



Improving Provision of Vasectomy

Practices

- Improve counseling on effectiveness and temporary side effects.
- Connect men considering vasectomy with men who have already chosen vasectomy.
- Use the no-scalpel technique and occlusion of the vas using fascial interposition.

Summary: Vasectomy is an extremely safe and effective method of contraception. It is simpler, safer, less costly, and equally effective as female sterilization, and yet it remains the least-used contraceptive method worldwide.

Despite commonly held assumptions about male attitudes or societal prohibitions, men in every region and cultural, religious, or socioeconomic setting have shown interest in vasectomy when seeking contraception. However, men often lack full access to information and services.¹ Efforts to improve access to and use of vasectomy need to include creating demand and improving services. Increasing access to and uptake of vasectomy can help men and women achieve their reproductive intentions and fosters male involvement in family planning.

Improve counseling on effectiveness and temporary side effects.

It is essential for counseling to emphasize that vasectomy is highly effective but has a slight possibility of failure.² Couples should be instructed to use a backup method of contraception for 12 weeks (the time to azoospermia) after the procedure and counseled on the possibility of failure. Additionally, post-vasectomy scrotal or testicular pain is a possible side effect. While such pain is usually minor and temporary, men should be informed that it can occur.

Connect men considering vasectomy with men who have already chosen vasectomy.

A crucial factor influencing vasectomy uptake is whether a man has spoken with another man who himself has chosen vasectomy.³ Studies of early vasectomy adopters in Colombia and Guatemala found that all had first contacted a man who already had a vasectomy.⁴

Use the no-scalpel technique and occlusion of the vas using fascial interposition.

The skill and training of a surgeon and the techniques used during a vasectomy can affect

the success rate, degree of pain, and number of complications experienced by a client.⁵ The no-scalpel technique of isolating the vas requires a shorter operating time and leads to fewer complications and less pain than does the use of a scalpel.⁶ Additionally, recent studies have shown that using fascial interposition to occlude the vas can reduce failure rates by half when compared with using ligation and excision alone, and that the use of fascial interposition with cautery can reduce failure rates even further. A recent study also found that these more effective methods of vasectomy are more cost-effective than ligation and excision without fascial interposition. They increase the cost of providing a vasectomy by only a few cents and reduce the number of unintended pregnancies after vasectomy.⁷

Additional Resources

No Scalpel Vasectomy: An Illustrated Guide for Surgeons. Third Edition. EngenderHealth, 2003. <http://www.engenderhealth.org/pubs/family-planning/nsv-illustrated-guide.php>

No Scalpel Vasectomy (video). EngenderHealth, nd. Order from: <http://www.engenderhealth.org>

Selected Practice Recommendations for Contraceptive Use. Second Edition. WHO, 2004. Effectiveness counseling: recommendation 14. <http://www.who.int/reproductive-health/publications/spr/index.htm>

MENU OF PRACTICES

For programs interested in improving the provision of vasectomy, FHI can provide technical assistance in:

- (1) updating policies
- (2) expanding service provision to include vasectomy

In addition, FHI collaborates with ministries of health and service delivery organizations to conduct formative and operations research on innovative approaches to revitalizing long-acting and permanent contraceptive methods, including vasectomy.

Vasectomy: Safe, Convenient, Effective—and

Underutilized. Global Health Technical Brief. Maximizing Access and Quality Initiative, 2005. <http://www.maqweb.org/techbriefs/tb7vasectomy.pdf>

References

- 1 *Maximizing Access and Quality Initiative. Vasectomy: Safe, Convenient, Effective—and Underutilized.* Global Health Technical Brief. Available at: <http://www.maqweb.org/techbriefs/tb7vasectomy.pdf>.
- 2 Barone MA, Nazerali H, Cortez M, et al. A prospective study of time and number of ejaculations to azoospermia after vasectomy by ligation and excision. *J Urology* 2003;170(3):892–96.
- 3 Mumford SD. Vasectomy: the decision-making process. *Stud Fam Plan* 1983;14(3):83–88.
- 4 *Moving Vasectomy Forward: An Expert Consultation on Priorities and Next Steps.* Meeting Summary Report, InterAgency Workshop, U.S. Agency for International Development, Washington, DC, November 20, 2006.
- 5 Labrecque M, Dufresne C, Barone MA, et al. Vasectomy surgical techniques: a systematic review. *BMC Med* 2004;2:21.
- 6 EngenderHealth. *No-Scalpel Vasectomy: An Illustrated Guide for Surgeons.* Third Edition. New York: EngenderHealth, 2003.
- 7 Seamans Y, Harner-Jay CM. Modelling cost-effectiveness of different vasectomy methods in India, Kenya, and Mexico. *Cost Eff Resour Alloc* 2007;5:8.



Research to Practice

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