

Provider Team Survey, Review and Analysis

Research Summary

- **Number of Vasectomies:** 2,523 vasectomies were performed from 2010-2012 due to rapid scale-up activities initiated by the Rwandan Ministry of Health (MOH).
- **Vasectomy Providers:** Hospital directors (n=15), physicians (n=45), and nurses (n=65) were surveyed and provided the following data:
 1. **Vasectomy training:** Physicians and nurses found the materials to be well written, accurate, and useful, and found the instructors prepared and knowledgeable.
 2. **Challenges to implementation:** Rumors and misconceptions about the procedure, a shortage of trained physicians, overburdened physicians, and reaching clients.
 3. **Key messages to encourage participation:** Men will still enjoy sex after vasectomy; the method is permanent; and the procedure is quick with a short recovery.
 4. **Implementation requirements:** Community knowledge, trained staff, supportive management and policies, and supplies necessary for procedures.
 5. **Task shifting:** Support exists among both doctors and nurses for shifting vasectomy services to A1 and A2 nurses.

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 MOH, with technical assistance from FHI 360, took initial steps to increase access to vasectomy as an FP option by training 64 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 provide technical assistance in monitoring several aspects of scale-up efforts. 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 110 providers from randomly selected district hospitals that employ trained staff in this new vasectomy method, as well as from 15 hospital directors.

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

Results

Providers including 15 hospital directors, 65 nurses (predominantly level A2 and some A1) and 45 physicians who per-

formed or assisted with vasectomies during the period 2010 – 2012 were surveyed about the implementation of the vasectomy scale-up program. In particular, they were asked about their training, confidence in performing vasectomies, the ability to shift performing the vasectomy to nurses, barriers to vasectomy delivery, community rumors and misperceptions, and recommendations for vasectomy messages and channels.

The training given to physicians and nurses was very well received with strong ratings on course content and design; participants reported a good mix of activities and lecture. They reported that the training materials were well written, accurate, and useful, and that the instructors were organized, prepared, and available for questions. More than 95% of physicians and nurses reported that the training increased their knowledge and skills, and that those skills are directly applicable to their job. The readiness of physicians and nurses for implementation was measured after the training.

Physicians and nurses reported that adequate implementation of vasectomy services requires: 1) correct information about vasectomy in the community, 2) trained physicians and nurses, 3) supportive management and policies, and 4) adequate supplies. Directors expressed confidence that hospitals had the equipment necessary to perform vasectomies and said that vasectomy should be a priority for the MOH (95%, both points).

Directors, physicians, and nurses noted two types of barriers to delivering more vasectomies within their districts: 1) those related to service delivery (i.e., overburdened physicians, scheduling challenges, and service delivery in rural areas); and 2) those related to community perceptions (i.e., awareness and acceptability of the method) (Figure 1).

All participants reported numerous rumors and misconceptions in the community,

which included: vasectomy is equivalent to castration (88%), men will stop wanting (54%) and enjoying sex (41%), men will not ejaculate (34%), and after a vasectomy a man will become a woman (12%) and become fat and lazy (12%).

Key messages that directors and physicians/nurses (providers) thought to be relevant to the community are: men will still enjoy sex after vasectomy (directors, 100%; providers, 81%); the method is permanent (89%; 79%) with few side effects (58%; 54%); and the procedure is low-risk (42%; 42%), not painful (37%; 30%), and has a short recovery period (32%; 24%).

All of the participants reported that community gatherings, CHWs, the radio, health care providers, and newspapers were the best channels for the dissemination of vasectomy information in communities. Directors reported that women's groups and friendly discussion were additional ways to disseminate information.

Over 90% of physicians and 80% of nurses were completely confident in performing a vasectomy after completing the training. We asked participants if they felt vasectomy could be provided by a trained nurse. Eighty-six percent of directors, 64% of physicians, and 64% of nurses suggested that this responsibility could be shifted to A1 and A2 nurses, together. Support for task shifting to nurses is shown in Figure 2. Only 22% of directors, physicians, and nurses reported that they received supervision on vasectomy.

Figure 2: Support for task shifting to nurses

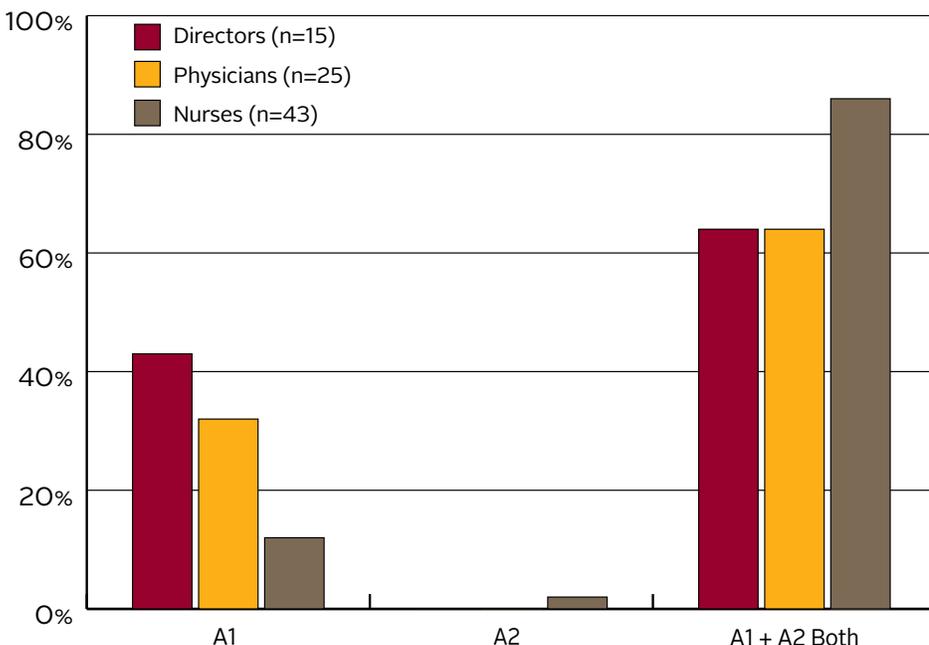
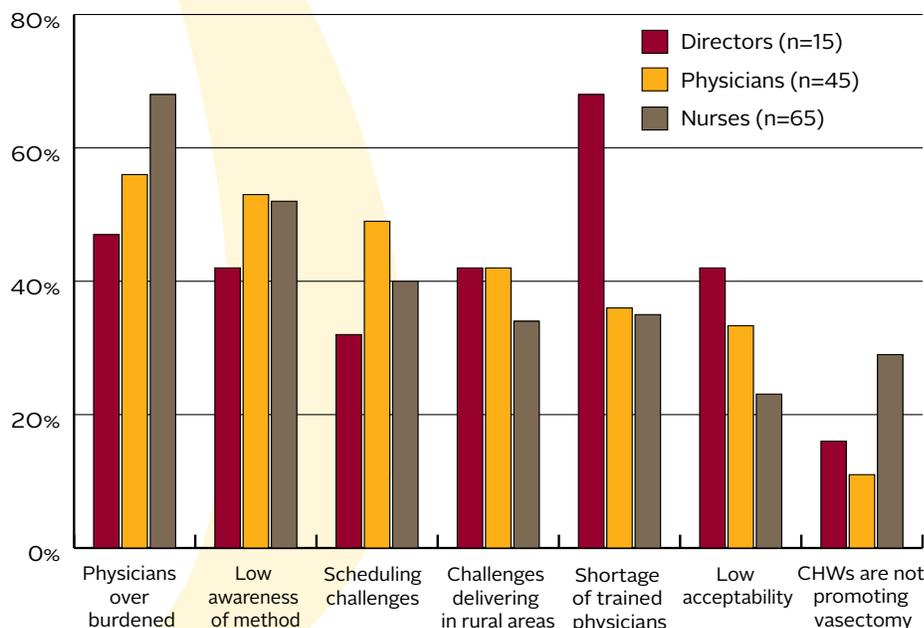


Figure 1: Provider reported barriers to vasectomy in their district



Conclusions

This study suggests several recommendations for capitalizing on the success of scaling up vasectomy in Rwanda in both supply and demand. To sustain and possibly increase supply, the following steps are recommended:

- Continue to train new physicians and nurses in NSV with thermal cautery and fascial interposition and provide regular supervision to ensure continuation and quality of services. Ensure an adequate number of trainers and a pace that maximizes comprehension and participation.

- Investigate the feasibility of task shifting vasectomy to A1 and A2 nurses.

To increase demand for the procedure, the following efforts are recommended:

- Tailor information, education, and behavior change communication messages to dispel persistent rumors and emphasize the benefits of vasectomy.
- Use all available channels to increase knowledge, dispel rumors, and encourage sign-up for future vasectomy services.

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

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. 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 360 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.

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