living with HIV (Mermin et al., 1991; Dussaix et al., 1993; Quayle et al., 1997; Pudney et al., 1998; Barone & Pollack, 2008).

Others suggested that while vasectomy has little effect on seminal shedding of HIV, the seminal vesicles (the secretions of which represent more than 60% of the seminal fluid), support HIV infection in vitro and in vivo and, therefore, have the potential to contribute virus to semen (Deleage et al., 2011). Most health service providers also indicate that vasectomy does not protect against HIV or other sexually transmitted diseases (Marie Stopes, 2014; IPPF, 2013; The Thomas Linacre Centre).

It should be noted that in addition to vasectomy's potential role in blocking HIV DNA from the seminal fluid, there has also been recent research which shows a relationship between long-acting reversible contraceptive (LARC) uptake and unprotected sex among HIV discordant couples. In Rwanda and Zambia, it was found that discordant couples who were counseled and offered a range of LARC options (vasectomy included) were less likely to have unprotected sex than couples using only condoms (Khu et al., 2013).

While there was less than minimal focus on this discussion point at the Cape Town meeting, concerted efforts were made at the Johannesburg meeting to have a more detailed discussion on this particular aspect.

Participants at the meeting were skeptical on the possibility of vasectomy being used as a viable option for HIV prevention strategies. In the final analysis it was suggested that the issue of vasectomy access would be kept separate from any discourse around HIV and its prevention.

DOES VASECTOMY HAVE IMPLICATIONS FOR WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

Another key discussion point was on whether vasectomy has any implications for women's sexual and reproductive health and rights

Although vasectomy is a method that is relatively effective, it will only become clear that it has failed upon becoming pregnant. By contrast, should condom failure occur, multiple oral contraceptive pills are missed or the male partner does not withdraw, there should be an opportunity to access emergency contraception to avoid pregnancy.

In a study of men seeking reversal of vasectomy, nearly 10% of pre-reversal ejaculates were found to contain sperm, suggesting higher method failure than was previously thought (Lemack & Goldstein, 1996). Xiaozhang (2008) suggests that it is possible that vasectomy failures are underestimated since some women may conceal this failure and elect instead to terminate their pregnancies. In many African contexts, access to safe abortion is not a reality for most women. This needs to be properly considered with respect to the potential implications of vasectomy method failure.

In general, most of the meeting's participants supported the view that vasectomy could provide some positive implications for women's sexual and reproductive health and rights.

In particular it could give men an opportunity to be an integral part of a shared responsibility in terms of the contraceptive options. This is more so because in most instances, it has always been assumed by society that the contraceptive responsibility lies mostly in the women's domain.

Even though it has been proven that some contraceptive options have some side effects and affected the health of women, it was still expected of them to continue to carry the burden of contraceptive responsibility.

It was suggested that vasectomy access could contribute to the reduction of the pressure placed on women to take the lead in terms of contraception.

One of the most powerful tools in a potential campaign – any campaign – is that of personal testimonies by people that communities can relate to, this is one such story shared by the coordinator of Sonke's One Man Can project.

HOW MIGHT VASECTOMY CONTRIBUTE TO GENDER EQUALITY?

Another worthwhile point of discussion is how vasectomy plays a role in gender norms, gender equality and male and female empowerment. It has been shown that differences in the way people perceive gender equality within relationships can impact use of contraceptives by women in Africa (Stephenson et al., 2012).

Further, it has been shown that programmes must work towards transforming traditional gender roles and expectations, especially in relation to HIV prevention (Kambou et al., 2009; Dworkin, et al., 2012).

In a recent study exploring contraception acceptability among HIV positive men in Kenya, some men cited discontentment with the short list of options that require co-operation of men. Some of their research participants reported the need for more male-focused approaches and voiced frustration about access to reversible male-controlled methods (Steinfeld et al., 2013).

During the meeting in Cape Town, this matter was discussed in great detail. The emerging thoughts from this discussion focused on how the patriarchal nature of the most of the South African society made it so difficult for most women to negotiate their space in terms of alternative male contraception methods. It was always assumed in most parts of society that the issues of contraception were largely the domain of women. Vasectomy offers a clear opportunity for men to take a more pro-active role in contraceptive use. The meeting agreed that the present scenario could be changed in favour of women if more men were exhorted to consider exploring the male contraceptive options such as vasectomy.

The major challenge was mostly the lack of awareness on the viability of male contraceptive options in large parts of society. However, it was a real possibility that given a chance, more men could consider taking on the responsibility of contraception on behalf of their female counterparts. There was thus a real need to upscale public awareness campaigns to promote the uptake of vasectomy as an alternative contraceptive option.

The meeting also had testimonials from two Sonke colleagues (Sikhangele Mabulu and Rodney Fortuin) who shared their experiences in terms of their personal attempts to increase public awareness on the vasectomy option. Rodney Fortuin shared a story on how he and his colleagues were using the social context of a soccer team set up to initiate serious public discussion on the benefits of vasectomy. Rodney had also taken the bold step of doing a vasectomy in order to give his dear wife a break from the ongoing use of non-permanent contraceptive options. Sikhangele Mabulu also shared the testimony highlighted above.

IS THERE A ROLE FOR VASECTOMY IN THE LGBTI COMMUNITY?

There was another key discussion point that focused on whether there was a role for vasectomy in the LGBTI community

There may be points of dialogue worth starting around how vasectomy may or may not be relevant for the LGBTI community in Africa. Dr. Coombs, who was part of the Krieger et al. (1998) study, suggest that vasectomy could possibly be used to prevent the spread of HIV among gay men.

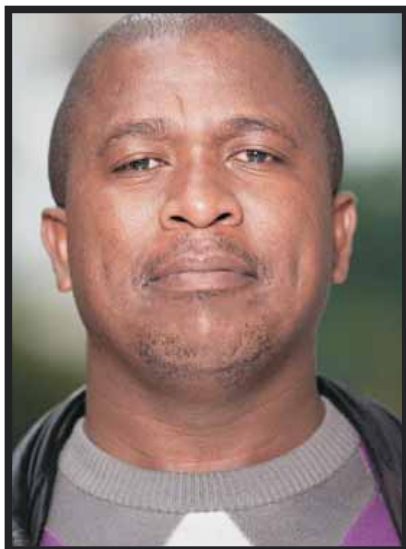
There is also some minimal preliminary research investigating perceptions around vasectomy as contraception in this community (see Sevelius, J. [2009] "There's No Pamphlet for the Kind of Sex I Have": HIV-Related Risk Factors and Protective Behaviours Among Transgender Men Who Have Sex With Nontransgender Men). In this area, there is certainly a need for more research into this issue.

While there was less than minimal focus on this discussion point at the Cape Town meeting, concerted efforts were made at the Johannesburg meeting to have a more detailed discussion on this particular aspect. Participants at the meeting were skeptical on the possibility of vasectomy having any particular role in terms of LGBTI related issues but clearly identified access to the procedure by all who demand it as a right. Participants at the meeting were also keen to emphasise that they remained aware of the specific challenges that were faced daily by the LGBTI community in the context of stigma and access to health services in general. There was thus a request to highlight the need to address the unique contraceptive issues related to the LGBTI community.

The discussion ended with an understanding that as long as vasectomy was promoted as a viable male contraceptive option, gay men would also benefit in the resultant increase in both the uptake and access to it.



VOICES FROM THE FRONTLINE: INTERVIEW WITH SIKHANGELE MABULU



The following is a text summary of an interview that was conducted by Daniel Molokele with Sonke's One Man Can Project Coordinator based in Cape Town, Sikhangele Mabulu (SK). SK shares his personal experiences with regards to vasectomy.

DM – Good Afternoon SK. Thank you for agreeing to meet up with me and talk to me with regards to your experiences with vasectomy. Basically we want to hear your story about what it means for you in terms of your personal experience with vasectomy, and your marriage experience and in general your family and also the people around you, like your friends and your peers. How you have been relating with them in the context of the vasectomy. So maybe you can just start by introducing yourself and then go ahead and share your personal experiences and your journey.

SK – My name is Sikhangele Mabulu. I was born in 1976 in Centane which is located at the South Eastern part of the Eastern Cape Province under Mquma local municipality. Their municipality falls under the jurisdiction of the Amathole District Municipality (ADM).

I come from a Xhosa family background. My parents were also born and raised at Centane. So my views are informed by the idealism of my local community and the social environment there. I grew up with some siblings; two brothers and a sister. I have been married for 12 years now (we got engaged 19 years ago), have 5 children; three sons and two daughters.

Since my childhood I was raised in a strong Xhosa culture of manhood. As I was growing up I was taught local principles of manhood such as the fact that a man must not just cry; a man must take care of his own family; a man must be responsible for his family and protect it.

I also went for circumcision in 1996 as part of my Xhosa cultural initiation to manhood. Some of the messages I got during the initiation process included the fact that I was now a man. That meant that as a man I should have a wife and children. If I did not start a family and have children there would be social stigma against me to say that I am not yet fully grown up into manhood. So these are the messages and pressures of manhood that we had to face growing up with my peers at the Centane village.

Later on I came to work in Cape Town and started to interact with different kind of peers who included Xhosa and coloured people. But it was still the same cultural pressure. I also joined the student leadership at my college and was elected into the Student Representative Council (SRC). At that time there was a process of new laws with the drafting of a new Constitution in the country. So we had to engage on various issues and policies that also seemingly challenged and criticised some of my cultural beliefs as a person including my views about manhood.

So as the SRC leadership at that time I was also faced with a serious conflict between pushing the new idealism under the new constitution but at the same time I was still expected by my local community to continue to uphold my moral and cultural values that I had been taught since my childhood years. So this was a very difficult experience for me.

After the college experiences I then joined the Treatment Action Campaign (TAC) in 2002. When I was at TAC, I started to engage even more on broader social issues. With the TAC our focus was on various issues. We had to engage on community level advocacy and also on laws and policies affecting us such as access to treatment. We also spoke about such issues as medical male circumcision and also promoted the use of condoms. So by using condoms it would mean that a man would not necessarily have children. Also by promoting medical male circumcision it also meant that one would be in conflict with the expectations of their own cultural beliefs that promoted the traditional initiation process.

So I eventually had to start making choices more on a personal than on a communal level. This is because I learnt to appreciate the personal benefits of such new things as medical male circumcision and condom use especially with regards to sexual transmitted illnesses such as HIV and AIDS. Of course this meant that I had to compromise my long held cultural beliefs and assumptions in favour of these new so-called modern methods.

So when I joined the Sonke Gender Justice network in 2011 I decided to do both the medical male circumcision and the vasectomy. Remember, I had already done the traditional circumcision in 1996 but I had come to realise that my foreskin had not been cut completely. So I decided to benefit from the medical male circumcision programme. Afterwards I went to the Melomed hospital in Bellville and I did the medical male circumcision.



Soon afterwards I also decided to do the vasectomy. This was also a very difficult decision for me to make due to my Xhosa cultural beliefs. Even when I shared my plan to do a vasectomy with some of my peers and friends, I could feel the sense of the stigma against it. Some of my friends told me openly that I was going to become an 'inkabi' in Xhosa (castrated male bull) since that was also a name given to a man who could not produce children. Some said I would also become a 'useless man' who would also be shunned by women. However I did not take the messages of discouragement personally since I was already actively involved in advocacy on these very same issues. But I also tried to convince many people at that time to also consider doing the vasectomy.

I also spoke to my wife and children about my decision to do the vasectomy. I spoke in detail with my wife who at that time was still not sure about my choice. But I had already made up my mind and so I told her that I would go ahead and do it.

It was thus later on in 2011 that I carried out my plan to do the vasectomy. There were basically two parts for the vasectomy procedure. I went to the hospital an hour before the operation at around 9am. This is because I had to clean myself first and get ready for the operation. After an hour, at around 10am I then got injected and killed my nerves to enable me not to feel the pain. I then slept till about 2pm after the operation was done. I was then allowed to rest a bit till about 4pm when I was allowed to leave the hospital and return to my home. I was advised to abstain from sex for about six weeks and also return to the hospital later to change the bandage. I must add that it was only the medical male circumcision part that was a bit painful but not so much. With regards to the vasectomy I never felt any pain at all. There was just a small wound and it was not easy to see it with a naked eye. But they actually did open up my testicles and did the cut off.

The thing I wanted to say is that it is so much easier for people to do the vasectomy. But one needs to be careful afterwards. One has to follow the rules, be clean and avoid any sexual activity till the end of the prescribed period of three months.

Afterwards I also needed to do the test to ensure that my sperm was clean and not able to produce a child. I must say it is important that people need to make sure that after the end of the prescribed period they must indeed return to the doctor and get tested to make sure. Other than that I am okay now. I continue to relate freely with my family. Also that later on my wife had a sterilisation procedure about two years later.

However I need to warn everyone that vasectomy alone is not enough against HIV prevention or STI's. It is mostly for prevention of pregnancy. So I advise sexual partners on the need to continue to play it safe. Sometimes even use the condoms if necessary. We talk a lot about HIV in the house. Of course it is not easy to discuss condom use with your partner in a marriage especially when you are also expected to be faithful. But these are the things you need to continually engage and negotiate with your partner from time to time.

I also had to engage with my children who are a bit grown up you know. My first born is already over 18 years old and so we speak freely about this with him. In fact I started to speak to him even before I did the vasectomy. But he has influence from his own peers too. He actually challenged me in my views since he noticed that I had to confront some of our cultural beliefs that he also seeks to uphold as a person.

But with regards to the vasectomy, he indeed fully supported me very much as my own child. He also understood the need for me not to have any more children. However the other children at that time were still too young to freely engage with me but nowadays I can freely talk to some of them about these issues

With regards to my wife, she was initially concerned that once I had done the vasectomy I could be tempted to engage in extra-marital sex since I knew I could no longer have any more children. So we spoke freely at length about her fears. I also assured her that at the end of the day I was also a responsible man. Besides I also engaged her on the benefits of both of us not having any more children. She also eventually decided to do her own sterilisation procedure.

In terms of my peers around me and the community, I am still facing the challenge of people with their traditional beliefs especially my Xhosa kinsman. Some are also worried about the question of what would happen if later on they decided to have children once again.

But all in all, we must note that vasectomy is a new thing for many people around us and so they need to be continually engaged on its benefits in order to win them over. This is not easy task to do. People feel uncomfortable to openly discuss these issues. So we have to find ways to help them to start speaking out. We must also ensure that those who end up making the choice to do a vasectomy must do so freely and from a very informed position.

We must continue to be aware of the pressure from the social stigma that people normally face with regards to both medical male circumcision and vasectomy. In general I think people must know that vasectomy, in terms of family planning, could be the best method for them to use when they decide to stop having more children. But we must also warn people always that in terms of HIV prevention, it is still better to continue to have safe sex including the use of condoms even after doing a vasectomy.

CASE STUDIES:

As alluded to, there is little precedence of widespread access and uptake of vasectomy not just in South Africa but also across the African continent. However in recent years, there has been some experimental approaches in some countries that sought to promote vasectomy as a viable option, and many of those directly reflect the importance of sharing the contraceptive responsibility.



World Vasectomy Day celebrates vasectomy providers, the organizations that support family planning, and the men who make the courageous and generous decision to do right by themselves, their families and our future.

On the occasion of the second annual celebration of World Vasectomy Day, November 7th, 2014, over 500 doctors in 32 countries performed an estimated 3000 vasectomies. It was the largest male oriented family planning event in history.. Find out more at worldvasectomyday.org

CASE STUDY - KENYA



In late 2012 in Kisumu, Kenya, The Tupange Project (a five-year Kenya Urban Reproductive Health Initiative (KURHI) led by Jhpiego and funded by the Bill and Melinda Gates Foundation) hosted a vasectomy camp to give Kenyan couples more choices for their reproductive health and rights.

Thirty-five men were given vasectomies over the three day event (Kagwe, no date). There are other programmes in the country, too, with Winam Safe Parenthood Initiative (WISPIVAS) a Kenyan organization offering information about vasectomy as well as online appointment booking. There has also been some research to model the cost-effectiveness of vasectomy in Kenya (Seamans & Harner-Jay, 2007), along with some recent work done to gauge perspectives on various forms of contraception among HIV positive men. The findings of this research suggest that there is a particularly large gap in knowledge related to vasectomy (Steinfeld et al., 2013).



Kencom house is located just off Moi Avenue in the Central Business District of Nairobi.



Dr. Charles Ochieng ...

... is one of Africa's best trained and experienced vasectomists. He has performed vasectomies in Africa, Asia, and Africa given lectures in India and in the Philippines and is a member of a global network of vasectomy providers who regularly share innovations about vasectomy. With a loving wife and 2 devoted sons, Dr. Ochieng is delighted with his own vasectomy, performed in 2008



KENCOM HOUSE
MOI AVENUE
FIRST FLOOR, UNIVERSAL CLINIC
(the office of Dr. Joseph Kiara)

"VASECTOMY DAYS"



Charles Ochieng, MD

Vasectomies are performed by Charles Ochieng, M.D., a Nairobi based Board-licensed doctor who has done over 100 vasectomies during special Saturday Vasectomy Days, at the Universal Clinic.

The fee is only 35000ksh!

TO LEARN MORE

You may learn more about Dr. Ochieng and the vasectomy technique he uses at

www.WispiVas.com

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Yes!

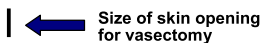
Vasectomy... a 15-minute nearly painless procedure that prevents sperm from getting into the semen so that the man who has the procedure cannot get a woman pregnant.

Who should consider vasectomy?

Any man who thinks he does not want to have any or any more children.

How does it work?

Simple. The vas tubes that transport sperm from the testes to the semen are blocked about an inch above the testes. The sperm that can't get into the semen are recycled, and their components are used to rebuild other tissues. Both sides can be blocked through a small hole, about this big:



No needle?

With a simple pressure spray applicator, an anesthetic solution can be delivered through the skin and around each vas tube. This anesthetizes the skin and each vas tube most men with just 2 quick squirts!

What changes after vasectomy?

Nothing except that sperm are no longer in your semen and you won't get anyone pregnant. You will probably notice:

- No change** in the semen.
- No change** in your sex drive.
- No change** in climax sensation.
- No change** in your testes or scrotum.
- No change** in your erections.



Can the tubes be put back together?

Vasectomy reversal has a pregnancy success rate of 30-75%, not 100%, so vasectomy cannot be considered a reversible form of birth control.

Are there any risks?

Problems with vasectomy are very rare but you could experience:

- Temporary scrotal swelling.
- Temporary scrotal bruising.
- Pea-sized swelling on the vas tube where it was divided.
- Congestion, or tender inflammation in the lower vas tubes on one or both sides; usually goes away in a day or two with non prescription drugs.
- Failure. The divided vas tubes could grow back together and sperm reappear in the semen, but this occurs in fewer than one in 5000 men.

Limitations of Vasectomy...

- Not reversible
- Must use other forms of birth control until sperm-free (usually 8 weeks later)
- Does not prevent transmission of sexually transmitted infections (STI's). A condom should be used unless a man is sure that he and his partner are free of STI's.

Advantages of Vasectomy...

- Low one-time expense.
- More dependable than any other form of birth control including female sterilization.
- Eliminates risks associated with birth control pills or shots and the IUD.
- No need for inconvenient and less dependable methods, so there are no more worries!

What's the cost?

For self-pay patients, the fee for vasectomy is 35,000 Ksh. For men whose income is low, all fees will be covered by No-Scalpel Vasectomy International (NSVI), and clients

will be paid an average 2-days wages (1000 Ksh) because they will be asked not to work until 2 days after the vasectomy. In addition, clients will be offered the opportunity to work as facilitators, to teach their friends about vasectomy and will receive for their efforts 300 Ksh for each referred friend who undergoes a vasectomy.

Any preparation on my part?

Avoid medicines containing aspirin for 5 days before the vasectomy (aspirin increases the risk of bleeding). You may shave the underside of the penis and the front wall of the scrotum, but if you don't get to do it, Dr. Ochieng will do it. No need to shower beforehand if you are coming directly from work, but we'll ask you not to shower on the evening of the vasectomy.

Down Time?

After the vasectomy, go right home and lay around. Next day, walking is fine, but no strenuous activity of any kind. You may return to work and have sex again 2 days after the vasectomy if you are not tender

It's EASY!

- 15 minutes
- Many say "painless"
- No scalpel
- NO NEEDLE!



No more worries!

CASE STUDY - RWANDA



In early 2011, the Government of Rwanda began to encourage men to have vasectomies in an effort to help control the country's growing population (BBC, 2011). The campaign was planned to run alongside the country's HIV prevention campaign which promotes male circumcision.

However, by October 2013 only 420 men of Rwanda's have had vasectomy since the method was introduced in February 2011 (Xinhua, 2013, October 23). Physicians indicate that misconceptions around the procedure have been the biggest barrier to uptake, and that education is the strongest gauge of acceptability or vasectomy in Rwanda (Xinhua, 2013, October 25). Other sources suggest that religion is also a barrier to uptake of vasectomy in Rwanda, with some pastors preaching warnings against vasectomy as an irreligious method (Kakimba, 2013, August 25). This blog by FHI360's Social and Behavioural Scientist Dominick Shattuck, shares some experiences of Vasectomy acceptance in Rwanda and speaks about the intersection of need, knowledge and access in that country.

"Our SUV bounced along the dirt road through the Rwandan mountains, which are noted for roads complicated by switchbacks and steep descents but dotted with stunning sites. On one side of the car, tea farmers pruned the lush green bushes atop raised beds of rich, black soil. We were destined for the Kinyihira Health Facility, and our goal was to provide vasectomies. After two decades of experience in East Africa, I could not imagine that we would have many clients. Worldwide, less than 2.4 percent of men of reproductive age have had a vasectomy. Vasectomy prevalence varies greatly in both developing and developed countries (Uruguay - 0.8 percent; China - 4.5 percent; Brazil - 5.1 percent; Nepal - 6.3 percent; New Zealand - 19.5 percent; Canada - 22 percent). In Africa, the prevalence of vasectomy is negligible, less than one percent.

Vasectomy uptake is affected by the world's common public health trifecta: limited access, accurate knowledge and deeply rooted misconceptions about the method. Studies on vasectomy in Africa have found that men and women have limited knowledge of the method and many misconceptions (2-4), including equating vasectomy with castration and attributing the procedure to a reduction in sexual performance or desire, weight gain and laziness.

In reality, vasectomy is safe, effective and the least expensive long-acting or permanent contraceptive method. Since 2010, FHI 360 has been providing technical assistance to the Rwandan Ministry of Health to scale up the delivery of enhanced vasectomy services using the no-scalpel vasectomy (NSV) approach and adding thermal cautery (TC) and facial interposition (FI) techniques, which significantly decrease the risk of vasectomy failure (0.15 percent failure rate). To increase demand for vasectomy, the program - one of the first national scale-up efforts in sub-Saharan Africa - has strived to provide reliable access along with facts and messages to dispel common myths about the procedure and its side effects.

PROGRESS IN KINIHIRA AND BEYOND

Kinihira was the second stop on a week-long tour in which physicians received hands-on training in providing NSV. I traveled with Dr. Michel Labrecque, a master vasectomy trainer and one of the top researchers on vasectomy procedures, to help facilitate this training of trainers and to better understand the dynamics around vasectomy service delivery and clients' rationale for uptake.

Our clients in Kinihira spend their days in the plantation below the health centre. Their exposure to weather and hard work shows on their faces and hands. My colleague, Theophile, asked our clients and their partners, "Why did you decide to have a vasectomy?" Many couples reported having large families, often more than five children. A significant number of women mentioned that they had tried to use hormonal methods, but the side effects were too significant. Almost all shared their struggles with feeding and educating their children on the small incomes generated through their fixed plots of land and the tea plantation collective. They communicated their desire to limit their family size but retain their ability to be intimate while free from the worry of pregnancy.

During the training, 67 men received vasectomies. The participating physicians learned quickly, reducing the time it took to perform the procedure from about 20 minutes to just at 10 minutes. Since the training in February 2010 and through December 2012, a total of 64 doctors and 103 nurses from 42 hospitals across all 30 districts in Rwanda have been trained in NSV, and 2,523 vasectomies were performed. Vasectomy is currently offered as part of the standard package of family planning services in Rwanda, and physicians from district hospitals travel regularly to rural health facilities to meet the needs of clients. Data from this scale-up process remained consistent with the clients we saw in the first training. Clients were typically over 40; they were in stable relationships (with a mean length of 19 years) and had many young children (with a mean of 5.5 children; 52 percent had children under 3 years). Limited financial resources, dissatisfaction with their existing family size, and the negative side effects of hormonal contraceptive methods were key motivators for vasectomy uptake. The motivations of vasectomy clients in Rwanda reflect those of vasectomy clients in other countries around the world. They are husbands, with the support of their wives, who want to have no more children.

LESSONS LEARNED

The Rwanda Vasectomy Scale-up Program is exciting because it has succeeded in spite of many men's lack of basic understanding of reproductive health and contraceptive methods.

Despite limited knowledge, men greatly influence the contraceptive methods women use. Recently, interventions around the globe have enabled men to more openly discuss family planning with their wives by increasing basic reproductive health knowledge and awareness of services, combating negative gender norms and helping men develop the vocabulary and approaches to have a thoughtful discussion about family planning. These interventions have improved couples' relationships, increased the amount of time men spend providing more child care and led to greater shared household decision making. It is this type of change that creates an enabling environment not only for contraceptive use, but also for development in general.

Rwanda's health and development activities since 2000 have not gone unnoticed. There is broad based political support and, in turn, high levels of acceptance for family planning. This has contributed to men's greater acceptance of vasectomy in the country. Other countries can benefit from Rwanda's experience. The success of Rwanda's Vasectomy Scale-up Program underscores the importance of raising awareness about the upcoming World Vasectomy Day on October 18, 2013. The goal of World Vasectomy Day is to increase awareness of this highly effective and underutilised contraceptive method and dispel long-standing misconceptions. Physicians from around the world, in nearly 25 countries, have agreed to deliver 1,000 vasectomies on this day. In Rwanda, there are clients and physicians who are prepared to contribute to this goal and a generation of men who are educated about their role in family planning and maternal health."



CASE STUDY - GHANA



GET A PERMANENT SMILE CAMPAIGN

In Ghana, vasectomy has been a relatively “invisible” contraceptive method. Prevalence is less than 0.1%; a total of only 18 vasectomies were performed in Ghana in 2003.

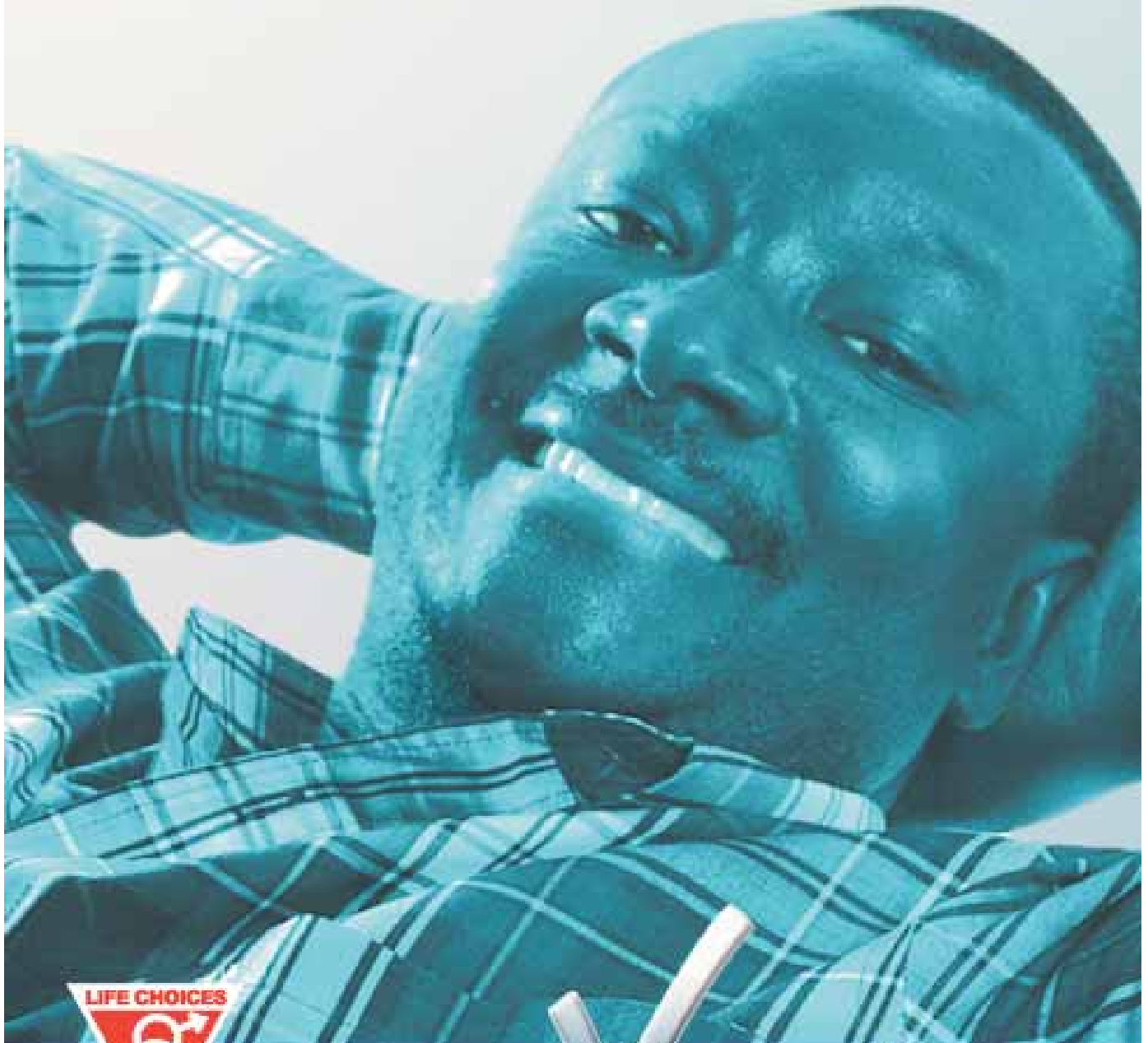
A review of research on vasectomy services and perceptions of the method by both providers and potential vasectomy users in Ghana identified four main barriers to vasectomy utilization: inadequate access to and quality of services; bias against the method on the part of providers and clinic staff; low awareness of the method; and the prevalence of myths and misinformation about the method, both among men and among the general public.

In 2003, the Ghana Health Service and EngenderHealth initiated a project to introduce and expand vasectomy services in a range of public- and private-sector health facilities in metropolitan Accra and Kumasi. Supported by the U.S. Agency for International Development (USAID), the project was designed to address both the supply-side and demand-side issues that have contributed to the underutilisation of vasectomy among couples potentially interested in a permanent family planning option. Meridian Group International, Inc., provided technical assistance to the design and implementation of demand-side interventions.

Evaluation of the initiative was undertaken by the ACQUIRE Project, a collaborative project funded by USAID that involves both EngenderHealth and Meridian.



Why is this man smiling?



Vasectomy

Give yourself a permanent smile

A cup of tea was being prepared for my wife as I went in to have a Vasectomy. When I came out in twenty minutes, she asked, still holding her cup of tea: "How long will it take?" "Oh I'm finished." I replied. I'd never seen my wife so thrilled at good news till then. It's now our little joke but that's how fast and simple Vasectomy is.

For more information, call the Vasectomy hotline 021 - 76 56 86

Seven providers were trained in no-scalpel vasectomy (NSV), and facility staff at seven sites were oriented to vasectomy and trained in male-friendly services, to increase their ability to work with men and their comfort level in doing so. Concomitantly, a communications initiative was designed both to serve as a catalyst for men considering vasectomy to take that final step and access services and to raise awareness of vasectomy as a contraception option and dispel rumours. Clinical and community health nurses organized community outreach events at each site. With technical assistance from Meridian Group International, Inc., a campaign was designed based on qualitative research with men, women, and providers in target communities. The campaign, which was anchored in the slogan “Vasectomy...Get a permanent smile” and featured satisfied vasectomy users, aired via two television advertisements, a television documentary, two radio advertisements, posters, brochures and flyers, and public relations efforts. A telephone hotline was also set up, with trained staff to answer calls during the project months. The hotline was promoted in all campaign materials and in community outreach and mobilization events.

Facility staff were oriented in 2003 and 2004. The media campaign was launched and outreach activities began at the end of February 2004, and both ran for four months through June 2004. The direct cost of the intervention, including the media time purchased, was \$180,000. (This does not include the cost of the project evaluation.)

Initial results indicate that the project was a success. After the program was launched in early 2004, the number of vasectomies performed quadrupled over the volume provided in the prior year. A total of 81 men requested and received vasectomies at service sites in 2004, compared with an annual total of 18 in the preceding year. This service volume was 6.6 times higher than the average number of procedures provided in the 10 years prior to the project (1994-2003). In addition, 425 callers received information from the hotline counselors during its working hours. Other men and women sought (and continue to receive) information from the telephone’s automated 24-hour prerecorded information menu of answers to frequently asked questions about vasectomy. A final component of the project was to assess the extent to which the project produced fundamental changes in the barriers to vasectomy utilization in Ghana. Special studies were conducted to gauge the impact of training on the quality of services and the impact of the communications campaign on people’s knowledge and perceptions of vasectomy. Pretest and posttest measurement of providers’ attitudes showed that their knowledge about and attitudes toward providing services to men both improved substantially. A mystery client study revealed some gaps in service provision, although all men who sought services were able to get the information they needed. The service level at these sites was thus considerably improved over the levels of access to services and information that existed prior to the project.

A panel study conducted in metropolitan Accra prior to and following the campaign among married men with three or more children showed that the number of men who were aware of vasectomy had nearly doubled. Fifty-six percent of the men who were interviewed recalled and were able to describe at least one element of the campaign, and more than half of the men who reported seeing the campaign television advertisements took action as a result, visiting a doctor or health centre to discuss vasectomy, discussing vasectomy with their partner/wife, and/or discussing vasectomy with colleagues. More than half of these men also were able to name a specific site where vasectomy services are offered. The men’s “intention to consider vasectomy” also doubled, with the proportion willing to do so increasing from one in every 10 men at baseline to one in five at follow-up.

Data from the first quarter of 2005 suggest that demand for vasectomy is higher than it was prior to the campaign. Thirteen vasectomies were performed at program sites in the first quarter of 2005, compared with zero and seven during the same quarter in 2003 and 2002, respectively. Also, men still call the project hotline with questions. The ACQUIRE Project and EngenderHealth/Ghana staff will continue to monitor service statistics to track the project’s longer-term impact. However, follow-up activities on both the supply side and the demand side should be undertaken if this positive momentum is to be sustained.

RECOMMENDED NEXT STEPS INCLUDE:

SITE-LEVEL SUPPORT

1. Continue periodic whole-site training of facility staff, to combat misconceptions concerning vasectomy, to expand their knowledge base, and to increase positive attitudes concerning vasectomy
2. Expand referral systems and possibilities for in reach among men and women in other health care services, referring interested clients to sites where services are offered
3. Periodically utilize mystery clients to assess the quality of both clinical services and counseling services and review the results with providers to identify any problem areas that should be addressed
4. Identify champions at each site who will devote sustained effort and energy to the vasectomy initiative
5. Focus on a small number of skilled providers and support expansion of access through those providers who perform well



DEMAND AND CLIENT COMMUNICATIONS

1. Repeat the media campaign in short, concentrated periods at least twice a year, to continue to improve awareness, knowledge, and use of the method and to support men considering
2. Vasectomy to take that final step and seek services
3. Run a hotline during and for at least three months after the campaign bursts, to serve as an intermediate action that interested men can take to get further, personalized information
4. Maintain the program's use of interpersonal communications channels (e.g., hotline, counseling opportunities, and community outreach) and time community-based interventions to coincide with the media campaign bursts
5. Conduct a follow-up workshop with participating clinic staff and other project stakeholders to pool their ideas and add them to a scaled-up project

Vasectomy "Get a Permanent Smile" Campaign International Version :45



MVO: Why is this man smiling?



For the same reasons over 42 million other men are.



Thanks to a simple procedure,



a vasectomy, he's chosen



not to have more children



and to do more for a family he already has.



A vasectomy



takes 20 minutes or less.



Minutes that



give a man



an important asset.



The power of



a permanent smile.



For more information, call the Vasectomy Hotline



or visit these centers



and join the brotherhood of men



whose smiles



go on and on.



Vasectomy.



Give Yourself a Permanent Smile.

Vasectomy "Get a Permanent Smile" Campaign

International Version :60



MVO: Why is this man smiling?



For the same reasons over 42 million other men are.



Thanks to a simple procedure,



a vasectomy, he's chosen



not to have more children



and to do more for a family he already has.



A vasectomy



takes 20 minutes or less.



Minutes that



give a man



an important asset.



The power of



a permanent smile.



CALL 021-774-854

Call 021-774-854 for the facts.



CALL 021-774-854

Then join the brotherhood of men



CALL 021-774-854

whose smiles



CALL 021-774-854

go on and on.



Vasectomy. Give Yourself a Permanent Smile.



ACCRA
PPAG Hospital
Lo Polyclinic
Nyaho Clinic
ASHRAHAM
Okama Clinic
Ashaiman Health Centre
KUMASI
Komfo Anokye Teaching Hospital
Kumasi South Hospital

Vasectomy services and information are available at the following clinics and hospitals in Accra,



KUMASI
Komfo Anokye Teaching Hospital
Kumasi South Hospital
KOFORIDUA
Regional Hospital
AKOSOMBO
VRA Hospital
TAKORADI
GPHA Hospital

Ashaiman, Kumasi, Koforidua, Akosombo and Takoradi.



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THE KEY EMERGING ISSUES

Even though there were several issues that were discussed both at the Cape Town and Johannesburg meetings, there are however some specific issues that eventually started to emerge from both meetings:

The first issue was the inherent conflict between the individual and communal rights when it comes to a rights based approach to vasectomy. Participants at both meetings emphasised on the need to always seek to balance the potential conflict between the two components. In the final analysis, it was conceded that the first preference would be given initially to the individual rights approach.

Another crucial issue that came out was that vasectomy offered men a clear opportunity to be an integral part of a shared responsibility approach in terms of contraception in the country.

The other issue that came out clearly was the prohibitive costs of vasectomy at a clinical level. This was a very key factor affecting both the uptake and access to vasectomy in the country. Related to the high costs of vasectomy was a key discussion point around the need to consider the use of 'task shifting' to reduce the dependence on specialists in the provision of vasectomy services. Task shifting has been successfully used in the country before to increase both the uptake and access to antiretroviral medicines (ARVs) in the fight against HIV and AIDS.

Crucially, another pattern had also emerged; the fact that even though most males in the country are black, the number of males doing vasectomy is mostly dominated by men from other races.

The patriarchal nature of the most of the local culture, traditions and religion also continually militate against the possibility of a marked increase in both the uptake and access to vasectomy. Vasectomy is always in danger of being wrongly associated with lack of masculinity in the broader societal circles. This could discourage most men from even considering it as a viable contraceptive option.

Slightly related to that is the need to learn from the lessons to date with regards to the current campaign by government to increase both the uptake and access to clinical male circumcision (CMS). Since the campaign was launched, government claims that more and more men have eventually heeded to the call to go to the hospitals and effect clinical male circumcision. As such it is clear that if some funding were to be allocated towards vasectomy services in the country, they could soon be a marked rise in the number of uptake statistics for vasectomy in South Africa.

Related also to MMC is also the issue of the rituals related to initiation into manhood. Just as some communities have struggled to respect the value of MMC, there is always a likelihood that they will also not recognise vasectomy due to its modern clinical nature.

Be that as it may, the general consensus that has emerged out of both the Cape Town and Johannesburg meetings clearly points out to a possible public support for both the increase of uptake and access to vasectomy in the country.

At the very least, there is a clear case of the need to ensure that at any given time every citizen be made aware that vasectomy is actually included in a basket of existing contraceptive options available in the country.



American Society of Clinical Oncology
Making a world of difference in cancer care

“Reasonable’ to Advise Men Who Have Had Vasectomies That They Have a Small Increased Risk for Lethal Prostate Cancers”

By Charlotte Bath, ASCO Post Online - August 15, 2014, Volume 5, Issue 13

Long-term results from the Health Professionals Follow-up Health Study have shown a 20% increased risk of advanced prostate cancer and a 19% increased risk of lethal prostate cancer among men who had vasectomies. According to the study’s lead author, Mohammad Minhaj Siddiqui, MD, it is “reasonable” to advise men of the association between vasectomy and prostate cancer, but that should be in the context of their overall risk. “The thing to keep in mind,” Dr. Siddiqui said in an interview with The ASCO Post, “is that although there is an increase of 10% in overall prostate cancer risk, and 19% in the lethal cancer subset, the absolute incidence of lethal prostate cancer within the overall population was relatively rare— 1.6%. So if you have a 19% increase on 1.6%, that translates essentially to a 0.3% increase overall,” he explained. “The risk is pretty small in the grand scheme of things,” he continued. “If a physician senses that some patients are really worried about prostate cancer, those patients may appreciate being advised that there is a small increased risk from vasectomy that may be present,” Dr. Siddiqui said. “Having that discussion is probably good, but only in the context of the magnitude of the risk that is discussed.” Dr. Siddiqui is Director of Urologic Robotic Surgery, and Assistant Professor of Surgery-Urology, at the University of Maryland School of Medicine in Baltimore, although his work on the study was conducted while he was completing his residency training at Massachusetts General Hospital in Boston. The study coauthors are affiliated with Massachusetts General, Dana-Farber Cancer Institute, Brigham and Women’s Hospital, and Harvard School of Public Health, all in Boston.

MAJOR STUDY FINDINGS

The findings, published ahead of print online by the Journal of Clinical Oncology, involved 49,405 men in the Health Professionals Follow-up Study who were aged 40 to 75 years old at baseline in 1986 and were followed for up to 24 years.

The vasectomy status of the men was updated every 2 years, and 12,321 men (25%) reported having vasectomies by the year 2000. During the study period, 6,023 men were diagnosed with prostate cancer, including 811 lethal prostate cancers. Multivariate analysis showed a 10% increased risk of prostate cancer overall in men who had a vasectomy. Vasectomy was not significantly associated with risk of low-grade prostate cancer, but the procedure was associated with a 20% increased risk of advanced-stage prostate cancer and a 19% increased risk of lethal prostate cancer. “We defined advanced prostate cancer as stage T3b, T4, N1, or M1 at diagnosis; development of lymph node or distant metastasis; or death as a result of prostate cancer before the end of follow-up. Lethal cancers, a subset of advanced cancers, were those that caused death or metastasis to bone or other organs before the end of follow-up,” the authors explained.

“There was a suggestion that the increased risk was more pronounced among men who were younger at the time of vasectomy,” the investigators reported, but “this pattern was not apparent when we examined age at vasectomy in quartiles,” they added. “The relative risk seems slightly higher, but it is not statistically significant,” Dr. Siddiqui said. “That story seems to have picked up a little bit of traction, but I don’t think it is something to emphasize, and I think it is actually incorrectly being emphasized.” An earlier 1993 report from the Health Professionals Follow-up Study also found an increased risk of prostate cancer in men with vasectomies, although it was based on only 300 new cases of the disease from 1986 to 1990 (age-adjusted relative risk = 1.66; 95% confidence interval = 1.25-2.21; P = .0004). The recently updated data include 19 additional years of follow-up.

NOT DECISION-CHANGING

Dr. Siddiqui agreed with comments in some news reports that the study findings should not be considered practice-changing. A CBS News report quoted Louis R. Kavoussi, MD, Chairman of Urology at North Shore-LIJ Health System, New Hyde Park, New York, as saying, “I would be cautious about applying these findings to clinical practice right now. This is not like cigarette smoking causing a large number of people to develop lung cancer. This is a small increase in the risk of prostate cancer.”



James M. McKiernan, MD, Interim Chairman of the Department of Urology at New York Presbyterian Hospital/Columbia University Medical Centre, commented in The New York Times, “If someone asked for a vasectomy, I would have to tell them that there is this new data in this regard, but it’s not enough for me to change the standard of care. I would not say that you should avoid vasectomy.”

The study authors concluded: “The decision to opt for a vasectomy remains a highly personal one in which the potential risks and benefits must be considered.” For men contemplating a vasectomy, it “would be reasonable,” to consider the association between vasectomy and prostate cancer as one of the many potential risks and benefits, Dr. Siddiqui told The ASCO Post, although it should also be noted that no biologic explanation for that association has yet been found.

BIOLOGICAL MECHANISMS

“If we can figure out the biologic mechanisms” for the association between vasectomy and lethal prostate cancer, “that may actually have wider implications beyond vasectomy. The increased risk associated with vasectomy itself is probably modest and not decision-changing for most patients, although it may be for some,” Dr. Siddiqui added. “We have been working on trying to see what kind of biologic explanations there might be. There are a lot of theories, but nothing has been proven,” Dr. Siddiqui stated. “Vasectomy leads to hormonal changes and changes in the contents of semen, such as different proteins that are present in the semen, and even immune changes in the body. It is feasible—and it has been shown in other studies—that these changes could be linked to prostate cancer pathogenesis, but it has not been definitively shown with vasectomy.”

As the study report states, “the challenge lies in the fact that there is usually a 20- to 30-year interval between vasectomy and detection of prostate cancer.” The study group is continuing to look at the data and at underlying biologic reasons. “We have some good gene-expression data on subsets of patients, and we are trying to study differences in the different groups.” Dr. Siddiqui said.

IMPACT OF PSA TESTING

The study report estimates that about 15% of men now get vasectomies, although the rate for the study population was 25%. Dr. Siddiqui said that the research team suspects the reason for the higher rate in the study population was that the men were all health professionals and relatively well off. “It is possible that with that background,” he speculated, “more of them opted for vasectomy as their method of birth control. This is a unique subset of patients; that is important to remember.”

They were also more likely to have had PSA testing during the study years, 1986 to 2010. “Having said that, since PSA testing is so closely related to prostate cancer diagnosis, we controlled for PSA testing using multiple methods. We controlled for that in the baseline analysis, but we also did sub-analyses of only patients with highly screened behaviours,” Dr. Siddiqui explained. In a cohort of 13,901 “highly screened men”- those getting PSA testing on a regular basis -27% reported having had a vasectomy by the year 2000, and “the overall findings were essentially the same as in the general cohort,” Dr. Siddiqui reported.

“That is one of the issues that has been historically challenging,” Dr. Siddiqui stated. “Patients who get vasectomies may be more plugged into their medical care. They have a relationship with a urologist, and they may be more likely to undergo prostate cancer screening than patients who do not get a vasectomy. So the detection of prostate cancer could be biased by the fact that you are checking for prostate cancer more often in men with vasectomy vs those who do not have vasectomy. The way to control for that is to look at all men who are regularly checking for prostate cancer, and exclude the ones who don’t look for prostate cancer as regularly. That was a new dimension to this study that built on previous studies.”

EFFECT OF 2012 SCREENING RECOMMENDATIONS

The study follow-up ended in 2010, which was 2 years before the U.S. Preventive Services Task Force updated its prostate cancer screening recommendation -the Task Force now advocates against PSA based screening for prostate cancer. “It is unclear” what if any effect this updated recommendation will have on PSA screening among men who have had vasectomies. Follow-up is continuing, but the recommendation probably won’t affect men in the study because “many of them have already been getting PSA tested for a while,” Dr. Siddiqui noted. “These are men who were enrolled in the 1980s and 1990s; we are not enrolling additional men now. So there won’t be many men who are getting PSA testing in 2012 for the first time.



Most of them have already passed the point at which they were going to get PSA testing anyway.” Dr. Siddiqui said that while “it is a subjective finding,” he thinks that the routine administration of PSA testing “has really dropped off.” Among urologists, “we see fewer and fewer people coming in with elevated PSA’s as the primary complaint,” he said. “Men with a family history or some other reason for concern about prostate cancer are not denied PSA testing,” he said. “It is just not a routine part of a yearly physical exam anymore.”

CONFOUNDING FACTORS UNLIKELY

The study also notes that confounding by infections or cancer treatment is unlikely.

“Studies have actually shown that prostate cancer is associated with sexually transmitted infections, in particular, *Trichomonas vaginalis* and herpesvirus,” Dr. Siddiqui explained. “Some people suggest that perhaps men with vasectomy are more prone to sexually transmitted infections because of behavioural changes, so that could be a reason for the increased risk of prostate cancer. But we didn’t see any association with infections in our study, and we had pretty good data on histories of sexually transmitted infections.”

Cancer treatments were considered as confounding factors because of concerns that differing treatments could affect whether particular cases were lethal or not. “Perhaps some men are getting lethal prostate cancer because they are getting treated differently.... Theoretically, it is possible that men with vasectomies have relationships with their urologists, so maybe they prefer treatments that the urologist offers, such as surgery, as opposed to men who haven’t had a vasectomy,” Dr. Siddiqui explained.

“Maybe those men fear surgery in general and so they opt for radiation or other treatments,” he continued. “But what we found was that there was no difference in the vasectomy and non-vasectomy group with regard to what treatments were used to treat the prostate cancer. So that does not explain the observed risk either.” ?

Disclosure: Dr. Siddiqui reported no potential conflicts of interest.



AUA RESPONDS TO STUDY LINKING VASECTOMY WITH PROSTATE CANCER

On July 7, 2014, an article reporting a modest association between vasectomy and lethal prostate cancer was published online ahead of print in the *Journal of Clinical Oncology (JCO)*, *Lethal prostate cancer was defined as prostate cancer that caused death or metastases.*

The largest association reported was between vasectomy and lethal prostate cancer in a sub-group of men highly screened for prostate cancer. As a result of this report, a number of media outlets released articles linking vasectomy to an "increased risk of the most lethal kind of prostate cancer" and caused anxiety among many of the millions of men who already underwent vasectomies and those who are considering the procedure. On September 20, 2014 the article was formally released in the JCO print edition and is receiving continued media coverage.

Based on a careful review of vasectomy literature from 1949 to 2011 (including the 1992 and 1993 papers by Giovannucci and co-author Stampfer [who are co-authors of the 2014 JCO article] et. al.), the AUA Vasectomy Guideline Committee concluded in 2012 that there is no association between vasectomy and prostate cancer or other significant health risks. The 2012 AUA vasectomy guideline goes further by stating that there is no need for physicians to routinely discuss prostate cancer in their preoperative counseling of vasectomy patients.

Following the new JCO publication suggesting a relationship between vasectomy and aggressive prostate cancer, the AUA Vasectomy Guideline Panel carefully reviewed this new JCO report as well as additional literature published since the 2012 release of the Vasectomy Guideline. Additionally, a new meta-analysis was completed inclusive of both the previously reported literature from the 2012 guideline as well as the newly incorporated publication.

The review of the JCO article identified (a) methodological limitations regarding its ability to properly evaluate the risks of lethal prostate cancer; (b) inconsistencies with previous reports on the same cohort of men; and (c) a risk of bias due to potential residual confounding factors. These issues raise doubts about the validity of the results reported in the JCO article.

The new AUA meta-analysis produced results that are very similar to the results of the original meta analysis reviewed in the 2012 guideline. The pooled relative risk ratio for the association between vasectomy and prostate cancer based on eight cohort studies is 1.05 (95% confidence interval 0.95 to 1.17), $p = 0.33$. The relationship is neither clinically nor statistically significant, indicating that when findings across the eight studies are combined, the overall conclusion is vasectomy is not associated with and is not a risk factor for prostate cancer.

Based on the newly examined literature and updated meta-analysis, the AUA Vasectomy Guideline Panel concludes that the preponderance of evidence is that there is no reason to change the statements in the 2012 AUA guideline on vasectomy. The Panel reaffirms vasectomy is not a risk factor for prostate cancer or for high grade prostate cancer and it is not necessary for physicians to routinely discuss prostate cancer in their preoperative counseling of vasectomy patients.



CONCLUSION

It is thus submitted by way of conclusion that the initial discussions in both the two meetings in Cape Town and Johannesburg have clearly indicated the vast potential that South Africa has as a country to promote the use of vasectomy. All indications were that given a chance to explore the male contraceptive options, more men could be amenable to the idea of taking the responsible role.

This is crucial especially when one considers the fact that the condom has been the only real option available to most men in the country as a viable male contraceptive method.

The initial indications from the think tank meetings clearly show the need to introduce a systematic public awareness campaign to promote the uptake and also access to male contraception such as vasectomy.

At the very least, vasectomy should be added on the open basket of contraceptive options available not just to men but also to all couples in the country. In this regard, there is a real need for civil society to start systematically pushing for a major policy shift from both the makers and implementers of policy to allow for a steady increase in the uptake and access to vasectomy services in the country. This must not necessarily be a large publicity campaign in the same mode with that of the MMC campaign; but it must be resourced well enough to start making a difference in the contraception market.

South Africa is now ripe for an evolution that will see a marked increase of both the uptake and access to vasectomy services. What is left for that to happen is to ensure that there is a well organised civil society movement that will take the lead in campaigning for change of not just the attitudes but also in the use of vasectomy as a viable male contraceptive option in sexual and reproductive health related matters.

It is thus suggested by way of conclusion that one practical way to this matter is for civil society to initiate and strongly lobby for the adoption by all the different and relevant stakeholders of a 'National Roadmap for Vasectomy in South Africa. A practical way to ensure that this matter moves forward and gains traction both nationally and regionally would be for civil society to advocate for the conceptualization, development and full funding of a "National Roadmap for Vasectomy in South Africa. This process could be used to contribute to the regional SRHR agenda. (See Annex A).

ANNEXURES

ANNEXURE A: PROPOSED VASECTOMY ROADMAP FOR SOUTH AFRICA

It is proposed that as part of the way forward beyond the May 2014 consultative meetings, the following actions be considered:

- The consultation meetings report be fully adopted and circulated far and wide to all the relevant stakeholders on vasectomy
- A civil society all stakeholders mapping exercise be conducted to fully identify all the organisation that could be keen to promote vasectomy in the country
- An all stakeholders civil society national conference be organised to allow for civil society to fully deliberate on all issues affecting uptake and access to vasectomy in the country
- A national civil society strategic action plan on vasectomy be adopted at the end of the conference to enable it to have a sustainable campaign on vasectomy
- National civil society working group and network be set up to help drive a sustainable national agenda for the promotion of vasectomy in the country

However, vasectomy in South Africa should not be regarded as merely a matter of civil society responsibility. Instead, civil society should ensure that all the other various and relevant stakeholders also join the national discourse and make an effective contribution.

These stakeholders must at the very least include the relevant national and local government ministries, Parliament, traditional leadership, faith based leadership, media, research and academia, professionals such as those from the medical and legal communities, and all the other relevant sectors.

It could also be ideal to also have a direct engagement with the relevant Chapter Nine institutions such as the Commission for Gender Equality and also the Human Rights Commission.

In this regard, civil society could take the lead in the national mapping process for the identification of all the relevant stakeholders that could play a crucial role in the promotion of vasectomy in South Africa.

It is further proposed that for the campaign to promote both the uptake and access to vasectomy to take root and become more sustainable, there is need for civil society to push for the adoption of a 'National Roadmap for Vasectomy' in South Africa.

The Roadmap will contain all the necessary policy considerations and advocacy actions in order to improve both the uptake and access to vasectomy in the country.

It will also provide for a national all stakeholders platform that will fully engage on all issues affecting both the uptake and access to vasectomy in the country. The platform will also lobby for more budgetary resources towards the promotion of vasectomy in the country.

It will also develop an effective mechanism for the continued monitoring and evaluation of progress in terms of both the uptake and access to vasectomy in the country. In this regard, two particular things are suggested. Firstly, there must be an annual national Vasectomy progress review report. Secondly, after the report is issued, it must be followed by the hosting of an annual national all stakeholders' conference on the promotion of vasectomy in South Africa.

ANNEXURE B: GUIDELINES - SOUTH AFRICAN NATIONAL CONTRACEPTION, FERTILITY PLANNING POLICY

In February 2014, South Africa launched two crucial documents; the National contraception family planning policy and the National contraception clinical guidelines. These guidelines replace previous documents issued in 2001 and 2003. The country's new guidelines include expanded contraception options, introducing the long-acting hormonal contraceptive implant Implanon Nxt.

The guidelines also seek to increase demand for other previously available but unpopular contraceptive choices such as the copper intrauterine device and the female condom.

Released in two documents, the new policy also caters for the needs of various groups, including women living with HIV, migrants, sex workers and same-sex couples. The Department of Health advises that the documents be read in tandem and treated as complimentary resources.

The issue of vasectomy is covered under chapter 2 and specifically section 2.5.2 of the contraception guidelines that can be summed up as follows:

MALE STERILISATION OR VASECTOMY

Male sterilisation, also called vasectomy, is a permanent surgical contraceptive method for men who do not want any more children. The method entails the simple surgical procedure, performed under local anaesthesia, of closing both vas deferens (two tubes that carry the sperm to ejaculatory duct) to prevent sperm from mixing with ejaculate. Male sterilisation is not the same as castration. During vasectomy the testes are not removed. Vasectomy does not interfere with intercourse or affect a man's sexual desire, function or appearance.

Male sterilisation is generally safer, somewhat more effective and less expensive than female sterilisation. It is a good way for men to share in the responsibility for contraception. See Table 19 for key characteristics. If a man is not certain about ending fertility, other highly effective reversible methods for his partner can be discussed. In terms of informed decision-making, alternative LARC methods should be considered (according to availability) before a final decision is made.

KEY CHARACTERISTICS OF MALE STERILISATION

Effectiveness over 99.8% in the first year after the procedure

- Age limitations From a medical perspective, no restrictions for age (although young men have a higher chance of regret later in life, so careful counseling is essential)
- Parity limitations
- From a medical perspective, no restrictions for parity (although incidence of regret is higher among men with few children so careful counseling is essential)
- Mode of action Surgical closure of both vas deferens (two tubes that carry the sperm to ejaculatory duct) to prevent sperm from mixing with ejaculate. Not effective immediately. Takes on average three months for vas deferens to be cleared of sperm
- Common immediate complications/problems
- Minor post-operative short-term effects (e.g. discomfort for a few days and scrotal bruising and swelling), bleeding from wound, haematoma, wound infection and, less frequently, chronic scrotal pain.
- Non-contraceptive benefits - None other than protection for man's partner from risks associated with pregnancy
- Effect on STI and HIV risk - Not protective
- Drug interaction - None
- Duration of use - Considered to be permanent and irreversible
- Return to fertility - Never unless the vas deferens is reconnected (spontaneously or by surgery, which is expensive and does not guarantee success).

PROCEDURES REQUIRED FOR INITIATION OF VASECTOMY

Screening for Medical Eligibility

No medical conditions prevent a man from having a vasectomy. Some conditions and circumstances, however, call for delay, referral or caution. In general these conditions fall into three categories: abnormalities of the genitalia that make the procedure technically more difficult or increase its associated risks; infections that must be treated prior to the procedure; and certain systemic disorders that require special precautions or possible hospitalisation for the procedure.

Screening Procedures - as for female sterilisation

Timing - any time a man requests it (if there are no medical reasons to delay)

Method - specific counseling

Similar with that for female sterilisation. Providers should also inform clients that the procedure does not cause any change in sexual functioning or satisfaction, and does not affect the male hormones nor change one's physical appearance. If possible, arrange for them to talk with other men who have had a vasectomy.

Follow-up

- After undergoing a vasectomy, it takes about three months before the ejaculate becomes sperm free (that is, the man is sterile).
- Clients should be counseled to use an effective contraceptive method in the interim period (condom or his partner to use a contraceptive method). Semen analysis at 3 months (12-13 weeks) is recommended.
- Clients should be advised to return to the clinic at any time if they develop complications, have any health concerns, questions or need help.
- Sterilisation offers no protection from STI and HIV; therefore condoms should be used if at risk of exposure to STI and HIV.

Management of Complications

- Bleeding. Control the bleeding, determine its cause and manage as appropriate.
- Haematoma. Advise warm packs and analgesia.
- Infection. Determine whether there is infection or abscess. If there is infection, clean the infected area and treat with appropriate antibiotics. If an abscess is present, either drain it or refer for drainage, and treat with antibiotics.

Availability

There are limited facilities that offer vasectomy. Vasectomy needs to be actively promoted, with a focus on:

- Raising public awareness and the understanding of vasectomy
- Training staff to provide no-scalpel vasectomy services more widely with at least one service point per district.

Chapter Three Focuses on Contraception for Special Needs

Adolescents, menopausal women, disabled women and women with chronic conditions.

Voluntary Sterilisation

Sterilisation is seldom an appropriate method for adolescents or young adults because it is considered to be permanent and irreversible.

Voluntary Surgical Contraception

Male or female sterilisation may be appropriate if an individual with a physical disability personally requests it. However, as with any client requesting sterilisation, careful counseling should be provided to ensure a thorough understanding of the procedure, especially its permanence and irreversibility, as well as of the equally effective long-acting reversible methods of contraception. It is important to ensure that the client's rights are respected, and that the client with a disability is not coerced into sterilisation.

Voluntary Sterilisation

Informed consent should be obtained if the client is capable of understanding the nature of the sterilisation procedure, and it is certain that they will not wish to conceive in the future. Health care providers should be aware of the necessary legal process that must be followed if the parents, guardian or curator request/s sterilisation for a client who is not considered competent to consent to surgery. The legal requirements are set out in the Sterilisation Act (No. 44 of 1998) and the Sterilisation Amendment Act (Act No. 3 of 2005). A team of professionals need to consider each case individually.

Sterilisation for HIV

Male or female sterilisation is appropriate only for individuals or couples who have been thoroughly counseled about the procedure and are certain that they never wish to have more children in the future and who have considered the implications thoroughly. The decision should be voluntary and fully informed, with clients being cognisant of their sexual and reproductive health rights. While HIV status may affect clients' decision to choose sterilisation, they should never be coerced into doing so.

Vasectomy and HIV

- Men living with HIV, AIDS, or those on ART can have a vasectomy safely.
- Special arrangements may be needed to perform a vasectomy on a man with AIDS.
- Presence of an AIDS-related illness may require the procedure to be delayed until health improves.
- Vasectomy provides no protection in terms of STI and HIV transmission; therefore consistent and correct condom use needs to be encouraged in addition to vasectomy.
- No one including HIV positive men, should be pressurised or coerced into having a vasectomy.

Medical Eligibility Criteria

Male Sterilisation

ACCEPT: no medical reason to deny or delay the procedure

- Sickle-cell disease
- Anaemia
- HIV positive or high risk of HIV

CAUTION: can be done in routine setting, but with caution

- Young age^[2]
- Previous scrotal surgery or injury
- Large varicocele or large hydrocoele
- Cryptorchidism
- Unilateral undescended testicle – perform vasectomy on normal side. Then, if any sperm is present in a semen sample after 3 months, the other side must be done
- Diabetes
- Depressive disorders

DELAY/REFER: until condition evaluated and/or corrected

- Local infections: scrotal skin infection, balanitis, epididymitis or orchitis
- Active STI
- Acute systemic infection or gastroenteritis
- Filariasis; elephantiasis
- Intrasrotal mass

SPECIAL: provide only in specialised clinical settings with experienced staff, equipment and back up that can handle potential problems

- Inguinal hernia (Should be repaired first or at the same time as vasectomy)
- Bilateral undescended testicles
- Blood clotting disorders
- AIDS

[2] Because men of young age are more likely to regret sterilisation later.

ANNEXURE C: CAPE TOWN PROGRAMME

SETTING THE NATIONAL AGENDA & SHARING CONTRACEPTIVE RESPONSIBILITIES SPOTLIGHT ON VASECTOMY ACCESS AND UPTAKE IN SOUTH AFRICA

Cape Town 20th May 2014

- 09:00 - 09:20 Introduction: Tian Johnson, Sonke Gender Justice
- 09:20 - 09:40 Vasectomy 101: Video, Bob Mwiinga Munyati, AAI
- 09:40 - 10:00 Challenges at Clinic Level: Clinic Nurse, Marie Stopes (Name TBC by Andrea Thompson)
- 10:00 - 10:20 Voices on Vasectomy from Abroad: Erin Stern, MenEngage SRHR Initiative
- 10:20 - 10:40 Rwanda and Australia Case Studies: Andrea Thompson, Marie Stopes
- 10:40 - 11:00 Tea Break
- 11:00 - 11:20 Report on work being done by the Association for Voluntary Sterilization of South Africa: Colleen Marco, AVSSA
- 11:20 - 11:40 Experiences at Groote Schuur Hospital: Interview with Urology Unit Head Dr John Lazarus: Phillipa Tucker, AIDS Accountability International
- 11:40 - 12:00 Voices from the Frontline: Sikhangele Mabulu, Prisons Project Manager, Sonke Gender Justice
- 12:00 - 13:00 Vasectomy Marketplace Mapping – Post It!
- Women's Rights & Shared Burden
 - Intergenerational Sex
 - Reproductive Choice
 - Possible Adverse Effect of Vasectomies
 - STI Prevention
 - Shared Responsibility
- 13:00 - 13:45 Lunch
- 13:45 - 14:15 Barriers/Enablers to Vasectomy & Action Plans
- 14:15 - 14:45 Work Planning
- 14:45 - 14:50 Closure

ANNEXURE D: CAPE TOWN PROGRAMME PARTICIPANTS

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ANNEXURE E: JOHANNESBURG PROGRAMME

SETTING THE NATIONAL AGENDA & SHARING CONTRACEPTIVE RESPONSIBILITIES SPOTLIGHT ON VASECTOMY ACCESS AND UPTAKE IN SOUTH AFRICA

Johannesburg 22th May 2014

- 09:00 - 09:20 Introduction: Tian Johnson, Sonke Gender Justice
 09:20 - 09:40 Vasectomy 101: Video, Phillipa Tucker, AAI
 09:40 - 10:00 Voices on Vasectomy from Abroad: Erin Stern, MenEngage SRHR Initiative, presented by Tian Johnson
 10:00 - 10:20 The Economics of Vasectomies: Naomi Lince-Deroche, HE2RO, WITS University
 10:20 - 10:40 Vasectomies and Young Girls and Early and Unwanted Pregnancies: Yumnah Hattas, Save the Children
 10:40 - 11:00 Tea Break
 11:00 - 11:20 Communicating with Men: Agnes Shabalala, Soul City
 11:20 - 11:40 Thoughts from the Interfaith Community: Phumzile Mabizela, INERELO+
 11:40 - 12:00 Ethics and Vasectomy: Preena Sastra, Urology Registrar
 12:00 - 13:00 Vasectomy Marketplace Mapping – Post It!
 • Women’s Rights & Shared Burden
 • Intergenerational Sex
 • Reproductive Choice
 • Possible Adverse Effect of Vasectomies
 • STI Prevention
 • Shared Responsibility
 13:00 - 13:45 Lunch
 13:45 - 14:15 Barriers/Enablers to Vasectomy & Action Plans
 14:15 - 14:45 Work Planning
 14:45 - 14:50 Closure

ANNEXURE F: JOHANNESBURG PROGRAMME PARTICIPANTS

NAME	ORGANISATION	EMAIL ADDRESS
Tian Johnson	Sonke Gender Justice	tian@genderjustice.org.za
Phillipa Tucker	AIDS Accountability International	phillipa@aidsaccountability.org
Naomi Lince-Deroche	Wits University	naomi.lince.deroche@gmail.com
Yumnah Hattas	Save the Children	yumnah.hattas@savethechildren.org
Nazli Jugbaran	Elli Lilly	nazli.jugbaran@gmail.com
Belinda Gqoboka	BIS Reproductive Health	bgqoboka@ibisreproductivehealth.org
Bafana Khumalo	Sonke Gender Justice	bafana@genderjustice.org.za
Vuyani Pule	South African Council of Churches (SACC)	saccyouthforum@gmail.com
Preena Sivsankar	Wits University	preenasastra@yahoo.co.uk
Tanya Charles	Sonke Gender Justice	tanyac@genderjustice.org.za
Agnes Shabalala	Soul City	agnes@soulcity.org.za
Elvis Munatswa		
Mzikazi Nduna	Wits University	mzikazi.nduna@wits.ac.za
Andile Mthombeni		

ANNEXURE G: SUMMARY OF CONSULTATIVE MEETINGS ON VASECTOMY

This report summarises the proceeds from a consultative meeting held first in Cape Town on Tuesday 20th May 2014 and in Johannesburg on 22 May 2014.

CAPE TOWN MEETING

Almost twenty participants attended the meeting that was mostly informal, interactive and highly informative in nature. The meeting started with a brief background presentation from Tian Johnson from Sonke (co-facilitator) who highlighted the need to explore the viability of vasectomy especially in the context of a rather very short list of available male contraceptive options in the country.

He was then followed by Phillipa Tucker from AAI (co-facilitator) who took time to explain the purpose of the consultation process and also the procedure/programme for the day.

All the participants then gave some brief introductions of both themselves and also the organisations that they were representing at the meeting. This was then followed by a video presentation that sought to explain the vasectomy procedure. This brief session was facilitated by Bob Munyati from AAI.

After the video presentation, the participants had a lively discussion. One of the key points of discussion was around the perception that men tended to regard their private parts as their own 'precious jewels'. The discussion focused on the need to demystify the male private organs as part of the efforts to motivate them to consider vasectomy as an alternative male orientated contraceptive method.

Another key point of discussion was on the somewhat wrong perception of vasectomy as a risky, painful and gruesome clinical procedure. Yet it was practically pain free and very reliable as a more permanent contraceptive option.

There was also a comparative discussion around the female orientated option of tubal ligation. This discussion was led by a brief presentation from Colleen Marco, the Director of AVSSA. Colleen also gave a detailed presentation on the entire process involved in their AVSAA vasectomy programme. She explained the procedure prior, during and after the vasectomy process. AVSSA had a thorough due diligence process known as the 13 points checklist. They also made sure that the clinical component was also largely private and as male user friendly as possible. Afterwards, they also had a very strict adherence regime to ensure a high success rate for the contraceptive option. However, Colleen also shared a very disappointing fact about the declining capacity of AVSSA. Due to lack of adequate funding, AVSSA has over the years scaled down its operations. The programmes in Gauteng and Kwazulu-Natal have been closed down leaving the one in Western Cape as the remaining active one.

The meeting then had another very interesting presentation from Andrea Thompson who highlighted some key issues with regards to the uptake and access to vasectomy at Marie Stopes clinics. Vasectomy services constituted a small component of the volume of their clinical services. But there were indications especially through the high rate of telephonic inquiries that the uptake could be increased. Access to vasectomy at their clinics was limited largely by two factors; it was a bit expensive and also that since it was done with external medical consultants, it was barely profitable for Marie Stopes.

The meeting then had a comprehensive discussion on the possibility of reducing the high costs of vasectomy services by exploring the use of the concept of 'task shifting'. This would allow less specialised staff to provide most of the vasectomy services and reduce the expensive reliance on some specialists. This concept already had a successful precedent in the HIV and AIDS battlefield. In this regard, it was also suggested that there was a need to explore the possibility of some flexibilities as provided for under the World Health Organisation (WHO) guidelines on vasectomy practice.

Another interesting factor with regards to the need to reduce the high costs of vasectomy services was related to the limited medical aid coverage. Most medical aid packages were designed in such a limited way to avoid incurring the high costs of the vasectomy services. One option would be to ensure that the vasectomy clients did not need to stay in a medical facility overnight. Just by being day patients on its own, would go a long way into reducing the high costs of private medical aid with regards to vasectomy.

Another interesting point that came out of this discussion was the fact that AVSSA and Marie Stopes, had had minimal contact. There was an opportunity to foster a co-operative approach between the two institutions so as to share experiences and ideas on both the uptake and access to vasectomy services.

The meeting also had an insightful presentation focusing on the voices on vasectomy from abroad done by Erin Stern from MenEngage SRHR Initiative. Erin highlighted various international experiences about vasectomy in such countries as Canada, China and India, among others. She also pointed out that historically in South Africa, chemical castration was used by the apartheid regime in the military and prison sectors. Another crucial aspect of her presentation was the fact that MenEngage had developed an advocacy campaign based on three position papers of which one of them focused on the promotion of vasectomy as a contraceptive option.

Phillipa then did a presentation on the vasectomy experiences at the Groot Schuur hospital. The presentation was based on an interview she had conducted with the head of the Urology unit at the hospital, Dr. John Lazarus. The main point that came out of the presentation was that both the provincial and national governments needed to be lobbied to invest more on funding vasectomy services. Groot Schuur hospital was unable to freely offer the public the option of vasectomy due to lack of adequate funding. However the hospital did have services for referrals from the AVSSA programme. AVSSA paid the hospital some service fees that they used to support their academic programmes including students' support that was not necessarily related to the promotion of vasectomy as an option.

The meeting then had a very inspirational testimonial from Sikhangele 'SK' Mabulu (Sonke) who spoke as an example of one of the voices from the frontline in the fight to promote both the uptake and access to vasectomy services. SK story was very fascinating because he was a deeply traditional Xhosa man who had over the years evolved to accept the advantage of such clinical services as MMC and vasectomy. Even though he had been circumcised initially as part of his Xhosa manhood initiation process, he had later on embraced modern health sciences by doing a second circumcision via the MMC option at a hospital. Afterwards he had also decided to do a vasectomy but first had to convince his wife to also undergo her own voluntary sterilisation process.

SK was now facilitating a highly successful MMC programme targeting prison inmates. He was also involved in the promotion of both MMC and vasectomy at his local community level. However he highlighted the fact that the cultural view of manhood was still a major challenge in the fight to promote both the uptake and access to vasectomy and MMC services.

SK's presentation was then followed by another presentation from Andrea (Marie Stopes) that focused on vasectomy experiences in such countries as Canada, Australia and Rwanda. These countries had launched national policies and programmes that sought to increase both the uptake and access to vasectomy services. Canada presently had a globally high uptake of over 22%. Australia also had a comprehensive roll out of a public programme that had over the years successfully increased both the uptake and access to vasectomy services in the country. In Rwanda, a similar nation programme had struggled to massively increase the acceptance of vasectomy in the country. This was due to a number of reasons that included the fact that Rwanda remained mostly as a rural and traditional country that valued large families as an economic advantage in a subsistence agricultural country. There was skepticism that affected the Rwanda campaign since it was also seen mostly as population control strategy instead of being a voluntary contraceptive option.

Andrea also had a brief video presentation that showed a highly informative interview she had conducted with one of the Marie Stopes staff members. The interviewee was Thato Mokheti who was actively involved in providing clinical services for vasectomy in the local Marie Stopes clinics.

There was also a focused discussion on the aspect of the failure rate of vasectomy as a contraceptive option. The meeting noted that it was very rare to have an unplanned pregnancy after vasectomy was done. However to ensure that this did not happen, both AVSSA and Marie Stopes gave detailed explanation on the strong emphasis they have on adherence by clients after the vasectomy procedure is done. This was because that the failure rate was mostly related to lack of compliance or adherence to the procedures to be carried during the post-vasectomy period.

The meeting then had an open discussion on various issues that had been raised during the various presentations. The participants then agreed that the meeting was a good starting point in the initiation of a national discussion around vasectomy. However they also agreed that it was also necessary to continue the discussion beyond the think tank meeting. Also that there was need to explore further the opportunities to share ideas and experiences with regards to providing services for vasectomy.

The participants also re-affirmed their commitment and continued availability in the fight to promote the increase of both the uptake and access to vasectomy services in South Africa.

JOHANNESBURG MEETING

The Johannesburg consultation meeting was held on Wednesday 22nd May 2014 at the Sonke offices. The meeting participants were slightly more than the one in Cape Town. However, just like the earlier meeting, this one was also informal, interactive and highly informative in nature.

The meeting started with a brief background presentation from Tian Johnson (co-facilitator) who once again among other issues; highlighted the need to explore the viability of vasectomy especially in the context of a rather very short list of available male contraceptive options in the country.

He was then followed by Phillipa Tucker (co-facilitator) who took time to explain the purpose of the consultation process and also the procedure/programme for the day.

All the participants then gave some brief introductions of both themselves and also the organisations that they were representing at the meeting.

Thereafter the meeting resolved to have presentations from Tian and Phillipa that highlighted the key discussion points from the Cape Town meeting. Some of the highlighted issues included the following among others:

- The need to learn more and also scientifically document the use of traditional herbal medicines as cheaper but effective contraceptives. (Some form of herbal vasectomy).
- The need to push the vasectomy agenda from a shared responsibility approach; but also to ensure that it is always from an informed choice point of view.
- The need to learn from the experiences garnered to date in the on-going national campaign to increase uptake and access to MMC in South Africa.
- The need to promote public awareness and dispel all the ignorance and adverse myths around vasectomy. For example and perhaps in the most basic of all terms what the difference was between semen and sperms. Another example was the fears by female counterparts that their male partners could become promiscuous in the post vasectomy scenario.
- There was also a need to have a progressive national discourse on Manhood, Fatherhood, Patriarchy and other social factors that affected the popular acceptance of vasectomy.
- With regards to the issue of Manhood, Tanya Charles (Sonke) also recommended that participants look out for the educative video documentary entitled as 'Ndiyindoda' that focused on cultural issues in the Eastern Cape around MMC.
- The importance of a strict adherence practice in the post vasectomy scenario to avoid the possibility of failure as a contraceptive option.
- Also the need to explore the possibility of 'task shifting' in the provision of vasectomy services.
- There was also an on-going inherent conflict between the need to promote the demand for vasectomy against the backdrop of minimal capacity for public service delivery.
- There was also a discussion around fuller research around the limited cover of medical aid on vasectomy services.
- What was also fascinating was the low rate of less than 6% in terms of requests for reversals. Added to that, after some counseling sessions, most of the requests for reversals were also being cancelled.
- Another interesting point was around the use of animated videos instead of real life videos in education campaigns on vasectomy. It seemed that most people were in favour of avoiding the use of real life videos since they could affect the acceptance of vasectomy.

Afterwards the meeting had a brief presentation on the voices on vasectomy from abroad. This was done by Tian on behalf of Erin from MenEngage SRHR Initiative.

This was then followed by a presentation on the economics of vasectomies that was done by Naomi Lince-Deroche (HE.Ro at Wits University). She expounded on the different models that were used to scientifically compare the costs of vasectomies the world over. She advised the initiative to make sure that a sound analysis was conducted on the cost effectiveness of vasectomies as an alternative contraception.

The meeting then had a presentation from Yunnah Hattas from the Save the Children Fund. Her presentation focused on how vasectomies were related to the fight against unwanted pregnancies among young girls. Yunnah has also developed a model that seeks to explain and help to programmatically resolve issues related to young girls and unwanted pregnancies. There was also a discussion on the possible links between vasectomy and trans-generational sex.

The meeting then had a brief presentation on the experiences at the Groot Schuur hospital based on an interview with Dr. John Lazarus who is the head of the Urology unit. The interview and also the presentation was done by Phillipa from AAI.

Afterwards the meeting had an insightful presentation on the aspect of ethics and vasectomy. This was done by Dr. Preena Sivsankar from the Wits medical school, who is also the Urology registrar at the Johannesburg General hospital. Her presentation also included some very interesting case studies.

The meeting then had a highly informative presentation from Agnes Shabalala (Soul City) on possible communication strategies on vasectomy. She shared from the experiences and lessons learnt by Soul City over the years in its various public campaigns.

The meeting then had an open discussion that focused on various aspects around the promotion of both the uptake and access to vasectomy services. Participants at the meeting resolved to continue the discussion and debate on vasectomy. They also re-affirmed their continued support to the vasectomy initiative beyond the two think tank meetings.



ANNEXURE H: MEDICAL AID COVERAGE FOR VASECTOMY

One of the discussion points that were raised during the consultation meetings was on the aspect of medical aid coverage for vasectomy by the local service industry. As a result, after the consultative meetings, a telephonic survey was conducted with some of the leading medical aid companies in South Africa.

The survey focused on arguably the top five most prominent medical aid service providers in the country. The relevant companies by order of ranking are Discovery, Bonitas, Momentum, Medshield and FedHealth. The survey revealed that all the leading five companies do provide medical aid cover for vasectomy.

Below is a tabulated summary of the outcome of the survey:

MEDICAL AID COMPANY	CONTACT DETAILS	VASECTOMY COVERAGE
1. Discovery Health covers over 2.5 million people	0860 99 88 77 (24/7) healthinfo@discovery.co.za	Available
2. Bonitas covers over 650 000 people	0860 002 108 bonitas@medscheme.co.za	Available
3. Momentum Health covers at least 200 000 people	0860 117 859 www.momentum.co.za/health	Available
4. Medshield covers over 191,000 people	0860 002 120 www.medshield.co.za	Available
5. FedHealth covers over 150 000 people	0860 002 153 fedhealth@medscheme.co.za	Available

ANNEXURE I: INTERVIEW WITH CLINICAL STAFF MEMBER FROM MARIE STOPES

The following is a text summary of the video interview that was conducted with a staff member of Marie Stopes based at Cape Town on his clinical experiences with regards to vasectomy. The interview was conducted by Andrea Thompson (AT) who spoke to Thato Mokethi (TM)

AT Hi Thato! How are you?

TM I am doing well and you

AT I am good thank you! Can you tell me your name and position?

TM I am Thato. My surname is Mokheti. I am currently working at Marie Stopes as the centre manager for Cape Town clinic and acting centre manager for the Wynberg clinic as well

AT So tell us what either Cape Town or Wynberg clinics have experienced around vasectomies, and the demand for the services around vasectomy

TM Okay, currently in Cape Town we don't have a branch that has a physician that does vasectomy. However we do still get let's say an amount of clients that come looking for the service

AT So what kind of requests do they make? Is it something they are looking for as a couple or is it some guys that come on their own? What kinds of clients come looking for a vasectomy?

TM One of five is guys. Single guys! But three out of five is a family or people who are married that come with their partners

AT And do you think that a lot of the males who show interest in vasectomy have already been clients of Marie Stopes either through their female partner or someone they know coming in for one of your other services?

TM Once again I will arrange it according to the scores. One out of five haven't been and three out of five have been via the female being the client of cause.

AT And what kind of services has the female partner been for?

TM Mostly, which is top, termination of pregnancy and some who came for the PAP smear and they end up asking us about the services.

AT You said it is not being offered at the Western Cape. What are the challenges of offering your services here at the clinic? What would be necessary?

TM Of cause, because we do have me as a provider but then we also need a trained GP or physician that can do the service. Currently that is the disadvantage. Yes.

AT And has it ever been offered before?

TM I believe it has been offered before I joined Marie Stopes and from my understanding it went well but I don't know how come or why it was stopped.

AT And what kind of clients, either to your knowledge or maybe your administrator was able to advise you who sees the clients either on the front end or on the phone. What kinds of man request are requesting the service in terms of age or demographics?

TM In terms of age, we are looking at the age between thirty five and fifty; and demographically we are looking at Indians, whites, white males and economic status you know, it is very good standard people..

- AT Okay. And it is people from a higher economic status. What do you think attracts them to Marie Stopes as compared to maybe another service provider? Why do think they prefer us?
- TM Maybe it because Marie Stopes is private. Obviously they are more concerned of the confidentiality around the situation and the fact that it is private assures them of the fact that it is the best service that is going to be rendered to them.
- AT And I asked you about this earlier when you were talking about demographics and we spoke about black man and you said, 'oh I don't think so!' Tell me why you think that is?
- TM Alright, generally from my general knowledge, and not really because of money but with black men it is always seen as a good man that has plenty of kids. And with black men don't forget that these guys are referred to us either by the partner or because the guy has a number of kids and now they want to take this birth control method necessarily because the partner doesn't want to be on a contraception, then obviously will influence the partner to come in. But mostly we black guys or black dominant we are seeing ourselves as Xhosa men, so it is either the woman will be on contraception or nothing. We want those kids. It doesn't matter whether it is five. We want those kids.
- AT Okay, and then tell me, tomorrow we are going to be a group of civil society organisations many of whom actually campaign with men around the country you know with men from all different backgrounds. What advice would you give in terms of attracting men to the service like those Xhosa men who are set on? You know what would appeal? It does not need to be any one group of people you know. How would you break down those barriers as a service provider?
- TM I think that what I can think of at this point in time is equality in a relationship you know; because the disadvantage of these black relationships is that the female doesn't really have a say if I may put it that way. So even if they are encountering some side effects on a contraceptive it is not easy for them to go to their partner and say you know I think you should also try some birth control unlike other demographic spheres. So if they could get to the black population and put it in that sense of equality in relationships or family households, then I think they could get through to a number of people.
- AT And then if that was a service that was offered at Marie Stopes? If we could get all our ducks in a row and everything else, what to you could be the ideal kind of message around vasectomy for all men? How would we market it?
- TM Okay currently we are saying that have a child by choice and not by chance. So it would be the same the same slogan we could use for that as well because don't forget that we are not doing termination as a contraception method but we try to initiate someone to take a contraception method. So if you have already been through that, we refer you to a contraception method. So it will have an impact, a good impact on the number of ToPs because some of the women are saying that we are not on the contraception because it is doing XYZ on me, and not that I want to be in the situation. So if we could have that service it could also help where the number of ToPs is concerned.
- AT I know you would like to do your one in five. And so of your five clients, how many women who come and who are not on contraception, would you say that it is their partner in some way who is the barrier you know whether he has a myth on what it would do to her body or he is worried whether she is going to get fat. How many of your five clients?
- TM Can you reiterate that please?
- AT Yeah, you know in five clients how many say they don't use contraceptives and they are currently not on a modern method; how man would sort of blame or point to their partners as the reason?
- TM Three out of five
- AT And condom use?
- TM Five out of five; because all of them will tell you that I am using a condom but I am here!
- AT Thanks Thato.
- TM Alright thanks very much Andrea
- AT Anything else you may want to add that I may not have asked you about in this conversation about vasectomy or men's involvement in family planning overall?
- TM As a neurology service provider at Marie Stopes, would I be comfortable to do this service? Yes, of course!
- AT And what do you think there is a lot of specialisation required? Because one of the things my colleagues have found, some of the people I will be meeting with tomorrow; they have found that there is a dearth of information on the service out there and there is a very few providers offering it. So in your clinical knowledge, does it require a lot of specific?
- TM Because of the physiology you know and the procedure itself, yes. Because even though it is a procedure done by the physicians there is still, just like any other procedure there is still a gap of failure. So one needs to be clear of what they are doing to make sure that the procedure is permanent and done.
- AT And your knowledge around reversal?
- TM I have never really came across or let us say came across a client that says mine was reversed you know. I know there is some information that says yes, but I have never really come across it. Because I have always ever since I started my profession, I have always known that it is a permanent procedure to be done.
- AT Good. Thanks Thato.
- TM Anything else?
- AT That's it for me
- TM Thank you very much

ANNEXURE J: WHO GUIDELINES ON CAN CONDUCT VASECTOMIES

One of the discussion points during the consultation meetings was on the question as to was recommended to surgical conduct a vasectomy. Specifically, is it such a complicated surgical process that requires only specially trained medical professionals such as urologists to conduct? If not, who else is eligible to surgically conduct the vasectomy?

The World Health Organisation (WHO) has some guidelines that clarify and also make recommendations on the aspect of surgical personnel for vasectomy.

According to WHO, Vasectomy can be learned and performed by general practitioners, specialist surgeons and other physicians. In all cases, operators must be carefully selected to ensure high quality service delivery. Knowledge, technical skill, and surgical proficiency are, of course, prerequisites. Moreover, it is important that the physicians chosen be committed to the task in hand.

Specialists, including some urologists, may be too preoccupied with more complex surgery and medical problems to take an active interest in vasectomy, an elective procedure that can become tedious and boring for the surgical expert.

Interestingly, some of the most successful vasectomy programmes have been organized and conducted by specialist obstetrician-gynaecologists who are closely involved with and committed to family planning.

Vasectomy may appeal to private practitioners because it requires little capital investment and can be done on an outpatient basis in the physician's treatment room. As private practitioners are a primary source of health care in many countries, programme managers should consider instituting training programmes for this important sector.

A number of countries have successfully trained and used paramedical personnel to perform vasectomy. Medical assistants, medical students, nurses and community health workers have performed the procedure competently and safely (14). Where it is legal and permitted by local regulations, this can free physicians to do other work.

Paramedical staff may find the surgical task challenging, interesting and rewarding and, thus, may be motivated to remain involved with the programme. It has been reported from some programmes that paramedical staff empathize.

Vasectomy and the health care system closely with clients and that this has led to better community and client acceptance. However, consideration should be given to the concerns of the community and other health care providers about provision of vasectomy by paramedical staff.

It is advisable that paramedical personnel work under the supervision of responsible physicians who themselves are competent in performing vasectomies (15). A physician must be available and ready to intervene in case problems are encountered.

Clearly, paramedical workers must be selected with great care for aptitude, surgical skill, dexterity, interpersonal skills and judgement. Their training must be more comprehensive than that provided to a physician. They should be required to perform a larger number of training cases to establish proficiency, and they should receive instruction in relevant anatomy, physiology and pharmacology (see Chapter 12).

Various kinds of personnel have been trained in vasectomy, including surgical specialists, for example, general surgeons, urologists, and obstetricians/gynaecologists, general medical practitioners, medical students, and paramedical staff.

TRAINING AUTHORIZED TO PERFORM MINOR SURGERY







The specific types of trainee chosen will depend upon the current situation in health staffing, and the national regulations concerning the performance of surgery such as vasectomy.

Trainees should exhibit a desire to learn and have a commitment to providing vasectomy as a family planning option. In addition, they should be sensitive to people's feelings and, if necessary, be able to reassure them about their fears. Experience in performing surgery under local anaesthesia is also desirable, since this is an essential aspect of safe and comfortable vasectomies. Trainees should be from institutions with a documented demand for vasectomy services, where they will have the opportunity to perform the procedure frequently after the training programme.

ANNEXURE K: GUIDE TO ADVANTAGES AND COSTS OF CONTRACEPTIVES

Guide to contraception

What the options and advantages are, and what it costs

	TYPE OF CONTRACEPTIVE	HOW IT WORKS	EFFICACY IN PREVENTING PREGNANCY	COST
	Copper IUD loop (intrauterine device) that is fitted into the uterus	Alters environment in uterus to stop sperm fertilising the egg	99%	R240 to R1 000
	Hormonal IUD loop made of plastic that is fitted into the uterus	Slowly releases low dosages of hormone to stop egg being released to meet sperm	99%	R3 000 to R4 500
	Implant	Slowly releases low dosages of hormone to stop egg being released to meet sperm	99%	R1 900
	Pill	Contains hormone that stops egg being released to meet sperm	97%	R60 or more every month
	Injection	Contains hormone that stops egg being released to meet sperm	97%	R50 to R150 every two or three months
	Patches	Contain hormone that stops egg being released to meet sperm	97%	R215 to R300 a month
	Condoms (male or female)	Provides a barrier to stop sperm entering the uterus	85%	R5 to R80 for a pack of three
	Female sterilisation	Stops tubes in female from carrying egg to meet sperm	95%	R2 500 (can cost up to R20 000 with a hospital stay)
	Vasectomy	Stops tubes in male from carrying sperm to the testes	90%	R1 500 (can cost up to R20 000 with a hospital stay)



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ANNEXURE K: GUIDE TO ADVANTAGES AND COSTS OF CONTRACEPTIVES

TYPE OF CONTRACEPTIVE	ADVANTAGES	DISADVANTAGES	PROTECTION AGAINST DISEASE HIV or sexually transmitted infections
Copper IUD loop	Nonhormonal, immediately effective and long-acting (five to 10 years)	Can cause heavier periods and cramping	 None
Hormonal IUD loop	Long-acting (five years). Low dosages of hormone	Can cause irregular periods or cause them to stop completely. Other possible side effects are breast tenderness, increased appetite, nausea or headaches	 None
Implant	Long-acting (three years). Low dosages of hormone. Is fitted under local anaesthetic	Can cause irregular periods or cause them to stop completely. Other possible side effects are breast tenderness, increased appetite, nausea or headaches	 None
	Can reduce premenstrual syndrome symptoms. Doesn't affect menstrual cycle or periods. Options available for breastfeeding women	Should be taken at the same time every day. Can cause breast tenderness, increased appetite, nausea or headaches	 None
Injection	Lasts two to three months	Can cause irregular periods or cause them to stop completely. Can also cause increased appetite	 None
Patches	Doesn't affect menstrual cycle or periods. Only needs to be changed weekly	Can cause increased appetite	 None
Condoms (male or female)	Helps to protect against HIV and sexually transmitted infections. Is nonhormonal, easy to access and only needed during sexual activity	Partner needs to agree to use. Some are allergic to latex or added lubricants	 Offers effective protection
Female sterilisation	Is permanent and immediately effective	Minor medical risk as with any surgery	 None
Vasectomy	Is permanent and requires a quick 10-minute surgical procedure	Need to abstain from sex or use condoms until all sperm is cleared (up to four months)	 None

Graphic: JOHN McCANN Data source: MARIE STOPE (SOUTH AFRICA)

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