

Community Health Workers Survey, Review and Analysis

Research Summary

- **Number of Vasectomies:** 2,523 vasectomies were performed between 2010–2012 due to rapid scale-up initiated by the Rwandan Ministry of Health (MOH).
- **Community Health Workers (CHWs):** 279 CHWs affiliated with 15 randomly selected district hospitals were surveyed.
- **CHW Demographics:** Older, male and female (50% each), with knowledge of vasectomy.
- **Role of CHW:** CHWs are in a position to counsel both women and men about vasectomy as a permanent family planning option.

The national scale-up efforts in Rwanda since 2010 have focused entirely on no scalpel vasectomy (NSV) with thermal cautery plus fascial interposition. In this article, "vasectomy" refers to this technique unless otherwise noted.

Objective and Purpose

Vasectomy, an underused family planning (FP) method in resource-poor settings, is safe, effective, and low cost. The 10-20 minute procedure is also faster and safer than female sterilization. No-scalpel vasectomy (NSV) is the optimal technique because it decreases the risk of surgical complications such as bleeding and infections and has a low failure rate. NSV procedures that use thermal cautery plus fascial interposition (FI) further decrease failure rates and have been found to be appropriate for low-technology and low resource settings.

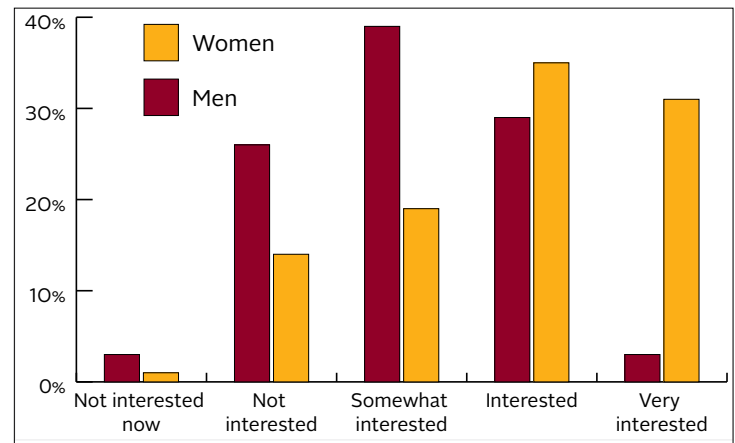
The Rwandan Ministry of Health (MOH) with technical assistance from FHI 360, took initial steps to increase

access to vasectomy as a FP option by training 64 Rwandan physicians and 103 nurses in 42 hospitals across all districts to provide vasectomy. Scale-up also relied on vasectomy counseling services provided by community health workers (CHWs) and strategic messaging disseminated by the MOH through various media outlets.

Study Objectives and Methods

The MOH asked FHI 360, through the PROGRESS project, to support it in monitoring several aspects of program scale-up. The specific objective of the monitoring effort was to understand institutional, structural, and individual factors influencing the choice of vasectomy in Rwanda and to improve the quality and efficiency of the nationwide program. Data were collected from 279 CHWs affiliated with 15 randomly selected district hospitals that employ trained staff in this new

Figure 1: Clients' and wives' perceived interest in vasectomy



vasectomy method. Additional data were collected from providers, clients and their wives, and from clinical records and are reported elsewhere.*

Results

Table 1 highlights the demographic profile of the 279 CHWs. Data reviewed indicated that they are similar in age and marital status to vasectomy clients and their wives.

CHWs are both male and female (~50%, ~50% respectively, a representative sample of the population)—there are three in every village. Most CHWs have a primary level of education and many have had some education in vasectomy.

CHWs reported that women are more interested in vasectomy than men. CHWs reported the differences

Table 1: Demographics of community health workers

Category	Demographic
Age (Mean)	41.7
Marital Status	88% Married; 7% Widowed
Years Married (Mean)	16.9
Religion	Catholic (57%), Protestant (31.9%), 7th Day Adventist (10.4%)
Education	Primary (54.8%); Secondary (29.7%)

as 66% of women and 32% of men reported being interested or very interested in vasectomy (Figure 1). CHWs believed the key reasons for someone choosing a vasectomy were: to avoid additional financial burden of supporting another child (77%) and/or because they were satisfied with their family size (74%) and to avoid effects of hormonal contraception (46%).

CHWs suggested that knowledge and utilization was low among men in their communities. On average, CHWs knew of only 2.2 men who had a vasectomy. Nearly three-fourths (74%) of CHWs noted that less than 20% of their clients were aware of vasectomy prior to counseling.

CHWs identified the most common community rumors about vasectomy as: vasectomy equals castration (92%), men will stop wanting and enjoying sex (87% and 53%, respectively), men will not ejaculate (30%), and vasectomy is painful (23%) (Figure 2). In general CHWs overestimated the rumors in comparison to what clients and clients' wives reported in a similar survey.

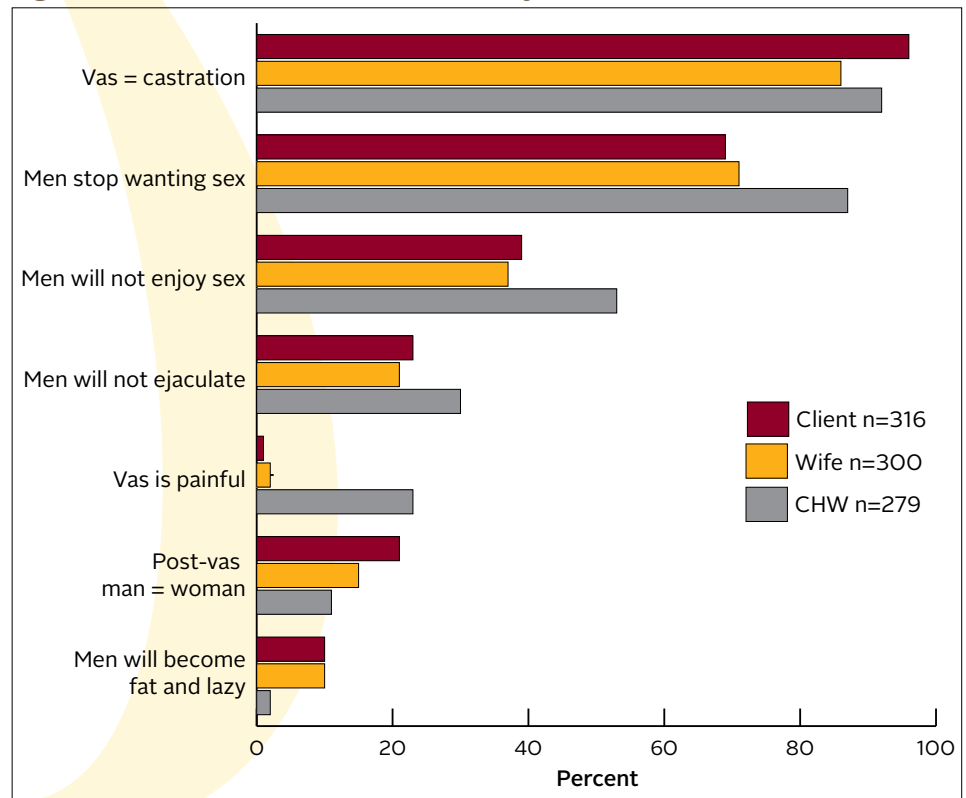
CHWs, similar to clients and their wives, suggested the importance of dispelling rumors on lack of sexual enjoyment post vasectomy and educating on the minimal side-effects. Far more CHWs, however, believed that education on the permanence of vasectomy is important.

CHWs identified the best ways to provide information about vasectomy to the community as: community gatherings (91%), the CHWs themselves (90%), health care providers (50%), radio (40%) and friendly discussions (38%). These mechanisms were also identified by clients and their wives.

Conclusions

Despite rapid scale-up, vasectomy remains an underutilized form of family planning in Rwanda. This study provides support for the continued

Figure 2: Perceived rumors about vasectomy



integration of CHWs in further scale-up activities based on their role as a front-line health care provider, understanding of local context and current experiences counseling individuals on family planning. CHWs have the opportunity to play an important role in family planning and vasectomy programs. That role can be maximized by strengthening CHWs' knowledge of family planning including vasectomy. They can dispel rumors and misconceptions about vasectomy and are able to position vasectomy as a FP option for clients who are content with their family size and are looking for a permanent FP method.

CHWs providing antenatal and postpartum/child nutrition counseling should also be trained in FP, including vasectomy, and encouraged to discuss FP with clients, particularly men who attend these meetings. Also, tools and materials related to vasectomy such as brochures should be created so that clients can discuss vasectomy in private.

* For additional information, see: www.fhi360.org/projects/progress-rwanda.

This work is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents are the responsibility of FHI and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of Cooperative Agreement GPO-A-00-08-00001-00, the Program Research for Strengthening Services (PROGRESS) Program. FHI 360 thanks the Rwanda Ministry of Health for the opportunity to work together on this project and acknowledges support also coming from the National University of Rwanda School of Public Health, the United Nations Population Fund, and IntraHealth.

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