INVITATION

Dear Partner,

AIDS Accountability International & Sonke Gender Justice hereby invite you to participate in one of two national think tank meetings on vasectomy access and uptake in South Africa being held in Cape Town and Johannesburg.

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%, whereas other parts of the world have rates as high as 20%. Government and civil society should be doing more to increase awareness and access to the procedure, whilst also ensuring that quality informed consent and quality services are not adversely affected. Yet a myriad of issues surround vasectomies, not least of which is that low access rates result in the bulk of the contraceptive burden being placed on women. Also of interest is access for women, adolescents, and people with diverse sexual orientations and gender identities in the broader context of sexual and reproductive health and rights. Recent government and civil society vasectomy campaigns in Rwanda and Kenya provide case study examples of the potential for vasectomy to be part of the selection of choices offered to men, women and couples as part of their sexual and reproductive health and rights in Africa.

To learn more, please join us to share, discuss and debate.

Cape Town - 20th May 2014
Venue: Sonke Gender Justice Boardroom, 1st Floor, Westminster House
122 Longmarket Street, Cape Town T: +27 (0)21 423 7088

Johannesburg - 22nd May 2014
Venue: Sonke Gender Justice, Stevensons Building, 3rd floor, 62 Juta Street, Corner of De Beer Street, Braamfontein, 2017, Johannesburg, T: +27 (0)11 339 3589

Time: 9:00am-3:00pm
Logistics: Refreshments and lunch will be provided

Please contact rsvp@aidsaccountability.org to book your place.

Tian Johnson, SRHR Portfolio Manager, Sonke Gender Justice & Phillipa Tucker, Executive Director, AAI
Setting the National Agenda & Sharing Contraceptive Responsibilities
Spotlight on Vasectomy Access and Uptake in South Africa

Cape Town 20th May 2014
Johannesburg 22nd May 2014

Programme Jozi

09:00 - 09:10 Introduction, Phillipa Tucker, AAI
09:10 - 09:40 Exploring the basket of Contraceptive Options. Sonke Vasectomy Ambassador
09:40 - 10:00 What is a Vasectomy? Marie Stopes
10:00 - 10:15 Vasectomy Introduction session: Marie Stopes
10:15 - 10:30 Procedure Video – Marie Stopes
10:30 - 10:45 HIV Prevention & Vasectomy – CAPRISA
10:45 - 11:00 Policy, Uptake & Costing - Marie Stopes SA Africa and The South African Department of Health
11:00 - 11:15 Tea Break
11:15 - 11:30 Overview of Current Vasectomy Guidelines – Ibis Reproductive Health
11:30 – 11:45 Vasectomies and young girls and early and unwanted pregnancies: Yumnah Hattas, Save the Children
11:30 - 12:30 Vasectomy Marketplace Mapping – Post It!
  • Women’s Rights & Shared Burden
  • Intergenerational Sex
  • Reproductive Choice
  • Possible adverse effect of vasectomies
  • STI prevention
  • Shared Responsibility
12:30 - 12:45 Thoughts from the Interfaith Community: Phumzile Mabizela, INERLEO+
12:45 - 13:15 Lunch
13:15 -14:15 Barriers/Enablers to Vasectomy & Action Plans
14:15 -14:45 Work planning
14:45 - 14:50 Closure
Programme Cape Town

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Is Vasectomy a Viable Option for Africa? A Discussion Brief

Introduction

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). Vasectomy is considered a form of permanent contraception, but the procedure can be reversed. It is a surgical procedure which involves the severing, clamping or otherwise sealing of the man’s vas deferentia which prevents sperm from entering into the seminal fluid. It is a simple outpatient procedure (taking 10 -20 minutes), with a short recovery period. It is also relatively inexpensive and highly effective and safe. There is a wide variety of techniques used, including ligation, excision, clips, cauterization, 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 requires sutures and reduces side effects such as pain, bleeding, bruising, hematoma and infection (Cook et al., 2007; Xiaozhang, 2008).

Objective

The overall objective of this discussion brief is to provide a background and context on vasectomy as a potential option for Africa. Its aim is to inspire discussion and debate about the available evidence for and against the procedure, based on scientific data, case study analysis and questions raised in the literature. This brief 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.

Methodology

This research brief has been written through a desk review of scientific peer-reviews journals and news articles, as well as publications from international institutions and non-governmental organizations.

Topics for Discussion

Is vasectomy a viable option for contraception in Africa?

Vasectomy is a highly effective method of permanent contraception (WHO, 2008). 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 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 is it 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 properly in a clinical setting 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.

*Is vasectomy 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 & Dejucq-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 counselled 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).

**Does vasectomy have implications for women’s sexual and reproductive health and rights?**

Another discussion worth having is how vasectomy related to women’s sexual and reproductive health and rights, particularly with respect to access to safe abortion in Africa. Although vasectomy is a method that is relatively effective, it will only become clear that it has failed upon falling pregnant. By contrast, if condoms break, multiple oral contraceptive pills are missed or the male partner does not withdraw, there is an opportunity for 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.

**How might vasectomy contribute to gender equality and male and female empowerment?**

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 contraception use 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).
Is there a role for vasectomy in the LGBTI community?

Lastly, 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 investing 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 Behaviors Among Transgender Men Who Have Sex With Nontransgender Men). In this area, there is certainly a need for more research into these issues.

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).

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 (WISPVAS) 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).

References


Xinhua (2011, October 23). Rwandan men shy away from government sponsored vasectomy campaign. Online at [http://mobile.nation.co.ke/lifestyle/-/1950774/2044012/-/format/xhtml/-/13luq4v/-/index.html](http://mobile.nation.co.ke/lifestyle/-/1950774/2044012/-/format/xhtml/-/13luq4v/-/index.html)