Increasing male participation in the uptake of vasectomy services

Hari Singh,[1] Ashutosh Mishra,[2] Dawood Alam,[3] Vivekanand Pandey[4]

[1]Project Director, EngenderHealth, Delhi, India
[2]Senior Program Officer – M&E, EngenderHealth, Delhi, India
[3]Senior Technical Advisor – Demand Generation, EngenderHealth, Delhi, India
[4]Senior Program Officer, EngenderHealth, Delhi, India

Correspondence to
Dr Hari Singh, EngenderHealth, B4/45, Safdarjung Enclave, New Delhi 110029, India; hsingh@engenderhealth.org

Received 28 May 2012
Revised 10 September 2012
Accepted 17 December 2012

To cite: Singh H, Mishra A, Alam D, *et al*. *J Fam Plann Reprod Health Care* Published Online First: [*please include* Day Month Year] doi:10.1136/jfprhc-2012-100406

WHY IS THERE A NEED TO INCREASE MALE PARTICIPATION IN FAMILY PLANNING?

In India, family planning is considered to be the woman's responsibility and tubal ligation is much more popular compared to vasectomy. For every 98 women who undergo tubal libation, only two men accept vasectomy, which reflects a serious imbalance and indicates gender inequity. About half the women in India are reported to be anaemic and a large proportion has reproductive tract infections. It is therefore not a good ideal for them to undergo tubal ligation or have an intrauterine device inserted; use of contraception by husbands could be a better alternative.

WHAT ARE THE ADVANTAGES OF NSV?

For men, a safe, simple and effective method of terminal contraception is No Scalpel Vasectomy (NSV). This is an improved technique over traditional vasectomy with minimal pain, no incision, no stitches and no blood loss. The entire procedure can be completed in 20 minutes and the client can leave the clinic after 1 hour. He can resume strenuous work 2 days after the procedure.

WHY IS NSV UNPOPULAR?

It has been known for decades that the myths and misconceptions around vasectomy or NSV are the main barriers to its acceptance. People relate it to old traditional vasectomy that was a relatively major procedure. They feel that NSV results in weakness such that they will not be able to do rigorous manual labour to earn their livelihood after the procedure. We conducted in-depth discussions with communities and health providers in an effort to understand what exactly they mean by weakness and why they link physical weakness with NSV. We learned that although people talk about physical weakness, their main concern is sexual weakness, which is a topic that they are hesitant to discuss. We learned that many people believe that during NSV the tubes that carry spermatic fluid are cut, therefore there will be no ejaculation during sexual intercourse and it will no longer be pleasurable. Not only individual community members but also many health workers were ignorant on this point. It was discovered that women were equally or sometimes more concerned because they feared that after having undergone NSV their husband will lose interest in sex. They offered to undergo tubal ligation rather than allowing their husbands to undergo NSV. Community members, outreach workers and health providers were all hesitant to discuss and clarify these issues.

HOW WERE MISCONCEPTIONS ABOUT NSV DISPELLED?

We adopted one-on-one communication with eligible couples to provide accurate, evidence-based information. The process of ejaculation was explained to them with the help of a simplified schematic diagram illustrating male human anatomy. The point is clarified that the sperms are produced in the testicles and that seminal fluid is produced by other glands (the seminal vesicles and the prostate gland). Ducts that carry sperm from the testicles are different from the ducts that transport seminal fluid. Sperm get mixed up with the spermatic fluid during ejaculation. In the NSV procedure only the ducts that carry sperm are blocked. The other ducts that carry the seminal fluid are not affected in any way. Therefore, after having undergone NSV, ejaculation of the seminal fluid occurs normally and the man experiences the same pleasure. The only difference is that the man's seminal fluid is devoid of sperm that can result in conception and pregnancy. It was also explained that erection or hardness of the man's penis is not affected by NSV.

Some of the stakeholders were apprehensive that people in conservative societies might have reservations about

discussing sex, erection, ejaculation and sexual pleasure. We pre-tested the interventions and found that even in the most conservative societies, men and women had absolutely no reservations about discussing these issues. Some people felt shy about initiating discussion or seeking clarification but none had reservations listening to health workers. After discussions many people were grateful to the health workers for providing them with the required information, and indeed a classical response given by many of the potential clients was "this is exactly what I wanted to know".

Due respect was given to the concept of informed and voluntary decision-making in family planning. Initially eligible couples were provided with information on all available methods of contraception. Only those who showed interest in NSV were provided with a detailed account of the procedure. No efforts were made to compare NSV with other contraceptive methods.

WHAT METHODOLOGY WAS USED FOR FIELD-LEVEL INTERVENTIONS?

We made the interventions in nine districts (Allahabad, Pratapgarh, Kaushambi, Kanpur, Kanpur rural, Kannauj, Meerut, Ghaziabad and Bulandshahr) in Uttar Pradesh, India. We identified four or five health facilities in each intervention district where NSV surgeons were available (a total of 44 facilities). These facilities had a total of 54 NSV surgeons. We oriented about 600 health providers and outreach workers from these facilities to the fact that NSV does not interfere with erection, ejaculation and sexual pleasure of the individuals concerned. We emphasised the importance of discussing these issues with eligible couples. Using a series of role plays, efforts were made to make the health providers and outreach workers confident and comfortable discussing these sensitive issues with the intended audience. We provided them with job aids, including a schematic diagram of the male anatomy with which to initiate discussions. Male workers discussed these issues with potential clients and female workers discussed them with the spouses of potential clients. We found that if the spouse of a potential client was convinced, then the chance of her husband accepting NSV was very high.

WHAT WAS THE RESULT OF TRAINING HEALTH PROVIDERS AND OUTREACH WORKERS?

In the initial stages we observed closely the outreach activities carried out by the trained workers and found that despite the training, only 10–15% of the workers were able to discuss these issues frankly with the intended audience. Whenever these issues were discussed frankly, NSV acceptance increased. The remaining 80–85% of workers only conveyed the broader message that everything will be alright following NSV or that everything will be as it was before the procedure. The workers could not talk explicitly about erection, ejaculation and sexual pleasure, and accordingly they were able to make very few referrals.

WHAT OTHER INTERVENTIONS TOOK PLACE?

Besides increasing demand, we made efforts to improve the quality of NSV services. Our NSV trainer provided on-the-job training to 54 NSV surgeons who were responsible for providing NSV services in the nine intervention districts. The NSV trainer visited each facility by rotation and supported the NSV surgeons in performing the standard NSV procedure. We trained these surgeons, as well as their support staff, in infection prevention protocols.

WHAT WERE THE RESULTS?

As a result of these interventions, the NSV acceptance in the nine project districts of Uttar Pradesh increased three-fold over a period of 2 years. At the beginning of the project 1646 people utilised NSV services from April 2009 to March 2010. After 2 years of interventions the NSV acceptance increased to 5009 (from April 2011 to March 2012). During this period the proportion of NSV to total sterilisations in the nine intervention districts increased from 2.4% to 9.1%. These data are obtained from the annual service statistics collected and published by the state of Uttar Pradesh (the financial and operational year of the state runs from April to March). The most important achievement of the project was that not a single case of post-operative complication or failure was reported from these districts in the second year of the project. Earlier there had been many cases of post-NSV complications – haematoma, infection or failure – which resulted in claims for compensation from the insurance company through the district health office. In the year 2011–2012 no NSV clients filed a case for compensation. Another important achievement is that the number of new clients who are referred by satisfied clients has been steadily increasing.

CONCLUSION

If accurate information is provided to people about NSV and they are explicitly told that NSV does not result in sexual weakness, and if they are offered good quality services, acceptance of NSV increases significantly, thus contributing towards increasing male participation in family planning.

Acknowledgements The authors would like to acknowledge the funding support provided by USAID and the technical support provided by EngenderHealth New York for the NSV Initiative project. The authors would also like to thank the government of Uttar Pradesh, the staff of supported facilities and project staff for their contributions towards the success of this project.

Funding USAID provided funding for this project.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.