Tishina: Greetings, and welcome to today's webinar on family planning service, expanding contraceptive choice, vasectomy. My name is Tishina Okegbe and I am the senior technical officer for community-based family planning for the Advancing Partners and Communities project. Before we begin today's presentation, I'd like to quickly review the Adobe Connect environment and set a few norms for today's webinar. Today's webinar has three presentations followed by a discussion period, during which, our speakers will address your questions.

Within the webinar environment, please make use of the Q&A box on the bottom-right side of your screen to share your thoughts, note your question, or ask for help with sound during the presentation. Questions you ask are only visible to you, our presenters, and technical support. If you are experiencing difficulties, our technical support will respond to your question privately. We will collect your questions for our speakers and we'll save them for the discussion period.

It is great that we are able to connect people from so many places today, but your experience may vary based on your internet connection and computer equipment. I will briefly go over a few troubleshooting steps if you have technology challenges today. A few troubleshooting tips, if you lose connectivity or cannot hear, close the webinar. Please reenter the meeting room in a browser other than Google Chrome by clicking on the webinar link provided. Use the Q&A box to ask APC techs for assistance. If the troubleshooting steps are not successful, please rest assured, the webinar is being recorded and you will receive an email with the link to the recording following today's event.

Questions that don't get answered during the Q&A session will be compiled after the webinar, shared with presenters, and responses from presenters will be shared with participants. To get us started today, I will now turn it over to our moderator, Joan Craft.

Joan: I'd like to welcome and thank everyone for joining today. My name is Joan Kraft. I'm a gender advisor in the Office of Population and Reproductive Health at USAID Washington. Today's webinar, Expanding Contraceptive Choice, Vasectomy, is organized by the Advancing Partners and Communities project in collaboration with the Family Planning 2020, the Implementing

Best Practices Initiative, and USAID's Office of Population and Reproductive Health.

This webinar series highlights a range a family planning methods. Each webinar focuses on a single method. The series provides information on family planning methods including basics like how to use them and hot topics specific to each method, country case studies, and service delivery channels. The objectives of the series are to provide technical information and updates on a range of family planning methods, discuss emerging trends with a global audience, highlight programmatic successes and challenges, and answer some method-specific questions that you might have.

Volunteerism and informed choice are the principles of any good family planning program, and what that means is that clients should have access to a broad range of methods, they should receive client-centered counseling on a range of methods, discuss their lifestyle and reproductive intentions with their providers, and be able to ask questions, then clients can freely choose their methods without coercion. They should also receive detailed information on that method and ask questions and discuss the method with the provider. Finally, providers should be able to counsel clients on all methods, even if they have to refer clients for particular methods.

And, with that, I would like to introduce our first speaker. Roy Jacobstein is the senior medical advisor at IntraHealth International. Roy?

Roy: Thank you, Joan, and good morning or good afternoon, everyone. Let's review what vasectomy is and then take a look at how it's faring in our programs. The presentation has four parts. We'll look at the method itself, we'll look at worldwide and regional trends, we'll look at some country data, and then various aspects of programming. Vasectomy is a quick and simple minor surgical procedure for permanent male sterilization, it's performed in outpatient settings under local anesthesia, and it entails accessing and then permanently blocking each of the two vas deferens, which are the tubes that carry sperm from the testes to the penis. The recommended method which has less pain and bleeding than the traditional scalpel method is the no-scalpel vasectomy technique.

Almost all men are eligible for vasectomy according to WHO's medical eligibility criteria and major complications with the procedure are rare. There are no adverse, long-term effects, and

after about two weeks, only 5 to 10 percent note minor complications such as pain.

Joan mentioned informed choice and sometimes there's a little confusion between informed choice and informed consent, so as we heard, informed choice is the bedrock principle in family planning programming and it entails the provision of adequate information and a wide range of modern methods so that clients can achieve their reproductive intentions and voluntarily choose their method to either delay space or limit births, and of course, vasectomy is one of the limiting methods.

Vasectomy is highly effective and comparable in effectiveness to the other three provider-dependent methods, the two long-acting and reversible contraceptive methods, or LARCs, that's the implants and IUDs and female sterilization, and that plus vasectomy are the permanent methods, but the two really important points about vasectomy, additionally, that sometimes people forget is that it's only effective after three months. It's not effective immediately, and so its success depends both on the skill of the operator and on the compliance of the client and the partner to use a temporary method for 3 months. Even then, there can be a very occasional failure subsequently, so permanent and infallible are not the same, and no method is infallible.

I wanted to mention a few aspects about the current context and the potential demand for vasectomy. All over the world, megatrends are driving a desired smaller – the small family norm is becoming universe and that means that millions of women and couples are spending half to two-thirds of their reproductive lives with the intention to limit. And the next speaker, Lynn Van Lith, and her colleagues, wrote a very important paper that showed that the demand to limit exceeds the demand to space among women who are married or in union in many countries, and this is true in most regions of the world.

In our field of family planning, we sometimes forget this because we're so rightly and understandably focused on youth, but the demand for limit is high and rising. In addition, another fact that people may not realize is how low the age can be at which more than half of the married have a demand to limit as opposed to a demand to space. Now, of course, this doesn't mean that all those clients will choose a permanent method, but a lot of them would if these methods were more available, including vasectomy. From the standpoint of cost, vasectomy is cost-effective, more so – and this

is a slide that considers all the service delivery costs, and vasectomy is second to IUDs in terms of its cost effectiveness.

Nonetheless, with all that said, this slide shows the trends in permanent method used over the last several decades and you can see that vasectomy has essentially plateaued, even though the number of people in the world has more than doubled, and female sterilization has generally kept up with that. In 1982, the ratio was roughly one in three, and now the ratio is one in eight, so that's one way of looking at the status of vasectomy.

This slide shows the worldwide and regional prevalence and number of users, and you can see that the highest prevalence, if you look at the third column, is in so-called Northern America, which is the United States and Canada, and in Oceania, the most vasectomy users reflecting the highest population is in Asia and the lowest prevalence and lowest number of users is in Africa. When we look at the countries that have high vasectomy use, they generally have high family planning access and use, high, if not universal, health coverage, and strong gender equity.

And you can see, these are the latest figures from the latest UN rendering, but you can see Canada has of vasectomy prevalence of 22 percent, the UK, 21, and Korea and New Zealand, also, if you look at the third column, those four countries all have a quarter or more of the share of modern method use, is due to vasectomy. This is among married women.

On the other hand, when you look at a lot of the countries where we work, priority countries for USAID, you can see that – especially if you look at the aspects in the red ovals, that vasectomy is not as well-known in a lot of countries, notwithstanding the high demand to limit that I spoke about earlier. What you see in the upper part of column two, the prevalence is extremely low, as you see in the right-hand column.

This is a slide from Lynn and her colleagues' paper, and this is showing the method mix, so this takes out the non-users and the traditional method users, and it shows you what method women who want to limit are using in all of those countries that we see in Africa. The permanent method use is in red and almost all of that is female sterilization, not vasectomy, so in almost all of the countries, you can see how low permanent method use is. This is not what we would see in the countries I showed in the previous slide of high vasectomy use, this pattern, and then vasectomy use in those countries, as we saw, is negligible.

There's a number of reasons that availability and use of vasectomy is so low. It's had low program and donor priority, so limited funding. It generally has not been seen or framed as an advocacy or a gender issue, which arguably might have led to more funding. It was seen often as a technical issue or simply a little attention to meeting the needs of limiters, but the idea that there are very few male methods, and this needs a lot of advocacy was not highlighted.

Then, of course policymakers and family planning providers themselves have biases and adhere to gender norms about masculinity and about who it is that ought to have the family planning responsibility. And so, in general, family planning and reproductive health services for men are limited in the countries where we work, and services are generally not only geared to women, but generally provided by women and men tend to prefer a male vasectomy provider. All of that leads to quite limited overall demand for vasectomy.

Some additional things, this next one, I think, could be easily rectified. I don't know if anybody from DHS program or PMA2020 is listening, but in only – as I recall looking at this recently, in 54 countries, only ten had vasectomy listed as a separate method on their population-based surveys, so it's not even an expectation. It's typically lumped with other methods because it's use is so low, but I believe that ought to be listed separately, and if it's 0.0, then people can focus on that and then realize that some attention should be paid to that.

When there are vasectomy efforts, they typically are too short and not long enough, and several things I've learned over the years are the PF small projects. You have small results and change takes time. I want to underscore that I believe we need a greater focus on vasectomy. It will be a while before we have a notable surge and uptake, but if we don't start now, we'll be in the same situation we've been in over the last several decades.

What we just looked at was why it's low, vasectomy use is low at the program level. Here are some aspects from the client perspective. As we saw, it's the least known of all methods and known in DHS parlance means people are aware of it, not that they have accurate knowledge. There are the cultural and gender norms that I alluded to where it's not that family planning is a woman's duty, and that the more children you have, the more masculine you are.

There are many rumors and misunderstandings about vasectomy, but these are those people's truths, and these are universal. This happens in all countries where – there are some countries where their language does not even have a word for vasectomy and castration is the same word, and there's fear that a man won't be able to have sex, that a vasectomy would make him weak or fat or less productive, and when I was Kazakhstan several decades ago, I could not even get my translator to say the word vasectomy because he thought I was talking about castration. And then there's anxiety about undergoing a surgical procedure.

What are we going to do about all this? In general, we have found that wherever there is a successful vasectomy effort, you have a champion. You have a champion at the head of the program, you have a champion provider, you have an advocate, and without that, that's a sine qua non of a program. Some other – Lynn is later gonna talk more about demand, but when we think about demand, it's important to emphasize the benefits to both the client and the partner.

We want to address women as well as men. They are part of the decision, often. We want to address the gender norms that limit men's participation in family planning, we want to use multiple communication channels, and we want to feature use and feature champion providers and satisfied clients. These are some posters from an effort a few years back under the ACQUIRE and RESPOND project in Ghana, Honduras, and Bangladesh that reflect some of those principles that I was talking about.

I believe that the main focus needs to be on demand, but of course, holistic programming is important, so when we do think about supply side aspects of vasectomy, it's important that we have male friendly services, not unlike youth friendly services for youth. It's important to have a whole-site approach where the whole staff of the facility understands and supports vasectomy, and that includes the actual gatekeepers who sometimes can misunderstand the situation and send clients away.

We want to address provider perspectives and rewards, their pay, giving them recognition, paying attention to their workload, and then, if need be, addressing your own gender and method biases. We want to use the providers that are dedicated to this in the sense that they have the time for it and the commitment to it, and then we want to nurture these champions. We have a tendency to not stay with the ones who are committed to this long enough, so that's

important. We want to focus on quality and client satisfaction, make sure the services are affordable, and, if we are able to, to train fewer providers, but then to stick with them longer. Training a whole host of providers when there are very few clients is not the logical thing to do.

What we want to accomplish in our program is we're trying to move up the diffusion curve from the lower left of an introduction or a pilot project up to the right across time to where the method is commonly thought about, considered, and we're appropriate, chosen, and used. This picture, the Maasai warrior with the cell phone just a few years ago was over on the left, but the cell phone is a great example of fast diffusion and understanding why things diffuse quickly, and then addressing that is good strategic programming.

The lack of vasectomy availability and access is an advocacy issue. It's a gender and framing issue. It's mainly a demand-side issue now. It's not widely understood, so one of the things that participants of this webinar should walk with is understanding that, among married women who are the bulk of family planning users, limiters are an underserved group, and we refer to vasectomy when we talk about women because they're relying on their partner's vasectomy.

The solution is to have substantial male services. If possible, vasectomy-specific efforts would be helpful. If that's not feasible, a male reproductive health project that involved various aspects of male reproductive health including circumcision for HIV, treatment of STDs, treatment of infertility, that could all be part of a male reproductive health program. And then we need adequate resources, and this is in terms of funding, in terms of attention, in terms of priority, and in terms of time. Thank you very much. The last slide, which I guess will be available to everyone, there are some references, but, again, thank you.

Joan: Thanks, Roy, and I'd like to encourage participants to continue adding your questions into the Q&A box for discussion, and the next presentation is from Lynn Van Lith, the technical director of the Breakthrough ACTION project at the Johns Hopkins Center for Communication Programs.

Lynn: Hi, everyone, can you hear me okay? I hope so. Unfortunately, I am unable to get onto Adobe, so if someone can advance the slides for me, I'd really appreciate it. I'm having a bit of connectivity issues here in South Africa. Thank you so much to APC for

inviting the Center for Communication Programs to present and thanks to Roy for that excellent overview. I can't think of anyone who understands the vasectomy landscape better than Roy, so it's really a pleasure to follow in his footsteps and try to bring out a few of the issues that he raised related to demand generation for voluntary vasectomy.

In my presentation, we're gonna take a bit of a trip around the world starting with Brazil, going to India next, and then ending in Kenya. Next slide, in Brazil, I'm gonna provide an overview of, over the decade, some of the demand generation efforts that have been undertaken, and the first is Brazil where, definitely, they had a little fun in designing that program.

If we move to the next slide, the focus in Brazil was really shifting machismo to responsibility, and Brazil considers itself one of the most macho of machismo countries, and so, the idea, really, here was to use playfulness and creativeness within the Brazilian culture to design a campaign to really motivate men who, with his partner, had decided to limit, would consider and use vasectomy as a couple's choice of family planning method.

The Brazil Dancing Hearts campaign was developed, and it was – I mean, again, it started in the late 90s, so it was quite some time ago, and the tagline is that vasectomy is an act of love. That was the main theme of the campaign. Are you able to hear me?

Female Speaker: We can hear you, Lynn, yes.

Lynn: Okay, great. Sorry, I heard some feedback. Vasectomy as an act of love, these keywords from the **[inaudible] [00:24:24]** and from the campaign came directly from men through the formative research. The idea was that – one of the first pieces of the campaign was this 30-second television spot that featured two animated hearts. One was a man, one was a woman, and through the animation and sound of excitement and kissing, the hearts unite twice and produce little baby hearts, but on the third attempt, the female heart scolds the male heart. It kind of pushes him away. You can go back a slide. Sorry. It basically talks about vasectomy as an idea for couples when they have reached their size that men can now take responsibility.

The campaign has sex at the center of it and that sexuality is a key construct of masculinity, but framed vasectomy in terms of including gender and couple dialogue within a relationship, and that it really requires couple communication on this kind of

decision-making, sharing aspirations related to sexuality, and offering an option, really, for couples to choose their family size.

On the next slide, we can see the impact of the campaign. The campaign occurred over a 15-month period and it was estimated to reach 4 million people throughout that period. The slide shows some of the data dating back as early as 1983 and the campaign ended in 1990, but the main point here is not to drag you back to 1983, but to really show that we had this long run of data and it showed that each time vasectomy is promoted and there is input into the demand generation side of things, that uptake goes up and that it is sustained at a higher level than before.

Every time there is more demand generation, there is an uptick. The drop at the very end was related to a financial collapse in Brazil, so that's sort of an aside, but the main point of this slide really is to show that every time investments in demand generation around vasectomy were included, there was a higher sustained leveling of vasectomy uptake.

Let's move now to India, and this really – this work really focuses on spotlighting of the client. Now, the RESPOND project, EngenderHealth colleagues were busy focusing on strengthening the service side to ensure that quality no-scalpel vasectomy services were in place, whereas, we at CCP really focused on the client and learning more about what influences their decisions to use family planning and undergo no-scalpel vasectomy.

On the next slide related to the PEER approach to vasectomy in Uttar Pradesh, we conducted some formative research using the PEER methodology, and PEER stands for participatory ethnographic evaluation and research, and this is more of a qualitative anthropological approach really based on developing a relationship of trust with the community. In this case, external folks are not invited in to conduct interviews or focus group discussions. Quite the contrary, what we did instead was to train community members themselves to conduct in-depth interviews with their own peers, so all of the interviews were carried out in the third-person.

The community members would ask questions such as, what do other people like you in the community say about this or about that issue? And the whole purpose of using this methodology is meant to enable people to speak more freely about sensitive issues and it sort of reveals some contradictions between what are in the social norms and people's actual lived experiences. These are the kind of

crucial insights that we really wanted to ascertain around how people understand and negotiate choosing vasectomy and really provide these rich peer narratives to help explain it.

We move to the next slide. Some of the emergent themes that came out of that PEER methodology are as follows. First, the wife is usually the initiator around family planning, but husbands in this context in India often reject family planning. There's a common belief that family planning is the concern of women and that men really can be actively uninterested, and as Roy mentioned in his presentation, there's resistance or lack of understanding related to no-scalpel vasectomy, not only among men, but particularly among women, and what an important audience women are to reach with demand generation messages.

The five main barriers that came out related to vasectomy uptake included an extreme fear of weakness, which was the largest factor, a fear that vasectomy may impact on sexual performance, and again, Roy mentioned this in his presentation, as well, and it very much came out in the research in India. There was a fear of the procedure and fear of failure of the procedure, and this really was that, if, for some reason, within that three month period, if men didn't fully understand that vasectomy was not immediate, that it could actually have quite severe consequences for women if there were charges of infidelity and they were kicked out of their home, so really making sure that those messages are clear is essential.

And then, of course, this idea that there is an availability of other contraceptive methods for women and the norm that somehow this is a woman's responsibility sometimes can impede vasectomy uptake, especially when we are not making concerted efforts to really highlight vasectomy as a viable choice.

On the next slide, we really tried to translate this learning and these insights into a strategy related to demand generation. The focus was primarily on couples who have completed their family size and really trying to promote vasectomy as an option for couples who want to limit at or soon after the birth of their second or third child related to postpartum family planning since that is the norm in terms of family size in the areas where we were we working. We worked with ASHA, the credited social health activists who are essentially community health workers, as a really essential link at the community level, and tried to address some of the barriers that came up.

We used powerful testimonials with assurances from qualified doctors who were reported to be quite trusted by men and women and tried to share positive testimonials among men who had undergone the procedure. The idea here was to address those barriers head-on by explaining that men – it's a very simple and short procedure, men can continue to work and provide for their family, and so we tried to position these messages around strength and being manly, but balancing that with couples appearing in all of the materials and using it as a way to help take the burden off women who so frequently undergo female sterilization, which is a popular method in India, and we really tried to take those gender dynamics into consideration and reframe vasectomy as a plausible option for men, which it's not often promoted.

Finally, focusing on men directly, we wanted to do this explicitly because, as I mentioned, family planning messaging is so largely focus on targeting women, we wanted to explicitly target men as well as women. On the next slide, here are some of the demand side approaches in terms of supporting the government in both Uttar Pradesh and Jharkhand, improving messages. We really tried to focus on incorporating some interpersonal communication skills building with ASHAs working at the community level and leveraging satisfied acceptors of vasectomy to speak to any barriers or fears that other men had and provided ongoing coaching of ASHAs and satisfied acceptors throughout the duration of the project.

We also developed an 18-minute film which was shown in waiting rooms as well as at the community level, all done in partnership with the government of India and aired on government of India radio programs. There were posters and brochures. You can see one of the posters here on the slide, and then, we also used these radio spots to increase awareness and expand our reach beyond what we could do at the community level.

On the next slide, we highlight some of the key messages, that NSV does not cause physical weakness, it's not a major surgery, therefore men can return to work quickly, that it's quite a simple procedure and does not cause any kind of sexual weakness, again, addressing some of the barriers and stressing consent in volunteerism, particularly given the history of sterilization in India, and you see one of the brochures on this slide.

Let's move quickly to impact on the next slide. As I mentioned, our EngenderHealth colleagues had done a great amount of work focusing on the service delivery side and ensuring that quality

services were available, so you can see the number of facilities supported, likewise, in Jharkhand, 19 facilities there, and what we saw through the duration of the project was a threefold increase in no-scalpel vasectomy acceptance in nine of the UP project districts and there were also significant increases in Jharkhand, and thanks to the work of EngenderHealth, there were no cases of complications, again, focusing on this high quality of services to be provided.

With that, I will move to the final country, which is Kenya, if you can switch to the next slide, and give you a few highlights of World Vasectomy Day from 2016. In the next slide, you can see that we really tried to generate support for vasectomy and held a Springboard event focusing on vasectomy, gender, and social and behavior change communication. Springboard, for those of you who are not aware, is an online platform. It's a network of over 7,000 members from 120 countries and the goal of Springboard is really to provide a form for social and behavior change professionals to share resources, source ideas, and network with other practitioners.

We used the Springboard platform to generate some buzz around World Vasectomy Day in Kenya, and the event itself was hosted by the Kenya Health Communication Network, which is the Springboard community of practice in that country and 40 social and behavior change communication practitioners from international INGOs, government, and local organizations were involved.

There were active discussions on male involvement in family planning, the importance of couple communication, and really addressing those barriers and misconceptions that Roy mentioned and that we saw in India and Brazil, as well. There were 760 page views on the Springboard site, and then we used social media and Twitter to reach an additional 115,000 people.

On the next slide, I want to also highlight the work of the K4Health project and their use of the power of stories. K4Health published eight stories related to male engagement on family planning through the FP Voices project leading up to World Vasectomy Day and then collected 13 stories during the event itself from World Vasectomy Day participants, and these include students like the gentleman pictured here named Kenneth. He's a law student at the University of Nairobi and he said that after attending World Vasectomy Day, he would personally consider undergoing vasectomy later in life because the World Vasectomy

Day has really changed his perception of vasectomy as an option.

While he has not started his family size yet, at least it is now on his radar as an option. And then, K4Health collected an additional six stories with other partners in Nairobi. And again, really, the idea here is to improve the sharing of knowledge and experience related to vasectomy and normalize it among the audience we're trying to reach, both in East Africa and globally.

In sum, on our final slide here, some of the ideas that came out from all of the countries and that really very much echo what Roy shared in his presentation is that moving men from interest to uptake is absolutely feasible in the realm of vasectomy, and if done right and done well and addressing the barriers that men say they face, it is absolutely possible, but investments are absolutely needed. Of course, it essential to gain in-depth understanding of male experience, how they understand gender, and looking at virility since these are all concerns of men.

Engaging men and women is really important, and highlighting some of those benefits, modeling supportive norms such as couples communication is effective, and really making sure that there are multi-channel approaches for the messages to really convey some of those benefits. These summary conclusions are also mirrored in some of the other USA-funded products including the Guide for Promoting Sexual and Reproductive Health Products and Services for Men that was developed under the HC3 project last year. With that, I will wrap up and pass things back to Joe and our moderator. Thank you.

Joan: Thanks, Lynn, and again, I'd like to encourage participants to add questions in the Q&A box. Our next presentation is from Ricky Lu. He's the director of family planning and reproductive health and cervical cancer prevention programs at Jhpiego.

Ricky: Good morning, Bonjour. I know we're across the globe but thank you very much, Joan, for this opportunity to participate in this meeting. For this presentation, I am with Devon McKenzie who is also at Jhpiego and working with the MCSP FP team. By way of some background on this one, Alfred, Dr. Alfred Twagiramungu is unable to present his body of work in Rwanda, so I'm stepping in to do the best that we can to share his work on vasectomy in Rwanda.

Generally, the next couple of minutes, we have 15 minutes, we want to be able to provide a context for the permanent method

work, particularly to vasectomy work that MCSP carried out in Rwanda as part of its overall program implementation. And then we'll also share some of the challenges and considerations, as well as some lessons learned, and I think I heard the previous presentations including the previous one regarding some of the providers, as well, particularly the man and woman's aspect of care on this one – is share some aspect of that one in this presentation.

What's evident in Rwanda, by way of giving a snapshot for women between age 15 to 49, is that the majority of the women still use a short-acting method. As you can see from this third-from-the-left bar, injectable is the most popular method that they're using, and when you look at permanent methods, the female sterilization, at least you can see the colors, but when it comes to male permanent sterilization like a vasectomy, it's barely there.

The demand for family planning in Rwanda is that there is currently estimated around 19 percent of currently married women have an unmet need for family planning and it split between a spacing and limiting with about 11 percent wanting another pregnancy but spacing it, and around eight percent wants to limit. But, among those who have the intention of limiting future birth, what is not surprising, I think, for most of us who have worked in family planning, is that when the service is not there, when access is an issue, a majority of couples and particularly women tend to use other methods just to meet their needs.

In this case, in Rwanda, as you can see, 46.4 percent are using shorter methods, and about the same percentage of these women are not using any method at all. It is in this context that MCSP started work in Rwanda back in October 2014. Out of the 30 districts in Rwanda, MCSP establishes presence in around one out of three of those districts, or ten districts. In the ten districts that MCSP was working on, we work across the continuum of care looking at service provision from a community to health center, to district hospital, provincial hospitals, as well as referral hospitals.

The numbers that you are seeing in your photo, particularly for the facilities, are sites where we have provided support. Overall, the objective of MCSP family planning work in Rwanda was to ensure access and equity of voluntary family planning services along the continuum of care to address unmet needs for family planning in the country, As you can see in the next series of bulleted points, we work across the health system trying to ensure that there is coordination at the level of the national groups, such as the Rwanda biomedical center, to make sure that the policies,

guidelines, as well as training materials, and related tools for family planning are up-to-date with the most recent standards.

At the midlevel, working with the technical working group, the family planning technical working group to translate and make sure that those updated training materials are included into the plan, panning and implementation, and critically, the monitoring of the FP program, and in this aspect, we were working permanent method that included vasectomy activities. And the third element was to actually work with the providers themselves, both at the level of the hospital and facilities who are going to be offering those services, and with the community health workers to ensure that there's coordination between the male generation as well as with the service provision.

Now, specifically for the portfolio of MCSP and permanent method, which started in October 2015 and continued until this year, June 2018, our primary goal was to develop capacity, and the whole idea was to ensure that we can bring the services to the lowest level as possible, which in this case was to make sure that the platform were routine permanent method services being made available which is in the hospital setting, and that based on need and number of clients that are coming in for services at the front line is that we develop, also, an outreach team who can go out and do the service at a fixed site.

In this instance, aside from just reviewing the updated training materials, we've trained 28 physicians to do the procedure as well as working with 18 nurses to support them, including primarily doing counseling in addition to training, because we know with permanent methods it's a surgical procedure – is that – in addition to developing competency, is that we also support that clinical membership, particularly to ensure that they become confident on the procedure that they're going to be doing, whether its in the hospital or at the health center.

Now, to make this work, even with a **[inaudible] [00:45:20]** skills to do the procedure is to ensure that the service actually is being provided, and so, for no-scalpel vasectomy, we ensure that a starter kit for NSV was being provided at the hospital. We also supplied them with consumables such as antiseptics, anesthetics, most of the things that are needed in order to provide services, and I think we'll learn from this, also, that this is one aspect of lessons learned in terms of wants to – part of the programming is to ensure that once the program ends, there is a mechanism to the transition between programs to – within projects to programs and sustain the

investment that has been made in a permanent method, particularly vasectomy.

Of course, we also did preemptive counseling tools such as leaflets, flipcharts to make sure that the community health workers actually – goes on. Aside from just working in training and setting up services, we also work with community health workers to ensure that there are regular activities that would allow our newly trained providers to practice and to stay in their confidence in the skill. We also made sure that there is a way to exchange information and to learn from each other through biannual coordination meetings with decisions and the no-scalpel vasectomy mentors.

This slide is just showing a sort of – in terms of the continuum of care and who does what at each of the levels of care. You can see that community health workers generally could offer injectables, pills, condoms, and CycleBeads, and for those at the hospital level is that there's a wider range of methods. It is from this aspect that the strategy was to make sure that the permanent method theme that conducts no-scalpel vasectomy and tubal ligation who are generally based at the hospital could actually cross, jump, or leapfrog this setup and be able to do the procedure much closer to the community than coming to the hospital.

They, of course, have the option of coming to the hospital, but generally, what we're seeing in this work in Rwanda is that bringing it much closer to the community removes some of the barriers for men to accept a vasectomy.

The next two slides are just showing results of this short-term work. This slide is indicating that, until October 13th, there was a program to work both on tubal ligation and permanent method and then the project ended, and so, things sort of started to wind down until we started again with tubal ligation and no-scalpel vasectomy. And as you can see with the red line, with the red graph, the tubal ligation new acceptors or started to increase as we had more access to services, whereas, the no-scalpel vasectomy, when we also started, we saw an uptick in the number of accepters, as well.

What I cannot explain – well, we've actually got some late breaking news for the reason why there's a big drop in the numbers towards the end of this graph. We learned, and I alluded to it earlier, we need to be able to plan the transition of services, in this case, when we transition the commodities, the payment for outreach, transportation services, etcetera, etcetera. That's when

we saw a drop of the hospital where the origin of the outreach services was coming from was struggling to support the outreach activities.

The next slide is just a comparison with when the outreach and hospital-based services. As you can see, the red line, which is a vasectomy in the hospital, we're seeing, more or less, a steady number of cases, but when we started a no-scalpel vasectomy in an outreach service, we saw a bigger uptick of this outreach service. In the outreach service, the way it happens is that once it's organized, clients are scheduled, the trigger point for when the team actually goes out is when they have three or more clients line up and the team goes out to do the procedure.

Some of the considerations, and I think this was alluded earlier to in the previous presentation, is the idea that most men would consider family planning as a joint couple responsibility, so if one of them is already doing it, that responsibility is over. I think one is that – that's one consideration. The second consideration was that it's not only about talking to men and being able to convince them that a critical aspect is also being able to convince the women or their partners about the benefits, advantages, as well as correct rumors and myths about what a vasectomy is.

And then, also, probably in a safety relationship or in which we don't really know that that's probably through counseling or through getting to know the client – is the sexual relationship or the relationship between husband and wife and how it impacts the decisions that they make when it comes to vasectomy, whether it's fidelity or infidelity as part of that equation when they make those decision.

And then, of course, I think it was already mentioned about the loss of sexual prowess, the idea of physical impairment because of the procedure, not only because of the procedure itself, but because of the loss associated with a castration or associated with losing potency, would they also be physically weaker in the long run because they don't have those hormones that make them physically strong? Those are things, I think, are at the back of our mind when it comes to working with providers to address some of those issues and reassure men and women when they come in for family planning counseling.

Some of the challenges, I think it's already been mentioned. We keep on hearing about rumors and misinformation, about men becoming impotent sexually, and also physically weak. One of the

common challenges that we have is the staff turnover. We invest a lot to develop their confidence, and eventually the confidence to do it, and then they get transferred or they leave the service, and so we have to repeat the training again and invest in another separate group. Because of the set up that this is an outreach service, we have to consider the primary responsibility of this provider, so it will be at the hospital.

Sometimes, we'll have a workload and we don't have enough staff. The outreach service becomes a secondary responsibility, and so, scheduling may be an issue and it probably may not happen at some point. And then, I think the other one that came up was that there's a number of facilities where faith-based organizations run them, and so some of these facilities are hesitant to support a permanent method, including a vasectomy.

Some of the additional lessons that we were not able to add to this slide, they just came in as a last minute update, were this whole idea that if there is the knowledge that there is a competent theme or a competent provider who can actually provide the service, it becomes **[inaudible] [00:53:34]** community health workers who are doing the community mobilization are a little bit more confident in being able to talk about access to no-scalpel vasectomy because they know when someone accepts it, they'll get the service.

And then, I think the second one that was mentioned by Alfred was the fact that with – bringing down the service closer to where the men are removes one more barrier for them to be able to say, I cannot do it because I have to go to the hospital and I'm not going to be able to work, blah, blah, blah, etcetera, and so, bringing it much closer removes an additional barrier, probably, creates a better environment for them to accept a vasectomy, as well. With that one, let me thank you for this opportunity. Devon, do you have anything to add that I missed?

Devon: No, that was perfect. Thank you, Ricky.

Joan: Thanks, everyone. Those were some great presentations, and we have time for each presenter to quickly answer one question. The first question for Roy is that permanent methods used to be considered a key part of a balanced reproductive health program **[inaudible]** what has changed?

Roy: They are indeed a key part of a program, and I wouldn't say that anything's changed about permanent methods. What we saw from

some of my slides is that, really, vasectomy has always been low, and I would imagine, even the very nice effort that Ricky outlined, you see, and this is not a criticism, simply an observation of how we tend to program, already, they had to start thinking about handing things over and not doing it as robustly after just a year or two.

We don't stick with it long enough and there are a number of excellent clinical methods that help a woman or a man achieve the demand to limit. And the other three, IUDs, implants, and female sterilization, have a greater demand. When I was saying that it needs to be a focus on advocacy and gender, it's coupled with the idea that this has to be a longer timeframe, but there's only two methods, so it's an equity – two male methods, so it's an equity issue, and it's a funding issue, because I don't know the details of that Rwanda program, but I – which is one of the more robust ones around, I would – that it was relatively minimally funded.

The order of magnitude needs to be higher and the donors and the program people in the countries need to understand that they're doing it to help expand the method mix, and that vasectomy will be adopted over time, but it's not gonna be in the usual two or three-year timeframe of somebody who's assigned to a country or assigned to a program and then they're moving on to something else, and I think that's part of why we haven't supporter this as strongly as we could have.

I hope that answers the questions, but permanent methods are and always have been a part of a full program, and I want to remind people that female sterilization is the most widely used single method in the world. The potential demand would be there, and vasectomy is easier to provide.

Ricky: Is it possible for me to add to that one? Because I totally agree with what Roy mentioned. There was a time when we had a lot of tubal ligation and vasectomy, and it seems to me that a sustained investment is needed to maintain because you cannot expect that providers will remain forever alive, and so that's one, and then second is, of course, that when things are working, attention goes somewhere else, and so additional investment in this area goes down and the service disappears. In any case, I just wanted to reiterate a little – always been part of that one. The challenge is actually being able to sustain it in a scaled-up way so that it's accessible to everyone when they need it.

Joan: Thanks, Ricky, and here is a quick question for Lynn, if you're still

on the line. In India, were NSV services provided in camp style on specific days similar to the camps for women, and if so, were lessons learned from women sterilization campaigns abide to NSV?

Lynn: Okay, thanks, Joan, and thanks for the question. NSV services throughout the RESPOND project in India that I described were provided both in camps as well as at fixed facilities. Definitely both were done and in terms of the lessons learned from women sterilization campaigns, I'm not sure if you're referring to lessons learned related to the services or the SBCC campaigned, but the work that we did in India focused solely on NSV in this aspect. We really drew primarily from the PEER formative research that I described with men and developed the campaign messages around addressing those barriers and facilitators. I hope that answers the question.

Joan: Thanks, and there is one other quick question for Ricky, and that is, how did you address provider biases in your program?

Ricky: Yeah, so thank you for that one, Joan, and I saw that question. I think I'll have to ask Alfred to respond to that one specifically, but I can share with you my experience in our other country programs where I was directly involved with in implementing that. One way that when we're going to be doing, for example, the contraceptive technology updates for providers who are going to be doing counseling, and it's almost the same as what we were doing with the nurses in this instance, is that it's not sufficient to just talk about vasectomy. What we have actually done is do a little bit of show and tell and actually use simulation to show how the procedure is done.

If we had video, we showed the video, but more often than that, we also had models, and if we don't have a model, we create one. There's a number of ways to create one and just explain the procedure, and get them to ask questions and get them to face what are some of their biases as well as misconception about what the procedure – and it's actually a great session to talk about because that's where a lot of that incorrect information comes, and then, the second is that it creates a confidence to talk about the male organ, about the testes, etcetera. When you conduct it in local language, there's always a – being coy, being shy about – to talk about penises and balls and scrotum, etcetera.

Anyway, I think, in principal, that one, aside from knowledge, is to also break down that mental block about talking about the male

genitalia, and I think one of the things that we also work with them is how comfortable they are working with men knowing that, more often than not, they see women and they don't get to work with men coming in directly and asking, can I have a vasectomy? I think it's an iterative process, but definitely, I think we should face these issues head on and include that in our preparation of providers to be able to talk about vasectomy correctly.

Devon: This is Devon. I just wanted to jump in if I could take a second. I know from Alfred that one of the focuses of the Rwanda program was this mentorship component, and so, I also think it's important to have champions among providers. I mean, we talk about it at the community level in terms of men sharing their positive experiences, but it's important at the provider level, as well, to have other people who can share how well they're doing with these other providers and kind of bring them onboard when you're rolling out something.

He had told me this great experience that they had with this WhatsApp group that they had created where the teams in the districts, including the directors of district hospitals, the MOH staff, and the MCSP staff and doctors could all share information and motivate each other, and that mentors have a venue to give guidance on provision of FP permanent methods.

Ricky: Thanks, Devon.

Joan: I'd like to thank all of you for participating or presenting. In the next couple of days, you'll be getting an email with a link to today's recording, but before we close the room, I want to ask everyone and encourage everyone to take a minute to fill out the poll questions because the feedback helps us to improve future webinars, and again, thank you to everyone for joining us today and a big thank you to the presenters for sharing their expertise and knowledge with us.

Female Speaker: **[Inaudible] [01:04:01]**.

Female Speaker: Hello?

Roy: Are we doing any postmortem or just signing off? Hello? Okay.

[End of Audio]

Duration: 66 minutes