

Figure 6-14. Tightening the Scrotal Skin

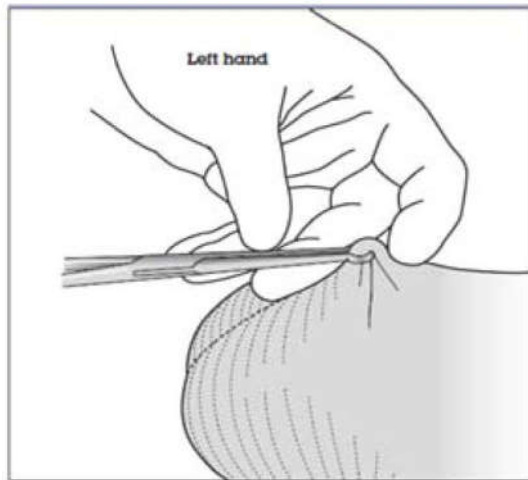
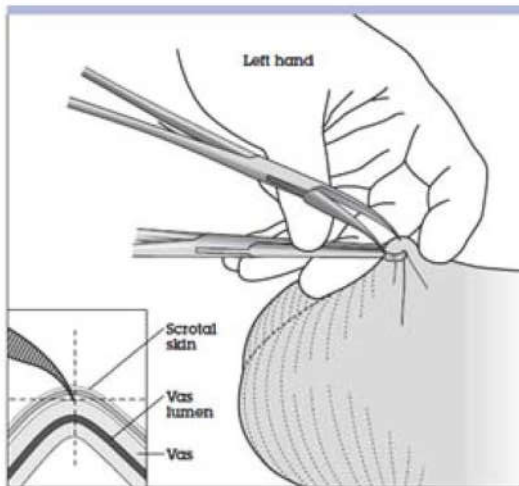


Figure 6-15. Piercing the Skin with the Medial Blade of the Dissecting Forceps



#### *Spreading the Tissues*

- After making the puncture, withdraw the medial blade of the dissecting forceps. Close the tips of the forceps.
- At the same 45-degree angle as before, insert both tips of the forceps in the same puncture hole, in the same line, and at the same depth as when you made the puncture with the single blade (Figure 6-16). The ringed clamp remains in place and locked while the skin is punctured.
- Gently open the tips of the dissecting forceps transversely across the vas to create a skin opening twice the diameter of the vas (Figure 6-17).
- In one motion, spread all layers of tissue from the skin to the vas deferens. The tips of the forceps should penetrate deeply enough to expose bare the vas wall. No harm is done if you enter the lumen. Be careful to keep the closed blades of the dissecting forceps parallel to the vas.
- The skin and vas sheath will remain open after the tissues are spread. By contrast, the opening in the vas will close after spreading; as it closes, the puncture site in the vas may look like a longitudinal groove. The stretched opening in the skin and sheath, which should be twice the diameter of the vas, will enable you to lift out a loop of the vas. The ringed clamp remains in place and locked while the tissues are spread.

The following two pitfalls must be avoided when spreading the tissues:

- ◆ If you fail to open the blades of the forceps transversely at a right angle to the vas, one blade could slip out of the puncture site. An unnecessary skin tear may result.
- ◆ Be sure to apply appropriate counterforce to prevent the dissecting forceps from slipping out of the puncture hole. Maintain depth of puncture, but do not push down further than the original puncture.

Figure 6-16. Inserting Both Tips of the Dissecting Forceps into the Puncture Site

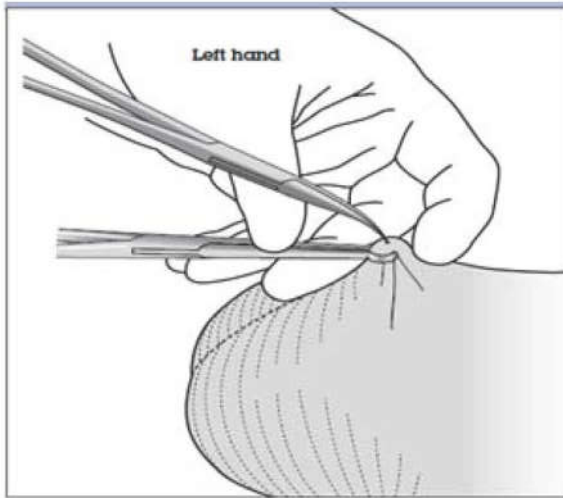
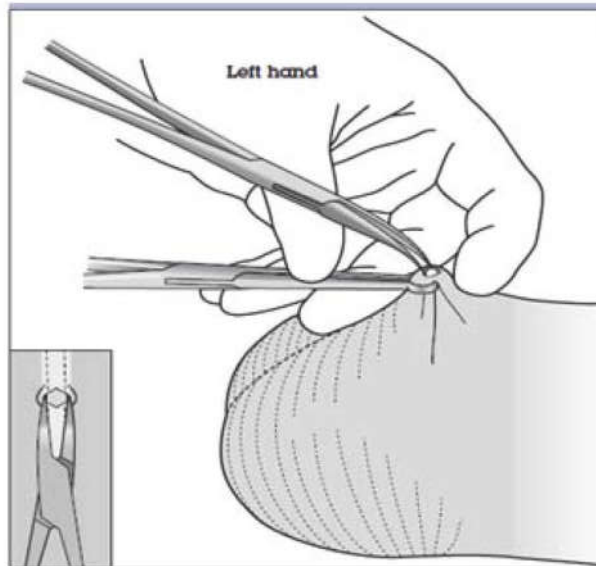


Figure 6-17. Spreading the Tissues



*Delivering and Elevating the Right Vas*

- Remove the dissecting forceps from the puncture hole.
- With the tip of the lateral blade of the dissecting forceps facing downward, pierce the wall of the vas deferens at a 45-degree angle (Figure 6-18). Use of the lateral blade enables the surgeon to rotate his or her wrist more easily.

- With the lateral blade skewering the vas and the ringed clamp still grasping the scrotal skin, rotate the handle of the dissecting forceps clockwise 180 degrees so the tips face upward to deliver a loop of the vas deferens (Figure 6-19 and 6-20).
- As you rotate the dissection with the right hand, slowly release the ringed clamp with the left hand, thus allowing the forceps to elevate the vas through the puncture hole (Figure 6-21). At the beginning of the rotation, your hand will be palm-side down; after rotation, it will be palm-side up.
- If the vas is difficult to deliver, more extensive spreading of the sheath may be required.

Figure 6-18. Piercing the Wall of the Vas

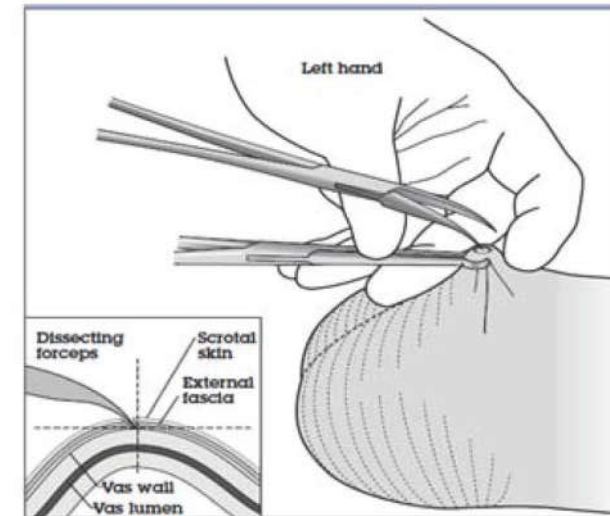
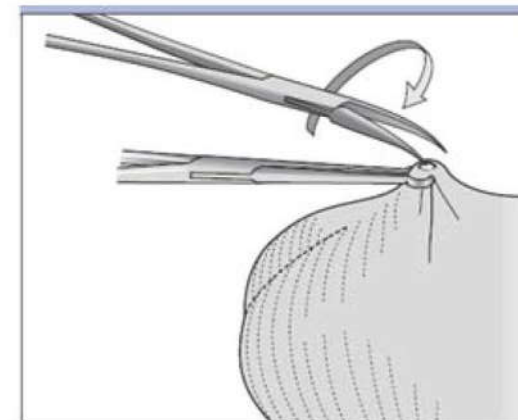
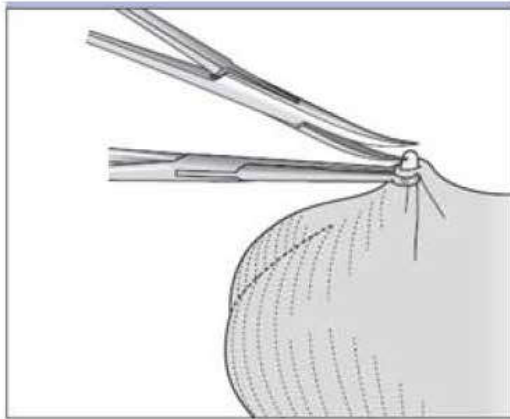


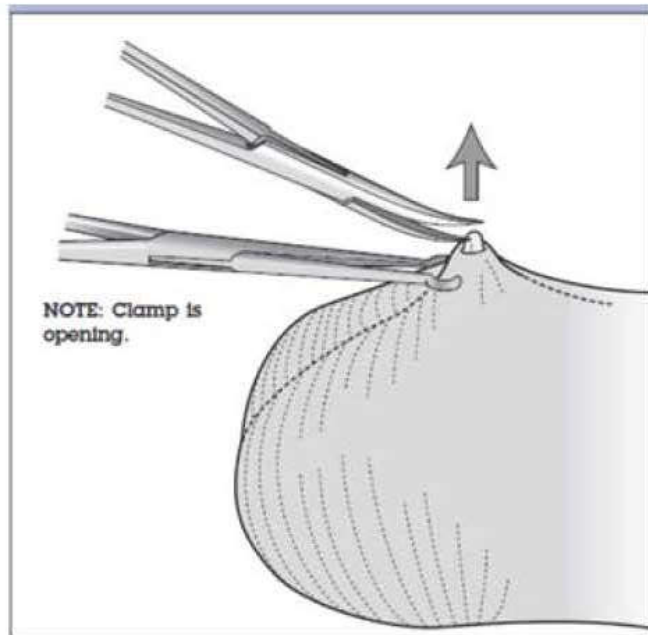
Figure 6-19. Rotation of the Dissecting Forceps, Part 1



**Figure 6–20. Rotation of the Dissecting Forceps, Part 2**



**Figure 6–21. Releasing the Ringed Clamp Before Elevating the Vas with the Dissecting Forceps—Ringed Clamp Open but In Place**



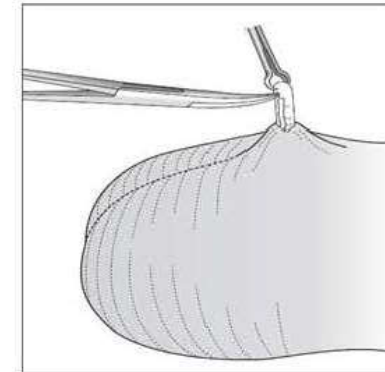
Watch out for two pitfalls while delivering the vas:

- ◆ Do not attempt to deliver the vas while the ringed clamp is locked. If you do, the vas may be severed.
- ◆ If fascial tissue is caught between the tips of the dissecting forceps, you will not be able to rotate and elevate the vas.

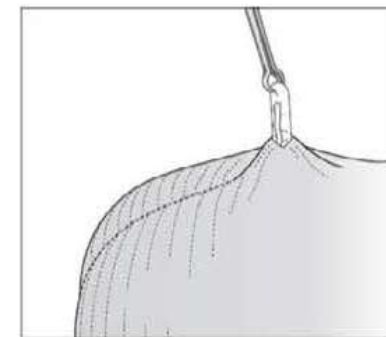
*Grasping the Vas with the Ringed Clamp*

- Once a loop of the vas has been delivered, gently close the dissecting forceps on the vas to prevent its slipping back into the scrotum while the ringed clamp is removed from the skin.
- Grasp a partial thickness of the loop of the vas with the ringed clamp.
- After you have grasped a partial thickness of the vas, release the dissecting forceps.

**Figure 6–22. Grasping a Partial Thickness of the Elevated Vas**



**Figure 6–23. Grasping a Partial Thickness of the Elevated Vas at the Crest of the Loop (with only the ringed clamp attached)**



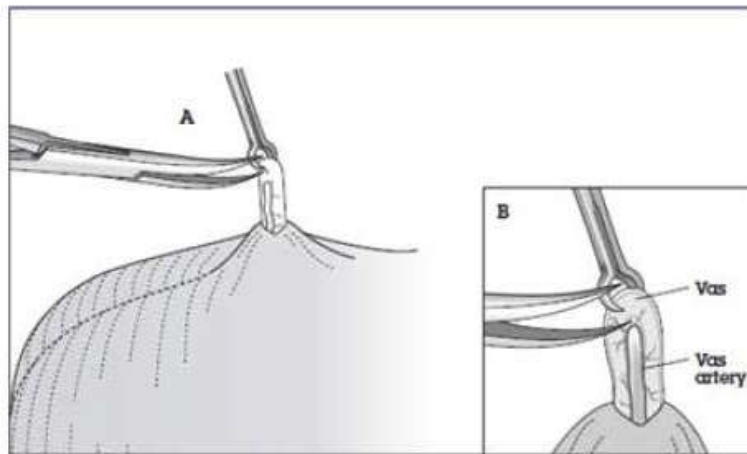
The following pitfalls must be avoided when grasping the vas with the ringed clamp:

- ◆ Be careful not to release the dissecting forceps until you have grasped a portion of the loop of vas with the ringed clamp (Figure 6-22). This procedure will prevent the vas from slipping back into the scrotum.
- ◆ Avoid damaging the vas artery by grasping the vas at the crest of the loop (Figure 6-23). Grasping elsewhere leads to asymmetrical stripping of the sheath from the vas.
- ◆ Grasp only a partial thickness of the vas. If the ringed clamp is placed around the entire circumference of the vas, the vas could slip back into the scrotum when it is divided.

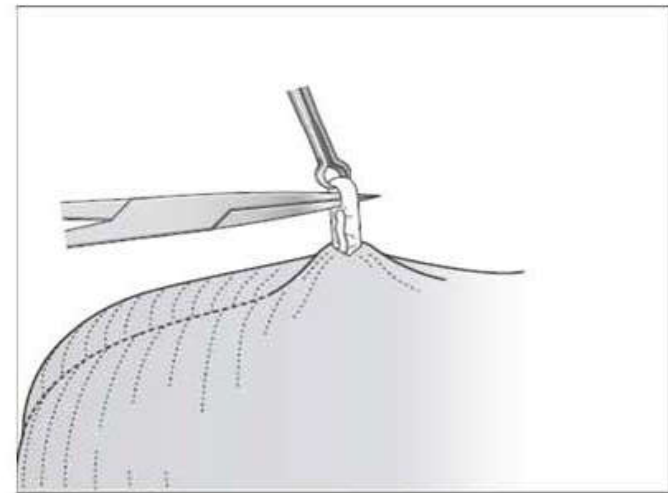
#### *Puncturing and Stripping the Sheath*

- With one tip of the dissecting forceps (tips facing up), gently puncture the vas sheath just below the vas, taking care not to injure the vas artery (Figure 6-24). Then, remove the tip.
- Close the tips of the dissecting forceps. Insert both tips (tips facing to the side) into the punctured sheath (Figure 6-25).
- Gently open the dissecting forceps (Figure 6-26). Strip the sheath and surrounding tissue downward for at least a 1 cm length of the vas. This motion is longitudinal, not transverse.
- Be careful to avoid blood vessels. Tie bleeders immediately. When checking for bleeding, pay particular attention to the abdominal segment of the vas, which is where bleeding from the vas artery could occur and result in hematoma formation.

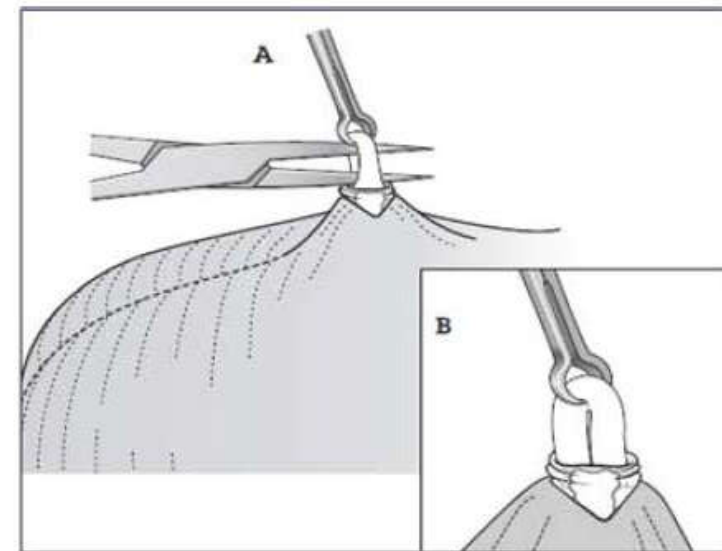
**Figure 6-24. Puncturing the Sheath with One Tip of the Dissecting Forceps**



**Figure 6-25. Inserting Both Tips of the Dissecting Forceps Into the Punctured Sheath (tips facing to the side)**



**Figure 6-26. Opening the Dissecting Forceps to Strip the Sheath**



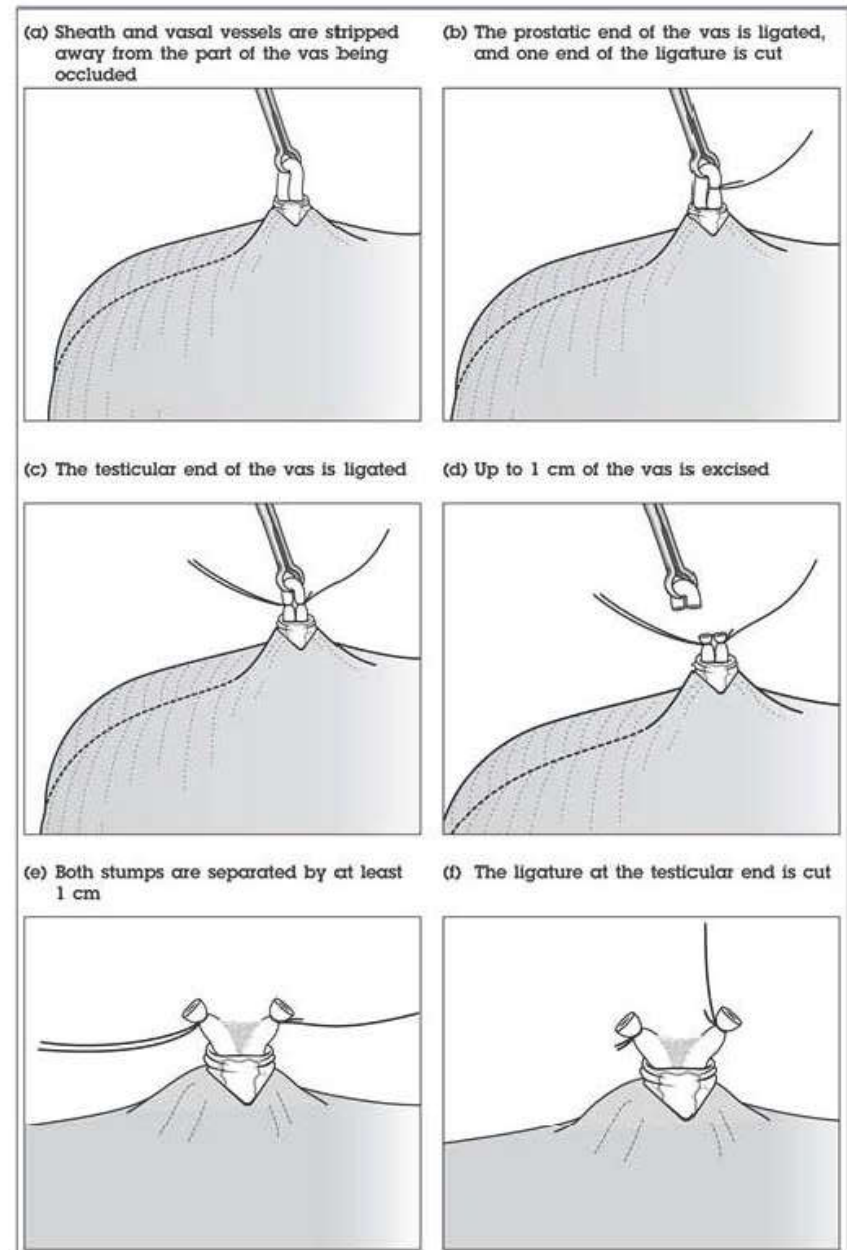


**Figure 6-27. Steps In Performing Vasectomy by Ligation with Excision**

*Ligating and Excising the Right Vas*

The chosen method for occluding the vas is ligation with excision and fascial interposition. Fascial interposition improves the effectiveness of vasectomy when used with ligation and excision of the vas. Fascial interposition places a tissue barrier between the two cut ends of the vas. The stump of the prostatic (proximal) end is outside the fascial sheath. When the vasectomy is completed, the stump of the testicular (distal) end is inside the fascial sheath.

- a. Before beginning ligation, make certain that all sheath and vassal vessels have been stripped away from the segment of the vas to be occluded.
- b. Ligate the isolated vas at two points about 1.5 cm or more apart using two separate ligatures, first ligating the prostatic end of the vas and then the testicular end.
- c. After ligating the prostatic end, cut one end of the ligature, leaving a single uncut end of about 5 cm to 7 cm in length (Figure 6-27b). In this way, the prostatic end will be identified. The single uncut end of the ligature will be used to retrieve the vas to facilitate fascial interposition.
- d. Ligate the testicular end and leave both ends of the ligature about 5 cm to 7 cm in length. When excising the section of vas, leave an adequate stump at each end of the vas (approximately 3 mm) to ensure that the ligature does not slip off later.
- e. Excise up to 1 cm of the vas. When excision is completed, assure that both stumps are not too close by pulling both ligatures.
- f. Separate both stumps by at least 1 cm (Figure 6-27e). Inspect for bleeding, and control it when it is present. Before the ligation of the testicular end is trimmed, hemostasis must be assured.
- g. After assuring that both stumps are separated, cut the ligature at the testicular end.

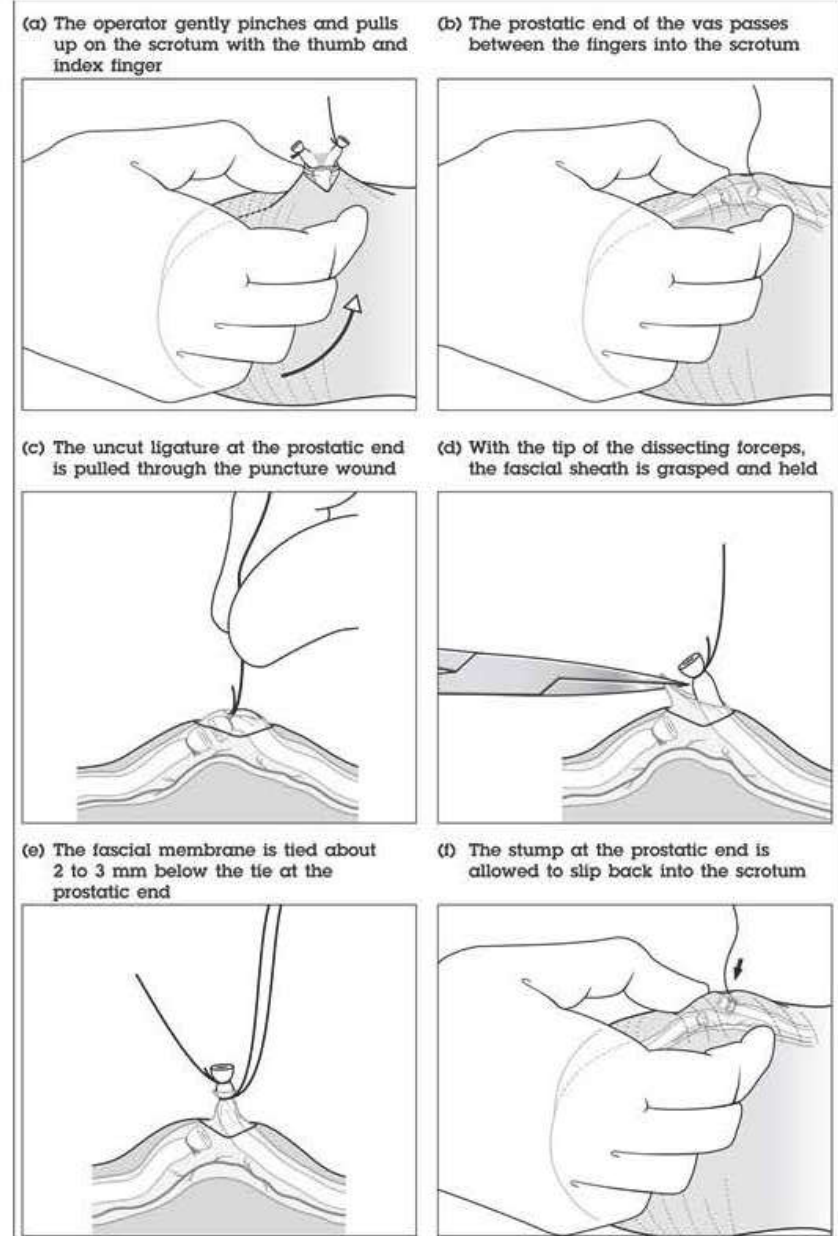


### Creating Fascial Interposition

- Allow both ends of the vas to drop back into the scrotum by gently pinching and pulling up on the scrotum with the thumb and index finger until the prostatic end is felt passing through the fingers.
- Start the fascial interposition technique by very gently pulling the uncut ligature of the prostatic end through the puncture wound (Figure 6-28c). As the vas appears, it should be covered with the fascial sheath, which is seen as a translucent membrane covering the stump of the cut vas. If the translucent membrane (the fascial sheath) is not seen covering the vas, the vas should be dropped back into the scrotum and gently pulled out again.
- Carefully grasp and hold tight the fascial membrane. Using the tip of the dissecting forceps (Figure 6-28d), tie the fascial membrane about 2 mm or 3 mm below the previous tie of the prostatic end (Figure 6-28e). Then, cut both ends of the ligature.
- Allow the stump of the prostatic end to drop back into the scrotum by gently pinching the scrotum so that the stump falls back to its original position.
- After assuring by palpation with the thumb and middle finger that the prostatic end is in the correct position, pull the single ligature just enough to see that the stump of the testicular end is inside the fascial sheath.

Make sure not to tie the fascia with the vas while ligating to occlude the vas. If the fascia is tied with the vas during ligation, then fascial interposition will be difficult and may not even be possible to perform.

Figure 6-28. Steps in Completing Vasectomy by Fascial Interposition



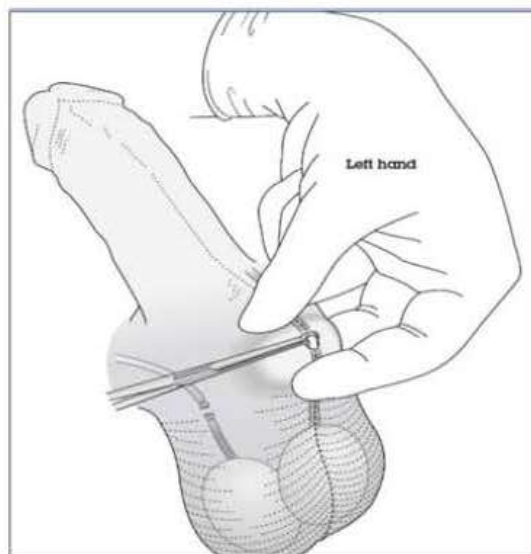
**Figure 6–29. Completed Fascial Interposition (with the stump of the prostatic end outside the fascial sheath and the stump of the testicular end inside the fascial sheath)**



*Isolating the Left Vas before Occlusion*

- a. Adjust the left hand to grasp the left vas deferens, using the three-finger technique.
- b. Place the middle finger below the scrotum, with the thumb and index fingers above the scrotum; position the vas directly under the previously opened puncture site. See Figure 6–30.

**Figure 6–30. Isolating the Left Vas Before Occlusion**



*Applying the Ringed Clamp to the Scrotal Skin and Underlying Left Vas*

- a. Still using the three-finger technique, tightly stretch the skin overlying the vas so that it is as thin as possible.
- b. Open the ringed clamp and press the tips onto the vas through the puncture site. Lock the clamp around the vas and overlying sheath (Figure 6–30). As with the right vas, use the “palm-up” approach to ensure that the instrument is applied perpendicular to the vas (90 degrees).

Occasionally, the sheath and underlying vas cannot be fixed with the clamp because of local edema. Insertion of the clamp into the scrotum to probe the vas increases the risk of both trauma and infection. Having the vas directly under the puncture hole then inserting the ringed clamp into the scrotal tissue to deliver the vas with its sheath diminishes trauma and infection.

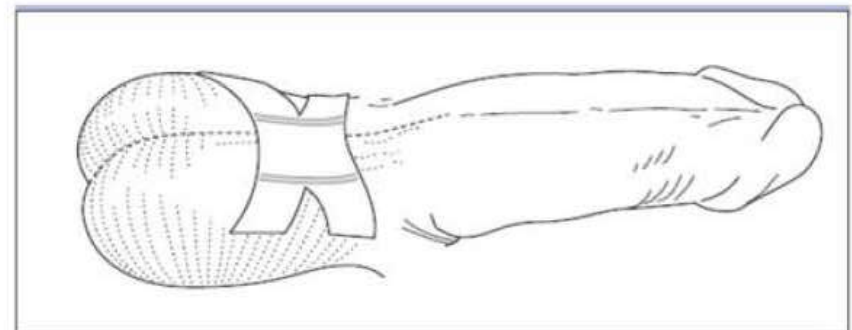
*Delivering, Elevating, and Occluding the Left Vas*

Follow the steps described for delivering, elevating, and occluding the right vas.

*Dressing the Wound*

- a. After both vasa have been occluded and returned to the scrotum, pinch the puncture site tightly for a minute. Inspect for bleeding. If bleeding is present, hemostasis must be achieved. No skin sutures are necessary.
- b. Swab the small wound with antiseptic solution. A sterile gauze dressing can be held in place with a scrotal supporter or tape, or a Band-Aid can be used to cover the small wound. Note that the width of each end of the tape has been divided in half, thus allowing the tape to fit better on the round scrotum.

**Figure 6–31. Dressing the Wound**



## POSTOPERATIVE CARE AND INSTRUCTIONS

Men who have undergone vasectomy may leave the health facility after resting for 30 minutes.

Explain to the client in simple language how to care for the wound, what side effects to expect, what to do if complications occur, where to go for emergency care, and when and where to return for a follow-up visit. Tell him that minor pain and bruising are to be expected and do not require medical attention. The client should seek medical attention if he has fever, if blood or pus oozes from the puncture site, or if he experiences excessive pain or swelling. Give him a brief, simply written summary of instructions.

The client must be informed of the low likelihood of vasectomy failure. He may resume normal activities and sexual intercourse with temporary contraception within two or three days if he feels comfortable. The client or his partner will need to use another method of contraception during the first 12 weeks following vasectomy to avoid an unplanned pregnancy. Every client should be offered the opportunity to have a semen examination after 12 weeks. Ideally, one or two sperm-free semen specimens should be obtained from the client to be reasonably sure that the operation has been a success.

## SESSION VII

# POSTVASECTOMY CARE

### OVERVIEW

*Identifying and preventing complications while the client is in the facility are important considerations during the immediate postvasectomy period. Therefore, proper physical assessment and sound service provision protocols are followed prior to client discharge.*

*This session provides the required knowledge and skills in providing postvasectomy care and instructions.*



## LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Explain the components of postvasectomy care in terms of
  - ◆ when to discharge the client
  - ◆ providing instructions to the client
2. Discuss the procedure of postvasectomy semen examination and follow-up based on the semen examination findings

# NARRATIVE

## IMMEDIATE POSTVASECTOMY CARE

Most men feel physically comfortable immediately after vasectomy and are in a medically stable condition. Clear and complete information on home care should be given to each client before leaving the clinic to prevent complications. Information on postvasectomy care can be given to the client before the procedure by the NSV provider or an assistant. If information on postvasectomy care is given to the client before the procedure, verify that the client understands the instructions and has a written copy of them after the procedure.

A man who has undergone vasectomy may leave the health facility after he has rested, has been re-examined for signs of bleeding, and has the capacity to walk comfortably. Complete the following steps before a client leaves your facility after a vasectomy.

1. Using language that the client understands, go through the sample written instructions (Figure 7-1).
  - ◆ How to care for the wound
  - ◆ What side effects to look for
  - ◆ What to do if complications occur
  - ◆ Where to go for emergency care
  - ◆ When and where to go for emergency care
  - ◆ When and where to go for a follow-up visit
2. Ask the client if he has any questions or concerns.
3. Provide the client with clearly written instructions on postvasectomy care. Provide written instructions to both literate and illiterate clients. Suggest to illiterate clients that they have a friend or family member read the instructions to them if they have any questions.
4. Invite the client to return to the clinic if he has any questions or concerns after he leaves.
5. If semen analysis is available, schedule a follow-up appointment for the client.
6. If practical, follow-up by contacting the client the day or evening after surgery.

## Figure 7-1. Sample Written Instructions

Note: Adapt these instructions for use in your facility.

### Written Postvasectomy Instructions for Clients\*

- ◆ Rest at home until the day after surgery. You may resume your normal activities after one or two days. Avoid work and strenuous exercise for at least 48 hours after vasectomy to help the wound heal.
- ◆ You may bathe on the day after surgery, but do not let the wound get wet.
- ◆ Do not pull or scratch the wound while it is healing.
- ◆ Wear a snug undergarment or scrotal support for at least two days after surgery to make you comfortable.
- ◆ Keep the bandage on for three days after the operation. Wash the wound with soap and water after removing the bandage.
- ◆ You may have sex with your partner as soon as it is comfortable with you, which is usually two or three days after the operation. Remember that vasectomy does not work immediately, and that you can still get your partner pregnant. Use condoms, or ask your partner to use another family planning method until you have had 20 ejaculations or until 12 weeks after the vasectomy, whichever comes first.
- ◆ Vasectomy does not protect you or your partner from STDs, including HIV, which causes AIDS. You can reduce your risk of STDs by using condoms or practicing abstinence, safe sex, or monogamy.\*\*
- ◆ You may notice some blood or blood clots in your ejaculate after the first few times you have sex. You may also experience some pain. The blood and pain are not points of concern unless they occur more than a few times. If pain during ejaculation persists after the first few times, you should consult your doctors.
- ◆ You may experience a slight pain, bruising, or swelling around the wound. A small amount of pain, bruising, or swelling that does not get worse is normal. Take the medication provided (or recommended) by the doctor. Be sure to follow the instructions given to you. An ice pack may help relieve the pain, bruising, or swelling. If the swelling worsens, contact your provider or facility.
- ◆ Return to the clinic or call your doctor
  - if you have a fever within one week of surgery,
  - if any bleeding or pus appears in the wound,
  - if pain or swelling around the wound gets worse or does not go away,
  - if your partner misses a period or thinks she is pregnant (This is very important because it may indicate that the operation has failed, and that your partner is pregnant.), or
  - if you have any questions or concerns.
- ◆ If semen analysis is available: After 12 weeks, return to the clinic for a semen analysis to make sure that the vasectomy was successful. You may collect a semen sample by masturbating into a clean container or from a condom used during intercourse. Collect the sample the day of the follow-up visit and bring it with you to your appointment.

Clinic address: \_\_\_\_\_ Phone: \_\_\_\_\_

<p>Your follow-up appointment is:*</p> <p>Day and Date: _____</p> <p>Time: _____</p> <p>Place: _____</p>
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at the subsequent follow-up, vasectomy failure may have occurred. Another semen analysis with the use of back-up contraception for four more weeks is recommended. If sperm cells are still found, inform the client of the need for a second procedure.

- \* If semen analysis is not available, no follow-up visit is required.
- \* The only difference between instructions provided to NSV clients and those provided to clients who have incisional vasectomy is that NSV clients do not need a one-week follow-up visit for removal of stitches.
- \*\* Make sure that clients understand the meaning of the terms STIs, abstinence, safe sex, and monogamy.

### SEMEN EXAMINATION

Postvasectomy semen examination is a simpler procedure than a complete semen analysis because the only concern is to determine the presence or absence of sperm.

#### Procedure for Semen Examination

1. Ask the client to return 12 weeks after the vasectomy. Ask him to collect and bring a semen sample on the day of the follow-up visit.
2. At room temperature, wait for the semen to liquefy. If the sample remains coagulated, break it up by drawing it up and down in a hypodermic needle and syringe slowly three or four times. Be careful not to introduce air bubbles into the semen. Once the specimen forms droplets, you can treat it as a normal sample.
3. Gently swirl the container to mix the semen. Mixing the semen ensures that the small sample you took is representative of the entire semen sample. Using a clean pipette, place a small drop onto a glass slide and place a cover slip on top. Wait for one minute to allow the specimen to spread evenly.
4. Using a microscope, initially view and focus the specimen under the 10x objective and then switch to the high power (40x) objective. Check the entire slide for the presence of sperm. No sperm should be present in the 12-week-old specimen.

#### FOLLOW-UP

- ◆ If no sperm is found, note the result in the client's record. Inform him that back-up contraception is no longer necessary, and that no further follow-up is needed.
- ◆ If sperm cells are seen, note in the client's record the number of sperm cells seen upon scanning the entire slide under high power. Instruct the client to continue using back-up contraception and to return after another four weeks. If the number of sperm cells increases

## SESSION VIII

# MANAGEMENT OF COMPLICATIONS

### OVERVIEW

*Serious complications related to vasectomy, especially to NSV, are rare. Nevertheless, the service provider must know how to identify and manage potential complications resulting from NSV. Most complications from vasectomy can be prevented.*

*This session provides the service provider information on the prevention, recognition, and management of potential complications resulting from NSV.*

### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Differentiate side effects from complications
2. State potential vasectomy complications and ways by which these side effects can be prevented
3. Discuss potential intra-operative vasectomy complications as to
  - ◆ Symptoms
  - ◆ Etiology/causes
  - ◆ Prevention
4. Explain the requirements for efficient, emergency management of intra-operative complications
5. Discuss potential postoperative vasectomy-related complications as to
  - ◆ Symptoms
  - ◆ Etiology/causes
  - ◆ Prevention
  - ◆ Treatment/management

## NARRATIVE

### OVERVIEW OF COMPLICATIONS

Serious complications related to NSV are very rare. The most commonly reported complications are small hematomas and skin infections, which occur in fewer than 3% of cases. The management of most potential complications is similar to that for other types of minor surgery.

### SIDE EFFECTS AND COMPLICATIONS

A *side effect* is a consequence of a procedure, contraceptive method, or medication other than that intended. A side effect does not require exceptional intervention, but it may require attention and management. Side effects of vasectomy are anticipated consequences, such as soreness, swelling, and bruising, of the surgery. These consequences do not require exceptional intervention, but you may need to reassure the client about them.

A complication is an unexpected condition that requires intervention or management beyond what was planned or what is normally provided during routine postoperative care.

### Potential Complications of Vasectomy

- ◆ Potential intraoperative complications include vasovagal reaction (neurocardiogenic syncope), lidocaine toxicity, and injury to the testicular artery.
- ◆ Potential postoperative complications include bleeding, hematoma, infection, sperm granuloma, chronic testicular pain, infectious and congestive epididymitis, pregnancy of the client's partner, and vasectomy failure.

### Prevention of Vasectomy-related Complications

Most vasectomy-related complications can be prevented by

- ◆ Carefully screening clients
- ◆ Following proper infection prevention procedures
- ◆ Using a gentle surgical technique
- ◆ Achieving hemostasis during surgery
- ◆ Ensuring that clients understand instructions for postvasectomy care
- ◆ Verifying that clients understand the need for postvasectomy contraception

Table 8-1 summarizes the management of potential intra-operative complications of NSV.

**Table 8-1. Potential Intra-operative Complications of Vasectomy**

	Vasovagal Reaction (Neurocardiogenic Syncope)	Lidocaine Toxicity	Injury to Testicular Artery
<b>Symptoms</b>	Fainting, nausea, weakness, lightheadedness, sweating, decrease in blood pressure, pallor, initial increase then decrease in heart rate, cold, clammy hands, restlessness	Numbness of tongue and mouth, lightheadedness, tinnitus, visual disturbances, slurred speech, respiratory distress/arrest, myocardial distress/arrest, myocardial depression, arrhythmia, cardiac arrest, convulsion, coma	Bleeding in fascia around the vas
<b>Treatment</b>	Reassurance, raise feet, lower head, atropine if PR less than 40, administer oxygen	Discontinue use of drug, general supportive measures, maintain airway and respiration, provide oxygen, administer diazepam or thiopental for convulsion, administer vasopressor (norepinephrine or dopamine) for hypotension	Perform cautery of ligation to control bleeding.

<b>Etiology</b>	Painful procedure, anxious client	Overdose of lidocaine, intravenous injection	Injury to blood vessels when stripping the fascia from the vas
<b>Prevention</b>	Gentle surgical technique, effective anesthetic block, advanced explanation of procedure to client, reassurance of client during procedure	Do not administer a dose >30 mL of 1% or >15 mL of 2% solution.	Strip the fascia from the vas carefully.

	Infection	Sperm Granuloma
<b>Symptoms</b>	Pus and swelling at the incision site or in the scrotum  Fever	Pain at the testicular end of the vas or tail of the epididymis  Nodule felt during palpation
<b>Treatment</b>	Superficial infections: clean and apply local antiseptic and clean dressing  Underlying tissue infection: antibiotics and wound care  Abscess: antibiotics, drainage, and wound care  Cellulitis or fasciitis: debridement, antibiotics, and wound care.	Asymptomatic: no intervention  Pain: administer nonsteroidal analgesics  Persistent pain: evacuate the cyst; cut and seal the vas ¼ inch towards the testis. Do not excise the granuloma. Rarely, chronic pain warrants an epididymectomy
<b>Prevention</b>	Observance of proper infection prevention procedure  Recognition of bleeding  Client should keep the wound dry after the vasectomy	Unknown



<b>Etiology</b>	Failure to follow infection prevention procedures  Unrecognized or untreated hematomas  Improper postoperative care of the wound	Occlusion of vas leads to accumulation of sperm
	Chronic testicular pain (rare)	Infectious and congestive epididymitis
<b>Symptoms</b>	Chronic unilateral or bilateral pain in the scrotum without palpable abnormality  Swelling (sometimes)  Pain during intercourse or strenuous activity	Fever (if caused by infection)  Scrotal pain  Swelling  Induration
<b>Treatment</b>	Nonsteroidal analgesics  Pain may gradually subside spontaneously.	Bed rest, scrotal elevation, ice packs  Nonsteroidal analgesics  Antibiotics
<b>Prevention</b>	Unknown	Infectious epididymitis: – Follow infection prevention procedures; screen clients for STDs.  Congestive epididymitis: – Pressure on epididymis resulting from sperm blockage
<b>Etiology</b>	Possibly caused by neuroma or a perineural irritation	Infectious epididymitis: failure to follow IP procedures; sexually transmitted pathogens  Congestive epididymitis: pressure on epididymis resulting from sperm blockage

	<b>Pregnancy of the Client's Partner</b>	<b>Vasectomy Failure</b>
<b>Symptoms</b>	Client's partner is pregnant.	Semen analysis shows sperm.
<b>Treatment</b>	Determine the reason for pregnancy:  – Estimate the date of conception – Ask if the couple had unprotected intercourse 12 weeks or 3 months after vasectomy. – Ask partner if she had intercourse with another man. – Request for sperm analysis – Refer couple for further counseling or prenatal care.	– Explain to the couple how the failure could have occurred. – Offer to repeat the vasectomy procedure.
<b>Prevention</b>	Instruct client to use back-up contraception before vasectomy and during the three-month postoperative period.  For vasectomy failure: Careful surgical technique	Careful surgical technique
<b>Etiology</b>	Pregnancy before the vasectomy Partner's sexual activity with a man other than the client Unprotected intercourse at any time up to 3 months after vasectomy Vasectomy failure	Failure to occlude the vas during the procedure Spontaneous recanalization

## Emergency Management of Intra-operative Complications

Complications become serious if

- ◆ Staff members fail to recognize signs of an overdose.
- ◆ Monitoring staff members are distracted by other duties.
- ◆ Staff members lack knowledge of emergency measures.
- ◆ Emergency equipment is unavailable or does not function.
- ◆ Emergency medications are unavailable.
- ◆ Staff members lack training in the use of emergency drugs.
- ◆ Staff members are unclear about their roles and responsibilities in emergency care.

### *Staff Preparation for Emergencies*

All staff members must be trained to effectively manage emergencies, and sites must have a predetermined plan in place who will be in charge should an emergency arise. Although the vasectomist is in charge in most circumstances, the staff members should also know who is in charge when the vasectomist is not present. All staff members must be skilled in administering intravenous fluids and drugs. They must understand which drugs may be used, how to administer them, and what their expected actions are. They must be knowledgeable of the use and availability of all emergency equipment. The person monitoring the client in the operating and recovery rooms must be capable of detecting early signs of complications and must be able to take initial emergency action. Emergency care supplies and drugs must be kept in an accessible place known to all staff members.

### *Emergency Equipment and Supplies*

The equipment listed below must be available for emergency use in the operating and recovery rooms. All emergency equipment must be immediately available, ready to use, and in good condition. A battery-operated light source should be available for back-up or for focused illumination of the operative site.

- Syringes and needles
- Butterfly set
- Intravenous infusion set
- Adhesives
- Ambubag
- Oral airways (2 sizes)
- Oxygen tank
- Face mask or tube
- Stethoscope
- Sphygmomanometer
- Gauze pieces
- Kidney tray
- Blanket
- Flashlight

### *Emergency Drugs*

The drugs listed below must be available in the operating and recovery rooms. The staff members should be well informed about the drugs, their use, dose, strength and route of administration, signs of toxicity, and treatment of overdose. The following emergency drugs are recommended:

- Atropine
- Epinephrine
- Norepinephrine
- Beta-blocker
- Diazepam
- Corticosteroids (dexamethasone or hydrocortisone)
- Aminophylline
- Furosemide
- Dopamine
- Dextrose 5%
- Dextrose 5% in normal saline

## SESSION IX

# MANAGEMENT OF QUALITY VSC SERVICES, INCLUDING VASECTOMY

### OVERVIEW

*Managers of VSC services are responsible for making safe, voluntary sterilization services available to the largest possible numbers of potential acceptors in their communities. As VSC is a surgical procedure and a permanent method of contraception, managers must ensure that VSC services are provided under conditions that minimize the possible risks and must verify that the client's decision to undergo the operation is voluntary.*

*This session discusses the principles and guidelines in managing VSC services to support trained service providers in continuously and sustainably providing effective and efficient VSC services.*

## LEARNING OBJECTIVES

1. At the end of the session, participants will be able to:
2. Explain the responsibilities of NSV service managers/providers in integrating vasectomy services into their facility's health care system
3. Describe the basic programming considerations in developing and managing vasectomy services
4. Describe the characteristics of a successful vasectomy program
5. Develop an action plan that includes the creation of mobile teams for the integration of vasectomy services into their health care system
6. State how potential complications related to vasectomy can be prevented
7. Identify and manage common complications

## NARRATIVE

### NSV SERVICE MANAGER/PROVIDER'S MANDATE

Managers or providers of vasectomy services are responsible for making safe, voluntary sterilization services available to the largest possible number of potential users by using affordable methods with long-term sustainability. NSV managers or providers must also ensure that sterilization is provided under conditions that minimize the risks associated with elective surgery.

Sterilization directly and permanently ends reproduction. Therefore, clients requesting this service must be given full information about its intended effects and consequences. Managers must ensure that services are offered without inducement or coercion and that meticulous attention is given to medical safety.

To provide high-quality services, managers must

- ◆ Ensure that all clients make voluntary, fully informed, and well-considered decisions.
- ◆ Ensure the medical safety and effectiveness of all clinical and surgical procedures.

To ensure well utilization and success of high-quality services, managers must

- ◆ Establish services that are responsive to the needs, preferences, and behavior of clients and the community.
- ◆ Make services widely available and easily accessible to all potential clients.
- ◆ Plan and manage services to ensure their efficiency and cost-effectiveness.
- ◆ Strive for long-term viability and sustainability of services.

### GENERAL PROGRAMMING CONSIDERATIONS

The information provided here is meant to describe some of the basic programming considerations for developing and managing vasectomy services; it is not meant to be an exhaustive explanation. Refer to Figure 9-1.

## Location of Services

With very little additional investment, vasectomy can be performed on a continuous, year-round basis in nearly all permanent health care facilities, including hospitals, multipurpose health care centers and clinics, specialized FP clinics, and treatment rooms of private physicians.

Although vasectomy programs can be integrated into existing health services, they may have to compete with urgent curative and emergency services. In addition, overworked personnel may not have sufficient time for vasectomy programs. Programs organized in specialized FP clinics can often sustain a high level of performance over an extended period. Resources specifically allocated for vasectomy are less likely to be diverted to other purposes. With enough resources, the surgical team can offer efficient and safe services. However, unless an adequate caseload can justify the use of resources, having a specialized service may prove expensive.

**Figure 9–1. Checklist for Planning and Organizing Vasectomy Services**

### Checklist for Planning and Organizing Vasectomy Services

1. Survey community, and identify potential obstacles.
2. Investigate local laws, legal issues, and regulations.
  - Obtain licenses and other approvals.
3. Estimate potential caseload.
4. Develop budget, and arrange financing.
5. Develop information and education programs.
6. Establish clinical facilities; select, prepare, and renovate site.
7. Arrange for supplies, equipment, and services.
  - Procure equipment, instruments, medicines, and supplies.
  - Establish storage and inventory systems.
  - Establish infection prevention procedures.
8. Establish essential policies.
  - Client selection criteria
  - Procedures regarding free and informed decision-making, counseling, and informed consent
  - Medical/surgical protocols and service standards
9. Develop and print record forms, information materials, and other documents.
  - Medical history/client record form
  - Informed consent form
  - Preoperative and postoperative instructions
  - Client brochures and other information materials
10. Staff the Program
  - Determine staff requirements, and develop job descriptions.
  - Recruit and select staff.
  - Train staff.

11. Establish client flow system and procedures.
  - Reception, intake, and registration
  - Record of patient history
  - Clinic-based information activities
  - Client counseling
  - Informed consent
  - Physical examination and medical screening
  - Referral for medical and psychological indications or for temporary contraception
  - Preoperative preparation
  - Surgical procedure
  - Complication management and emergency treatment procedures
  - Postoperative monitoring
  - Postoperative instructions and discharge
  - Follow-up procedures
12. Others:
  - Financial accounting procedures
  - Data collection and service statistics
  - Monitoring and evaluation

### Facilities

- ◆ As discussed above, vasectomy can be offered in different permanent and temporary locations. However, the following space requirements must be met to provide high-quality, comprehensive services:
- ◆ A comfortable waiting room for new arrivals and follow-up clients
- ◆ A private space for counseling
- ◆ An examination room for preoperative and follow-up examinations
- ◆ An area for storage and retrieval of records
- ◆ An area for laboratory investigations (blood, urine, and semen analyses)
- ◆ A clean room for surgery, isolated from the outside and from clinic traffic
- ◆ Areas where vasectomy personnel can scrub
- ◆ Toilet and washing facilities for clients
- ◆ A rest area for clients after surgery
- ◆ Facilities for sterilization or HLD of surgical instruments and supplies
- ◆ Waste disposal facilities
- ◆ A laundry room

Several of these functions may share a common space, especially in facilities that are not very busy. As the caseload increases, a separate area may be assigned to each function. The accommodation



should be planned to permit an orderly flow of clients through the clinic, particularly as their number increases. Some of the components listed above, such as laboratory tests, laundry, and autoclaving, may be contracted out or handled by a central supply unit in multiple-site programs.

### **Medical Personnel Who Can Provide Vasectomy**

Vasectomy can be performed by general practitioners, specialist surgeons, and other physicians. In all cases, operators must be carefully selected to ensure high-quality service delivery. Aside from knowledge, technical skills, and surgical proficiency, commitment to providing vasectomy services must be possessed by physicians who are to perform vasectomy.

Specialists, including urologists, may be too preoccupied with more complex surgical and medical problems to take an active interest in vasectomy, an elective procedure that can become tedious and boring for surgical experts. Interestingly, some of the most successful vasectomy programs have been organized and conducted by specialist obstetrician-gynecologists who are closely involved with and committed to FP.

Vasectomy may appeal to private practitioners because it requires little capital investment and can be performed on an outpatient basis in the physician's treatment room. Private practitioners are a primary source of health care in many countries; thus, program managers should consider instituting training programs for this important sector.

### **Staffing**

- ◆ Determining the personnel required for a vasectomy service is a complex task. Program managers must arrange for sufficient staff to handle the following duties:
- ◆ Receiving clients and maintaining records
- ◆ Providing information and education
- ◆ Counseling clients
- ◆ Examining clients, performing surgery, and conducting follow-up
- ◆ Performing laboratory tests (optional)
- ◆ Sterilizing or high-level disinfecting equipment and supplies
- ◆ Doing laundry
- ◆ Cleaning and maintaining facilities

Only a nurse and a physician may be needed in clinics with a small caseload. A well-trained vasectomy assistant might easily receive the client, take the preliminary medical history, counsel the client, handle the laboratory tests, assist the surgeon in the operating room, and sterilize instruments. As the caseload increases, more personnel, each responsible for one area, may be needed.

### **Client Follow-up and Medical Referrals**

Follow-up is a crucial part of vasectomy services. If mobile teams are used, local physicians or specially trained community health personnel may conduct follow-up examinations. Paramedical staff must be trained to identify problems and to refer clients to the nearest health center when serious complications are encountered. Clients themselves must be instructed to seek assistance if they encounter postoperative problems.

Programs must always be prepared to refer clients to another department or another sector of the health system when appropriate. A client showing rare, life-threatening complications may be referred to another facility better equipped to handle the situation. The vasectomy provider must be prepared to treat or refer the client if medical problems, such as the presence of an STD, are discovered during the prevasectomy examination. Screening and counseling may occasionally identify psychological problems that require referral for further counseling or psychiatric treatment.

### **Semen Analysis**

In many settings, semen analysis is difficult or impossible to provide on site because it requires special training and equipment. For some programs, semen analysis may be less expensive and more convenient to arrange in an independent laboratory or another health facility. Some programs cannot provide semen analysis at all.

### **Vasectomy Reversal**

Vasectomy should not be offered or promoted as a reversible method because it is intended to be a permanent procedure. Although reconstructive surgery can be performed to reverse a vasectomy, the surgery is expensive, time consuming, difficult, and not guaranteed to result in subsequent pregnancy. Every program should therefore include a client assessment or counseling component to help identify and screen out clients who are likely to regret their decision.

Despite all precautions, a few clients may regret their choice because of unanticipated events, such as remarriage and death of a child. Hence, a comprehensive vasectomy program may make vasectomy reversal services available. Experience has shown that one reversal request can be expected for every 400 to 700 vasectomies.

### **Assessing the Receptiveness of the Local Community**

Before introducing vasectomy services, managers must consider the environment or community in which the services are to be located. Political, cultural, and religious attitudes must be identified and considered. The effects of local laws and regulations, guidelines for medical practices, and codes of ethics on vasectomy services must be studied. All necessary permits and licenses must also be obtained.

Managers must investigate the level of community knowledge and practice of FP, as well as the availability of other FP services. Existing data, group discussions, and community surveys can help identify common myths and misinformation about vasectomy that can be addressed with information and counseling. In addition, local medical and health professionals should be interviewed in preliminary community surveys to determine their attitudes about vasectomy, their readiness to collaborate in the provision of vasectomy services, and their willingness to refer potential clients.

### **Estimating the Potential Caseload**

Service managers must estimate the potential demand for vasectomy to develop services that meet local needs. This estimation is important in determining the facilities, staff, and other resources needed. The actual number of clients who request services will be influenced by such variables as the cultural acceptability of sterilization, the design and accessibility of services, the

existence of similar services in the community, and the impact of information and education.

Requests for vasectomy may be limited when services are first introduced into a community. However, the caseload can be expected to increase as the number of satisfied clients grows, as accurate information becomes increasingly widespread, and as fears are allayed and misconceptions corrected. Estimating the potential number of clients can assist service managers in forecasting and planning for growth rather than being overcome by it.

### Sustainability

Managers must understand and use the principles of budgeting and other aspects of financial planning and management to provide services efficiently and continuously.

Financing services can be a complex problem involving multiple sources of funding. The most common sources of funds for sterilization services are the following:

- ◆ *Government subsidies.* Although subsidies may initially help services available, subsidized services may be difficult to manage and sustain over the long term.
- ◆ *Grants from donor agencies.* Several international donor agencies provide grants for sterilization services during the first few years of operation. Most of these agencies have policies to phase-out support and encourage self-sufficiency.
- ◆ *Client fees for services.* Fees must be set at a level that covers costs but does not discourage the use of the service. Accommodations must be made for clients who cannot afford even modest fees; no client should be denied services because of an inability to pay.
- ◆ *Insurance schemes.* Private or government health insurance may cover the cost of sterilization.
- ◆ *Income-generating schemes.* Organizations sometimes help support the costs of sterilization by raising funds or by using profit from temporary FP or other reproductive health services.
- ◆ *Combined financing mechanisms.* Different sources may also be combined to provide financial support. For example, sliding-fee scales may be combined with profit from other services and grants from donor agencies.

Services should also pay attention to financial management and accounting procedures. Effective accounting and auditing systems help managers keep costs under control, stay within budget, and avoid or anticipate financial difficulties. Governmental and other donors often require particular accounting systems, but all services should maintain internal accounting systems that are designed to permit periodic internal and external audits.

### Planning for Self-sufficiency

An important advantage of sterilization is its cost effectiveness in relation to other methods of contraception. Nevertheless, the costs of sterilization are relatively high and immediate, whereas those of temporary methods are usually spread over a long period. Clients who cannot afford the cost of sterilization will require subsidy.

New services often rely on outside funding or on sources of income that may be unreliable for the long term. Therefore, managers must prepare for the future and continuously monitor and improve the efficiency and sustainability of services.

Services that rely on subsidies are continuously compensating for reductions in funding. To reduce this problem, nongovernmental organizations should diversify and balance their sources of funding so that the elimination of one source will not drastically affect their ability to provide services. In most for-profit enterprises, the sustainability mandate is clear: costs must be transferred to clients or recovered from third parties (such as insurance companies or governments) as soon as possible, or the institution will be forced to close. Governments and donors may be willing to support for-profit organizations during their early stages but will not usually provide funds indefinitely for recurring costs.

Managers should consider the following strategies in working toward self-sufficiency:

- ◆ Keep costs to their absolute minimum without sacrificing quality.
- ◆ Review service options to deliver services as economically as possible.
- ◆ Achieve economies of scale so that costs are shared among more cases.
- ◆ Work toward cost recovery by gradually increasing reliance on fees and insurance.
- ◆ Adopt supplementary income-generating schemes.

### CHARACTERISTICS OF SUCCESSFUL PROGRAMS

The activities listed so far are all essential for the organization of a vasectomy program. However, these activities may not be self-sufficient in launching and managing a successful program that meets the needs of the community. Public health professionals have compared an unsuccessful and a successful vasectomy program. A few characteristics shared by successful programs are summarized here.

#### Client Satisfaction is of Paramount Importance

##### *Emphasis on Quality and Client Satisfaction*

Satisfied clients are an important source of referrals for a vasectomy program. A program cannot afford mistakes, especially in the early stages. Maintaining high-quality services is important: lowering standards to achieve a large volume is self-defeating in the long run. Negligence and inconsiderate treatment of clients must not be tolerated. A vasectomy program that has established a reputation for excellent service is likely to produce a self-generating demand through word of mouth from clients and local health professionals.

Good planning is essential to establish high-quality services. Apart from competent, well-trained staff with good surgical techniques, the treatment of clients in nonsurgical situations must also be given special attention. Thorough counseling and good preoperative examination eliminate clients who are at risk of vasectomy-related complications or regretting the operation at a later date. Whenever possible, semen analysis should be done three months after vasectomy to identify failed vasectomies before unwanted pregnancies occur.

The way clients are treated by clinic staff will undoubtedly influence their satisfaction with, and perceptions of, the services. If staff members are attentive and compassionate, even clients who experience complications are more likely to leave with a favorable impression and to share that impression with potential clients.

##### *Attention to the Special Needs of Men*

Programs that specifically consider the psychological characteristics of men are more likely to succeed. In some societies, the vasectomy program should be physically separate from female

FP services, or the key clinic staff should be men. Clinic hours should be convenient for clients; evening, weekend, or holiday sessions may be suitable for men who cannot leave their jobs on weekdays. Finally, educational materials and information programs should carefully address common misunderstandings about vasectomy.

#### ***Working Within the Community***

A vasectomy service may be more acceptable and successful when it is located within the community it is intended to serve. Some programs have had good results by employing staff who reside in the clinic's neighborhood. As much as possible, staff members should have the same socioeconomic, cultural, and ethnic characteristics as their clients. Finally, the clinic should have good connections with other local institutions, such as social welfare organizations, local health facilities, community-based FP programs, and local government councils or groups. In sum, the program should strive to be part of the local social fabric.

#### ***Developing Leadership***

A successful vasectomy program is usually headed by a professional who has taken a personal interest in involving men in FP and who is committed to the success of the project. A leader who is introducing vasectomy in a locality for the first time must be patient, persistent, committed, and willing to be a pioneer.

#### **Features of Successful FP Programs**

Vasectomy services should operate within the context of a client-centered FP program and should be well integrated into existing services. The main features of successful FP services are as follows:

- ◆ Provides a wide choice of methods of contraception
- ◆ Places the concept of FP within the broader context of each client's experience
- ◆ Ensures accessibility of FP methods through various staff and delivery systems
- ◆ Supports clients by providing full information and counseling and by providing reassurance when problems arise
- ◆ Enhances the quality of services by promoting the highest possible standards of care appropriate to the setting
- ◆ Responds to clients' needs and preferences for methods and services
- ◆ Provides effective outreach and follow-up
- ◆ Encourages active client participation at all stages of service development and implementation
- ◆ Undertakes research and evaluation to elicit clients' perceptions and preferences



# ACTION PLANNING

## LEARNING OBJECTIVE

At the end of the session, participants will be able to develop an action plan that will integrate the principles and skills learned in the course to his/her job.

## NARRATIVE

Action planning is the process of planning what needs to be done, when it needs to be done, by whom it needs to be done, and what resources or inputs are needed to do it. It is the process of operationalizing the strategic objectives.

Most action plans consist of the following elements:

- ◆ a statement of what must be achieved (the outputs or result areas)
- ◆ the steps or activities that must be done to achieve what needs to be achieved
- ◆ a time schedule for when each activity must take place and how long it is likely to take (when)
- ◆ a clarification of who will be responsible for making sure that each step is successfully completed (who)
- ◆ a clarification of the inputs/resources that are needed to implement the activity

Developing an action plan that indicates how and when new skills will be applied increases the opportunity that training will be transferred to the job. It ensures that the trainee can establish how his/her newly acquired skill would positively contribute to the improvement of his/her performance and how it will affect program goals and objectives.

The trainer assists the trainees in developing an action plan that is realistic and reflects the principles and skills learned in the course. During the post-training monitoring of the trainees, the trainer determines the extent to which the action plan has been achieved and assists each trainee in resolving issues that impede the implementation of his/her action plan.

# ANNEX I

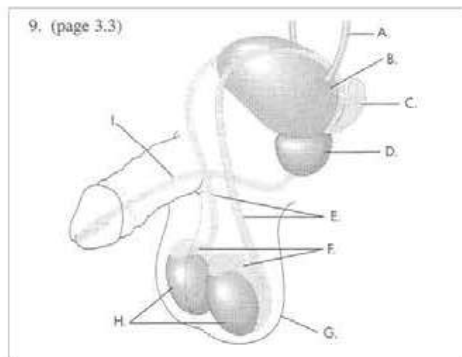
## NSV Knowledge Assessment Test

**Note:** This test will not be graded. It will be used by the trainer to adapt this course to best suit your needs. Decide whether each of the following statements is T (true) or F (false). Write your answer in the space provided for each statement.

### Anatomy and Physiology

1. \_\_\_\_\_Sperm is produced in the seminal vesicles.
2. \_\_\_\_\_Seminal fluid continues to be produced after vasectomy.
3. \_\_\_\_\_Sperm passes first through the vasa deferentia and then through the urethra.
4. \_\_\_\_\_If a vasectomy is performed correctly, subsequent development of antisperm antibodies would not occur.
5. \_\_\_\_\_After vasectomy, sperm can build up in the epididymides.
6. \_\_\_\_\_Each vas deferens is approximately 35 mm long, begins at the seminal vesicle, and ends at the prostate gland.
7. \_\_\_\_\_Testosterone is produced in the prostate gland.
8. \_\_\_\_\_Men who have had a vasectomy should be screened frequently for cardiovascular disease and prostate cancer.

9. Identify the parts of the internal male reproductive organs clockwise from A to H in the diagram below



- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_
- E. \_\_\_\_\_
- F. \_\_\_\_\_
- G. \_\_\_\_\_
- H. \_\_\_\_\_

10. Identify the parts of the spermatic cord clockwise from A to J in the diagram below

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_
- E. \_\_\_\_\_
- F. \_\_\_\_\_
- G. \_\_\_\_\_
- H. \_\_\_\_\_
- I. \_\_\_\_\_
- J. \_\_\_\_\_

### Counseling and Informed Consent

11. \_\_\_\_\_A trained counselor or a doctor is the best person to choose an appropriate contraceptive method for a couple.
12. \_\_\_\_\_NSV surgeons should verify a client's informed consent by talking with him before the procedure.
13. \_\_\_\_\_During vasectomy counseling, the client should be assured that he can change his mind at any time before the procedure without losing the right to other medical services.

### Prevasectomy Evaluation

14. \_\_\_\_\_A man with diabetes cannot have a vasectomy.
15. \_\_\_\_\_A prevasectomy evaluation includes a medical history, a complete physical, and a hemoglobin count or hematocrit.
16. \_\_\_\_\_A client with syphilis should be treated before having a vasectomy.
17. \_\_\_\_\_A client whose vasectomy needs to be postponed should be counseled about alternative methods of contraception.
18. \_\_\_\_\_Prophylactic antibiotics should always be given before vasectomy.



## Infection Prevention

19. \_\_\_\_\_ An iodophor is an appropriate antiseptic to use on the scrotal area before NSV.
20. \_\_\_\_\_ Instruments that have been boiled for 20 minutes can be used in NSV.
21. \_\_\_\_\_ Instruments can be high-level disinfected by soaking them in alcohol or an iodophor for 20 minutes.
22. \_\_\_\_\_ Instruments and gloves can be decontaminated by soaking them in a 0.5% chlorine solution for 10 minutes.
23. \_\_\_\_\_ Handwashing is needed before putting on and after removing sterile or high-level disinfected gloves to perform a vasectomy.
24. \_\_\_\_\_ Used hypodermic needles should be recapped, bent or broken, and then disposed of in a puncture-resistant container.

## Postvasectomy Care

25. \_\_\_\_\_ After vasectomy, a man should use an alternative contraceptive for three weeks.
26. \_\_\_\_\_ A man who has bruising and/or passes a blood clot during ejaculation should immediately return to his NSV provider.
27. \_\_\_\_\_ Following a vasectomy, a man should avoid strenuous activity and wear a snug undergarment for 48 hours.
28. \_\_\_\_\_ Vasectomy provides protection against pregnancy and STIs.
29. \_\_\_\_\_ After vasectomy, a man can resume sexual intercourse after three months if he has zero sperm count.
30. \_\_\_\_\_ A man who developed fever, swelling, and severe pain in the scrotum should immediately return to the service provider.

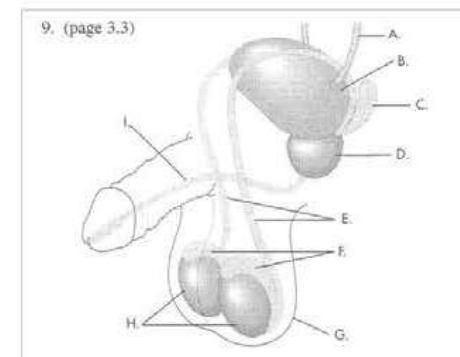
# ANNEX II

## ANSWERS: NSV Knowledge Assessment Test

**Note:** This test will not be graded. It will be used by the trainer to adapt this course to best suit your needs. Decide whether each of the following statements is T (true) or F (false). Write your answer in the space provided for each statement.

## Anatomy and Physiology

1. \_\_\_\_\_ Sperm is produced in the seminal vesicles.
2. \_\_\_\_\_ Seminal fluid continues to be produced after vasectomy.
3. \_\_\_\_\_ Sperm passes first through the vasa deferentia and then through the urethra.
4. \_\_\_\_\_ If a vasectomy is performed correctly, there should be no subsequent development of antisperm antibodies.
5. \_\_\_\_\_ After vasectomy, sperm can build up in the epididymides.
6. \_\_\_\_\_ Each vas deferens is approximately 35 mm long, begins at the seminal vesicle, and ends at the prostate gland.
7. \_\_\_\_\_ Testosterone is produced in the prostate gland.
8. \_\_\_\_\_ Men who have had a vasectomy should be screened frequently for cardiovascular disease and prostate cancer.
9. Identify the parts of the internal male reproductive organs clockwise from A to H in the diagram below



- A. \_\_\_ Ureter \_\_\_\_\_  
B. \_\_\_ Bladder \_\_\_\_\_  
C. \_\_\_ Seminal vesicle \_\_\_\_\_  
D. \_\_\_ Prostate gland \_\_\_\_\_  
E. \_\_\_ Vas deferens \_\_\_\_\_  
F. \_\_\_ Epididymis \_\_\_\_\_  
G. \_\_\_ Scrotum \_\_\_\_\_  
H. \_\_\_ Testicle \_\_\_\_\_  
I. \_\_\_ Urethra \_\_\_\_\_

10. Identify the parts of the spermatic cord clockwise from A to J in the diagram below

- A. Vas .....
- B. Vas lumen .....
- C. Scrotal skin .....
- D. Dartos .....
- E. External spermatic fascia .....
- F. Cremasteric fascia .....
- G. Cremasteric muscle .....
- H. ....
- I. Artery .....
- J. Veins .....

### Counseling and Informed Consent

- 11. \_\_\_F\_\_\_ A trained counselor or a doctor is the best person to choose an appropriate contraceptive method for a couple.
- 12. \_\_\_T\_\_\_ NSV surgeons should verify a client's informed consent by talking with him before the procedure.
- 13. \_\_\_T\_\_\_ During vasectomy counseling, the client should be assured that he can change his mind at any time before the procedure without losing the right to other medical services.

### Prevasectomy Evaluation

- 14. \_\_\_T\_\_\_ A man with diabetes cannot have a vasectomy.
- 15. \_\_\_F\_\_\_ A prevasectomy evaluation includes a medical history, a complete physical, and a hemoglobin count or hematocrit.
- 16. \_\_\_T\_\_\_ A client with syphilis should be treated before having a vasectomy.
- 17. \_\_\_T\_\_\_ A client whose vasectomy needs to be postponed should be counseled about alternative methods of contraception.
- 18. \_\_\_F\_\_\_ Prophylactic antibiotics should always be given before vasectomy.

### Infection Prevention

- 19. \_\_\_T\_\_\_ An iodophor is an appropriate antiseptic to use on the scrotal area before NSV.
- 20. \_\_\_T\_\_\_ Instruments that have been boiled for 20 minutes can be used in NSV.

- 21. \_\_\_F\_\_\_ Instruments can be high-level disinfected by soaking them in alcohol or an iodophor for 20 minutes.
- 22. \_\_\_T\_\_\_ Instruments and gloves can be decontaminated by soaking them in a 0.5% chlorine solution for 10 minutes.
- 23. \_\_\_T\_\_\_ Handwashing is needed before putting on and after removing sterile or high-level disinfected gloves to perform a vasectomy.
- 24. \_\_\_F\_\_\_ Used hypodermic needles should be recapped, bent or broken, and then disposed of in a puncture-resistant container.

### Postvasectomy Care

- 25. \_\_\_F\_\_\_ After vasectomy, a man should use an alternative contraceptive for three weeks.
- 26. \_\_\_F\_\_\_ A man who has bruising and/or passes a blood clot during ejaculation should immediately return to his NSV provider.
- 27. \_\_\_T\_\_\_ Following a vasectomy, a man should avoid strenuous activity and wear a snug undergarment for 48 hours.
- 28. \_\_\_F\_\_\_ Vasectomy provides protection against pregnancy and STIs.
- 29. \_\_\_T\_\_\_ After vasectomy, a man can resume sexual intercourse after 3 months if he has zero sperm count.
- 30. \_\_\_T\_\_\_ A man who developed fever, swelling, and severe pain in the scrotum should immediately return to the service provider.

# ANNEX III

## FAMILY PLANNING SERVICE RECORD (FP Form 1)

**Side A**

1. Fill out or check the required information at the far right of the form:

- ◆ Client number
- ◆ Husband’s name, giving the family name first, date of birth, education, and occupation
- ◆ Wife’s name using her maiden family name, date of birth, education, and occupation
- ◆ Monthly family income in peso
- ◆ Choose “yes” or “no” for the couple’s plan for more children
- ◆ “New” or “current” for type of acceptor
- ◆ Number of children: desired and actual
- ◆ Birth interval desired in years
- ◆ Previous method used; duration of use and reason for discontinuation
- ◆ New/current method
- ◆ Completed desired family size, economic, others for reasons for accepting permanent methods
- ◆ Complete address of the client: number of the house, street, barangay, municipality, and province
- ◆ Wife’s age

2. Fill in the required information on medical, obstetrical/gynecological history, physical examination, pelvic/genital examination, client signature and date, name, and address of health facility.

3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

**Side B**

1. Fill in the required information at the far left of the form on client number and name.

2. On the first column, record the date when the service was delivered to the client.

3. On the second column, record the method accepted/number of supplies given.

4. On the third column, record the following:

- ◆ Medical observations
- ◆ Complaints
- ◆ Services rendered, procedures/interventions done (Lab, treatment)
- ◆ Reasons for stopping or changing the methods
- ◆ Laboratory results

5. On the fourth column, record the name of the provider with the corresponding signature.

6. On the fifth column, record the next service date or appointment date.

# ANNEX IV

**NSV CLINICAL SKILLS CHECKLIST**

TASKS	EVALUATION		
Trainers: When rating tasks for evaluation, use the following codes: <b>S = Satisfactory:</b> Performs the task according to the standard guidelines <b>U = Unsatisfactory:</b> Does not perform the task according to the standard guidelines	Circle one: (M=model C=client) <b>M M M</b> <b>C C C</b>		
<b>All critical steps must be performed satisfactorily for the participants to be assessed as competent.</b>			
<b>Prevasectomy Evaluation</b>			
1. Greets client.			
2. Ensures that the client has been appropriately counseled about the procedure.			
3. Takes medical history and performs heart, lung, and abdominal examination.			
4. <b>*Performs genital examination.</b>			
<b>Preprocedure Tasks</b>			
5. Ensures that the room is warm enough to relax the client’s scrotum.			
6. Reviews chart for relevant medical history.			
7. <b>*Verifies informed consent</b>			
8. Washes hands.			
9. Examines operative site to ensure that spermatic cords are mobile.			
10. Clips hair at operative site, if necessary.			
11. Ensures that the operative site is clean.			
12. Retracts the penis upward on the abdomen in the 12 o’clock position, and anchors it comfortably.			
13. Performs surgical scrub, and wears sterile gloves.			
14. Prepares a syringe to administer 10 cc 1% or 5 cc 2% lidocaine (without epinephrine), and attaches a 1.5 inch (or metric equivalent) small-gauge needle (22 to 27 gauge)			
15. Adequately prepares the operative site with body-temperature antiseptic.			
16. Isolates operative site (scrotum) with sterile sheet(s) or towel(s).			
<b>Procedure Tasks</b>			
17. Observes and communicates with the client.			

**\*A critical step that must be performed satisfactorily for the participant to be assessed as competent.**

TASKS	EVALUATION					
18. *Identifies, isolates, and fixes the right vas deferens under the median raphe midway between the base of the penis and the top of the testicles. Traps the right vas firmly using the three-finger technique.						
19. *Raises the skin wheal using 0.5 cc of 1% or 2% lidocaine (without epinephrine). Advances needle in the right external spermatic fascial sheath toward the inguinal ring approximately 1.5 in above the wheal, aspirates, slowly injects 2 cc to 5 cc of lidocaine into the sheath without withdrawing the syringe, and then removes the needle.						
20. *Uses the three-finger technique to firmly trap the left vas. Reintroduces the needle through the puncture. Advances the needle in the left external spermatic fascial sheath toward the inguinal ring approximately 1.5 in above the wheal, aspirates, and then injects 2 cc to 5 cc of lidocaine into the sheath.						
21. Pinches the skin wheal between the thumb and forefinger to reduce local edema, and waits 2 to 3 minutes for the anesthesia to take effect.						
22. Fixes the right vas under the skin wheal using the three-finger technique.						
23. Applies upward pressure with the middle finger underneath the scrotum; presses the open tips of the ringed clamp onto the skin wheal overlying the vas; grasps the right vas, applying the clamp at a 90° angle perpendicular to the vas, with the palm facing up.						
<b>For Steps 24 to 44, fill the columns for right and left with S or U as appropriate.</b>	R	L	R	L	R	L
24. Checks with client to ensure that the anesthesia is sufficient. If not, repeats local infiltration being sure not to exceed the maximum dose.						
25. Elevates the entrapped vas by lowering the handle of the ringed clamp.						
26. *Uses a quick, sharp, single movement to pierce the skin down to the vas lumen using the medial blade of the dissecting forceps, introduced at a 45° angle.						
27. *Withdraws the medial blade of the dissecting forceps, closes both blades, and inserts both tips of the dissecting forceps into the puncture site to the same depth down to the vas.						
28. Gently opens the blades of the dissecting forceps and spreads the tissue to make a skin opening twice the diameter of the vas.						
29. *Withdraws the dissecting forceps, uses the tip of the lateral blade of the dissecting forceps to pierce the vas wall (or holds the dissecting forceps. In line with the long axis of the vas and grasps the bare vas directly), and rotates the dissecting forceps clockwise 180°.						
30. *Delivers the vas through the puncture hole while releasing the ringed clamp but still keeping it in place.						
31. Grasps a partial thickness of the elevated vas with the ringed clamp.						
32. If the sheath is not completely dissected, gently punctures the vas sheath with one tip of the dissecting forceps, removes and closes the dissecting forceps, and then reinserts to strip the vas sheath.						

\*A critical step that must be performed satisfactorily for the participant to be assessed as competent.

TASKS	EVALUATION					
<b>Occlusion – Ligation With Excision and Fascial Interposition</b>						
33. Ligates the prostatic end of the vas after carefully separating the fascia and blood vessels from the vas.						
34. *Cuts one end of the suture approximately 2 mm to 3 mm from the knot, leaving a single uncut end of approximately 5 cm to 7 cm in length.						
35. Ligates the testicular end approximately 1.5 cm from the prostatic end ligature, and leaves both end of the suture to approximately 5 cm to 7 cm in length.						
36. Excises up to 1 cm of vas in between the two ligatures.						
37. *Pulls both ligatures to ensure that both stumps are separated by at least 1 cm.						
38. Ensures hemostasis						
39. Cuts both ends of the testicular suture, leaving approximately 2 mm to 3 mm						
40. *Allows both ends of the vas to drop back into their original position in the scrotum by gently pulling on the scrotum with the thumb and index finger.						
41. *Very gently pulls the long suture of the prostatic end of the vas to re-expose the cut ends of the vas, which will be covered with fascia.						
42. Gently grasps the fascia of the spermatic cord with the tip of the dissecting forceps and ties the fascia around the vas 2 mm to 3 mm below the previous tie of the prostatic end.						
43. Cuts the suture, and allows the stump to drop into its original position in the scrotum.						
44. Pulls slightly the prostatic end again up to the puncture wound, and cuts the single long end of the suture						
45. Isolates the left vas under the puncture site using the three-finger technique						
46. Grasps the left vas at the lower end of the puncture site with the ringed clamp						
<b>Repeats steps 24 to 44 for the left vas.</b>						
47. Pinches the puncture site tightly for a minute						
48. Inspects again for bleeding						
49. Secures sterile gauze dressing to the wound with a tape or a bandage						
<b>Postprocedure Tasks</b>						
50. Flushes the needle and syringe, and places all instruments in a 0.5% chlorine solution for decontamination						
51. *Ensures the disposal of waste materials and sharps in accordance with infection prevention guidelines						
52. *Immerses both gloved hands in 0.5% chlorine solution						
53. *Removes gloves by turning them inside out. <ul style="list-style-type: none"> <li>If disposing of gloves, places in a leak-proof container or a plastic bag</li> <li>If re-using surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination</li> </ul>						
54. Washes hands thoroughly with soap and water, and dries with a clean cloth						



55. Asks the client how he feels									
56. Provides the client with written postoperative instructions and information when and where to return for follow-up									
57. Reviews instructions orally, and asks if the client has any question									
58. Reviews the need for back-up contraception for at least 12 weeks, and provides the client with condom, if needed									
59. Advises the client to return for semen analysis (if available) after 12 weeks.									

\*A critical step that must be performed satisfactorily for the participant to be assessed as competent

Evaluation for: \_\_\_\_\_  
(Print NAME OF PARTICIPANT)

The Participant is \_\_\_\_\_ COMPETENT \_\_\_\_\_ NOT COMPETENT IN SCROTAL MODEL PRACTICE

The Participant is \_\_\_\_\_ COMPETENT \_\_\_\_\_ NOT COMPETENT TO DELIVER NSV SERVICES

Trainer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ANNEX V

### MODEL INFORMED CONSENT FORM FOR VASECTOMY\*

\_\_\_\_\_

Name of Facility

\_\_\_\_\_

Address

**INFORMED CONSENT FOR VASECTOMY**

I, \_\_\_\_\_, the undersigned, request that a vasectomy  
(Client's name)

be performed on my person. I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are temporary contraceptive methods available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. The surgical procedure involves benefits and risks, both of which have been explained to me.
4. If the procedure is successful, I will be unable to have any more children.
5. The effect of the procedure should be considered permanent.
6. The procedure does not protect me or my partner from infection with sexually transmitted infections, including HIV/AIDS.
7. I can decide against the procedure at any time before the operation is performed (without losing the right to medical, health, or other services or benefits).

\_\_\_\_\_

(Signature or mark of client) \_\_\_\_\_  
(Date)

\_\_\_\_\_

(Signature of attending doctor or delegated assistant) \_\_\_\_\_  
(Date)

If the client cannot read, a witness of the client's choosing (male or female) and who speaks the same language as the client must sign the following declaration:

I, the undersigned, attest that the client has affixed his thumbprint or mark in my presence.

\_\_\_\_\_

(Signature or mark of witness) \_\_\_\_\_  
(Date)

**SAMPLE INFORMED CONSENT IN FILIPINO:**

\_\_\_\_\_  
Pangalan ng Ospital/Center

\_\_\_\_\_  
Address

**PAHINTULOT SA PAGTATALI SA PARAANG  
NO-SCALPEL VASECTOMY (NSV)**

Ako, si \_\_\_\_\_, ang nakalagda sa ibaba, ay kusang loob na humiling na gawin sa akin ang pagtatali sa paraang no-scalpel vasectomy (NSV). Ito ay ayon sa aking sariling kagustuhan at walang pumilit sa akin. Nauunawaan ko ang mga sumusunod:

1. May mga pamamaraan na maaari kong gamitin at ng aking asawa o kinakasama upang pansamantala siyang hindi mabuntis o hindi ako makabuntis.
2. Ang pamamaraang gagawin sa akin ay isang simpleng operation na ang mga detalye ay ipinaliwanag sa akin.
3. Bukod sa mga ipinaliwanag na mga benepisyo sa pamamaraang pagtatali na no-scalpel vasectomy, nauunawaan ko na may bihirang pagkakataon na nalalagay sa alanganin ang mga sumasailalalim sa operasyong ito.
4. Ang no-scalpel vasectomy ay isang permanenteng pamamaraan ng pagpapalano ng pamilya. Subalit hindi garantisadong lahat ng operasyon ay 100% na matagumpay. Mayroong bihirang pagkakataon na ang inoperan ay nakakabuntis parin. Kung ang operasyong gagawin ay magtatagumpay, hindi na ako makakabuntis pang muli.
5. Ang pamamaraang ito ay hindi makapagbibigay ng proteksyon sa akin at sa aking asawa o kinakasama laban sa mga nakahahawang sakit na nakukuha sa pakikipagtalik tulad ng gonoreya o sipilis, pati na rin sa HIV na nagdudulot ng sakit na tinatawag na AIDS.
6. Ako ay hindi pipilitin kung sakaling magbago ang aking desisyon bago simulan ang operasyon (at walang ano mang serbisyo o benepisyong pangkalusugan ang ipagkakait sa akin dahil sa pagbabagong ito).

\_\_\_\_\_  
Lagda o tatak ng kanang hinlalake ng pasyente

\_\_\_\_\_  
Petsa

\_\_\_\_\_  
Lagda ng doktor o kanyang assistant

\_\_\_\_\_  
Petsa

Kapag hindi nakakabasa ang pasyente, isang saksi na lalaki man or babae at kalengwahe o kawika ng pasyente ang dapat pumirma sa sumusunod na pahayag:

Ako, si \_\_\_\_\_, na akalagda sa ibaba, ay nagpapatunay na nasaksahihan ko and pagtatak o paglagda ng pasyente sa dokumentong ito bilang pagsang-ayon sa mga nakalahad sa kasulatang ito.

\_\_\_\_\_  
Lagda ng Saksi

\_\_\_\_\_  
Petsa

# ANNEX VI

## MODEL PREOPERATIVE EVALUATION SURGICAL RECORD

### PREOPERATIVE NSV SCREENING CHECKLIST

Name of Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Client's Profile: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Client \_\_\_\_\_ Age \_\_\_\_\_ No. of Living Children \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Age \_\_\_\_\_ Telephone # \_\_\_\_\_

Complete Address: \_\_\_\_\_ Religion \_\_\_\_\_

Preoperative Counseling Done by: \_\_\_\_\_

Previous Method Used: \_\_\_\_\_

Current Method Accepted: [ ] No-scalpel Vasectomy [ ] Conventional Vasectomy

Reason for accepting NSV: [ ] completed family size [ ] financial difficulties/economic reason [ ] health reason – contraindication with other FP methods [ ] Others \_\_\_\_\_ Specify

Informed consent explained/taken by: \_\_\_\_\_

#### Medical History and Physical Examination

[ ] allergy to drugs/anesthesia/medicines/food \_\_\_\_\_

[ ] difficulty of breathing/asthma [ ] other medical conditions \_\_\_\_\_

#### Check for the following:

Conditions that require extra caution

( ) Previous scrotal injury ( ) Large Varicocele ( ) Large Hydrocele ( ) Cryptorchidism

# ANNEX VII

## SAMPLE NO-SCALPEL VASECTOMY SURGICAL/OPERATING ROOM RECORD

Name of Facility: \_\_\_\_\_  
 Address of Facility: \_\_\_\_\_

### NO-SCALPEL VASECTOMY SURGICAL/OPERATING ROOM RECORD

Name of Client: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Operation: \_\_\_\_\_ Case Number: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Anesthesiologist: \_\_\_\_\_

Surgical Assistant: \_\_\_\_\_ Circulating Nurse: \_\_\_\_\_

Anesthesia: Lidocaine 1% or 2% Local Infiltration, Paravasal Block; Quantity Used: \_\_\_\_\_

Time Started: \_\_\_\_\_ Time Ended: \_\_\_\_\_

Preoperative Diagnosis: Normal Fertile Male desiring Permanent Contraception by NSV

#### Operative Techniques for No-scalpel Vasectomy:

1. Asepsis and antisepsis procedures, including application of surgical drape (eye sheet) exposing only the scrotum, were performed.
2. Using the three-finger technique, the right vas was identified, isolated, and then fixed under the skin at the median raphe midway between the base of the penis and the top of the right testicle.
3. 0.5 mL of 2% lidocaine was infiltrated at the site of puncture using a G25 disposable needle and then re-directed and inserted along the right vas approximately 1.5 cm away from the puncture site directed to the inguinal ring, and 2 mL of anesthesia was deposited.
4. The needle was withdrawn, and the same procedure was performed on the left vas.
5. The skin at the puncture site was pinched to reduce skin edema.
6. Using the same procedure in isolating the right vas, it was grasped by the ringed clamp just near the puncture site.
7. Dissecting forceps were used to pierce the skin down to the anterior aspect of the right vas.
8. The vas was freed by dissection, hooked outside the scrotum, and then clamped by the ringed forceps approximately 1.5 cm of the vas id divested with the spermatic fascia.
9. The exposed vas was tied at each end with silk 2-0, and approximately 1 cm was excised between the two ligatures (-----X---X-----).
10. A fascial interposition was conducted on the prostatic end of the vas and then dropped inside the scrotum and spermatic cord. (No bleeding is noted before the dropping is performed.)
11. The same procedure was carried out on the left vas.
12. No bleeding or abnormal findings were noted.

13. The puncture site was pinched for about a minute and confirmed the absence of bleeding; a JJ band aid was applied.
14. The patient walked back to the ward with postoperative instructions, including postoperative care.

Postoperative Diagnosis: No-scalpel vasectomy, bilateral done on a normal fertile client

Operation Done: No-scalpel vasectomy, bilateral

Suture Used Number: \_\_\_\_\_ pc/s Silk 2-0 (or 3-0), two strands per vas

Sponge Count; \_\_\_\_\_ Estimated blood Loss \_\_\_\_\_ mL

Intra-operative Complications Noted (if any) [ ] bleeding [ ] hematoma [ ] others; describe:  
 \_\_\_\_\_

Postoperative Condition: \_\_\_\_\_

Postoperative Medicines Given: [ ] Amoxicillin 500 mg TID p.o. for five days  
 [ ] Mefenamic Acid 500 mg TID p.o. for pain or  
 [ ] Others: \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF SURGEON OVER PRINTED NAME

## ANNEX VIII

### SAMPLE: MALE VOLUNTARY SURGICAL CONTRACEPTION REFERRAL FORM

#### Male Voluntary Surgical Contraception Referral Form

Date: \_\_\_\_\_

Name/Address of Referral Facility: \_\_\_\_\_

Name of Client: \_\_\_\_\_ Age \_\_\_\_\_ Civil Status \_\_\_\_\_

Address: \_\_\_\_\_ No. of Children \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Reason for Referral:  Preoperative assessment and counseling

for NSV Operation  Postoperative counseling

Post NSV Semen Analysis  Management of complication

Other Information:

\*for management of complication, please attach a copy of the client service record and the surgical or operative record;

Name/signature and designation of person making the referral:

\_\_\_\_\_  
Name and Signature

\_\_\_\_\_  
Designation

Referring facility and address \_\_\_\_\_

## ANNEX IX SAMPLE VASECTOMY LEAFLET

### Vasectomy

is a permanent minor surgical procedure where the vasa deferentia, which serve as the passageway of the sperm from the testes to the seminal vesicle, are identified, cut, and then tied or blocked. This procedure is performed under local anesthesia and/or sedation. A new technique called no-scalpel vasectomy makes the procedure faster and safer.

#### How does vasectomy work?

The disruption of the tube prevents the meeting of the egg (ovum) and the sperm. After vasectomy, the man still produces semen but not sperm; hence, no pregnancy occurs.

#### When can a man have a vasectomy?

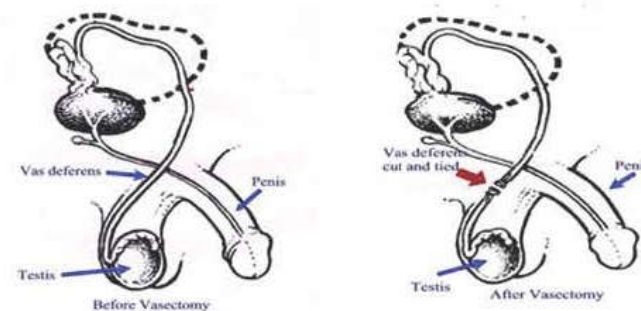
Any time he decides that he will never want any more children.

#### How effective is vasectomy?

Vasectomy is 99.99% effective. However, a newly vasectomized man is not yet considered sterile until after a negative sperm count taken after 15 to 30 ejaculations.

#### Who can undergo vasectomy?

- ◆ Males among couples who have completed the desired family size
- ◆ Men whose wives' lives could be in danger if impregnated



#### Who cannot undergo vasectomy?

Men who have the following conditions:

- ◆ Diabetes mellitus
- ◆ Infection at the site of incision
- ◆ Clotting disorders
- ◆ Enlarged or painful testicles
- ◆ Hernia or hydrocele

**If you have decided to undergo vasectomy, consult the nearest FP clinic for assessment, schedule, and/or referral to the service center**

#### **Instructions to the Client:**

##### **Before the Procedure:**

- ◆ Bathe thoroughly especially the genital area and upper thigh.
- ◆ Wear clean, loose-fitting clothing to the health facility.
- ◆ Do not take any medication 24 hours before the procedure unless otherwise instructed by the health care provider.

##### **After the procedure**

- ◆ If possible, apply cold compress on the scrotum for four hours to lessen swelling. You may experience some discomfort, swelling, and bruising, which should stop within two to three days.
- ◆ Rest for two days. Do not do any heavy work or vigorous exercise for a few days.
- ◆ Keep the incision clean and dry for two to three days. You can use a towel to wipe your body clean, but you should not soak it in water.
- ◆ Wear a snug underwear or pants for two to three days to help support the scrotum. Doing so will lessen swelling, bleeding, and pain.
- ◆ Take paracetamol or another safe, locally available pain reliever as needed. Do not take aspirin or ibuprofen because these medicines slow down blood clotting.
- ◆ You may have sex within two days after the procedure if comfortable.
- ◆ However, use condom or another effective family planning method for the next 20 ejaculations or 3 months after the procedure, whichever comes first..

##### **Return to the clinic or hospital if**

- ◆ you experience pain, fever, or enlargement of scrotum immediately or within seven days or two weeks after the procedure.
- ◆ your wife misses her menstruation or thinks she is pregnant.
- ◆ you have any questions or problems of any kind.

##### **Return to clinic immediately if you develop the following:**

- ◆ High fever (38 °C) in the first four weeks, but especially within the first week after the procedure
- ◆ Bleeding or pus from the wound
- ◆ Pain, heat, swelling, or redness at the incision that becomes worse

**Vasectomy is a safe, permanent, effective, affordable family planning method**

**For more information about vasectomy, consult the nearest family planning clinic:**

**Produced by:  
CMEN**

**For the  
National Family planning Program**

**This publication was made possible through the assistance of the UNFPA and DOH**

**EFFECTIVE.....SAFE....EASY TO USE,  
AFFORDABLE**

# **VASECTOMY**

**A Permanent Method  
for Planning the  
Family for Men with  
completed family**



ADMINISTRATIVE ORDER No. 153 S 2002

SUBJECT: IMPLEMENTING GUIDELINES for the CREATION and OPERATIONALIZATION of  
OUTREACH/ITINERANT TEAM FOR VOLUNTARY SURGICAL CONTRACEPTION

I. Background and rationale

The ultimate goal of the family planning (FP) program has always been to improve the quality of life of the Filipino family. As such, the program efforts to assist couples or individuals to meet their desired family size or fertility intentions are geared toward achieving healthier, happier, and productive individuals and families.

However, meeting the unmet needs for FP services both for spacing and limiting methods remains a major challenge for the program. The 1998 National Demographic Survey showed a 20% rate (2.0 million) of unmet demands for FP services among women of reproductive age. Of these, 11% (or 1.1 million) do not want to have additional children yet they are unable to avail of services. This statistics reflects the backlog in terms of provision of permanent methods. Moreover, the incidence of abortion is estimated to be 300,000 to 500,000 per year, indicating a huge number of unplanned, unintended, or unwanted pregnancies. Abortions also reflect failure of provision of FP services.

Increasing access and availability of voluntary sterilization (VS) services, including bilateral tubal ligation and vasectomy, have emerged as vital and urgent concerns of the FP program. The current use of surgical FP methods is only 10.3% for BTL and 0.2% for NSV, clearly illustrating the need for an invigorated, concerted action to reinforce the past and on-going efforts in strengthening the VS program. Some of these efforts include identifying new and innovative strategies. The provision of VS services has encountered various difficult programmatic challenges. To respond to these challenges, the DOH and other key stakeholders have been working to assemble and implement a comprehensive program to make quality VS services available and accessible to Filipino couples. Previous efforts undertaken under the VS program include the following:

1. Improving the availability and accessibility of services through assistance to upgrade DOH and LGU hospitals to become VS capable sites with appropriate equipment and trained VS providers;
2. Strengthening selected DOH regional hospitals and medical centers to become functional training centers for VS;
3. Strengthening the capability of key staff in the Centers for Health Development (CHD) to become effective monitors of the VS program;
4. Improving referral mechanisms between the peripheral field health units and the VS service sites to strengthen dissemination of information on the availability of VS services to potential clients inside hospitals as well as outside in the surrounding communities;
5. Providing augmentation funds/external resources through special projects to reduce costs of the procedure (including drugs and supplies) to make the services more affordable.

However, lingering casual factors continue to hinder clients from availing VS services. These factors include physical/geographic inaccessibility and the limited number of VS sites that can routinely offer VS services. Another persistent constraint involves the transportation

costs that would have to be shouldered by the clients, their companion (usually a member of the family), and the barangay health worker, if the referral hospital is far from the client's residence.

These constraints could be adequately addressed by the fielding of outreach/itinerant VS teams and by bringing the services to communities where the potential VS clients live.

In this regard, the DOH issues AO 50-A s 2001, mandating all hospitals to create itinerant teams available for dispatch to respond to the surgical needs of urban and rural poor communities. Furthermore, this AO provides that "FP shall form part of the standard services to be delivered by these hospitals in all their medical missions and outreach activities."

The DOH believes that fielding outreach/itinerant VSC teams can answer these needs. Hence, all DOH hospitals were mandated through the AO No. 50-A Series of 2001 to create and deploy FP itinerant teams to communities with high unmet needs. Furthermore, this AO provides that "FP shall form part of the standard services to be delivered by these hospitals in all their medical missions and outreach activities."

II. Coverage and Scope

The coverage and scope for the provision of itinerant VS services should include areas in the country where the VS services must be brought directly to communities where the clients live. The DOH-CHD, in coordination with the concerned DOH hospital and the LGU community, should identify these areas as follows:

- a. Communities with a documented demand for surgical methods and without trained service providers to provide the VS services;
- b. Communities with existing VSC sites inadequate to meet the demand for VS.

III. Creation of Itinerant Teams

1. Organizational Structure

The Itinerant VS teams shall be organized in all DOH regional and medical centers, which will serve as the base of the team. A minimum of two VS teams should be available per hospital. The chief of the respective regional hospital or medical center, through the chairperson of the Department of OB-GYN/FP Center, shall be responsible for the creation and organization of the teams. A hospital order should be issued to create and operationalize the itinerant VS teams.

(The Governor, through the Chief of Hospital at the provincial and/or district level, shall organize and issue an office order to create and operationalize itinerant teams.)

2. Staff Composition

One Itinerant team will be composed of the following:

- a) A BTL Surgeon who is proficient in ML-LA procedure and/or
- b) A trained vasectomy surgeon
- c) A surgical nurse or midwife
- d) A circulating staff

#### IV. Operationalization

##### 1. Service Delivery

###### a. Facilities, Equipment, and Instruments

- ◆ If the itinerant VS site is a hospital (DOH or LGU managed), it should have an available operating room facility that complies with minimum requirements for performing minor surgery, tubal ligation, and vasectomy procedures.
- ◆ If the Itinerant VS service is a health center or a nonhospital venue, it should be refurbished to comply with the minimum requirements for providing MLLA and NSV.
- ◆ MLLA must be performed in a space that could be refurbished to simulate a restricted operating room, measuring 3 m × 3 m × 3 m in size, including provisions for a semi-restricted area.
- ◆ NSV must be performed in a clinic that is enclosed, well ventilated, and with fly-proof windows.
- ◆ The Itinerant VS teams should be equipped with a minimum of five (5) minilaparotomy sets and three (3) NSV sets during each scheduled Itinerant VS service. When necessary, a team should bring with them an OR table, OR light and mini-sterilizer or boiler.

###### b. Drugs and Supplies

- ◆ The DOH regional hospital or medical center should maintain a minimum stock level of drugs and medicines adequate for 30 clients. These drugs and medicines will be brought by the team to the site during the schedule for itinerant VS service.
- ◆ The CHD should provide augmentation funds for the purchase of drugs and supplies for VS provision to be used by the Itinerant teams from the DOH hospitals
- ◆ Alternatively and whenever appropriate, the outreach Itinerant team/ VS site or the LGU community may be tapped to provide VS drugs and supplies.

###### c. Personnel Requirements, including Duties and Responsibilities

###### i. Itinerant Team

- ◆ Two Itinerant VS teams should be dispatched during the scheduled itinerant services
- ◆ The itinerant surgeons will be responsible for the screening and final selection of clients, verification of informed consent, and assurance of quality of care, including proper infection prevention practices
- ◆ The provision of VS should be performed in accordance with the DOH-approved MLLA for female clients and NSV for male acceptors.
- ◆ Members of the itinerant VS team must ensure proper examination and monitoring of clients in the immediate postoperative period and upon discharge on the same day;
- ◆ The Itinerant VS team must secure copies of the records of all BTL and NSV cases performed and will be responsible for submitting reports of performance to the DOH-CHD every month.

###### ii. Staff of the Outreach VS Site

- ◆ FP counseling should be provided by trained staff of the outreach VS site. Counseling activities should be done regularly and during the scheduled outreach VS services;
- ◆ The staff of the outreach VS site should provide both verbal and written postoperative instructions, including follow-up schedules, to the client prior to discharge.
- ◆ They shall keep charts/records of all BTL and vasectomy clients, complete name of clients, age, address, number of children, and the date the procedure was performed.
- ◆ A medical personnel should be made available and tasked to do follow-up visits.

###### d. FP Counseling and Information Dissemination Activities

- ◆ All clients undergoing BTL or vasectomy should undergo FP counseling prior to the procedure. The staff of the outreach VS site should be properly trained to provide FP counseling.
- ◆ Informed consent must be explained by the surgeon to the potential VS clients during the counseling. Signature for consent should then be secured after the client has decided to undergo the procedure.
- ◆ The CHD will be responsible for coordinating activities with the LGU in connection with strengthening referral activities, linkages with other NGOs, and information dissemination for outreach VS services.
- ◆ BHWs should actively seek out and identify potential clients from the surrounding communities and refer them to the outreach VS sites for appropriate screening and counseling.
- ◆ All referrals should be adequately documented, both at the referring and referral units utilizing appropriate referral forms.

###### e. Schedule of VS Services

- ◆ The DOH regional hospital or medical center should coordinate with the outreach VS site in arranging a two-day schedule for itinerant VS services to be regularly conducted on a monthly basis
- ◆ The CHD should assist the DOH hospital itinerant team and VS site in the appropriate scheduling of the itinerant VS services.

##### 2. Financial Resources

- a. The DOH regional hospitals and medical centers should ensure that funds for the medical missions and outreach services of the itinerant teams are incorporated in their regular annual budget preparation and annual procurement plan. This is to reiterate the same provision in the DOH A.O. No. 50 s 2001 that said health facilities should also allocate funds for the operation of the itinerant VS teams, including their travelling cost, etc.

b. The DOH Center for Family and Environmental Health and the DOH-CHD should provide augmentation funds to DOH-retained hospitals to support the VS program including the itinerant VS teams.

V. Supervision and Management

- a. The Chief of Hospital, through the Chairperson of the Obstetrics and Gynecology Department, should ensure that the Itinerant VS teams are operational and functional as provided for in the guidelines
- b. The CHD should exercise oversight functions and ensure that the Regional Hospitals and Medical Centers at their respective areas are delivering outreach VS services through the Itinerant VS teams, as they have been mandated.

This order shall take effect immediately.

Sgd.: MANUEL M. DAYRIT, MD, MSc.  
Secretary of Health



Republic of the Philippines  
Department of Health  
OFFICE OF THE SECRETARY

JUN 27 2012

ADMINISTRATIVE ORDER  
No. 2012 - 0009

Subject: National Strategy Towards Reducing Unmet Need for Modern Family Planning as a means to Achieving MDGs on Maternal Health

I. BACKGROUND AND RATIONALE

Today, around six million Filipino women are estimated to have unmet need for modern Family Planning (FP), either for *limiting* (women who want no more children) or for *spacing* (women who want a child after three or more years). About half a million of these women have unplanned, unwanted, or mistimed pregnancies, that have 20 percent higher likelihood of complications during pregnancy and childbirth, including untimely deaths. This is because women with unplanned pregnancies are less likely to avail of adequate maternal care (NDHS, 2008). Unplanned pregnancies also affect the health conditions of mothers, which can lead to poor maternal and fetal outcomes. Demand and supply side factors alter rates of unmet need.

Demand side factors that influence the level of unmet need for modern FP include: (1) lack of correct information on FP methods which result in fear of side effects, myths and misconceptions, and partner's refusal to any FP method or non-participation in decision-making process; (2) lack of information on what, how and where FP goods or services can be accessed; (3) lack of financial capacity to pay for FP goods and services; and (4) poor health-seeking behavior of clients. While the NDHS 2008 reported high level of awareness on FP (98 percent), this has not been translated into practice, in that only 34 percent reported use of any modern FP method.

On the other hand, supply side factors include: (1) inadequate availability of FP goods owing to irregular or maldistributed supply, poor logistics management; (2) inadequate number and capacity of both facilities/equipment and service providers (specially for long-acting and permanent methods or LAPM services); (3) missed opportunities during point of contact between client and information/service provider; (4) inadequate or unsustainable budget allocation (i.e., financial and/or policy support) for FP at all levels; and (5) limited PhilHealth FP coverage and benefits.

Government-led intervention to address unmet need for modern FP is therefore necessary due to (1) inadequate and inappropriate information on FP and means to address unmet needs; (2) the serious and long-term health effects of having unplanned pregnancies; and (3) the need to minimize the costs of reducing unmet need.

In addition, the use of unmet need as the basis for developing programs and assessing progress in FP is consistent with the policy that focuses to meet needs rather than trying to change people's preferences on FP.

*for*

However, current efforts to address unmet need for FP remain inadequate and fall below desired targets. The 2008 NDHS reported that there were an estimated 900,000 new FP acceptors from 2003 to 2008, or an average of only about 180,000 new FP acceptors per year. At this rate, it would take the country 30 years to address the problem of unmet need in the country.

Reducing unmet need for modern FP is a critical element in attaining the MDG goal of reducing by two-thirds the maternal mortality. Attaining MDGs is part of the third strategic thrust of *Kalusugan Pangkalahatan* (KP), which is the administration's execution plan meant to achieve Universal Health Care. KP provides that public health effort and resources will be focused towards areas with high concentrations of poor families listed in the NHTS-PR, where access to health services remains low. (AO No. 2010-0036 and DO No. 2011-0188).

## II. OBJECTIVE

This Order provides for an updated and comprehensive approach to reduce unmet need for modern FP services in support of the strategic thrust to attain health-related MDGs by the year 2015, and is part and parcel of the implementation of the Aquino Health Agenda to achieve Universal Health Care as described in the *Kalusugan Pangkalahatan* Execution Plan.

## III. SCOPE AND COVERAGE

This Order shall apply to the health sector, from both the public and private sectors: DOH Central Office, Centers for Health Development (CHDs), and DOH-retained hospitals; Central offices and regional units of the Commission on Population (POPCOM), Philippine Health Insurance Corporation (PhilHealth), and other DOH attached agencies; LGUs as provided for in their agreements with the DOH that involve resource transfers, and DOH-ARMM as provided for in the Memorandum of Agreement between DOH and ARMM dated 23 April 2009; Development Partners, in the context of their strategic agreements for health with the Government of the Philippines; private health care providers; and all others concerned.

## IV. DEFINITION OF TERMS

1. **Community Health Team (CHT)** – a group of health volunteers having a critical role in increasing awareness on and recognition of health risks among families, promoting healthy behaviors, and prompting individuals to seek and utilize affordable and accessible health care services, particularly among poor families. DOH, DepEd, DSWD, and DILG JMC No. 2011-0073 provides for the creation of a TWG on CHTs, while DOHDM No. 2011-0286 provides for guidelines on the mobilization of CHTs.
2. **Cross-docking** – a practice in logistics management of unloading materials from the incoming bulk supplier and then loading these materials directly into outbound carriers/forwarders for direct delivery to the end distribution points, with little or no storage in between except for the time needed to obtain samples for quality control.

3. **Family Development Sessions (FDS)** – an integral activity of 4Ps that seeks to expand the knowledge and enhance the skills of beneficiary parents, in order to help them appreciate and comply with the health and education conditionalities of the program. (DSWD Manual of Operations)
4. **FP Competency-based Training (FP CBT)** – training for FP on infection prevention, client assessment, provision of certain FP methods (i.e., standard days method, hormonal contraceptives, and condoms), counseling, and FP clinic management that uses a ladder approach, exposing participants to levels of training based on developed knowledge, skills, and behavior. The modified training system, which is performance-based, develops the knowledge, attitudes, and skills of participants on the requirements of quality family planning (FP) service provision. FP CBT 1 covers knowledge on the different modern methods and skills on counseling, pills dispensing, injectable, condom insertion, and cycle beads FP methods, while CBT 2 covers IUD insertions. Specialized course on FP includes Natural Family Planning Methods, Minilaparotomy under local anesthesia (BTL), and No-scalpel vasectomy (NSV)
5. **Informed Choice and Voluntarism (ICV)** – a standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misrepresentation. Guidelines on ensuring compliance to ICV in the delivery of FP services are contained in DOH AO No. 2011-0005.
6. **Interpersonal Communication and Counseling (IPCC)** – a face-to-face, verbal and non-verbal exchange of information. Effective IPCC between health care provider and client is one of the most important elements for improving client satisfaction, compliance and health outcomes.
7. **Kalusugan Pangkalahatan (KP)** – also known as the Aquino Health Agenda to achieve Universal Health Care (AHA-UHC), KP is a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform. KP's three strategic thrusts are i) rapid expansion in NHIP enrollment and benefit delivery using national subsidies for the poorest families; ii) improved access to quality hospitals and health care facilities through accelerated upgrading of public health facilities; and iii) attainment of the health-related MDGs by applying additional effort and resources in localities with high concentration of families who are unable to receive critical public health services. DOH AO No. 2010-0036 and DO No. 2011-0188 provide for the agenda and the execution plan to achieve UHC/KP, respectively.
8. **MDG 12 Areas** – these are sub-national areas of NHTS-PR poor households that have also been determined to have high concentrations of unmet need for public health services (including modern family planning), in accordance with DO No. 2011-0188 or the KP Execution Plan. These areas are: Metropolitan Manila, Negros Occidental, Quezon Province, Cebu Province, Pangasinan, Iloilo, Cavite, Maguindanao, Zamboanga del Sur, Leyte, Davao del Sur, and Pampanga.

9. **Municipal/City Links (MLs/CLs)** – serve as the link between the DSWD and LGUs in the over-all supervision of 4Ps implementation in municipalities/cities, in coordination with the Municipal Social Welfare and Development Office (MSWDO), and community facilities, like schools and health centers. They monitor compliance and grievances of all stakeholders in the program. Similarly, they provide training and capability building activities to beneficiaries.
10. **National Household Targeting System for Poverty Reduction (NHTS-PR)** – an information management system that identifies who and where the poor are, with its implementation being spearheaded by the DSWD. In compliance with EO No. 867, s. 2010, the DOH as a national government agency has adopted the NHTS-PR as a mechanism in prioritizing the beneficiaries of its programs and projects.
11. **National Online Stock Inventory Reporting System (NOSIRS)** – a logistics management initiative with standard and formal reporting systems that can generate logistics information at all levels of the health care system. NOSIRS utilizes Supply Management Recording (SMR) as the recording tool to efficiently track the status of commodities at health facilities and hospitals nationwide.
12. **Pantawid Pamilyang Pilipino Program (4Ps)** – a poverty reduction strategy that provides cash grants to extremely poor households to allow their family members to meet certain human development goals. The focus is on building human capital in the poorest families (through investments in their health/nutrition and education) because low schooling, ill health and high malnutrition are strongly associated with the poverty cycle in the Philippines. The 4Ps conditionalities for beneficiaries to remain in the program include the requirement for pregnant household members to attend at least one family planning counseling session prior to delivery, and another one within the first six weeks after childbirth. DSWD AO No. 16, s. 2008 provides for guidelines on the implementation of 4Ps.
13. **Parent Leaders (PLs)** – a beneficiary parent of 4Ps who has been determined by consensus of his/her peers to be the point person between the DSWD/4Ps, the LGU link, and the household grantees at the barangay level. The tasks of a PL include the follow-up and monitoring of attendance of household grantees in community assemblies and family development education sessions, as well as the conduct of home visits to household grantees who have not been attending the community assembly. (DSWD 4Ps Manual of Operations)
14. **Priority Municipalities for Poverty Reduction (Priority 609)** – these are municipalities tagged as the Aquino Government's priority areas for poverty reduction, pursuant to NAPC MC No. 2011-001.
15. **Private Sector Providers (PSPs)** – are health care providers (both for-profit and not-for-profit) that are not directly operated or controlled by the state or any of its instrumentalities. PSPs may be natural or juridical persons, and they may either provide health care services or goods.
16. **Service Delivery Network (SDN)** – refers to the network of facilities and providers within the province-wide or city-wide health system offering a core package of services (which includes modern family planning) in an integrated and coordinated

manner, pursuant to the MNCHN Strategy Manual of Operations (DOH DM No. 2011-0117).

17. **Social and Behavioral Change Communication (SBCC)** – an approach that looks at the role of communication in bringing about social change, including individual behaviors and social norms. SBCC utilizes a strategic mix of communication interventions using audience-appropriate interpersonal and mass media communication channels to engage individuals, families and communities to promote, stimulate and sustain behavior change.
18. **Unmet Need for Modern Family Planning (UMFP)** – the number of women who are fecund and sexually active but are not using any modern method of contraception, and report not wanting any more children (limiting) or wanting to delay the birth of their next child (spacing).

#### V. STATEMENT OF POLICY

- A. Filipino families have fundamental, constitutional human rights to determine the number of children they want to have. Given their preferences and understanding of the health risks involved in pregnancy and delivery, Filipino families shall have access to all modern FP methods in order to allow them to determine when to have children and meet their desired family size.
- B. The reduction of unmet need for modern FP shall respect the personal preferences of individuals involved. It shall be contextualized as a human rights-based intervention guided and anchored on the following principles: respect for the sanctity of life, respect for human rights, informed choice and voluntarism (AO No. 2011-0005), and respect for the rights of clients to determine their desired family size.
- C. Modern FP shall include among its methods the following: pills; injectables/DMPA; condoms; IUDs; natural family planning/NFP (AO No. 132 s. 2004) including lactational amenorrhea method (LAM); bilateral tubal ligation (BTL); vasectomy (AO No. 56-A s. 2001); and any other method deemed to be safe and effective by the DOH.
- D. The demand for modern FP methods among the priority beneficiaries shall be accelerated alongside the enhanced and expanded equitable provision of FP goods and services at all levels of the health care system. A whole-of-society, client-centered and social determinants approach shall be adopted.

#### VI. GENERAL GUIDELINES

- A. FP as a program shall be implemented at the national and local levels with the active involvement of both public and private sectors. It shall have the following key elements (RA No. 6365, Sec. 2 as amended by PD No. 79):
  1. Quantitative estimates centered on the elimination of unmet need for modern FP, used for determining logistics and budget requirements for planning purposes (AO No. 2011-0005, provision VI.1.f);



2. Information and education campaigns targeted to priority beneficiaries and delivered mainly at the interpersonal level; and
  3. Provision of affordable and accessible counseling, supplies, commodities, and services of all safe and effective methods to couples desiring to space or limit family size.
- B. The implementation of the FP program shall be *integrated and synchronized* with other public health programs/campaigns (e.g., Maternal, Neonatal, and Child Health and Nutrition or MNCHN programs, *Garantisadong Pambata*, etc.) in the broader context of the KP Execution Plan. It is expected that resources shall be optimized for joint use where applicable with other health priorities. A client-centered, life cycle approach on delivering FP services at any point of contact shall be adopted.

In particular, the following shall be accomplished:

1. Expansion of the enrollment of poor families into the NHIP. This shall include information and guidance on use of PhilHealth benefits for FP through organized Community Health Teams or by some other means that is practicable and sustainable;
  2. Enhancement of the service delivery network (SDN) capacity of providers for FP, especially for LAPM, by upgrading public facilities and to consider contracting private service providers where there are gaps for implementation; and
  3. Fast tracking of procurement and streamlining of distribution and replenishment of goods such as pills, injectables, condoms and IUDs according to the estimates and preferences of beneficiaries in priority areas.
- C. Informed choice and voluntarism (ICV) shall be promoted by all public or private health care providers rendering FP services. Clients shall not be denied any right or benefit including the right to avail of any program of general welfare or health care, as a consequence of any decision regarding FP services; neither shall they be coerced to use any particular FP method.
- D. Priority shall be given to delivering additional/enhanced FP services in localities that have the highest estimated unmet need for modern FP methods. Nevertheless, the delivery of additional/enhanced FP services shall be carried out such that current levels of modern FP use in priority and other areas are equitably maintained.
- E. Contraceptive self-reliance shall be encouraged. Resources such as grants, supplies and commodities, and training/capacity building may be provided to the priority LGUs as lead implementers, in order to leverage for good FP program performance. LGUs that receive such support or assistance are expected to provide complementary allocations to implement health programs.
- F. Interventions to reduce unmet need for modern FP shall be tailor-fitted to prevailing local conditions and needs of province- or city-wide health systems, in close consultation with LGUs.

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- G. In highly populated or urbanized areas and where there are gaps in LGU services, private sector providers (e.g., private practice health professionals, lying-in clinics/birthing facilities, non-government organization clinics, etc.) of FP goods and/or services shall be engaged through the provision of grants, commodities, and technical assistance or any other acceptable mechanism.
- H. Monitoring and evaluation of progress in reducing unmet need for modern FP shall focus on indicators based on factors that influence demand and supply, and the resulting outcomes from these interventions.
- I. All Social and Behavioral Change Communication (SBCC) activities for KP shall be not be independent of the overall unifying communication strategy for KP that addresses individual knowledge and behavior, collective attitudes or norms, and societal level policies and regulations.

## VII. SPECIFIC GUIDELINES

- A. The delivery of additional/enhanced FP services shall be executed according to the estimates of unmet need for FP in the following beneficiaries, in order of descending priority:
1. NHTS-PR poor households living in MDG 12 areas;
  2. NHTS-PR poor households living in the Priority 609 municipalities;
  3. All other NHTS-PR poor households not included in items 1 and 2 above; and
  4. Other poor households that may be identified, as a result of need or availability of resources.
- B. The procurement and distribution of commodities shall be streamlined according to the following:
1. Commodities shall be procured according to the estimated needs of priority populations based on the preferred method mix per age group, as determined by data on observed health-seeking behaviors using the most recent demographic health survey or its equivalent, or by some other comparable scientific method as deemed appropriate by the DOH.
  2. Commodity grants to be provided to LGUs shall take into consideration the local availability of FP commodity stock supply, strength of the private sector market, LGU commodity self-reliance activities, and the commodity assistance of development partners.
  3. Supply chain management shall promote efficiency with the end goal of the expedited distribution of quality-checked commodities to beneficiary families. Towards this end, innovations such as but not limited to cross-docking of commodities shall be adopted.
  4. A unified information and communication technology (ICT) solution (e.g., NOSIRS/SMR) shall be used to track commodity flows in real time, from the point of initial procurement to the point of receipt by beneficiary families.
  5. Commodity assistance or donations for FP from Development Partners shall be coordinated with DOH, who will allocate the said commodities according to the prioritization of beneficiaries in this

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Order. Donated commodities shall be reserved for distribution to LGUs with supply gaps.

- C. LGUs shall take the lead in implementing FP programs and services. Consistent with applicable provisions of AO No. 2008-0020, DOH shall provide assistance through grants, commodities, facility enhancement, technical assistance, and/or training/capacity building in the context of other assistance packages under KP. Assistance shall be delivered through grant mechanisms that shall promote collaboration and innovation among local partners such as the private sector, labor associations, NGOs, or civil society.
- D. The training/capacity building of FP providers shall proceed according to the following:
1. Standardized training for the provision of all modern FP services shall be offered to all government/public and private sector providers at a reasonable cost (e.g., meals and accommodation, among others). Once trainees complete the prescribed courses/activities, they shall be included in the SDN of their respective areas;
  2. All DOH regional medical centers are hereby designated as training centers for permanent methods of FP, such as BTL via mini-laparotomy under local anesthesia (MLLA) and no scalpel vasectomy, provided that they shall also be training centers for IUD insertion in areas where there are no preceptor sites for FP CBT Level 2;
  3. CHDs and LGU health offices shall organize and conduct FP CBT Level 1 and natural FP training courses; and
  4. Where there are gaps in public sector trainers, private sector partner training institutions/training centers shall be contracted to provide capacity building.
- E. FP services are to be provided to poor families with zero co-payment on their part, consistent with KP policy on No Balance Billing (NBB). PhilHealth shall be the main source of financing to pay for FP services, according to the terms and conditions of its benefit packages for FP.
- F. The upgrading of public hospitals and other health facilities shall ensure the availability of appropriate FP services according to their respective service delivery mandates, and shall be part of the hospital development plan.
- G. Social and behavioral change communication (SBCC) activities shall be customized and targeted for direct delivery to beneficiary families at the *interpersonal* level, according to the following, among others:
1. Community health teams (CHTs) and other community based volunteers shall be mobilized to conduct household visits to inform families, assist in health use planning, as well as follow-up and refer couples to appropriate health facilities/providers;
  2. Parent Leaders (PL), in coordination with the DSWD and LGUs, shall be integrated into or shall work with CHTs for mobilization to 4Ps families, including the conduct of Family Development Sessions (FDS) on responsible parenthood and family planning. Municipal

Links (ML) shall be tapped to assist in organization of FDS centered on modern FP; and

3. The conduct of outreach activities to the poor shall generate supportive social norms for family planning, stimulate behavior change for the utilization of modern FP methods, and provide opportunities to serve clients (e.g., provision of mobile clinics).
- H. In areas where there is significant presence and activity of private sector providers and other stakeholders (e.g., urban areas), they may be contracted to provide and/or support FP services so that DOH, LGU, and other public sector effort and resources can be focused on isolated and hard-to reach areas (e.g., GIDAs).
1. Each province- or city-wide health system shall carry out measures to reduce unmet need for modern FP, which includes the following major steps:
    1. Using the latest data on the identities and locations of the priority beneficiary families (i.e., lists of 4Ps families and NHTS-PR families), estimate the magnitude of unmet need for modern FP as well as the magnitude of current modern FP use.
      - a. The overall approach to reducing unmet need among the poor is conceptually illustrated in Annex A.
      - b. Annex B provides the detailed estimates of unmet need for modern FP for CY 2012, subject to validation with actual households.
    2. Using the latest data on modern FP service and commodity preferences/method mix of the population, estimate the volume and cost of required commodities and services needed by the beneficiary families.
    3. Determine and document the inventory of available resources and capacities (budget, infrastructure, and trained personnel) for modern FP commodities and services from the central, regional, and local level, coming from the LGU, DOH, Development Partners, and private sector providers.
    4. Match/assign available resources and capacities for modern FP to the beneficiary families' requirements for commodities and services with the use of a geographic information system (GIS) such as Google Earth/Google Maps, or some other similar platform.
    5. Determine commodity and service gaps, if any, and propose solutions by which these gaps can be filled.
    6. Designate/contract at the level of municipalities/barangays public or private providers that can provide FP goods and services to the beneficiary families at no balance billing (NBB).
    7. Specify mechanisms for the delivery of FP services to families at the points of use, given local conditions and preferences, in consideration of both estimated unmet need and current use.
    8. Coordinate the timeline of activities to meet specific targets for reduction in unmet need and maintenance of current use with timelines at the regional and national levels.

- J. The planned outcome of families using safe, affordable, and high quality FP commodities and services according to their preferences shall be achieved by ensuring that inputs (e.g., budgets, commodities, and other resources) shall lead to the necessary outputs (e.g., health use plans for FP) within a specific timeframe. An operational monitoring and evaluation system for FP services shall be integrated with its overall counterpart for KP, with data quality checking and adequate information systems management. In particular, CHTs shall validate the estimates of unmet need for modern FP with the expressed need of clients.

## VIII. ROLES AND RESPONSIBILITIES

- A. A Technical Steering Committee (TSC) shall lead the implementation of this Order.
1. The TSC shall be co-Chaired by the heads of the DOH CO Technical Clusters supervising POPCOM and NCDPC. The Executive Director of POPCOM shall be the Vice Chair of the TSC.
  2. TSC members shall include the Directors IV of NCDPC and NEC; a representative of PhilHealth; and one Regional Director for each Operations Cluster, to be designated by the respective Operations Cluster heads.
  3. The TSC shall take the lead in terms of policy development, standard setting, advocacy, resource mobilization, capacity building, networking and coordination, and monitoring and evaluation, according to the provisions of this Order.
  4. The TSC shall report directly to the Secretary of Health and the DOH Executive Committee on the organizational, programmatic, and communication arrangements to implement this Order.
- B. The Department of Health (DOH) shall coordinate and work closely with their respective national and local counterparts of the DSWD, DILG, NAPC, other national government agencies including Civil Society Organizations (CSO), so that the national strategy for reducing unmet need for FP services is shared and implemented synchronously at all levels.
1. The National Center for Disease Prevention and Control (NCDPC) through the Family Health Office shall assume technical leadership over the FP program while providing logistic supplies and arrangements, as well as developing policies and plans for establishing, developing, and sustaining FP services at all levels in high priority areas. Specifically, NCDPC shall:
    - a. Identify the medium- and long-term quantifiable estimates to reduce unmet need for modern family planning;
    - b. Prepare and oversee centralized procurement requests for FP commodities based on the forecast demand;
    - c. Develop standards and protocols for the delivery of FP services (e.g., screening of women with unmet need for modern FP; participation of the private sector), for reference and use by LGUs in their service delivery activities and PhilHealth in their accreditation of FP providers;

- d. Develop a monitoring and reporting mechanism to track progress in the implementation of this Order.
  - e. Coordinate with the following: the Health Policy Finance and Research Development Technical Cluster in developing principles of FP grants; the NCHFD for the upgrading of DOH and LGU hospitals and facilities; the NCHP for the development and implementation of an FP communication plan; and CHDs to provide technical support; and
2. Centers for Health Development (CHDs) of their respective Operations Clusters shall identify approaches and interventions that are most appropriate for the LGUs within their respective regions, and provide technical support to LGUs in the following areas:
- a. Development of the FP service delivery network and capacity building for FP CBT 1 and 2 and Natural Family Planning;
  - b. Demand generation from women and couples with unmet need;
  - c. Sustaining the current use rate for modern family planning;
  - d. Design and implementation of FP grant mechanisms by consolidating available resources from the central office, regional funds, retained hospitals, and development assistance; and
  - e. Monitoring and reporting of progress in reducing unmet need for modern FP.
3. DOH-retained hospitals, including among others the Fabella Memorial Hospital, shall influence local performance by:
- a. Creating FP itinerant teams and making them available for dispatch to respond to the needs for surgical methods especially in urban and rural poor communities (AO No. 50-A, s. 2001);
  - b. Being resource centers for technical assistance, training and research including logistics;
  - c. Being local benchmarks for clinical practice and procedures, following the Philippine Clinical Standards Manual on Family Planning 2006;
  - d. Being sources of competitive pressure so that local private and public facilities are influenced to deliver quality and affordable care; and
  - e. Being end referral facilities that will complement services provided by LGU hospitals and facilities.
4. The Health Policy Finance and Research Development Technical Cluster, through the HPDPB and the BIHC, shall:
- a. Ensure that programs of units in the sector support the implementation of this Order by integrating programs, projects, and activities for FP into existing plans of KP;
  - b. Integrate the monitoring and reporting mechanism to track progress in the implementation of this Order into the overall monitoring and evaluation frame for KP;
  - c. Coordinate with Development Partners to ensure that their operations for FP are consistent with this Order.

5. The National Center for Health Facilities Development (NCHFD) shall:
    - a. Provide standards for health facility enhancement related to FP services;
    - b. Coordinate with Operations Clusters and CHDs so that the upgrading goals for DOH and LGU hospitals and facilities shall include the capability to provide FP services; and
    - c. Work with NCDPC to coordinate, consolidate, and maximize interventions for FP services.
  6. The Central Office Bids and Awards Committee (COBAC) shall, in coordination with the NCDPC, undertake necessary measures to facilitate timely and appropriate procurement of FP supplies and commodities, according to the provisions of this Order and in coordination with the TSC.
  7. The Materials Management Division (MMD) shall, in coordination with the NCDPC, undertake necessary measures to strengthen logistics management to ensure, among others, the prompt delivery, tracking (e.g. use of NOSIRS) and distribution of FP supplies and commodities according to the provisions of this Order and in coordination with the TSC.
  8. The Food and Drug Administration (FDA) shall facilitate the availability of safe, good quality, efficacious and cost-effective FP goods, including devices, by undertaking measures which include but are not limited to the release of necessary documents (e.g. CPR) for government procured or donated FP goods.
  9. The National Center for Pharmaceutical Access and Management (NCPAM), in coordination with the FDA and NCDPC, shall ensure that FP goods are included in the Philippine National Drug Formulary, based on acceptable scientific standards, such as the WHO recommendations on Essential Medicines List.
  10. The National Center for Health Promotion (NCHP) shall develop and implement an FP communication plan at the national, regional, and local levels, with focus on interpersonal communication and counseling (IPCC) to families through CHTs or any other mechanism, in tandem with the POPCOM, in order to generate increased demand for FP goods and services.
  11. The National Epidemiology Center (NEC) shall provide technical assistance and operational support such as, among others, FP studies and surveys including the Field Health Surveillance and Information System (FHSIS), data quality assurance, and analysis of data related to FP indicators, in coordination with the TSC.
  12. The Information Management Service (IMS) shall explore and implement options for developing and sustaining information systems for the FP program.
- C. The Commission on Population (POPCOM) shall have a pivotal role of ensuring increased demand for FP goods and services, while assuming technical leadership over policies on human population and development, ensuring effective collaboration with major stakeholders, and lastly, providing an enabling environment for capacity building on advocacy.

Specifically, POPCOM shall:

1. Be the lead technical resource for FP advocacy particularly for LGU officials and in developing LGU capacity for demand generation;
  2. Take the lead in assisting in the design and conduct of demand-generation activities based on the communication plan of LGUs and other stakeholders, such as private sector FP providers;
  3. In coordination with the DOH-NCHP, launch advocacy/information and education campaigns on FP, with emphasis on interpersonal communication to families through mechanisms like the CHTs; and
  4. In coordination with DOH-NCDPC, DOH-CHDs and DOH-ARMM, provide technical assistance and operations support in the monitoring and reporting of progress in reducing unmet need for modern FP.
- D. PhilHealth shall exercise leadership in ensuring financial risk protection by providing options for optimal enrolment of recipients of FP services, and expanding benefits to its members to achieve goals of reducing unmet need for modern FP services.
- Among others, it shall review its standards for accrediting and contracting health professionals (e.g., midwives, nurses, and physicians) and facilities (e.g., BHS, RHUs, private clinics, ambulatory surgical clinics, birthing centers, hospitals, etc.) alongside with the Bureau of Health Facilities and Services, in order to expand benefits and develop packages for FP services.
- PhilHealth shall give due consideration to developing mechanisms to finance FP services delivered through alternative service delivery mechanisms such as outreach programs or by itinerant teams.
- E. Local Government Units (LGUs) are encouraged and shall be assisted to:
1. Execute and implement the major steps needed to reduce unmet need for modern FP, as enumerated in item VII. I. of this Order;
  2. Ensure that demand generation initiatives are implemented in the locality by providing local policy support, as well as budget allocation for all identified activities;
  3. Support the institutionalization of the participation of community-based volunteers in the locality for demand generation by providing incentives for their follow-ups/household visits;
  4. Participate in the SBCC campaigns by way of budget allocation for translation to local dialects and reproduction of SBCC materials;
  5. Mobilize and support local population officers/workers and barangay service point officers (BSPOs) or their designates to be the focal/resource persons in the conduct of the RP/FP module of the 4Ps FDS, as well as to be in-charge of overall reporting and monitoring of all RP/FP classes;
  6. Ensure that the FP service facilities are adequately accessible with trained service providers, appropriate equipment and commodities;

7. Ensure contraceptive self-reliance particularly to meet the FP unmet needs of their poor constituents;
8. Provide assistance in capacity building of MLs/PLs and community-based volunteers through the use of local facilities, equipment and vehicles and provision of budget for meals and snacks and materials for training; and
9. Monitor, submit and disseminate performance indicators on a regular basis through the CHDs, in coordination with the TSC.

F. Development Partners, within the context of the Sector-wide Development Approach for Health and subject to agreements with the DOH, shall ensure that their assistance to FP (commodities or otherwise) shall be consistent with the provisions of this Order. All FP-related projects shall be coordinated with the TSC, through the Bureau of International Health Cooperation (BIHC).

**IX. ANNEXES**

The following Annexes are an integral part of this Order:

- Annex A** – Illustration of the overall approach to reducing unmet need among the poor, for planning and budgeting purposes
- Annex B** – Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

**X. REPEALING AND SEPARABILITY CLAUSE**

All orders, rules, regulations, and other related issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

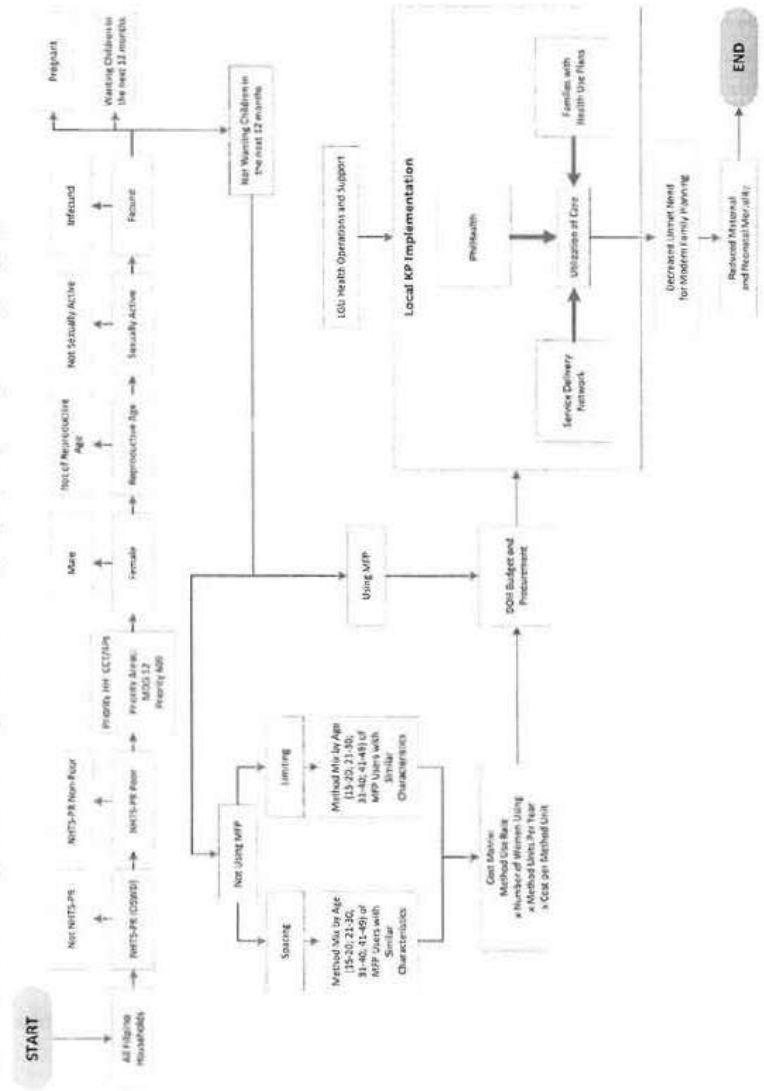
In the event that any provision or part of this Order is declared unauthorized or rendered invalid by any Court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

**XI. EFFECTIVITY**

This Order shall take effect immediately.

*ET Ona*  
**ENRIQUE T. ONA, MD**  
 Secretary of Health

Annex A – AO No. 2012-\_\_\_\_\_  
 Illustration of the overall approach to reducing unmet need among the poor, for planning and budgeting purposes





Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

## Estimates of Unmet Need for Modern FP for CY 2012

Area	Number of NHTS-PR poor households*	Number of CCT/4Ps households*	Estimated UMFP of NHTS-PR poor households	Estimated UMFP of CCT/4Ps households
<b>Philippines</b>	<b>5,255,094</b>	<b>2,991,466</b>	<b>2,232,963</b>	<b>1,316,838</b>
<b>Northern and Central Luzon Operations Cluster</b>	<b>768,438</b>	<b>331,640</b>	<b>768,438</b>	<b>147,584</b>
<b>CAR</b>	<b>79,816</b>	<b>55,570</b>	<b>41,187</b>	<b>29,086</b>
ABRA	17,544	12,422	8,966	6,586
APAYAO	10,838	7,413	4,473	3,160
BENGUET	17,947	11,195	11,685	7,340
IFUGAO	12,229	9,270	6,772	5,202
KALINGA	13,605	9,818	6,980	5,135
MOUNTAIN PROVINCE	7,653	5,452	2,310	1,662
<b>CHD I</b>	<b>247,882</b>	<b>116,296</b>	<b>107,457</b>	<b>51,636</b>
ILOCOS NORTE	24,890	14,785	8,240	5,816
ILOCOS SUR	34,213	13,219	3,517	6,605
LA UNION	40,178	16,114	17,255	6,959
PANGASINAN	148,601	72,178	41,135	32,255
<b>CHD II</b>	<b>118,118</b>	<b>80,315</b>	<b>45,353</b>	<b>31,171</b>
BATANES	178	0	66	0
CAGAYAN	38,270	28,413	15,536	10,039
ISABELA	54,678	35,330	25,566	12,867
NUEVA VIZCAYA	16,500	10,289	4,722	5,072
QUIRINO	8,492	6,283	1,416	3,193
<b>CHD III</b>	<b>322,622</b>	<b>79,459</b>	<b>136,876</b>	<b>35,692</b>
AURORA	9,333	6,516	3,864	5,788
BATAAN	16,655	3,049	5,475	1,468
BULACAN	73,683	10,141	19,504	5,336
NUEVA ECIJA	96,863	31,226	36,147	11,021
PAMPANGA	55,328	9,258	21,273	2,852
TARLAC	46,956	12,279	15,519	5,422
ZAMBALES	23,804	6,990	5,056	3,805
<b>Southern Luzon and NCR Operations Cluster</b>	<b>1,410,509</b>	<b>691,167</b>	<b>687,302</b>	<b>355,598</b>
<b>CHD IV-A</b>	<b>389,811</b>	<b>156,346</b>	<b>181,470</b>	<b>78,774</b>
BATANGAS	105,359	49,597	36,189	17,637
CAVITE	58,536	11,019	25,612	4,986
LAGUNA	55,417	11,877	32,267	7,197
QUEZON	122,139	81,625	68,726	48,085
RIZAL	48,360	2,228	18,677	869

Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

Area	Number of NHTS-PR poor households*	Number of CCT/4Ps households*	Estimated UMFP of NHTS-PR poor households	Estimated UMFP of CCT/4Ps households
<b>CHD IV-B</b>	<b>242,633</b>	<b>159,441</b>	<b>104,468</b>	<b>71,219</b>
MARINDUQUE	14,152	7,315	6,512	3,411
OCCIDENTAL MINDORO	37,421	24,045	22,735	15,031
ORIENTAL MINDORO	73,878	52,272	30,731	22,491
PALAWAN	95,952	60,551	36,260	24,103
ROMBLON	21,230	15,258	8,230	6,183
<b>CHD V</b>	<b>461,242</b>	<b>307,665</b>	<b>245,583</b>	<b>172,110</b>
ALBAY	88,242	31,544	48,471	18,287
CAMARINES NORTE	40,802	28,546	25,517	18,872
CAMARINES SUR	136,208	98,721	70,763	53,198
CATANDUANES	16,743	13,724	9,372	7,939
MASBATE	103,478	77,645	56,843	45,797
SORSOGON	75,769	57,485	34,617	28,018
<b>NCR</b>	<b>316,823</b>	<b>67,715</b>	<b>155,780</b>	<b>33,495</b>
Manila	58,329	17,515	19,894	6,162
Mandaluyong	5,445	1,465	2,895	795
Marikina	11,997	1,750	6,164	903
San Juan	2,166	338	1,170	182
Navotas	20,633	4,639	12,714	3,018
Las Pinas	11,185	2,206	4,763	1,017
Makati	7,552	909	3,145	386
Peranaque	12,705	1,280	5,076	541
Muntinlupa	10,213	2,307	4,147	947
Pateros	2,436	317	1,015	131
Quezon City	51,445	9,416	25,739	4,784
Pasay	9,430	2,727	3,904	1,539
Valenzuela	18,615	3,051	11,339	1,941
Malabon	21,563	4,256	13,291	2,726
Caloocan	40,160	8,418	24,705	5,499
Pasig	19,131	3,781	10,373	1,596
Taguig	13,818	3,340	5,447	1,327
<b>Visayas Operations Cluster</b>	<b>1,035,376</b>	<b>683,684</b>	<b>464,239</b>	<b>318,921</b>
<b>CHD VI</b>	<b>385,516</b>	<b>253,171</b>	<b>173,669</b>	<b>116,298</b>
AKLAN	34,924	23,207	14,425	9,858
ANTIQUE	38,155	27,103	18,217	13,409
CAPIZ	39,855	33,446	12,947	11,058
GUIMARAS	11,148	6,574	10,079	6,166
ILOILO	122,770	76,187	61,745	39,434
NEGROS OCCIDENTAL	138,664	86,654	56,256	36,374
<b>CHD VII</b>	<b>314,652</b>	<b>205,925</b>	<b>126,512</b>	<b>86,183</b>

Annex B – AO No. 2012-

Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

Area	Number of NHTS-PR poor households*	Number of CCT/4Ps households*	Estimated UMFP of NHTS-PR poor households	Estimated UMFP of CCT/4Ps households
BOHOL	70,028	45,996	37,939	25,681
CEBU	151,425	94,498	50,872	33,181
NEGROS ORIENTAL	88,548	62,937	34,769	25,663
SIOUJOR	4,651	2,494	2,932	1,657
<b>CHD VIII</b>	<b>335,208</b>	<b>224,588</b>	<b>164,058</b>	<b>116,440</b>
BILIRAN	8,070	6,386	5,574	4,539
EASTERN SAMAR	38,487	22,118	16,723	10,106
LEYTE	132,377	88,549	52,422	37,162
NORTHERN SAMAR	59,262	44,255	24,975	19,758
SAMAR (WESTERN SAMAR)	73,827	46,437	44,759	30,527
SOUTHERN LEYTE	23,185	16,843	19,605	14,349
<b>Mindanao Operations Cluster</b>	<b>1,509,245</b>	<b>971,194</b>	<b>379,451</b>	<b>380,620</b>
<b>CHD IX</b>	<b>369,236</b>	<b>227,352</b>	<b>144,689</b>	<b>95,304</b>
CITY OF ISABELA	10,596	5,029	6,039	3,168
ZAMBOANGA DEL NORTE	113,816	73,749	40,221	28,264
ZAMBOANGA DEL SUR	170,181	98,555	69,172	42,884
ZAMBOANGA SIBUGAY	74,643	50,019	29,257	20,988
<b>CHD X</b>	<b>338,749</b>	<b>233,083</b>	<b>122,277</b>	<b>88,493</b>
BUKIDNON	98,107	71,037	25,435	19,282
CAMIGUIN	7,470	4,889	3,869	2,752
LANAO DEL NORTE	94,007	63,471	37,825	26,868
MISAMIS OCCIDENTAL	46,061	34,191	17,364	13,818
MISAMIS ORIENTAL	93,104	59,495	37,784	25,773
<b>CHD XI</b>	<b>272,932</b>	<b>172,182</b>	<b>83,949</b>	<b>56,061</b>
COMPOSTELA VALLEY	58,148	38,283	16,795	11,946
DAVAO DEL NORTE	58,934	33,261	18,738	11,304
DAVAO DEL SUR	111,655	67,558	36,126	23,214
DAVAO ORIENTAL	44,195	33,080	12,290	9,598
<b>CHD XII</b>	<b>296,043</b>	<b>185,645</b>	<b>112,486</b>	<b>72,090</b>
COTABATO (NORTH COTABATO)	99,021	65,779	38,259	26,081
COTABATO CITY	19,434	10,992	12,184	6,975
SARANGANI	44,469	28,844	16,258	11,017
SOUTH COTABATO	70,771	40,552	26,849	16,047
SULTAN KUDARAT	62,348	39,478	18,936	11,971
<b>CARAGA</b>	<b>232,285</b>	<b>152,932</b>	<b>96,738</b>	<b>68,671</b>
AGUSAN DEL NORTE	49,437	28,412	22,896	13,989
AGUSAN DEL SUR	65,473	45,441	33,650	25,347

Annex B – AO No. 2012-

Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

Area	Number of NHTS-PR poor households*	Number of CCT/4Ps households*	Estimated UMFP of NHTS-PR poor households	Estimated UMFP of CCT/4Ps households
SURIGAO DEL NORTE	58,209	39,635	26,260	19,257
SURIGAO DEL SUR	59,166	39,444	13,932	10,079
<b>ARMM</b>	<b>531,526</b>	<b>313,781</b>	<b>190,410</b>	<b>114,115</b>
BASILAN	41,142	26,514	16,482	10,595
LANAO DEL SUR	109,725	82,024	52,578	38,760
MAGUINDANAO	227,599	111,343	69,991	34,219
SULU	122,218	77,663	39,521	24,235
TAWI-TAWI	30,842	16,237	11,838	6,306

\*Data as of April 2012 update from DSWD CO NHTS-PR and 4Ps Offices

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