

Increasing the Availability of Vasectomy In Public-Sector Clinics

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A program designed to improve the availability of vasectomy in public-sector clinics trained physicians at 43 facilities in no-scalpel vasectomy between 1993 and 1995. Among the 38 clinics that responded to a follow-up survey in 1996, the number of clinics providing vasectomies rose from 23 to 32, an increase of almost 40%, while the number of vasectomies performed rose by 18%. Seventeen of the 32 clinics performed more vasectomies after the training; 10 of the 17 had not previously provided the procedure. In-depth interviews with staff from seven sites that experienced large caseload increases and from seven that experienced decreases identified three elements for the successful establishment or expansion of vasectomy services—sufficient numbers of trained providers, funds to subsidize vasectomies for men who cannot afford them and activities to raise awareness about the availability of low-cost or free vasectomy.

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Half a million men in the United States undergo sterilization each year.¹ According to the 1991 National Survey of Men, the majority are white, well-educated men in their mid-to-late 30s.² Data collected from women in the 1988 National Survey of Family Growth provide supporting evidence: Half of women whose partners have been sterilized have more than a high school education, nearly two-thirds have incomes above 300% of the poverty level, two-thirds are in their late 30s or early 40s, and 96% are white.³

Does the concentration of vasectomy among white, middle- and upper-class males indicate a lack of interest among minority and low-income men? Our experience in the United States and around the world suggests another angle: that the low utilization of vasectomy by low-income, minority men reflects the lack of availability of the service—and information about it—at the places where they go for health care services.

In the private sector, 94% of urologists, 29% of general surgeons and 18% of family physicians provide vasectomy in their practice,⁴ and 85–90% of private insurance plans cover the procedure.⁵ In the public sector, however, the situation is different: Only 23% of family planning agencies pro-

vide vasectomy.⁶ Moreover, only 2% of Title X funds or Medicaid funds spent for family planning are spent on men.⁷

The Training Program

To improve the availability and quality of vasectomy services for low-income men, AVSC International developed a program to train physicians in no-scalpel vasectomy. In this technique, developed in China in 1974, specially designed instruments are used to reach the vas through a small puncture in the scrotum; no stitches are required to close the opening. We contacted the 10 regional clinical coordinators of the U.S. Public Health Service, the directors of the 15 largest family planning councils in the United States, 57 state family planning administrators and 169 Planned Parenthood affiliates and offered free training in the procedure for physicians working in clinics that provide publicly subsidized family planning services.

From August 1, 1993, through December 31, 1995, we trained physicians at 43 clinics from 17 states in no-scalpel vasectomy; 23 of the clinics were already providing incisional vasectomy. These facilities included 15 community health centers, nine state or county public health departments, nine Planned Parenthood clinics, seven hospital-based clinics, two Indian health centers and one military hospital. We trained one physician at each of 36 sites, and 2–3 at each of the seven remaining facilities. Except for three who were urologists, all of the physicians at these sites were family physicians.

AVSC provided two free sets of no-scalpel vasectomy instruments and training materials for each clinic, as well as the cost of an honorarium for the trainer. The trainee institution was requested to cover the cost of the trainer's travel to the site. The 15 physicians who acted as trainers used the standard guidelines described in *No-Scalpel Vasectomy: An Illustrated Guide for Surgeons*.⁸ The training included didactic and practical training from the trainer, who stayed at the site for a full day and worked with the trainee to provide no-scalpel vasectomy services to a minimum of four clients. Four sites that had expressed interest in receiving vasectomy information and training in counseling for their service providers also received this type of assistance.

Thirty-seven percent (16) of the physicians trained had never performed a vasectomy prior to the training. The remainder had received training in the procedure during their residency, but had not received specialized hands-on training in the no-scalpel technique, nor had they been given any other vasectomy training while in practice at the clinics.

Evaluation of the Program

Methodology

During March and April 1996, we contacted all 43 public-sector clinics where we had trained physicians in no-scalpel vasectomy; physicians at 38 clinics completed surveys. We collected information on each clinic's vasectomy caseload before and after the training, and gathered more in-depth, contextual information about each site through open-ended questions. In addition, we made follow-up calls or visits to collect detailed information from 14 clinics that had experienced dramatic caseload increases or had reported decreases.

Results

Twenty-three of the 38 responding clinics had offered incisional vasectomy services prior to the training in the no-scalpel technique. On average, each clinic had provided 60 vasectomies a year, for a collective total of more than 1,400 vasectomies annually. Currently, 32 clinics are providing 1,650 vasectomies annually, an increase of 250 per year. Of these clinics, 38% are

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providing 1–24 vasectomies a year, 28% are providing 25–49 and 34% 50 or more. Thus, the training program has increased the number of clinics providing vasectomies by 39% and the number of men obtaining them by 18%. Seventeen of the clinics reported an increase in their vasectomy caseload after the training. Ten clinics that had not provided vasectomies before the training now provide a total of more than 350 per year. One clinic that had provided 100 vasectomies a year before the training lost its provider and is not currently offering the procedure.

Seven clinics had sharp increases in their vasectomy caseload after the training, while seven others reported decreases. The in-depth follow-up interviews conducted with providers at these 14 sites revealed three key ingredients of successful vasectomy services.

- *A sufficient number of providers committed to serving men and providing a quality service.* A major constraint to expanding or initiating vasectomy services is the lack of staff trained to provide no-scalpel vasectomies. Three clinics lost their no-scalpel vasectomy provider within one year of his being trained; only two of the three have hired and trained new staff. Three other sites noted that they do not have enough providers to absorb any increased demand for vasectomy and have therefore not done any marketing.

Staff at several clinics reported a decline or no change in vasectomy caseload, saying that “many men are chicken” or that the clinic’s Hispanic population is “too macho.” In contrast, the programs that had a cadre of staff—from receptionists to counselors to physicians—who welcomed men for vasectomies, irrespective of their background, saw their caseload increase.

- *Activities to raise awareness among women and men about the availability of vasectomy services.* Many men—and women—are unaware that some family planning clinics serve men or that vasectomy services may be available at community health centers or county health department clinics. Moreover, many men are not knowledgeable about their own health care needs or about the health care system in general. In our sample, the clinics that reached out to their female and male clients to let them know about the availability of vasectomies were the most successful in increasing their vasectomy caseload.

Marketing strategies need not be expensive: A clinic can place a sign in the waiting room or include flyers about the vasectomy program in mailings to Medicaid recipients. At the other end of the spec-

trum are more aggressive and entrepreneurial marketing programs. One clinic invested \$3,000 in radio advertisements and generated stories on a local television news show and in the newspaper by sending out a press release on their new no-scalpel vasectomy service. Unfortunately, many clinic administrators and staff lack the time, experience and funds to market their services to men.

- *The commitment of funds to subsidize vasectomies for men who cannot afford them.* Many low-income men have nowhere to go for low-cost family planning services. Some service providers, however, commented that publicizing the availability of public funding to provide free vasectomies has increased the demand for their services. These sites have done relatively little marketing; they simply mention to women coming to their clinics that vasectomies are covered by Medicaid, Title X or other public programs. Some clinics that did not offer free vasectomies but priced their services considerably lower than did other providers in the community also saw their caseloads increase, demonstrating that demand exists among men who previously had no source other than private physicians for a vasectomy, but lacked insurance coverage to pay for the procedure.

Discussion and Recommendations

The increase in demand for vasectomies at sites that initiated or expanded free or low-cost services is evidence that there is a demand for vasectomy among low-income men. The three key elements of the successful programs—sufficient providers, funding to subsidize services for low-income men, and marketing to publicize the services—point in turn to three policy and training recommendations for expanding the availability of vasectomy in the public sector.

The first, and perhaps most important, element is a continued commitment to training staff. Physicians have been the only recipients of clinical no-scalpel vasectomy training, and funds should be made available to train those who are interested. However, to expand vasectomy services to the 7,000 U.S. clinics that offer family planning services, more providers are needed. Midlevel clinic staff—nurse practitioners and physician assistants—could be trained to do no-scalpel vasectomy, thereby easing the burden on physicians, reducing costs and increasing access. In November 1996, the National Association of Nurse Practitioners in Reproductive Health (NANPRH) approved a resolution supporting nurse practition-

ers’ provision of vasectomy. NANPRH is now collaborating with the Center for Health Training, in Seattle, on a pilot project to test the provision of vasectomy by nurse practitioners.

Clinical instruction is just one component of the training needed. As noted, the most successful vasectomy programs have an entire staff committed not only to directly providing the service, but also to informing and educating all clinic clients about vasectomy. Thus, clinics should inform all staff about the benefits of vasectomy and include information on the vasectomy service in all one-on-one education and counseling sessions.

Second, funding is needed to subsidize vasectomies for men who cannot afford them. In 1995, the unit cost of vasectomy was estimated at \$353 in a public payer model—making it second only to the Copper-T IUD in cost-effectiveness over five years.⁹ Thus, policymakers who determine how federal and state funds are spent should be informed that subsidies for vasectomy services are a cost-effective investment. Likewise, program administrators need to recognize that funds allocated to vasectomy services are well spent.

Finally, many clinics need assistance in designing messages and marketing their vasectomy programs. Just as critical are funds to help clinics buy advertising time and space in local media outlets so that all men in the community can learn that high-quality, low-cost vasectomy services are available to them. Unfortunately, as was pointed out in a recent review of studies about men and family planning, we know very little about how to reach men with messages about family planning and reproductive health: “Are the channels of communication that reach men effectively different from those that reach women? While wives are known to be a source of information about contraception for their husbands, are there advantages to approaching men directly? Do men respond more positively to information provided through the workplace or through male peers than through female sources?”¹⁰ As this series of questions makes clear, research is needed to determine the most effective messages and media for reaching men about vasectomy.

Vasectomy is available at one-third of private physicians’ offices in the United States. The challenge now is for public health agencies—and funders—to recognize vasectomy as a practical, inexpensive and safe family planning method that is worth the investment of their time, personnel and funds.

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