

**KNOWLEDGE AND ATTITUDES OF MEN AND WOMEN  
TOWARDS VASECTOMY AS A FAMILY PLANNING  
METHOD, IN WINAM DIVISION, KISUMU DISTRICT**

BY

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## DECLARATION

This project is my original work and has not been presented for a degree to any other university



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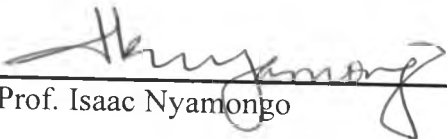
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Date

This project has been submitted for examination with my approval as the university supervisor.



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Prof. Isaac Nyamongo

4/11/2010.

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Date

## **DEDICATION**

To my mother, Mildred T. Oyamo, for believing in the power of educating a woman;  
giving me a future.

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First and foremost I would like to express my gratitude to the Almighty God for the gift of life, strength and courage to do this course. I would also like to thank my parents Maurice and Mildred Oyamo for values that they instilled in me, especially the value of working hard and never giving up.

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## ABBREVIATIONS AND ACROYNMS

AFPA	Ahmedabad Family Planning Association
AVSC	Association of Voluntary Surgical Contraceptives
BMZ	Germany Federal Ministry for Economic Cooperation and Development
FHI	Family Health International
FGD	Focus Group Discussion
FP	Family Planning
FPM	Family Planning Methods
GoK	Government of Kenya
IFPP	International Family Planning Perspective
IUCD	Intrauterine Contraceptive Device
KDHS	Kenya Demographic and Health Survey
LAM	Lactational Amenorrhoea Method
LAPMs	Long Acting Permanent Methods
MSI	Marie Stopes International
MWRA	Married Women of Reproductive Age
NCST	National Council for Science and Technology
OBA	Output Based Aid
ORG	Operation Research Group
TL	Tubal ligation
UNFPA	United Nations Population Fund
VSC	Voluntary Surgical Contraceptives
WHO	World Health Organization
WHRDC	Women Health and Development Resource Centre



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## ABSTRACT

This study investigated the knowledge and attitude of men and women towards vasectomy and how this influenced its uptake at Marie Stopes International, Kibuye in Winam division. The research contributes to the body of knowledge on vasectomy. At policy level, the research provides more insight to the use of vasectomy as a family planning method. The study also examines the knowledge and information available on vasectomy.

The study applied the Theory of Planned Behaviour which questions the classical model of Belief, Attitude, and Behaviour. The theory speaks to the concept of perceived control over the opportunities, resources and skills necessary to perform a behaviour. It operates from the premise that, behaviour is determined by one's intention, and intention is determined by the person's attitude toward the behaviour and the influence of the person's social environment or norms attitude towards behaviour; and that specific behaviour will have concrete consequence. The data were collected using a survey questionnaire, key informant guide, FGD guide and a narratives guide. A total of 40 respondents, 4 key informants and 6 narratives and 2 spouses of men who have undergone vasectomy were interviewed.

The finding of the study indicates that a majority of the respondents had knowledge on vasectomy; however, the uptake is low. This is because there is a general lack of understanding of facts on vasectomy, due to incorrect or misinformation on vasectomy; and insufficient documented information on the effectiveness of vasectomy, as a family planning method.

The study recommends better advocacy, more publicity and efficient dissemination of accurate information on vasectomy. Also that the government should formulate a policy which will ensure vasectomy is offered as one of the family planning options; through ongoing monitoring and evaluation of services and that the use and effectiveness of vasectomy is effectively evaluated and documented.

# CHAPTER ONE: BACKGROUND TO STUDY

## 1.1 Introduction

Population growth is a great concern to the Kenyan government, recent Kenya Population and Housing census placed the total population of Kenya, at 40 Million-evidence that more needs to be done if Kenya is to achieve the first Millennium Development Goal of poverty reduction (Kenya Bureau of Statistics, 2009). Taking cognizance that planning a family improves the health and the living standards of a household, there is need to control the birth rate and family size. Kenya is among the first countries in Africa to develop a favourable policy towards family planning (Gathiti, 1997), in trying to curb the problem of high population growth rate, the government launched the National Population Policy for Sustainable Development in 2000. Among the key objectives were; sustenance of the ongoing demographic transition to further reduce fertility and mortality especially infant and child mortality and to continue motivation and encouragement of Kenyans to adhere to responsible parenthood (KDHS 2008-09).

Despite declining fertility rate in Kenya, we still have pockets of increasing fertility in some areas. Birth control has mainly been viewed as the problem of women and this burden has resulted in inconsistency and non use of contraceptives; seen as major contributing factors to the persistent high fertility levels prevailing in Kenya. This is further enhanced by the non involvement of men as supportive partners or clients, mainly because men are the “forgotten 50%” in family planning programmes (Otieno, 2000). Vasectomy then, is one of the few methods that allow men to take personal responsibility for contraception (Kols and Lande, 2008), which could be used to effectively control population in Kenya as is the case in Pakistan (Marie Stopes International 2010, Global Impact Report, 2009).

Vasectomy is a family planning method, which involves surgical removal of part of each of the ducts through which semen passes from the testicles, especially as a method of birth control (Advanced Learners Dictionary). A small opening is made in the scrotum using dissecting forceps and exposes a loop of the sperm carrying tube – the vas deferens – which is tied in two places. The section between the two ties is then cut. After vasectomy, the testicles continue to produce sperm, which eventually

degenerate and are excreted like any other unused sperm or body cells, while the glands that produce semen will continue to produce in the same amount and after 15 - 20 ejaculations the semen is considered safe as it contains no sperms (WHO, 2002). Contrary to the fears, vasectomy does not change physical traits of masculinity; which include facial hair, muscle tone, body strength, sexual drive, erections or climaxes, as it does not affect production of male hormones. It has limited or no side effects, with only a few men experiencing short-term blood clotting or infection (considered to be minor problems) unlike the many side effects associated with contraceptive on women, such as bone disease and other diseases related to low-levels of oestrogen and progesterone (Kols and Lande, 2008). While vasectomy and tubal ligation (female sterilization) are both equally effective as permanent methods of contraception, vasectomy has many advantages. Clinically, it is a quicker and relatively safer procedure to perform, with a shorter recovery time. Programmatically, it is cost-effective and can be delivered in more settings than tubal ligations.

Although vasectomy has been successfully used in developed countries like USA, Canada, Australia, U.K, New Zealand and China and even more popular than female sterilization in Pakistan, Bhutan and Tajikistan both developing countries (Kols and Lande, 2008), Vasectomy is not widely known or used in Kenya. In the 1989 KDHS, only 35% of the men surveyed and 20% of women had heard of vasectomy, while awareness of female sterilization was higher: 83% and 73%, men and women, respectively. Moreover, vasectomy has been a somewhat politically sensitive issue, and the Ministry of Health had banned advertising for it, until November 1991 “vasectomy workshop” when the ban was lifted (National Council for Population and Development et al., 1989). Presently only 0.1% of Kenyan men have had vasectomy (personal communication, MSI Kisumu, 2009).

According to Gathiti (1997), people need good information and reinforcement to encourage them to practice family planning regularly, consistently and effectively. As such, exposure to information has a powerful influence on the opinions, attitudes and behaviours of the individual. People hear of family planning from media: Television and radio, schools, social programmes and communities.

According to Julie Douglas (MSI, London), there is less information available about Vasectomy, compared to women's methods. For this, there are a number of reasons why men might be reluctant to use vasectomy as a family planning method in Kenya. Among them, is the fact that the use and effectiveness of vasectomy has not been effectively evaluated and documented, leading to lack of information on vasectomy as an effective family planning method in Kenya. There are also myths men hold about vasectomy, especially on loss of sexual drive. Many believe vasectomy would leave a man energy sapped and affect his libido. However, research findings showed without the worry of pregnancy and the concern of using temporary contraception, some men reported increased sexual pleasure after undergoing vasectomy (WHO, 2002). Another obstacle is the stigma associated with vasectomy which makes it difficult for men who have had vasectomy to freely discuss and share their experiences.

To dispel these beliefs and succeed in controlling population growth rate, there is need to focus on men as target of family planning programmes. There is also need for education and motivation on modern contraceptives e.g. vasectomy, because the resistance to these methods are largely based on rumours and attitude towards contraceptives use (Rono, 1994). Hence, this study aimed at investigating knowledge and attitudes towards the use of vasectomy as a male specific family planning method.

## **1.2 Problem Statement**

Non Use of contraceptives is one of the contributing factors to the persistent high fertility levels prevailing in Kenya. The government therefore, made a move to reduce the population growth rate by establishing family planning as a "persuasive policy" aimed at controlling fertility, with female sterilization (4.8%), pill (7.2%), IUD (1.6%), injectables (21.6%), male condom (1.8%), Lactational Amenorrhoea Method (LAM) (0.5%), period abstinence (rhythm methods) (4.7%), withdrawal (0.7%), folk methods (0.7%), others include implant, post coital Estrogens (morning after pills-72hrs), vaginal ring, implants and female condom as the most used methods of family planning in Kenya (KDHS 2008-09). However, vasectomy which is a Long Acting Permanent Method (LAPM) for men was not even documented in this survey.

The fact that the use and effectiveness of vasectomy has not been effectively evaluated and documented, leading to lack of information on vasectomy as an effective family planning method in Kenya, has led to a general reluctance by men to adopt vasectomy as a family planning method. This prompts questions like, are men uninterested in family planning? Or are they resistant to male family planning methods? Is it the vasectomy operation itself that is a barrier? Would interest in vasectomy be greater if men knew more about it? And lastly, where can men find answers to these questions? Against this background, then what is the knowledge and attitudes of men and women towards use of vasectomy as a family planning method?

The study aims at developing a framework whereby fertility behaviour is seen not only as the outcome of effects of well known intermediate and proximate determinants of fertility, but also as a result of the combined roles of the knowledge, attitude, and influence of attitude e.g media exposure, spousal communication and social-cultural environment of the people, on uptake of vasectomy. These determinants indeed constitute the subsurface forces to which lot more attention needs to be considered (Kols and Lande, 2008). This study seeks to fill this information gap, guided by the following research questions:

- What is the knowledge of men and women on vasectomy as a method of family planning?
- What attitude do men and women have regarding vasectomy as a family planning method?
- Does attitude influence the choice of vasectomy as a family planning method?

### **1.3 Objectives**

#### **1.3.1 General Objective**

The study aims at investigating the knowledge and attitudes of men and women which influence the choice of vasectomy as a method of family planning in urban area of Kisumu.

### **1.3.2 Specific Objectives**

- To explore men's and women's knowledge on vasectomy as a family planning option.
- To determine the attitude of men and women towards Vasectomy as a method of family planning.
- To explore the influence of attitude on the choice of vasectomy as a family planning method.

### **1.4 Justification of the Study**

This research aimed at contributing to the body of knowledge on vasectomy and provides opportunity for research into this field of vasectomy as a family planning method countrywide. At policy level the research aimed at prompting more pro-active inclusion of vasectomy as a family planning method in Kenya, training more service providers and availing better facilities. The study focused on qualitative data- that is try to get the men and women tell us in their own words why they may /may not adopt vasectomy as a method of family control. It aimed at understanding the true determinants of male attitude towards choice of vasectomy, given that presently it is under-utilised in an urban African city like Kisumu, Kenya. There was need to examine the social factors which would form the attitude and influence uptake of vasectomy- especial those relating to family and children. The findings of this study will also serve as a theoretical contribution to the debates surrounding vasectomy, which much is not documented on, in Kisumu and Kenya in general.

### **1.5 Scope and Limitations of the Study**

This study was conducted at Marie Stopes Clinic Kibuye, Winam division, Kisumu district and was limited to knowledge and factors influencing attitude towards use of vasectomy as a FPM in this region only. As a result of limited funding, the study was a qualitative and quantitative cross-sectional study, on a small sample focusing on reasons "for" or "against" uptake of vasectomy looking at knowledge and attitude of Marie Stopes clients who visited the clinic for family planning services.

Matters of vasectomy are very sensitive, and as such, there were only a limited number of informants to be interviewed on the subject matter. This small size is



therefore, not representative or sufficient enough to allow for the findings to be generalised to the entire Kisumu population. The study acknowledges that there is lack of adequate information on vasectomy which may have limited its findings. There was challenge in finding the number of experts initially proposed as many of them were not versed in the area of vasectomy, with only one doctor offering the services at the clinic.

The study had also proposed to interview only married men, but in the course of data collection, the study encountered a single man who had come to undertake vasectomy and the researcher felt his information was very vital to the study. Although the study did not propose to interview the spouses of men who had undergone vasectomy the researcher found it necessary; for balanced view of some of the benefits mentioned by the clients of vasectomy.

## CHAPTER TWO: LITERATURE REVIEW

### 2.1 Introduction

In literature review, focus is on Family planning in Kenya, knowledge of vasectomy, factors influencing attitude towards vasectomy and how these influences the uptake of vasectomy as a family planning method.

### 2.2 Family Planning in Kenya

Most of the literature from the previous studies in Kenya have tended to focus mainly on family planning for women, and the role of men in women's family planning issues (Otieno, 2000) and have been carried out under the population studies perspective with quantitative approaches as the prime method and provision of statistics as key (Olungah, 2006). Since 1950s and 1960s, we have witnessed enormous amount of research and writing on population programmes and their impact on women's fertility and choices, but one would be hard pressed to find any survey and articles on men.

According to Mbizvo and Adamchak (1991) African family planning promotion programmes and population policy developments have been hampered by their neglect of men. These programmes are also hindered by the relative scarcity of information about men's knowledge, attitude and practise regarding family planning and vasectomy in particular.

Men seem to have been "the forgotten 50%" of family planning programmes. This is true of family planning in Kenya as men are rarely interviewed in fertility survey of any kind as clients (Otieno, 2000). Family relations are in conflict, and that the benefits and costs of children and child-bearing are not distributed equally between men and women, thus neither the husband nor the wife should be ignored in an attempt to understand fertility behaviour (Salway, 1994).

In Kisumu, especially in the informal settlements which houses 60% of Kisumu residence, population growth is one of the causes of high poverty level which is responsible for a host of ills that plague the town, such as; the high rate of maternal

and infant mortality, malnutrition, low meaningful and profitable involvement in socio economic activities, poor sanitation, low education levels, marginalization and unplanned and large ill-fed families (UN-Habitat, 2009). For this reason, there is need for active and positive family planning interventions. However, birth control has mainly been viewed as the problem of the women. This burden of family planning on women has resulted to inconsistency and non use of contraceptives; seen as major contributing factors to the persistent high fertility levels prevailing in Kenya, enhanced by the non involvement of men as clients and supportive partners in family planning (Otieno, 2000).

### **2.3 Vasectomy as a method of Family Planning**

Vasectomy is a permanent method of family planning involving a surgical process where the service provider cuts the *vasa deferentia*, through which sperm travel from the testicles to combine with semen making the semen sperm free. Vasectomy is effective, safe and cheap to perform and has few side effects (Kols and Lande, 2008).

Unfortunately, knowledge on vasectomy as a method of family planning is poor. With the exception of Bhutan and Tajikistan, female sterilisation is more common than vasectomy in the world. In Africa, Namibia boasts of the highest usage at 0.8%, with Kenya only having 0.1% (Kols and Lande, 2008). In a 1989 study in Nairobi respondent's knowledge on vasectomy was poor and approximately 1/2 of the population did not appear to be confident in their control of their own fertility (Wilkinson, 1989), 6.5% were interested in having a vasectomy; those not in favour stated issues of sexuality and reproduction as the main reason for their objection. Nonetheless almost 1/2 of the respondents wanted to know more about vasectomy (Kols and Lande, 2008).

Vasectomy is not widely known or used in Kenya. In the 1989 KDHS, only 35% of the men surveyed and 20% of women had heard of vasectomy, while awareness of female sterilization was higher: 83% and 73% to men and women respectively (National Council for Population and Development et al., 1989). Moreover, vasectomy has been a somewhat politically sensitive issue, and the Ministry of Health

had banned advertising for it until November 1991 vasectomy workshop when the ban was lifted (National Council for Population and Development, 1989).

A record review by Association for Voluntary Surgical Contraceptive (in urban Kenya) to determine characteristics of Kenyan men who had had vasectomy between January 1976 and September 1988, found 185 reported procedures. From the report, vasectomy at AVSC-supported sites in Kenya showed a total of 246 procedures performed between 1987 and 1991 (AVSC, 1992). In all, 7% expressed interest in vasectomy, and 46% of the men wanted more information on it. These were younger men who were more likely to talk to their wives about contraception. From the same study it was found that the average age among acceptors was 37 years; some 48% had more than 6 children; on average, acceptors had 5.5 children; typically they were in a married, stable relationship with the mean duration of marriage of 14 years; overall, 49% had secondary or university education; some 73% of acceptors had used a family planning method, and for 39% the last contraceptive method used was condoms; 38% had learned about the method from other vasectomised men, 29% from a health worker, and 16% from the media (AVSC, 1992).

Landry et. al, (1997) in a study of attitude towards vasectomy among rural men of Chogoria, found out that 86% of the 300 male participants said they would like to have more information on vasectomy. On average, the interval from obtaining information on vasectomy to undergoing the procedure was 24 months. Of the acceptors, 38% learned of the information from another vasectomised man, 29% from a health worker, and 16% from the media.

Wilkinson et al, (1996) summarized the following as barriers to acceptance of vasectomy in Kenya: men have limited knowledge about vasectomy procedures, men have fear about health and side effects, especially loss of sexuality as they often equate vasectomy with castration, men fear their children may die and they will be unable to have more, many men believe it is the woman's responsibility to use family planning, men want to talk to other vasectomised men, but since the pool of acceptors is so small, this is difficult, many service providers have misinformation, men want to obtain information from health workers, but most family planning service providers are women, and lastly men want to talk to doctors about the procedure, but many

doctors have little knowledge of vasectomy (EngenderHealth, 2000). There have been health concerns over the relationship between vasectomy and prostate cancer, and vasectomy and coronary heart disease. However, study showed there was no increased risk of prostate cancer on those who have undergone vasectomy (Stanford et al., 1999). There is also no increase of coronary heart disease as a result of having had vasectomy, showing that vasectomy has no effect on heart disease (Pewitt et al., 1984).

The above findings are evident that there are varying factors which determine the choice of vasectomy as a family planning method.

## **2.4 Attitude towards vasectomy**

### **2.4.1 Myths and misinformation influencing attitude towards vasectomy**

According to Gathiti (1997), people need good information and reinforcement to encourage them to practice family planning regularly, consistently and effectively. As such, exposure to information has a powerful influence on the opinions, attitudes and behaviours of the individual. People hear of family planning from the media: Television and radio, schools, social programmes and communities.

Lynam et. al (1993), in a survey carried out in Nairobi, found out that there was a good deal of misunderstanding about vasectomy. While vasectomy is a sterilization process, many men equate vasectomy with castration. There was realization that men have limited knowledge about vasectomy, and that they have fears about health and side effects, especially loss of sexuality as vasectomy would leave a man energy sapped and affect his libido. The fact is vasectomy does not affect production of male hormones that control the sex drive, erection, or masculine feature, such as facial hair or muscle tone.

There is also the fear that vasectomy may increase the risk of prostate cancer. However, recent research findings indicate there is no link between cancer and vasectomy (Kols and Lande, 2008). For those who had some information on vasectomy, they assumed it is a painful process, expensive and can lead to

complications in the future. However, vasectomy is a simple painless process that last between 5-15 minutes, cheaper than female sterilization and effective method with limited complications, only 1 % has been reported, which are simple and correctable (Sharma, 2003).

In most communities, it is the fear of the unknown that kept men away, for example, a man fears that their children may die, or their wife, or even divorce, and they will be unable to have more children. The greatest fear however, is the potent fear of losing their “macho-image” in case the news of a man undertaking vasectomy leaks to his peers. Of interest are women rejecting vasectomy in some societies e.g. Bangladesh, because infidelity is a common practise and having a sterilized husband may become a problem if the woman becomes pregnant (Sharma, 2003).

#### **2.4.2 Demographic factors and influence on attitude**

Musyoka (2007) cites demographic factors as one of the determinants of attitude towards family size, hence family planning. Where fertility and child mortality influence one another interchangeable, so that in societies where child mortality is high, the fertility was also high and vice versa. In the case of Kisumu, the district experiences high infant and child morbidity and mortality. Infant mortality stands at 90 deaths per 1,000 live births, while under 5, mortality is at 110/1000 (UN Habitat, 2009).

Esipisu (1992) concurs that a woman who is confident that her child will survive is less likely to want more children merely as an insurance against some dying. The same could be said of men because one of constraints against vasectomy is fear of unknown future; of not being able to father a child in case the children they have die (WHO, 2002). One of the major concern couple have on vasectomy, is the unknown future; in case they loss their children and need to have others.

#### **2.4.3 Socio-cultural factors and choice of vasectomy**

Social cultural factors influencing use of vasectomy are manifested in the socialization process. From childhood- as future heir to the throne - boys are socialized to be decision makers and in authority, enhancing the belief that ‘male

power' or control is innate. But psychologists argue that these power relations are learnt through social learning process- a child who watches other men take control of their homesteads, are bound to do the same in their adult life. Socialization defines gender roles; where men are seen as breadwinner and should be spared the bother of family planning; it is therefore a woman's duty to undergo the surgery, according to a research by Ahmedabad family Planning Association (AFPA). This has influenced the attitude of men and women towards the uptake of vasectomy as family planning method. Despite the independent nature of some marital relationships, a study in Ghana indicates that men have the primary decision-making power in matters of family planning. Vasectomy is more accepted if the discussion is initiated by the man-being the effective decision-maker on fertility (Vernon, 2007).

Patriarchal societies associate masculinity with strength. Sociologist Janet Saltzman Chafetz (1974) describes seven areas of traditional masculinity: **Physical**- virile, athletic, strong, brave, unconcerned about appearance and aging; **Functional**- breadwinner, provider; **Sexuality**- sexually aggressive, experienced single status accepted; **Emotional**- unemotional, stoic; **Intellectual**- logical, intellectual, rational, objective, practical; **Interpersonal**- leader, dominating, disciplinarian, independent, individualistic. Other characteristics include success- oriented, ambitious, proud, egotistical, moral, trustworthy, decisive, competitive, uninhibited, and adventurous. Stereotypic notions of masculinity, such as all of the above, put a lot of peer pressure on men to identify with masculinity and dictate the gender roles. There is appreciation of "machismo"- (also called testosterone poisoning). To appear weak, emotional, or sexually inefficient is a major threat to their self-esteem. To be content these men must feel that they are decisive and self-assured, and rational, among the issue, is the need to feel conquering in regard to sexual matters and work.

#### **2.4.4 Religious influence on attitude to vasectomy**

Religion plays a major role in many people's opinion towards certain aspects of life. Different value systems and beliefs associated with religion bring about differentials in reproductive behaviour, as it gives the role of men and women, and the place of family in the society (Karoki, 2008). Thus, religion could influence the way people

behave. Birth control is a controversial subject among Christians because the Bible does not clearly condone or condemn its use. Neither does it address permanent forms of birth control such as tubal ligation or vasectomy as these procedures were unknown in Bible time. In Isaiah 56:3-5 the Lord promised that even eunuchs (a man who was voluntarily or forcibly castrated) who followed the ways of the Lord would be welcome in his house and would receive a reward better than children. However, arguments against use of contraception quote, “Be fruitful, multiply and fill the earth...,” (Genesis 1: 28).

Biblically, “Children are a heritage from God, the fruit of the womb a reward. Like arrows in the hand of a warrior are the children of one's youth. Blessed is the man who fills his quiver with them! He shall not be put to shame when he speaks with his enemies in the gate,” (Psalm 127:3-5). They are not burdens to bear, but blessings to receive with joy. In Christianity then, it is a sin to contemplate interfering with the conception of a baby, according to the book of Jeremiah 1:5, “Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations.”

The decision for permanent birth control should not be made based on selfish ambition or vain conceit (Philippians 2:3-4), but out of a desire to live in ways that are pleasing to God. The Roman Catholic Church, for example, opposes modern population control, and is repressive against those who practise and advocate for them. The Catholics see the primary purpose of intercourse as procreation. However, because the Bible does not forbid contraception, either temporary or permanent, it cannot be sufficiently argued that it is wrong in all circumstances.

For increased acceptance of vasectomy, involving men and obtaining their support and commitment to family planning is of crucial importance, given their elevated position in the African society- due to patriarchy. Men should realize that managing their ability to make children, is making decisions about their reproductive health, and adopting modern family planning methods results to profound changes in both personal behaviour and cultural norms.



## **2.5 Influence of Attitude on use of vasectomy**

### **2.5.1 Mass media and exposure to vasectomy**

Exposure to media (mass and print media) on family planning helped influence people's attitude towards usage of family planning methods (Church, 1989). Promoting vasectomy through mass media campaigns can be particularly effective in urban-centres that have high quality accessible service (Vernon, 1996). Currently in Kenya, there are many media houses, broadcasting in local vernaculars, which can be effectively used to reach the rural masses. However, People are not sufficiently exposed to vasectomy as a family planning method through the media.

Esipisu (1992) argues, it is possible, by means of mass media propaganda to weaken the hold on old norms and therefore, plausible to suggest that information to people in traditional environment broadens their view of opportunities and potentials of life besides including their suspicions of social change.

Siringi (2006) found that complimentary messages about family planning may help to create an environment where the practise of contraceptive is positively perceived, as family planning communication campaigns have been shown to increase contraceptive use. A media campaign in Kenya by AVSC in May 1991, by means of advert in a newspaper in both English and Kiswahili produced 800 written inquiries within a few weeks, an unexpectedly large response. Most of the inquiries came from rural Kenya in response to the Kiswahili paper. In addition, 67 letters on comments were received, all favourable to the campaign. Follow up of the inquirers who had received pamphlet showed that at least seven had accepted vasectomy soon thereafter (Wilkinson et al., 1996).

Osiro (2001) argues that in family planning promotion, evidence is accumulating that well planned mass media approaches can influence attitude and behaviour change. Osiro cites "Sibido Miguel television programme" or "soap opera" on family planning, as an example of media influence, which showed an increase in family planning acceptance. A song by Tatiana and Jonny to promote sexual responsibility among Latin youth were reported to have promoted thousands of calls and letters to counselling centre for young people (Piotrow et. al, 1990). A soap opera, which

encouraged men's increased demand for contraceptive services in Zimbabwe, was associated with change in beliefs and attitudes (Mbizvo et al., 1996). In Ghana, exposure to media showed a strong association between respondent's exposure and their talking to someone about family planning and seeking a service provider (Thomas, 1994).

Otieno (2000) found out that men knew more of female contraceptives than male specific contraceptives, with 86.3% for female sterilisation as compared to 54.5% for male sterilization. Only 47.8% of the men knew where they could get vasectomy services. The most widely known methods were; condoms 94.5%, pill 92.9%, tubal ligation 86.3% and periodic abstinence or rhythm 84.2%.

Siringi (2006) argues that media creates a climate for open discussion of taboo topics, prompt people to consider adopting a new behaviour, creates a sense of belonging to a broader social network and pass along to other what one had learnt inside his or her social network. A report by KDHS (2003) noted that three regular radio programs on family planning and population were being broadcast in Kenya, for women. However, vasectomy was considered a somewhat politically sensitive issue, and the Ministry of Health had banned its advertisement in the media until November 1990, when the ban was lifted (EngenderHealth, 2000).

According to Yoder et al (1992), Radio and television drama have become increasingly popular as a means of educating the public about health issues in developing world. IFPP report of 1999, confirms that Commentary messages may help to create an environment where the practise of contraception is perceived positively.

### **2.5.2 Spousal Influence on attitude towards vasectomy**

Spousal discussions are important in the decision to get a vasectomy, and such discussions are normally initiated by the male partner (Vernon, 1996). Family relations are both in congruence and in conflict, and that the benefits and costs of children and child-bearing are not distributed equally between men and women, thus

neither the husband nor the wife should be ignored in an attempt to understand fertility behaviour (Salway, 1994).

A study carried in Tanzania reported low level of communication between spouses about family size and family planning because such decisions are made by men (Bunce, 2007). Women with low levels of contraceptives use also reported little spousal communication (Osiro, 2001). For some method of family planning such as sterilisation, spousal communication seemed to be a precondition for acceptance. Nearly all 88% of men who were vasectomy acceptors in a Columbia study had discussed the decision with their wives (Vernon, 1989)

Ndege (1991) cites lack of sufficient communication between spouses, as one of the major hindrances to the success of family planning use in rural Kenya. Open communication between spouses about family planning also provides couples with an opportunity to discuss family size preference and means to achieve that (Becker, 1997). There is a general feeling that African men do not discuss family planning and reproductive health issues together (JHU/ Centre for Communication Programs, 1996:9). However this communication must occur to bear meaningful results.

A study in Brazil found that, smaller families' size was associated with greater equality in decision making between husband and wife (Vernon, 1996). Men are concerned for women's reproductive health, and are willing to participate in making decisions, (UNFPA, 1997). The problem may be communication: husbands and wives may want the same thing, but they don't tell each other. However, there is limited study on how men communicate with their spouses about male specific family planning, such as vasectomy.

Beckman (1983) argues that a more egalitarian decision making process or reduced male dominance within the family is associated with lower demand for children, higher effective contraceptives and lower fertility. Because of lack of communication, many women do not know what their husbands think about FP (Beckman, 1983). Many women think that their husbands disapprove of FP, when in fact the husband approves.

Stycos (1996) found a sharp division of gender roles, sharp enough so that husbands and wives failed to communicate on mundane matters, but especially on matters of sex and reproduction, this often resulted in failure to pool commonly held aspirations and information that could have expedited small-family goals.”

In Burundi, 94 per cent of men surveyed approved of contraceptive use, but only 48 percent had discussed it with their wives in the preceding year (UNFPA, 2000). In USA, 78% of men sampled in a survey said, “Contraception is a joint decision, and 87% of men strongly agreed that men have the same responsibility as women for the children they father” (Grady, 1996).

Women should feel free to discuss the issue they experience in using contraceptives in order for men to understand the need for men to step in and take responsibility. They should be open and suggest to their husbands to take up the responsibility of family planning by undergoing vasectomy.

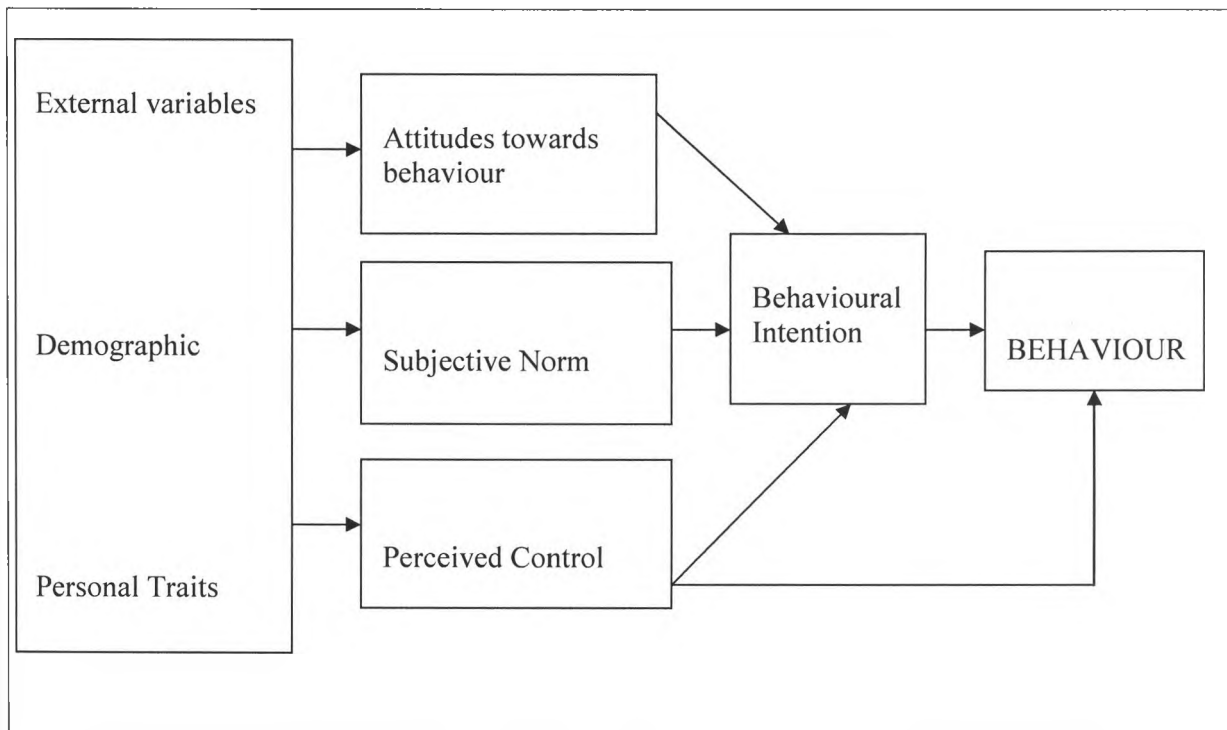
## **2.6 Theoretical Framework**

The study was informed and guided by the Theory of Planned Behaviour (TPB). The proponent of this theory is Ajzen. TPB states that individual behaviour is driven by behavioural intentions where behavioural intentions are a function of an individual's attitude toward the behaviour, the subjective norms surrounding the performance of the behaviour, and the individual's perception of the ease with which the behaviour can be performed (behavioural control). This perceived “behavioural control” is presumed to not only affect actual behaviour directly, but also affect it indirectly through behavioural intention (Ajzen and Fishbein, 2005).

Attitude toward the behaviour is defined as the individual's positive or negative feelings about performing behaviour. It is determined through an assessment of one's beliefs regarding the consequences arising from behaviour and an evaluation of the desirability of this consequence. The centrality of Behavioural Intention questions the classical model of Belief, Attitude and Behaviour (Conner & Sparks, 1995). Behavioural control is defined as one's perception of the difficulty of performing behaviour. TPB views the control that people have over their behaviour as lying on a

continuum from behaviours that are easily performed to those requiring considerable effort, resources, etc. **Figure 2.1** below gives an illustration of Theory of Planned Behaviour.

**Fig 2.1:** Theory of Planned Behaviour



*Source: PCPP Working paper NO.4: Health-seeking behaviour and health System Response*

In TPB behavioural intention is determined by several factors. To begin with, attitudes towards behaviour are determined by the belief that a specific behaviour will have a concrete consequence and the evaluation or valorisation of this consequence. Secondly, are the subjective norms or the belief in whether other relevant persons will approve one's behaviour, plus the personal motivation to fit in with the expectations of others. Another factor is the Perceived behavioural control, determined by the belief about access to the resources needed in order to act successfully, plus the perceived success of these resources (information, abilities, skills, dependence or independence from others, barriers, opportunities etc). And lastly, are the socio-demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioural control.

**Application:** So far, Theory of Planned Behaviour has more than 1200 research bibliographies in academic database. An outstanding aspect of the TPB is the central role of social network support. Health promotion among sex workers, with the collaboration of committed sex workers who were trained to distribute information and to offer support to their colleagues, provided positive results in a South African mining community (Campbell & Mzaidume, 2001).

### 2.6.1 Strengths and Limitations of the Theory

**Strength:** The advantages of the TPB includes its taking into account the motivational aspects of personal control in decision making and taking responsibility over one's reproductive health. Also by adding "perceived behavioral control," theory of planned behavior can explain relationship between behavioural intention and actual behavior, since an individual's behavioural intention cannot be the exclusive determinant of behavior where an individual's control over the behaviour is incomplete.

**Limitation:** Unfortunately, Theory of planned behaviour is based on cognitive processing and level of behaviour change; overemphasising on psychological factors, while under-valuing structural factors like limited access or availability of resources. It also overlooks emotion variables such as threat, fear, mood and negative or positive feeling and assessed them in a limited fashion. In the health related behaviour situation, given that most individuals' health behaviours are influenced by their personal emotion and affect-laden nature, this is a decisive drawback for predicting health-related behaviours (Dutta-Bergman, 2005).

### 2.6.2 Relevance of the Theory to the study

Theory of Planned Behaviour is important in this study because it specifies the nature of relationships between beliefs and attitudes. Because adopting modern family planning methods often involve profound changes in both personal behaviour and cultural norms. The model is thus a very powerful and predictive model for explaining human behaviour. According to these models, people's evaluations of, or attitudes toward behaviour are determined by their accessible beliefs about the behaviour, where a belief is defined as the subjective probability that the behaviour will produce a certain outcome. From the literature review, men are reluctant to take vasectomy

because of the outcome and its implication in the future. These attitudes a man has determine whether he will accept or reject vasectomy as a family planning method. Important to note is that behaviour is also influenced by the social environment, that is, the community or society in which one lives or regards as important.

To understand why a family adopts or do not adopt a method of family planning requires knowledge of their social-cultural background, their socialization and how their attitudes have formed. For a long time, the role of family planning was left to women, but at the same time men have control over reproduction issues including the number of the children in a household. This makes TPB relevant because of its encouragement of feelings of self-control, which would be useful in the case of men choosing vasectomy as a family planning method. The theory promotes feelings of control and self-efficacy in negotiating with partners.

Theory of Planned Behaviour is therefore important to understanding the entire process of decision making in either to adopt or not adopt vasectomy as an option in family planning. The planned behaviour view of reproduction has a bearing in the process of choosing methods and by extension, the perception of the success and safety of the said method.

## 2.7 Study Assumptions

- Men and women have enough knowledge on vasectomy as a method of family planning.
- Media, myths, demography, religion, and socio-cultural factors influence men's and women's attitude towards vasectomy as family planning method.
- Attitude influence the choice of vasectomy as a family planning method.

## 2.8 Definition of key Terms and Concepts

**Attitude:** these are ways of thinking and behaving (Collins English dictionary).

**Family Planning:** ability of the individual to anticipate and attain their desired number of children and the spacing and the timing of their births, achieved through contraceptives.

**Vasectomy:** Vasectomy is a permanent method of family planning involving a surgical process where the provider cuts the vasa differentia, through which sperm travel from the testicles to combine with semen making the semen sperm free.

**Knowledge:** the information, understanding and skills that you gain through education or experience (Oxford Advanced Learners Dictionary).



## CHAPTER THREE: RESEARCH METHODOLOGY

### 3.1 Introduction

This section describes the research site, research design, sample population and sampling procedures, methods of data collection and data analysis. It also covers anticipated problems within this study and ethical concerns observed during the study.

### 3.2 Research Site

The study was conducted at Marie Stopes Clinic Kibuye in Winam, present Kisumu Town district. Kisumu is a port city in western Kenya at 1,131 m (3,710 ft). It has a total area of 918.5 sq. km with a current population of about 968, 909 (Kenya National Bureau of Statistics, 2009). Winam is in urban Kisumu (00°06'S 034°45'E) on the shores of Lake Victoria, Kenya, with a population of 355,024 ((Kenya National Bureau of Statistics, 1999). Lying on the equator, Kisumu climate is hot all year (83°F), making it hot and humid, with temperatures ranging from 11.25 to 27.95 (Celsius). Kisumu experiences long and short rainy seasons from March to May and September to December, respectively (UN-Habitat, 2006-2009).

Kisumu has gradually developed to an industrial town and the hub of political, industrial and economic activities in Western Kenya. It currently hosts some of the major industrial enterprises in Kenya as well as the provincial headquarters of Nyanza province. A good number of international and local NGOs also have their bases in Kisumu. This has led to an increase in rural-urban migration in search of employment, mainly in the informal sectors. As a result of this and other economic factors, Kisumu currently experiences the highest average urban poverty levels at 48% against a national average of 29%. Available statistics indicate that Kisumu, which is a net food importer, registers one of the highest incidences of food poverty with 53.4% of its population living below the *food poverty line* as compared to Nairobi (8.4%), Mombasa (38.6%) and Nakuru (30%) (UN Habitat, 2009)

Kisumu is mainly dominated by the *Luo* community, a *Nilotic* tribe that is the 3<sup>rd</sup> largest ethnic group in Kenya. The *Luhya*, the *Kisii* and the Asian community form the other considerably large tribes in Kisumu with the Asians forming a large business enterprise block. Its cosmopolitan nature has attracted other ethnic groups like *the*

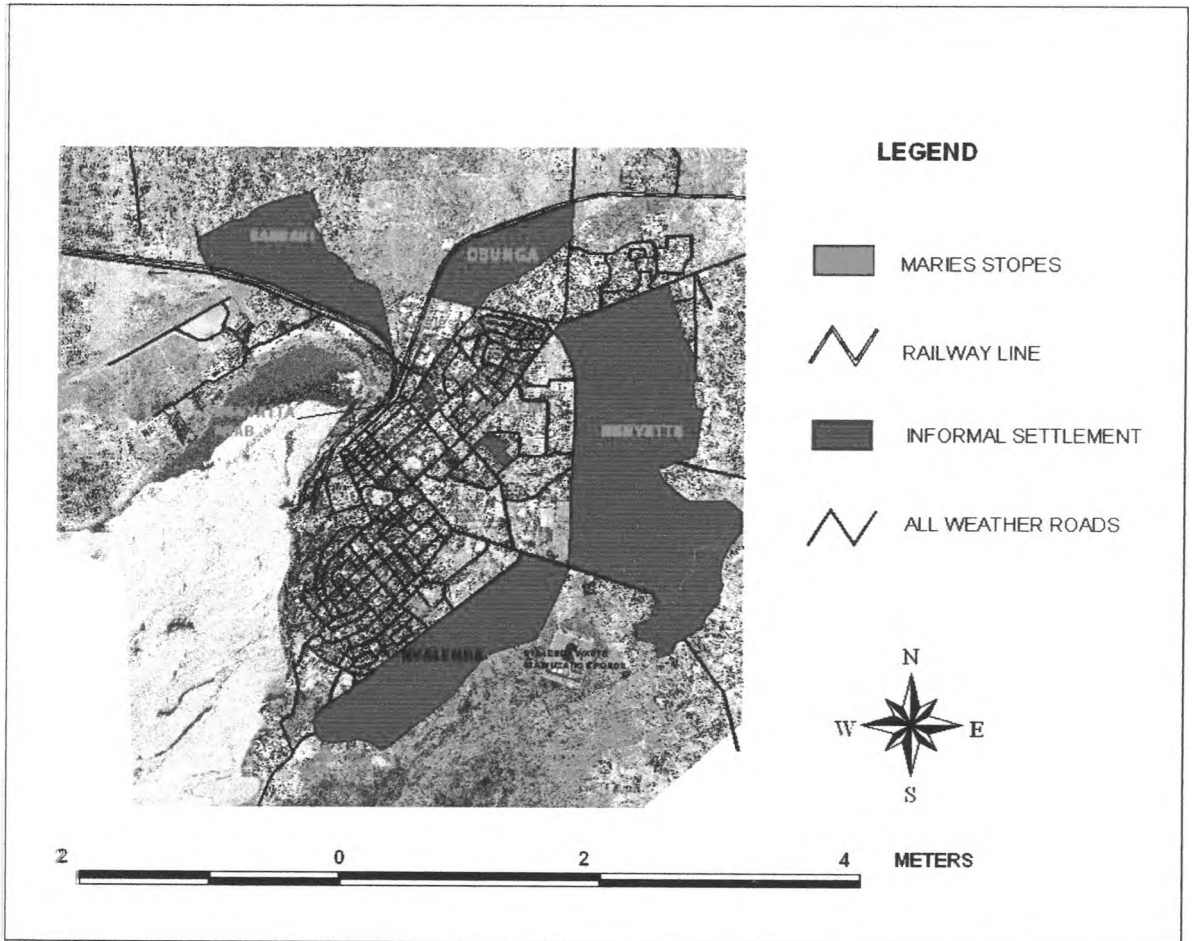
*Kikuyu, the Kalenjin, the Maasai and the Akamba* who ply their trade in the Town. This has made Kisumu a cultural “melting pot” as a result of the interaction between different communities that have settled within Kisumu and its environs. All this development has led to Kisumu being accorded the first Millennium City in Kenya.

### 3.2.1 Political and social Division

Kisumu district has four (4) administrative divisions, Winam, Maseno, Kombewa and Kadiboo divisions. Winam division has the highest population; 350,365 (GoK, 2008)

**Figure 3.1** below, shows a map of Marie Stopes clinic Kibuye, in Winam division and the settlements surrounding it, namely; Kaloleni, Bandani, Obunga, Manyatta, Nyalenda and Manyatta Arab. These are all informal settlements. **Figure 3.2** and **Figure 3.3** shows pictures of the study sight.

**Fig. 3.1:** Map of Winam Division, Kisumu Division



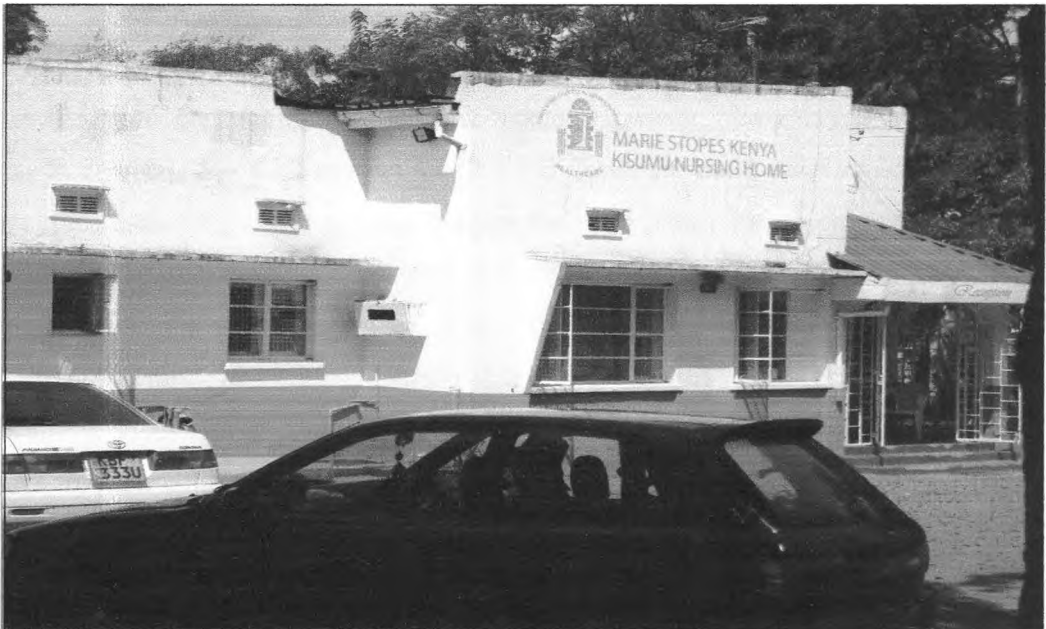
Source: Kisumu Town Council, 2010

**Fig. 3.2:** Sign board of Marie Stopes International- Kibuye



*Source : Primary Data*

**Fig. 3.3:** picture of Marie Stopes International, Kibuye



*Source : Primary Data*

### **3.2.2 Population**

The 2009 census showed that Kisumu District had a population of 504,359; in 2002 the population was 535,571, which was projected to reach 576,256 by 2010, with a growth rate of 2.0 per cent per annum. Life expectancy of the population is 49 years with women at 50.7 while men at 47.2 years. The district experiences high fertility with Total Fertility Rate (TFR) standing at 5.8 children per woman (<http://www.ncbi.nlm.nih.gov/pmc/articles> ).

In 2000 there were more females than males i.e. 258,880 males to 267,913 females. The trend has remained the same with 284,554 females (2005) compared to 270,724 males .The population is mainly youthful with two thirds (67%) of the population aged below 25 years. Those aged 65 years and above account for only 3.4 per cent of the total population. The youthful population has put pressure on the available educational, health and other social facilities. This has also contributed to the high dependency ratio of 1:1.18 (UN-Habitat, 2009).

### **3.2.3 Health facilities and Marie Stopes International**

Most of the health facilities particularly hospitals are found in Winam Division and are therefore concentrated in Kisumu Town. However, the average distance to a health centre is 5 – 8 kilometers making it difficult for most people to access health facilities especially those coming in from the rural areas. The doctor/patient ratio is 1:5,379. The district experiences high infant and child morbidity and mortality. Infant mortality stands at 90 deaths per 1,000 live births while under 5 mortality is at 110/1000. The deaths are high mainly due to inaccessible health facilities, inadequate health services and high poverty incidence where most parents cannot afford medical care for their children (UN-Habitat, 2009).

Marie Stopes International (MSI), a global non profit sexual and reproductive healthcare organisation, was founded in 1976, and has been working in over 43 countries, Kenya included. It provides a variety of services around the world, including; family planning; safe abortion; vasectomy; female sterilisation; and maternal healthcare, for low-income women and couples worldwide. MSI targets

underserved areas with limited access to sexual and reproductive health care by overlapping with existing government health services and filling gaps where these exist. They assist the government by providing services in areas where there is a shortage of government health providers and simultaneously expands access to contraceptive services. This public-private partnership model of service delivery in conjunction with the government has been the key to MSI's expansion of reproductive health care. It ensures wide distribution of high-quality, affordably-priced contraceptives with an emphasis on long-term methods, with vasectomy being one of its mandates.

Marie Stopes International Kisumu in conjunction with Germany's Federal Ministry for Economic Cooperation and Development (BMZ), have a programme called Output-Based Aid (OBA) which subsidizes low-income health care clients. The patients receive vouchers entitling them to a free delivery at the Marie Stopes Nursing Home. The programme also caters for long-term and permanent contraceptive methods for family planning annually, where all costs are reimbursed to Marie Stopes Kenya by the programme's management agency ([www.mariestopeskisumu](http://www.mariestopeskisumu)). For every free vasectomy performed, the agents reimburse Marie Stopes International, London KShs. 30, 0000 (personal communication; vasectomy provider, MSI Kibuye.)

### **3.3 Study Design**

The study design was cross-sectional, combining both quantitative and qualitative methods of data collection. The study was designed to investigate knowledge, attitude and its influence on uptake of vasectomy in MSI, Kibuye. The study involved interviews with key informants; these were people who are experts in the field of family planning and vasectomy. The study carried out three (3) Focus Group Discussions (FGDs) to obtain qualitative data and explored some of the issues pertaining to vasectomy that emerged in the questionnaire survey. The study also conducted 5 narratives, during which in-depth interviews were conducted with the men who had undergone vasectomy. Although not initially intended, the study interviewed 2 women whose husbands had undergone vasectomy; to get their side of the story. The study also involved quantitative data; this included, free listing (within the survey questionnaire) to find out knowledge and ranking of vasectomy as a

method of family planning and a survey questionnaire to determine issues to explore on knowledge and factors which influence attitude towards acceptance/ rejection of vasectomy.

### **3.4 Sample and sampling procedures**

The study targeted clients of Marie Stopes Kibuye. Using convenient and purposive sampling, the study sampled 40 respondents, 20 married men and 20 women in the reproductive age visiting the clinic for various family planning services finding out why people accept/reject vasectomy, despite being offered as a free service at the clinic. Using convenient sampling, 4 key informants were sampled and interviewed; these are people who have information on family planning and vasectomy; they include nurse in-charge of Marie Stopes clinic (Kibuye), Vasectomy provider and reproductive health providers, clinic H.I.V counselor.

The researcher carried out 3 FGDs. For 2 FGDs, the study used purposive sampling so as to get a homogenous group of married participants; for the 3<sup>rd</sup> FGD the researcher, using the clinic register and with the help of vasectomy service provider, located 6 men who had undergone vasectomy. Using the same individuals, the study also obtained 6 narratives discussing their experience and how they are coping having undergone vasectomy, during which the study conducted in-depth interview.

The individual was the unit of analysis. This was because the aim of the study was to capture the attitude of both men and women towards vasectomy as a family planning method and factors which influenced their attitude, resulting in vasectomy being under used.

The choice of Marie Stopes Kibuye, Winam division, in Kisumu was convenient as the clinic is already actively offering free services for vasectomy. Kisumu also exhibits a physical environment suitable for the study being cosmopolitan with well established infrastructure such as health and education systems, etc.

## **3.5 Data collection Methods**

### **3.5.1 Key Informant interviews**

The study interviewed 4 key informants considered to be well conversant, specialist, articulate, knowledgeable and experienced in the area of reproductive health, family planning and vasectomy. The study used structured questions to obtain factual information and open-ended questions to obtain opinions, explanations or descriptions on knowledge and attitude on vasectomy. The information they gave shade light on the attitude towards uptake of vasectomy and experiences of those who had taken vasectomy, as well as challenges faced by the institution. Some of the issues determined through this method included availability of vasectomy, knowledge and attitude of both men and their partners; understanding of the people on vasectomy as a long-term FPM: challenges faced by clients such as cultural hindrances; confidentiality and coping mechanism in situation where the client suffers social stigma.

### **3.5.2 Questionnaire Survey**

The study used this method to collect quantitative data. Through purposive selection 40 respondents were interviewed using a standard questionnaire which comprised of both closed and open-ended questions to allow for probing as well as precision and efficiency during coding (Bernard, 2000). The first phase of the questionnaire, included free list question, asking the respondents to list down all the methods of family planning they know, to determine where vasectomy is ranked in their list. The factors which were taken into consideration included, reproductive age, education level, marital status, communication with partners, cultural influences and socialization, as well as role of media in forming attitude.

### **3.5.3 Focus Group Discussions.**

This method was used to provide qualitative data on major themes, which helped contextualize the use of vasectomy as a fertility control method and information from it was useful for comparison with those of other methods. The study conducted three FGDs; one with married men, one with married women and another with men who have undergone vasectomy. The concerns determined included themes such as

acceptance and rejection of vasectomy; social cultural influence on use of vasectomy; peer pressure and acceptance; masculinity stereotyping; communication and sharing of information between spouses and from those who have undergone vasectomy and coping mechanism in the society after undergoing vasectomy. The questions were asked in a clear and non-directive manner in order not to predetermine or lead the answers.

#### **3.5.4 Narratives**

The study gave opportunity to 6 individuals who had firsthand experience with vasectomy to narrate their stories on vasectomy as FPM. With help of Vasectomy Service provider and using the clinic register, the study sampled participants across time duration of May 2009- June 2010. The researcher identified one person among the first men to receive vasectomy in Marie Stopes clinic Kibuye, then picked the second participant among the middle group and the last person was 25 years old man (youngest client of vasectomy) who undertook vasectomy (on 30<sup>th</sup> June) during the time the researcher was in the field collecting data. His experience was so crucial that, although he did not meet the criteria of married men, the study opted to co-opt him for the narratives. The study covered areas such as; where they heard of vasectomy; what motivated them to undertake vasectomy; how the decision was received by family, friends and community at large; how their concerns and complications (if any) were addressed and confidentiality. Using structured questions, the study also carried out in-depth interview using the narrative guide, to try and get more information on individual's attitude and experience; as individual's subjective experience especially in the narratives, gives relevant information on the participant's experience which may not have been directly observed by the researcher (Burns, 2000).

#### **3.6 Data Analysis**

Data was analyzed using both qualitative and quantitative methods. However, since the study was mainly descriptive, there was inclination towards qualitative techniques of data analysis. Qualitative analysis emphasizes how data fit together as a whole, bringing together context and meaning (Ulin et al, 2002). Content analysis was done by identifying emerging themes in the data and labels attached to them. Data was then coded and grouped, relating the themes to the study objectives to find out how they



contributed to answering the study problem. This was to bring out the perspective of the people. Direct quotes and comments from key informants participants and respondents were used to help in understanding the reproductive health view of the people under study. For quantitative analysis, the results of the questionnaire survey, especially the closed ended questions were coded for analysis using both SPSS program and Microsoft Excel, reducing the people to numbers and simple frequency table, pie and bar charts and percentages generated to summarize the data.

### **3.7 Ethical Considerations**

Data collection always carries with it the possibility of doing harm, to others and these risks must always be minimized (McCall and Simmons, 1969). Given that the study was on a sensitive and controversial topic; the study received all the necessary approval with a research permit issued by National Council for Science and Technology (NCST), Nairobi, the Kisumu District Education officer and Winam division Education Officer as instructed by NSCT; as well as the management of Marie Stope International Kibuye (Dr. Nancy Nyakiti). The principle of informed consent was always upheld throughout the data collection, with participants, especially the men who had undergone vasectomy being informed in advance and consent form signed; Participation was voluntary. The research sought to respect the privacy, anonymity and confidentiality of all those studied. Where in doubt, the respondents were encouraged to be anonymous and pseudonyms were used to conceal their identity. The research observed the principle of beneficence by promising to share the write up with the clinic management and the vasectomy service provider at the clinic. Already, the recommendations, such as; the need to update the price-board in the reception (which still stated vasectomy was Kshs 3,000, although it was offered free) has been done. Also, the need for a more private and male friendly wing at the clinic, as well as a more efficient and inclusive hospital register for a more accurate data recording has been suggested. The research has ensured that there is no falsification, plagiarism or other unethical practices at any stage of the research.

## CHAPTER FOUR: FINDINGS AND DISCUSSION

### 4.1 Introduction

This chapter discuss the research findings interprets and presents the information on knowledge in winam division under the following themes; Demographic characteristics of resprondents interviewed, knowledge of both men and women on vasectomy, attitude of men and women towards vasectomy and the influence of attitude on the uptake of vasectomy as FPM.

### 4.2 Demographic characteristics of respondents

The general information of the study population is described in terms of age, sex, occupation, marital status, religion and educational level. All the mentioned aspects were considered to be important for the study since they provided general characteristics of the group that would likely use family planning methods. **Table 4.1** show the demographical data of respondents. The first column portrays categories in each area of interest; the second column indicates the number of respondents in each category; and the third column indicates the percentage of respondents in each category.

The table shows a total of 40 respondents (20 women and 20 men-married/have been married) who were surveyed during data collection process. In the sample, the largest age group interviewed was the cohort of 25-34 years old, followed by the cohorts of 35- 44 years old. Age is a demographic factor that affects people's opinions and daily operations due to exposure, experience, and knowledge and their position in the society.

Of these respondents 45% worked in the informal/Jua kali sector while 25% were engaged in farming, the remaining 30% were professionals engaged in formal employment. Majority of the respondents, 80% lived in informal settlements. This could be so because; one of Marie Stopes' mandates is to provide reproductive health services to the economically vulnerable members of the society. Religion was widely practiced in this community with a majority of the respondents being Protestant 60% ,

followed by 20% Catholics, none believers and Muslims made up 5% and 2.5% respectively. However, the study found that most of the women who visited the clinic for family planning services were not highly educated with a majority only attaining primary education. On the other hand, most men had acquired some skilful training which they were using in their informal sector.

**Table 4.1:** Demographic characteristics of respondents

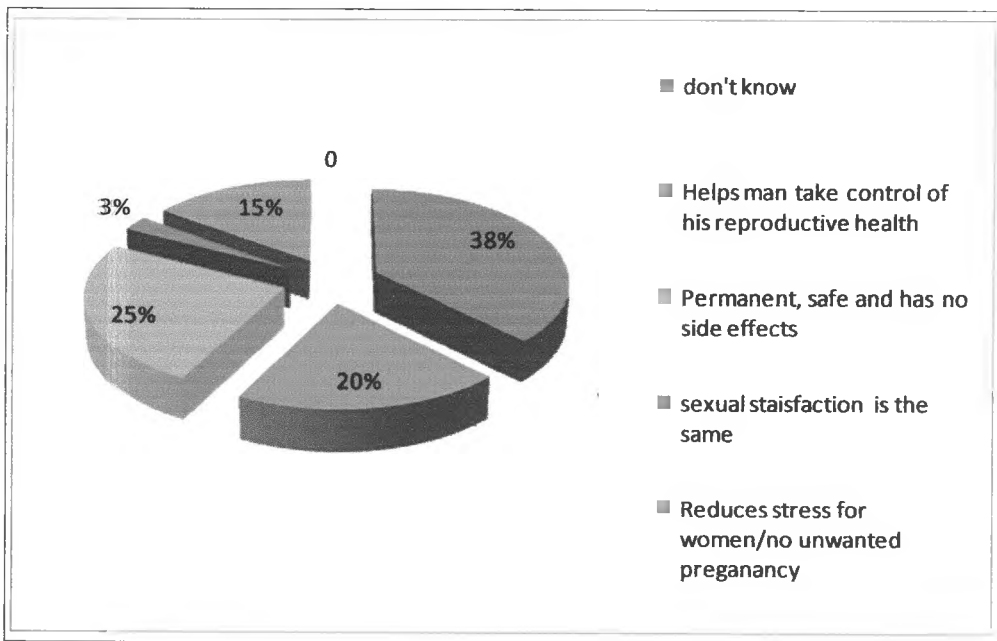
<i>Category</i>	<i>#</i>	<i>%</i>
<b>Age</b>		
18-24	8	20
25-34	18	45
35-44	10	25
45-54	3	7.5
55+	1	2.5
<b>Gender</b>		
Male	20	50
Female	20	50
<b>Marital status</b>		
Married	38	90
Single	0	0
Separated/Divorced	3	7.5
Widowed	1	2.5
<b>Occupation</b>		
Jua Kali/ small Business	15	37.5
Farmer	10	25
Housewife	3	7.5
Professional person	12	30
<b>Education level</b>		
1. None	2	5
2. Primary	10	25
3. Secondary	9	22.5
4. Tertiary	10	25
5. Degree	5	12.5
<b>Religion</b>		
Protestants	24	60
Catholics	8	20
Muslim	1	2.5
None believer	2	5

*Source: primary Data*

### 4.3 Knowledge of men and women on vasectomy

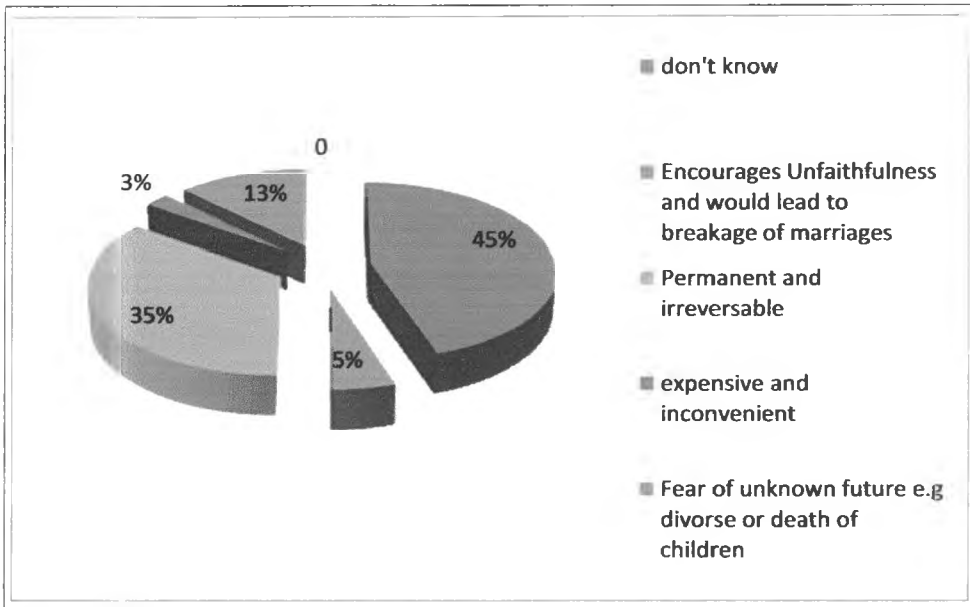
Knowledge is a necessary step in the adoption of a new idea and practice such as vasectomy as FPM. The quality and adequacy of knowledge deserves attention, because poor and inadequate knowledge hinder the adoption process and create resistance to the practice (Bunce et al, 2007). Lack of information, misunderstanding and rumours about vasectomy process contribute to many people's reluctance to choose vasectomy. The study found that, although the knowledge of vasectomy was 82.5% (respondents had heard of vasectomy), the acceptance and uptake was very low. This is because the respondents had heard of vasectomy as a male specific FPM, but, on further interview and discussion the study found that majority of the respondents and participants did not understanding or have tangible facts and information on vasectomy. **Figure 4.1** and **Figure 4.2** below, shows the respondents' list of the advantages and disadvantages of vasectomy. 45% of the respondents did not know of any disadvantages, while 37.5 % of the respondents did not know of any advantage of vasectomy.

**Fig. 4.1: Advantages of vasectomy given by the respondents**



Source: primary Data

**Fig. 4.2: Disadvantages of vasectomy given by the respondents**



Source: primary Data

The free listing which was administered before carrying out the questionnaire also **Table 4.2** below shows the ranking of vasectomy using free listing. Although, 85% men and 87.5% women knew of vasectomy, only 2.5% men and 2.5% women ranked vasectomy 1<sup>st</sup>; most respondents ranked it from 5<sup>th</sup> onwards. Vasectomy as a family planning method was not prioritized; this could explain the disparity between knowledge and actual practice. The study also found that 15% of men and 12.5% of women interviewed excluded (not ranked) vasectomy as a family planning method.

**Table 4.2: Respondents' free-listing (ranking) of vasectomy**

Gender	Position ranked									Total
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>	7 <sup>th</sup>	8 <sup>th</sup>	None	
<b>Male</b>	1	2	2	1	1	2	3	2	6	20
<b>Female</b>	1	2	1	2	4	1	2	2	5	20

Source: primary Data

However, there was increased acceptance of vasectomy as the potential clients got more information. **Table 4.3** below give a summary of all the family planning service offered at Marie Stopes International, Kibuye, which includes; pills, injection ( Depo),

Intrauterine contraceptive device( IUCD), Jadelle, condoms, tubal ligation (TL) and vasectomy, June 2008- June 2010, as recorded in the clinic register (which was noted not to be up to date/Accurate). From the table below, there was notable increase in the number of vasectomy clients in the month of June and July 2009. This increase could be attributed to an increased in the media coverage of Dr. Ochieng's (vasectomy client) story; during which, a lot of questions raised were answered by the Dr and other experts, giving relevant information and improving people's knowledge on vasectomy (personal communication, Dr. Ochieng-MSI, Kibuye). The study found that 57.5% of the respondents would undergo vasectomy as a family planning method if they had all the facts about it.

**Table 4.3:** Family planning service offered at the clinic (June 2008-June 2010)

months	Pills	Inject	IUCD		Jadelle		condo	BTL	Vasectomy
			Insert	Rem	Insert	Rrem			
<b>June 2008</b>	12	40	0	1	6	7	0	7	0
July	18	42	2	0	6	3	600	7	0
Aug	21	35	1	0	6	3	0	1	0
Sept	1	26	3	1	2	0	0	0	0
Oct	3	40	6	0	12	3	0	4	0
Nov	0	42	5	0	9	0	0	2	0
Dec	0	33	6	0	7	1	0	2	0
<b>Jan 2009</b>	9	25	4	0	11	1	0	0	0
Feb	5	39	3	1	9	3	200	3	1
Marc	31	4	9	3	6	2	0	3	3
April	3	26	8	0	1	3	0	0	0
May	3	37	1	0	2	0	0	0	0
<b>June</b>	<b>0</b>	<b>35</b>	<b>4</b>	<b>0</b>	<b>10</b>	<b>1</b>	<b>400</b>	<b>4</b>	<b>8</b>
<b>July</b>	<b>6</b>	<b>50</b>	<b>4</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>8</b>
Aug	0	45	15	1	12	0	0	6	0
Sept	4	52	12	0	8	3	0	1	0
Oct	2	44	8	0	1	7	0	0	0
Nov	8	42	9	0	8	7	0	3	0
Dec	0	28	3	0	7	3	0	6	1
<b>Jan 2010</b>	0	15	6	1	5	1	0	2	2
Feb	0	38	6	0	32	0	0	1	1
Marc	0	43	3	2	7	1	0	2	2
April	0	15	2	0	9	1	0	5	2
May	2	46	4	2	6	3	0	2	2
June	0	0?	6	0	4	2	0	3	2
<b>Total</b>	<b>104</b>	<b>842</b>	<b>130</b>	<b>12</b>	<b>193</b>	<b>55</b>	<b>1200</b>	<b>67</b>	<b>32</b>

Source: Primary data

### 4.3.1 Myths and misinformation

In the FGDs it emerged that there were a lot of myths surrounding the undertaking vasectomy, with a vast majority believing it affects the sexual performance of the man; only 2.5% were aware that a man's libido and performance is not affected. Some of the respondents argued that vasectomy is a conspiracy by the government to reduce the Luo population; currently the political arena is controlled by the number of people in the region, many wanting to know if vasectomy was also offered free in other regions of the country. Others myths included: absence of sperms in the semen would make it cold and as such may cause the woman (spouse) to develop pneumonia; that men work very hard (physically) and that sex was the most important way to relieve themselves and with vasectomy this could not be achieved as one could not release fully; vasectomy restricted movement of the sperm this would lead to accumulation of sperms in the body and this would have negative/harmful effect such as, the scrotum swelling (mistaking genital elephantiasis with vasectomy), and lastly men who had adopted vasectomy were not regarded as not "real man", they are castrated, and this does not settle well with the Luo culture where the strength of a man, lay in his ability to sire children" *Ka nungo e teko*"( the waist is the strength-ability to sire children is one's strength), with some respondents feeling very strongly about this, according to one participant

*"Vasectomy would lead to reduced ssexual desire and this would distortort one's family leading to marriage break -up, this is in contradiction to Luo culture, because the power of a man is in his ability to sire."* Participant response

Misinformation could also be a hindrance to acceptance of vasectomy, The study found that, the facility which provided vasectomy did not give correct information to the potential clients; for despite vasectomy being offered free, the price board stated that it was offered at Kshs. 3,000 making it seem more expensive as compared to female contraceptives such as; pills, Kshs. 300, Depo Kshs. 300 and IUCD Kshs.1000 among others, hence, seeming cheaper. So, for a community already economically strained, vasectomy would be the last choice. **Figure 4.3** below shows the prices of the various family planning services offered at Marie Stopes International, Kibuye.

**Fig. 4.3:** Prices of the family planning services offered by MSI Kibuye clinic

SERVICE	FEE
CONSULTATION	500/-
CHILD WELFARE	200/-
ANTE-NATAL CARE	3000/-
PAP SMEAR	1000/-
PILLS	300/-
DEPO-PROVERA INJECTION	300/-
IUCD INSERTION/REMOVAL	1000/-
MIRENA INSERTION	5000/-
MIRENA REMOVAL	1000/-
JADELLE INS./REMOVAL	2000/-
TUBAL LIGATION	3000/-
VASECTOMY	3000/-
CIRCUMCISION	3000/-
LAPARATOMY	2000/-
ULTRA SOUND	30.000/-
POSTINOR 2	1500/-
LABORATORY & PROCEDURES	200/-
NORMAL DELIVERY	VARY
CAESERIAN SECTION	8000/-
DRUGS & TREATMENT	35.000/-
MACDONALD STITCH	VARY
MACDONALD STITCH REMOVAL	5.000/-
CONDOMS (RAHA)	5.000/-
N/B ENQUIRE FOR OTHER SERVICES	50/-

Source: Primary Data

#### 4.4 Attitude towards vasectomy

From the literature review, there are several factors which influence people's attitude, hence opinion on vasectomy. These include: education, family norms, religion, peers, culture, socialization, myths and misinformation. **Table 4.4** below shows how certain values influence people's decision making process, giving the frequency and percentages of the respondents. 67.5% of the respondents said their lives were vastly influenced by their education, 45% family norms had strongly influenced their decision making, while only 2% of respondents acknowledged the influence of the peer and culture. Therefore, their attitude towards uptake or rejection of vasectomy was largely influenced by their level of education, their social background, religious belief and how they were brought up.



**Table 4.4:** Extend to which certain values influence decision on vasectomy

Variable		Frequency	Percentage
<b>Education</b>			
	Very	27	67.5
	Averagely	9	22.5
	Very little	3	7.5
	Not at all	1	2.5
	<b>Total</b>	<b>40</b>	<b>100</b>
<b>Religious Beliefs</b>			
	Very	14	35.0
	Averagely	17	42.5
	Very little	5	12.5
	Not at all	4	10.0
	<b>Total</b>	<b>40</b>	<b>100.0</b>
<b>Ethnic /Culture</b>			
	Very	2	5
	Averagely	14	35.0
	Very little	15	37.5
	Not at all	9	22.5
	<b>Total</b>	<b>40</b>	<b>100.0</b>
<b>Peers</b>			
	Very	2	5
	Averagely	11	27.5
	Very little	17	42.5
	Not at all	10	25
	<b>Total</b>	<b>40</b>	<b>100</b>
<b>Family norms</b>			
	Very	18	45.0
	Averagely	16	40.0
	Very little	5	12.5
	Not at all	1	2.5
	<b>Total</b>	<b>40</b>	<b>100.0</b>

Source: primary data

#### 4.4.1 Peer, culture and attitude

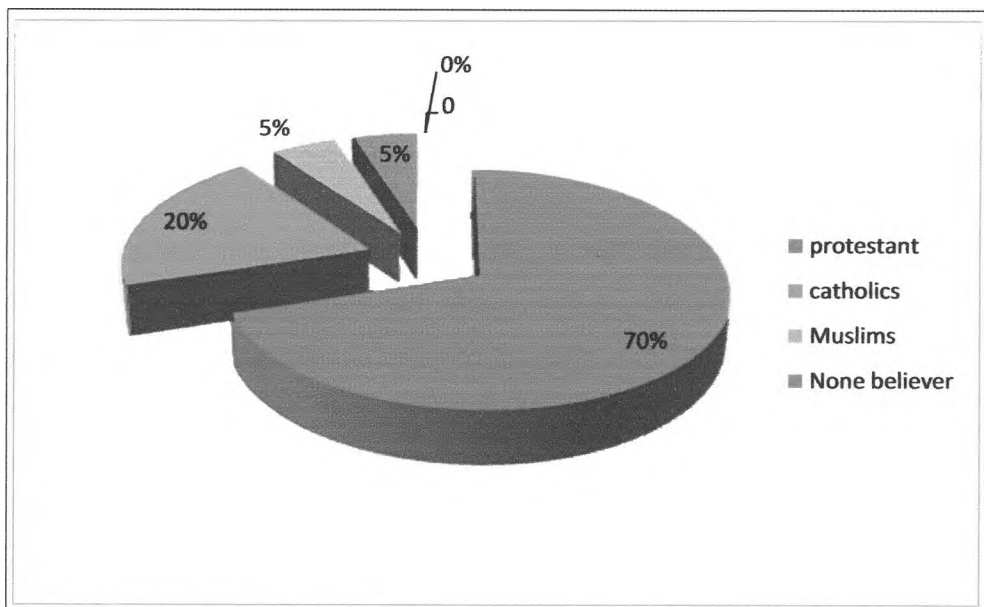
35% of the respondents said culture played minimal role in influencing their lives. However, when it comes to family planning, 42.5% felt that reproductive responsibility should be left to the women. As such, vasectomy (equated with male castration) was seen as a foreign ideology which has no roots in the Luo culture which is meant to undermine the Luo culture and therefore unacceptable. Culturally, one participants said, “*kanungo e teko*” (ability to sire is what makes a man) the ability to sire children gave the man control over his wives and the homestead, without which the man is no longer the head of the family, and would not earn the respect from the wives.

An impotent man is the laughing stock among his peers and the village at large, and that was what happened when one underwent vasectomy. According to a participant “nyathi e mwandu ng’ato” (children is one’s wealth), there was no limit to the number of desired children; however should this arise then it was determined by the number of ‘boy child’ in the family. A man who undergoes vasectomy was thus seen as running away from his responsibilities as a man; as polygamy was accepted. One who undergoes vasectomy had to live with social stigma, as the community and individuals have low opinion of those men who have undergone vasectomy. The figures below give a summary of how these factors influence one’s attitude towards certain aspects of life.

#### 4.4.2 Religion and influence on attitude

Religion plays a major role in influencing people’s attitudes towards certain aspects of life, especially contraception, and therefore uptake vasectomy. Different value systems and beliefs associated with religion bring about differentials in reproductive behaviour. **Figure 4.4** below shows percentages of religious denomination of the respondents, with a vast majority-90%, being Christians, while Muslims and none believers made up 5% each.

**Fig. 4.4:** Respondent’s denominations



Source: Primary data

Although the perception of religious' importance is clear, according to data in **Figure 4.4**, the degree to which it actually influences people's decision making is less (Bunce et al., 2007). The study found that, although 90% of the respondents were Christian only 2.5% felt having vasectomy was an ungodly practice. Many of the respondents did not feel religious belief would stop them from undertaking vasectomy. All the 6 vasectomy clients the study interviewed were Christians and all admitted that religion did not hinder their decision to have vasectomy.

*“God gave us a will to choose between right and wrong and I don't believe God would want us to bring children into this world, who are hungry and naked, after all the church accepted Eunuchs (castrated men,) ”* a client of vasectomy

### **4.4.3 Gender roles, socialization and Attitude**

Gender roles and socialization seemed to play a major role in determining use of family planning in general not mentioning male specific family planning. 22.5% of those interviewed felt men should take responsibility of family planning, solely because they are the head of the family and hence the decision makers. 42.5% felt women should take the responsibility of family planning because culturally, reproductive health is a concern of the woman, as they understood their bodies better and were in control of their menstrual cycle; which had nothing to do with the man. 35% felt family planning was a responsibility of both men and women, however, most of these stated so, with reference to female family planning, and not male specific family planning like vasectomy, which in most cases was not up for discussion.

**Table 4.5** below shows how our perception, attitude and behaviour are determined by our socialization. Gender roles are determined by how we are socialized. From the study, 50% of the respondents believed that men were the breadwinners in the family and for that, they are so busy and work too hard; by evenings they are too tired to again worry about family planning issues. 45% of the respondents felt that women should take up responsibility of family planning because they were less busy; economic reasons consistently appeared in the transcript as a major consideration for taking vasectomy, while only 12% of the respondents felt that health should be a consideration for family planning, this then was in line with the Luo cultural belief of

the man being the bread winner, and reproductive roles as, “*Thako ema thi tede*” (literary translates to a woman is the one who goes to cook- a woman gets married) and reproduction is the domain of the women. According to one participant pregnancy is not an illness neither is it a health condition,

*Ich ok en tuo, mon matinde ema yomyom, giketore ni gituo ka gipek.* (Pregnancy is not an illness, it is these modern women who are lazy and make pregnancy an illness), a male participant.

**Table 4.5:** Influence of socialization and cultural beliefs on attitude towards use contraceptive

Statement	%		
	Totally agree	Partially agree	Totally disagree
Men are the breadwinners in a household	50	30	20
Men and not women should make decision on the number of children	10	30	60
It's husband's responsibility to decide whether his wife should use Family Planning methods	15	20	65
A real man does not discuss Family Planning issue with his wife	17.5	17.5	65
Financial considerations is the primary motivation for Family Planning use	30	40	30
Health and the need for women to 'rest' should be the primary motivation for Family planning	12.5	22.5	65
Women are created to be good mothers and wives and a good woman sits at home and takes care of the family	10	7.5	77.5
A woman should use Family planning because she is less busy	42.5	25	30

Source: Primary data

There is also the belief that, men are bread winners and should be spared the responsibility of vasectomy. From the above data, Women are therefore, expected to take care of family planning issues with (40%) totally agreeing and (25%) partially agreeing that women were less busy.

The study found that, the issue of unfaithfulness was a concern for women. Although some women felt they could not be burdened by children from their husbands extra-marital relationships others women could not trust their husband's fidelity after performing vasectomy, with no observable consequence of their unfaithfulness, according to one female participants,

*“Allowing my husband to take vasectomy, is a warrant for him to be promiscuous”*  
(one Female participant).

#### **4.5 Influence of attitude on vasectomy**

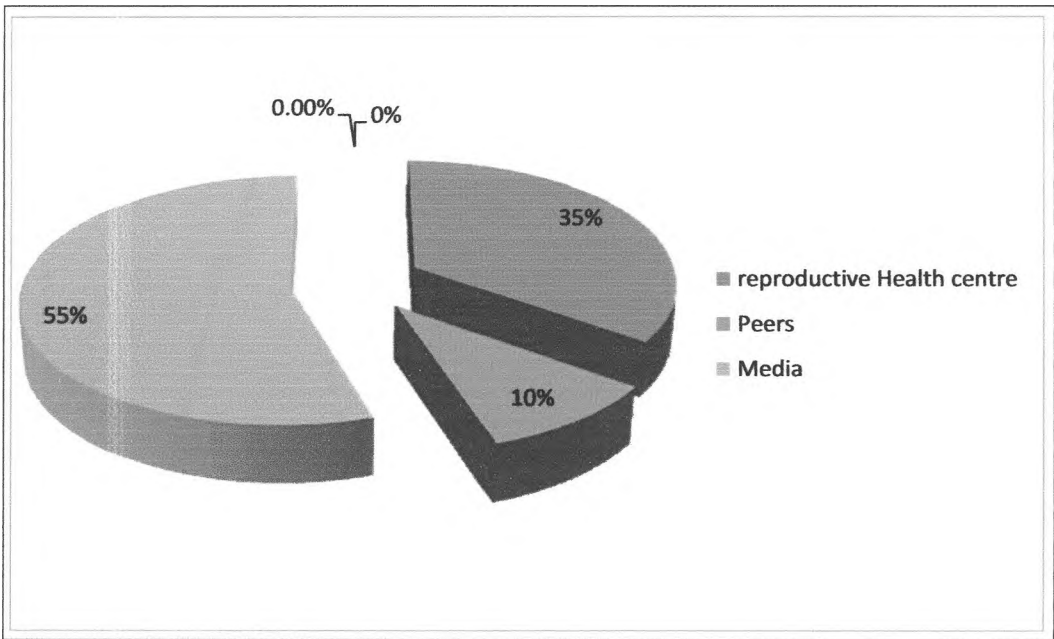
Marie Stopes Kibuye clinic offers vasectomy for free and for this population, the problem of access has been solved; despite this the uptake is very low. The attitude and perception people have greatly influenced the uptake or rejection of vasectomy, as FPM. However a few individuals are making the effort to inform people about vasectomy. In addition to raising awareness, satisfied clients have become advocates for vasectomy services. They provide a ‘living example’ of the experience of having a vasectomy, and are well placed to persuade other men of the benefits. One informant who has undergone vasectomy said he had become a self proclaimed “*ambassador*” of vasectomy.

*“I talk to people when I am in any gathering especially when I attend funerals in my village, telling them about vasectomy and its benefits.”*

##### **4.5.1 Mass media and vasectomy**

Media plays a vital role in influencing people's attitude towards certain aspects of life, hence the decisions they make. The study found that majority of the respondents (55%) had heard of the Family planning they were using through the media as illustrated by **Figure 4.5** below.

**Fig. 4.5:** Source of information on family planning used by respondents



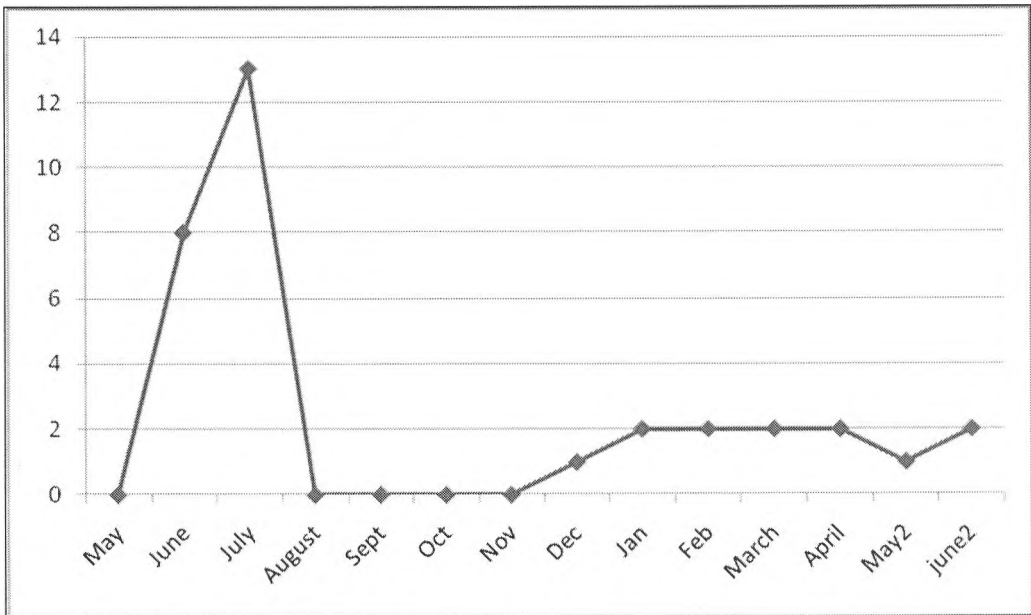
Source: primary data

In the month of June 2009, the print media carried a story on a “Dr. Ochieng” who gave his experience of undergoing vasectomy; thereafter it was followed up by a live interview with KBC and then Ramogi radio in the month of July. Dr. Ochieng, who took part on the T.V and Radio interviews said;

*“During these interviews there was a lot of interest, with (call-in) participants in the programme asking many questions of concern. It gave me an opportunity to give them facts on vasectomy.”*

After the media coverage in June/July 2009 there was a sharp rise in the number of men who seek vasectomy as a family planning method as shown in **Figure 4.6**. This could be because people got facts during the media campaign programmes, and a lot of their concerns and fears were assuaged by the Doctor and other experts. They got knowledge on vasectomy which in turn influenced their attitude towards undertaking vasectomy as a method of family planning.

**Figure 4.6:** Number of vasectomy clients at MSI-Kibuye, May 2009-June 2010



*Source: Primary Data*

However, according to **Figure 4.6** above, after July there was zero uptake of vasectomy (as indicated in the clinic register), but this was not the case on the ground, it was a case of inaccurate recording by the clinic.

#### **4.5.2 Spousal influence on acceptance to vasectomy**

All vasectomy clients in the study reported to have discussed with their spouses the option of vasectomy, and were in agreement. 57% of the respondents and participants said they discuss family planning with their spouses, while 42% said they don't. Of these, 60% of the respondents felt both men and women should be involved in the discussion on the number of children. However, the study found - on further discussion during FDG- that communications were mainly on the use of female family planning and not the male specific family planning. All the six participants who have undertaken vasectomy mentioned that they consulted their wives before making the decision. One key informant (service provider) at the clinic stated that no operation could be carried out without confirmation of both husband and wife being part of that decision (both attended the counseling session). According to the service provider- Dr. Ochieng

*“Clients who opt for a vasectomy are given counseling before the procedure. They are fully informed about the complications and risks associated with the operation, including the difficulty of reversing the procedure. We insist that the decision has to be a family decision, where the wife is also informed. We then take medical history and conduct a full examination to ensure suitability for the procedure and to check for underlying health problems using the acceptance form.”*

The vasectomy clients must give voluntary informed consent before the procedure begins, by signing the “Acceptor’s Voluntary Vasectomy Registration” (included in appendix). However, none of the wives accompanied their husbands to undergo the operation, although the opinion of the spouse was very influential, as one potential vasectomy client admitted,

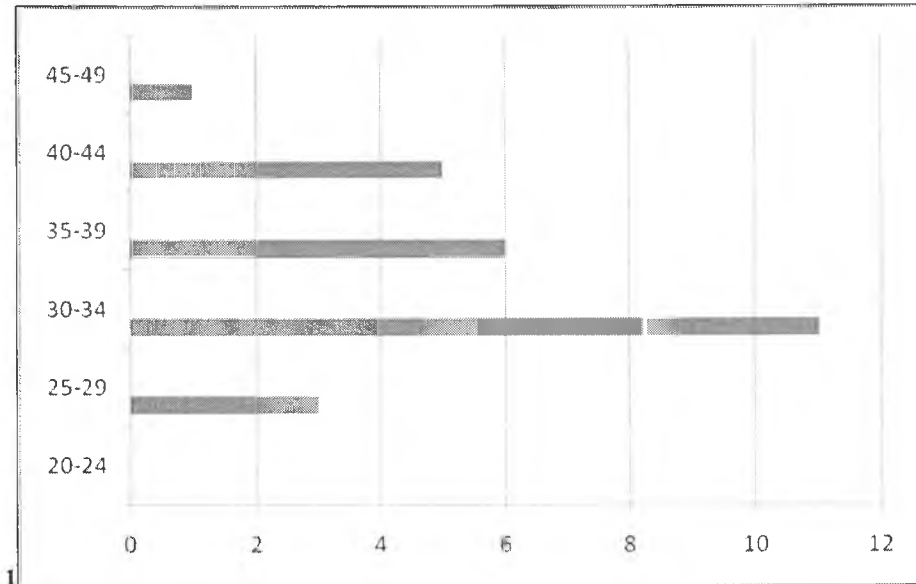
*“I have a wanted to undertake vasectomy for a long time now. However, my wife is against it. I talked to her about it and brought her to meet the provider- who insisted that she must be in agreement before I can perform the procedure, but still she has refused. She cites the negative effect it may have on my sex life, but the real truth could be she fears I might be promiscuous.”* - Potential vasectomy client.

Ndege (1991) observed that lack of sufficient communication between spouses, is one of the major hindrances to the success of family planning use in rural Kenya. Family planning works best when both the man and the woman are in consultation and in agreement, especially in the case of sterilization.

The study also found that, a majority of those who have had vasectomy were in the age bracket of 30-34 years, followed by 35-39 age brackets. These age group were individuals; who were young fathers; who could be more exposed and hence better informed; are very aware of the economic implications of big families; readily discusses family planning and hence going against the cultural norms of men participation in family planning. **Figure 4.7** below shows the age brackets of the vasectomy clients and their frequency, between May 2009 and June 2010 set out in age brackets.



**Figure 4.7:** Age and number of vasectomy clients at MSI-Kibuye



Source: Primary Data

At Marie Stopes clinic in Kibuye vasectomy is presented as one of a range of long-term and permanent methods of contraception available. The youngest client to undertake vasectomy was a 25 year old man, who was single and had no children of his own. His narrative and that of another client are captured below.

### CASE 1

John\* is a 25 year old man and the youngest client of Vasectomy; he underwent vasectomy on 14<sup>th</sup> June 2010. A projectionist with Silver Bird Cinemas, John is the first born in a family of 5. He grew up with his father in Busia, at one time living with the catholic priests, and he mentions that he envied their way of life, which was free from family stress and strain, while his mother and the other siblings lived in Naivasha. He is single, and has no child; however, he has a girlfriend who, according to him has agreed to the decision. He also discussed the issue with his mother and she gave her consent. John does not intend to have any child and he has never wanted one. According to John, he comes from a family with inherited Asthmatic condition. The whole family suffers from Asthma and he watched his father suffer till death.

*“I have watched my family struggle with Asthmatic medical condition and opted not to have children to go through the same.”*

John learnt of vasectomy from his teacher in school (a religious school), who discussed sex education freely and openly. Later as he lived and worked in Kisumu he saw the free services at Marie Stopes announced on a poster outside Godwill clinic in Nyalenda, who on enquiry sent him to Marie Stopes Kibuye.

John believes strongly in having one sexual partner and wants to maintain that. He intends to marry his girlfriend and according to him she is ok with this arrangement and has agreed to marry him. He also feels - especially observing the life style of his peers - that a man should only have children they can take care of, and free from the suffering his family has gone through.

## CASE 2

Mark Onyago\* (\* not his real name) is a 32 year old man, who lives in Mamboleo but rural home is Uyoma Kagwa. He went to school until class 8 and is currently a carpenter working at Kibuye market. As a child, Onyango grew up with his 9 siblings (5 deceased) in the rural parts of Uyoma. He is married with 5 children (3 boys and 2 girls). The first child born in 1998 is currently in class 3. As a carpenter Onyango felt life was becoming too costly and could not adequately provide for his wife and the 5 children. Onyango, contemplated Tubal Ligation (TL) for his wife, who until then had not used any FPM. However when he heard of the complications associated with TL, he shelved the idea. Through a friend working at Marie Stopes, who has since become a voluntary ambassador of vasectomy, Onyango came to hear about male FPM called vasectomy. He talked about it to his wife and later visited the service provider at the clinic alone. After a long talk, guidance and counselling Onyango opted for vasectomy.

*“My friend out of concern confided in me that there was away to help myself, and that he had done the same, he introduced me to the service provider at Marie stops, after that I never looked back,” (Mark)*

Mark says that he discussed the issue with his family and they had no objection to it. Since then, Mark feels his life is more relaxed, he is comfortable that he will not get

another baby; at the same time he notes that the wife is more relaxed. He mentions that he enjoys his sex life as usual as nothing has changed.

*“Mark has become a more caring husband, and a better father, now more than ever, he spends more time with the children, maybe it is the realization that we are all he has,”* (Mark’s wife).

Marks concurs with this *“vasectomy has made me appreciate women, especially my wife, more because she is all I have, I no longer have the mentality that women are many; however, that would not make me be frustrated because I already have my children and would remain with them if my wife leaves.”*

However, he feels that more needs to be done to enlighten the people on this FPM, as majority, even at his place of work are not aware. He suggests talks and campaign via Radio Lake Victoria, Ramogi FM and barazas.

### CASE 3

Dr. Ochieng (gave permission for use his real name) is a medical doctor at Marie Stopes International, Kibuye. He is currently the only doctor trained to perform vasectomy procedure at the clinic and at time doubles up for the same at New Nyanza general Hospital. He was among the first people to go public with his vasectomy status. This going public was later to be an eye opener for other potential vasectomy clients. He is a father of two and because he did not want any more children, he opted for vasectomy because of the side effects his wife experienced with other family planning option. He underwent vasectomy in May 2008, and at that time, there was no clinic offering vasectomy in Kisumu, therefore, Dr. Lumumba had to travel all the way from Nairobi to perform this procedure on him. According to Dr. Ochieng culture, religion etc have never had any influence on his decisions in life.

*“I believe I have always been a person of my own, I like taking responsibility over my life; and maybe this personality is what made it easy for me to opt for vasectomy as a family planning option other than the fact that my wife was suffering, a lot, as result of side effects of the family planning option she was using; so I opted for vasectomy, after all, I had enough children and did not intend to have any more. I look at life*

*differently, to begin with, when I was in form 2- way before, circumcision was a campaign in Luo Nyanza- I went for circumcision. My father was initially against it, and he sorted the intervention of his brothers (my uncles) to try and find out what was wrong with me. They felt this was not our cultural practise and if I was not bewitched, then my “little” education was getting into my head, yet, according to them I was not the first to go to school in that family. (Dr. Ochieng)*

He admitted having a rough time with his relatives who felt he was embracing foreign ideologies which would led to his destruction as a Luo man, at times his peers would keep off, at the advice of their parents –who considered Dr. Ochieng bad influence.

*“The shock of their life to my extended family was when my story appeared in the paper that I had undergone vasectomy. I had not mentioned it to any of my relatives. It was a private and personal affair. They thought for sure I had gone mad. My parents- in-law (who are Luhya-inter marriage) called me enquiring if what they had heard (from a neighbour) was true, when I affirmed their query, they hang up. They could not comprehend why I did it; they called my wife to confirm my sanity. It took them along time to come to terms with it, but now they are fine, especially now that they have come to appreciate it was for their daughter’s good. Today, everyone seems to have accepted and respected my decision, after all my family is well taken care of, I can afford to give my children what they want and I believe Kenya being a capitalist society, that is what matter (a man’s success is judged by his economic status).”*

Dr. Ochieng feels enough is not being done to disseminate information to the potential clients; he believes vasectomy is the best option for men especially when one attains the number of children they want. It give you time to plan for your family’s future, apart from contributing to the well being of your wife. He decries lack of funding, not as much money is channelled towards vasectomy as compared to female TBL, so as to reach remote places.

## 4.6 Discussion

Vasectomy, the only other male specific method of family planning, is least known, almost non-existent, except for a few clients in Kenya, all other Africa countries, but is a common family planning in Europe, being the leading family planning method used in the UK. A study conducted in USA showed that attention given to vasectomy today has been stimulated by a variety of societal change- an interest in the family planning for men; better understanding of men and women of the separation of sex and reproduction, and the knowledge that man's sexuality will be unaffected by the operation; and others choose an alternative life styles, which do not include child bearing. However, to the people included in this study, marriage is synonymous to child bearing and sex is the "home" (ability to sire children- manhood). This study was consistent with this latter observation where one of the vasectomy clients, was only 25 years, unmarried and did not want to have children. Being asthmatic and seeing his family struggle with this hereditary condition, he did not want to see another patient of asthma; not his child.

The overarching domain identified in this study as contributing to acceptance or rejection of vasectomy were consistent with other research conducted in Tanzania (Bunce et al., 2007), Guatemala (Vernon et al., 2007) Sub-Saharan Africa (Mbizvo and Basset, 1996) among others, they included; lack of knowledge and understanding, uncertainty about future, financial consideration, religion, media and spousal communication. This study posed lack of knowledge and incorrect or incomplete information concerning the vasectomy procedure as a hindrance to acceptance of vasectomy. There is, therefore, need to improve dissemination of accurate information to masses through media, which is the leading source of information for vasectomy.

The fear of impotence and equation of vasectomy to castration have been reported in many studies conducted in Sub-Saharan Africa (Bertrand, 1990; Mbizvo and Basset, 1996) Tanzania (Bunce et al., 2007) and Guatemala (Vernon et al., 2007). These past studies have also identified such barriers as concern about sexual functioning and physical strength of the husband. This study also found that, this was a concern for many respondents and participants; because this is central to marriage union among the Luos, where manhood is equated to ability to sire children. However, vasectomy

clients reported that their concerns regarding sexual desires were assuaged by the service provider.

Unlike study in Bangladesh, where because of rampant promiscuity women were against use of vasectomy because it would lead to divorce if a woman became pregnant yet the husband had had vasectomy, this study found that most women respondents and participants expressed fear of their husbands' fidelity once they underwent vasectomy. The lack of observable consequences of extra-marital affair, though good - because one will not be stressed with children born out of these affairs - it might expose them to sexual transmitted diseases such as H.I.V AIDS. This, as observed in other studies - the study in Tanzania - raises need for an in-depth study of sexual behaviour and relationships, knowledge and understanding of vasectomy and perception of risk.

Studies conducted in Kenya (Rono, 1994; Wilkinson, 1996; AVSC, 1997; Becker, 1997; Otieno, 2000), Tanzania (Bunce et al., 2007), Mexico, Brazil and Guatemala (Vernon, 1996) have acknowledged the importance of economic pressure on vasectomy. In Bangladesh, vasectomy was becoming more popular because of poverty level, in this study economic consideration featured predominantly in men's transcripts, this could have been as a result of men feeling pressured by the gender role expectation of being bread winners, hence, have to provide for their family. In this study economic consideration was the underlying reason for adopting vasectomy, where vasectomy clients felt they needed to fend for their family - basic needs and education.

Educational level is also believed to have influence on acceptance of vasectomy. Research conducted in Brazil and Mexico (Vernon, 1996; Marchi et al., 2008), reported that potential vasectomy clients came from well defined population of relatively young, well educated men who had small families and were already using contraception. A study in Tanzania (Bunce et al., 2007) also concurs that over 70% of the acceptors were of relatively high education and with small families of not more than 3 children. However, this study found that almost all the vasectomy clients interviewed were not highly educated, with a majority not completing secondary

school. This suggests that life experience and economic hardships could have surpassed influence of level of education on choice of vasectomy.

Both negative and positive religious opinion exists, with some churches e.g. the catholic, really against contraceptives. In this study all the vasectomy clients were practising Christians; however, church/religion was not a consideration in their decision to have vasectomy. They argued that family planning was a private issue and raising a family was solely an individual's responsibility - church does not give financial assistance to bail one out. That these clients would choose vasectomy against the will of the church, would contribute to our understanding on the role of religion in contraceptives and its relevance to people's life choice. Maybe for religion to be relevant in people's life it should promote family planning and adapt to meet its follower's needs and discuss reality of life concerns.

Another domain the study identified was influence of spousal communication. Previous studies identified decision to have vasectomy as a joint process among couples or autonomous choice of men. Laundry and Ward (1997) found that although most couples agreed that decision should be a joint one, it was primarily made by the men alone. This study concurs with this, for, although all the vasectomy clients reported having discussed the decision with their spouses, none of them was accompanied by the spouse when he went to have the procedure, leaving doubt, whether the wives were involved or they were not comfortable with the cultural implication of the same; Luo being a patriarchal society and still strongly practising its cultural beliefs.

A study conducted in 2009 in India (Yadav et al., 2009), reported that men were interested in acquiring family planning information; but lacked knowledge about available information services, which hampered their ability to make informed choices. This finding is consistent with the finding of this study where 57.5% of the respondents said they would consider taking vasectomy if they had accurate information. Men's lack of adequate knowledge on all available methods of family planning has led to many men ending up encouraging their wives to adopt female sterilization. Family planning services need to be aware of male knowledge and perception to family planning, and make appropriate modification to communication.

## CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION

### 5.1 Introduction

This section of the project provides the conclusion from the research and recommendation on the best way forward. It is noted that the uptake of vasectomy would require proper channels of providing information, which would then influence the attitude towards vasectomy and the general choice of the same as FPM.

### 5.2 Summary and Conclusion

This study attempted to study the knowledge and attitude of both men and women on vasectomy and the influence of attitude on the uptake of vasectomy as a family planning method, at MSI, Kibuye.

The finding of this study provides important insight into factors affecting the uptake of vasectomy, which included; knowledge, uncertain future, religion, media and financial pressures. Although there is little documented information on vasectomy, the key informants, and the men who have undergone vasectomy have provided relevant information, which can be used to enlighten the people.

The study found that, a majority of the respondents had knowledge of vasectomy, however many had heard about it, but did not however, understand/have much fact about vasectomy; that vasectomy acceptance is limited by the fact that men and women hold many of the same misunderstanding about vasectomy including a fear of decreased sexual performance as a result of the procedure.

### 5.3 Recommendations

This study has applied its key findings to develop recommendations which may be used to inform policy formulation on vasectomy and may also form basis for further research. Some of the recommendations are:-

- There is need for better advocacy and more publicity; better education and dissemination of accurate information curb the myths and misinformation held about vasectomy, as well as present vasectomy as an effective family planning



vasectomy, especially its advantages over female sterilization and temporary methods: men's concern for their wives health; their desire to share responsibility; freedom from unintended pregnancy that vasectomy confer.

- Vasectomy services must be offered as part of full range of family planning options to ensure maximum contraceptive choices. The use and effectiveness of vasectomy has to be effectively evaluated and documented; currently there is almost no documentation on the use and effectiveness of vasectomy at MSI Kibuye.
- Given that vasectomy is still a culturally foreign ideology, there is need to break the social barriers- and the clinic being a service and an information point for vasectomy- it should be more male-friendly; currently it is seen as a “women's place” – a maternity and family planning centre as written on the signboard at the gate. At hospital reception, almost all the clients waiting to be served were women with a few men who had accompanied their spouses to seek various reproductive health services, as seen in the picture (photos in appendix).

#### **5.4 Further study**

There is need for further study on the use of vasectomy and a follow up on the clients who have undergone vasectomy to establish its impact on their lives. Currently there is very little documentation on all the clients who have undergone vasectomy. There is also need for further study on the sexual behaviour and relationships, knowledge and understanding of vasectomy perception of risk.

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# Appendix 1: survey Questionnaire

Good \_\_\_\_\_, my name is Evelyne Agingu, a student at the University of Nairobi pursuing a Masters Degree in Gender and Development Studies. In order to fulfill the requirements of the program, I am undertaking a study on “**Knowledge and attitude of men and women towards vasectomy as a family planning method**” The findings of this study will contribute to knowledge in this area; opening up this area for further research.

Name (optional) ..... Date .....

- 1. Age: .....
- 2. Gender: Male ( ) Female ( )
- 3. Marital Status: Single ( ) Married ( ) Divorced ( ) widowed ( ) separated ( )
- 1. Religion: Catholic ( ) Protestant ( ) Muslim ( ) None ( ) other Specify ( ) ....
- 5. Residence: .....
- 6. Level of education completed. None ( ) Primary ( ) Secondary ( ) Tertiary ( Degree ( ) others, (Specify).....
- 7. Occupation .....

### Question

List all the forms of family planning methods you know.

•	•
•	•
•	•
•	•
•	•

**THANK YOU**

8. To what extent is your way of life influenced by the following sources

Source	Very	Averagely	Very little	Not at all
Religious beliefs				
Educational values				
Parents/family norms				
Ethnic/peer group practices				

9. How many siblings (brothers and sisters) do you have? .....

10. Were you raised together with them or not. Together ( ) Not together ( )

11. In your opinion how many children are ideal in a family .....

12. In your community, who do you think should take responsibility of family planning?

Man ( ) woman

why.....

13. To what extend does cultural beliefs contribute to the following statements about men and women in the community

Beliefs	Totally agree	Partially agree	Totally disagree	Don't know
Men are the breadwinners in a household				
Men and not women should make decision on the number of children				
It's husband's responsibility to decide whether his wife should use Family Planning methods				
A real man does not discuss Family Planning issue with his wife				
Financial considerations is the primary motivation for Family Planning use				
Health and the need for women to 'rest' should be the primary motivation for Family planning				
Women are created to be good mothers and wives and a good woman sits at home and takes care of the family				
A woman should use Family planning because she is less busy				

14. Do you discuss family planning issues with your spouse /partner? .....

If yes, how often have you talked about family planning in the last 6 months?

Always ( ) rarely ( ) none ( )

15. As far as the number of children and family planning is concerned do you believe it is

- i. Joint decision
- ii. God's decision
- iii. Man's decision,
- iv. wife decision
- v. Don't know

16. How many children do you have .....

17. Have you ever used any method of family planning with any partner? Yes....No..... (If not go to question 19)

18. Where do/did you go to obtain your family planning services? .....

19. What was the main source of the family planning method you are using?

- i) Radio,
- ii) Television,
- iii) clinic,
- iv) Peers,
- v) written print
- vi) health provider? .....

**(Circle the sources)**

20. Do you think it's appropriate to talk about Family planning on radio, Television or press etc? Yes..... No ..... Why .....

21. Should men take responsibility of their reproduction? Yes ( ) No ( )  
Why.....

22. Which family planning methods for men, do you know of?  
.....?

23. In your opinion would you say a big number of people have adopted modern family planning methods? Yes ( ) No ( )

If yes, which ones .....

24. Have you ever heard about vasectomy..... ?

If yes, from where..... ?

If No, would you like to know about it.....?

25. What do you know about vasectomy? .....

26. In your opinion, what could be advantages having vasectomy?

- .....
- .....
- .....

27. In your opinion, what could be disadvantages having vasectomy?

- .....
- .....
- .....

**Thank you for your responses and participation.**

## Appendix 2: Focus group discussion guide

Good \_\_\_\_\_, my name is Evelyne Agingu, a student at the University of Nairobi pursuing a Masters Degree in Gender and Development Studies. In order to fulfil the requirements of the program, I am undertaking a study on **“Knowledge and attitude of men and women towards vasectomy as a family planning method”** The findings of this study will contribute to knowledge in this area; opening up this area for further research.

Group..... Date.....Time.....

1. Who should handle family planning e.g. contraceptives issues? Why?
2. What would be reason for taking any form of family planning?
3. How would you define vasectomy? What is the availability and cost of vasectomy?
4. What are some the reasons given by those who take vasectomy as the (motivational factors influencing them to undergo vasectomy)?
5. What has stopped you from undertaking vasectomy?
6. What role does religion play in the way you lead your life- and decision-making process?
7. What social/ emotional procedures/ steps should be taken before undergoing vasectomy? E.g. counselling.
8. Have you ever had any opportunity to have a discussion with someone who has had vasectomy, if not, would it make a difference in the way you perceive vasectomy?
9. What should be the role of women in the process of vasectomy?
10. How confidential and private is Marie Stopes Kibuye clinic for those seeking vasectomy?
11. What are the advantages and disadvantages of vasectomy?
12. What coping mechanism should be available for those who have gone through vasectomy especially if it gets to the public domain against their wish?

**Thank you.**

### Appendix 3: Key Informants guide

Good \_\_\_\_\_, my name is Evelyne Agingu, a student at the University of Nairobi pursuing a Masters Degree in Gender and Development Studies. In order to fulfil the requirements of the program, I am undertaking a study on “**Knowledge and attitude of men and women towards vasectomy as a family planning method**” The findings of this study will contribute to knowledge in this area; opening up this area for further research.

Name: .....

Occupation .....

Institution ..... Date.....

Contact ..... Religion.....

1. How would you define vasectomy? Vocabulary used to describe vasectomy to illiterate people or uninform people?

\_\_\_\_\_

2. What is the availability and cost of vasectomy and how do they (clients) get you or how do you get them? \_\_\_\_\_

\_\_\_\_\_

3. What are the advantages and disadvantages of vasectomy?

\_\_\_\_\_

\_\_\_\_\_

4. What are the reasons given by clients of vasectomy as the motivational factors influencing them to undergo vasectomy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Are there any social/ emotional procedures/ steps clients are taken through before undergoing vasectomy? E.g. counselling. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



6. Do the clients ever mention or confirm that they discussed the decision with their spouses/ partners? \_\_\_\_\_  
\_\_\_\_\_
7. Do the women accompany their husbands during these stages? (Moral support) or part of the process? Role of women in the process of vasectomy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. In case a one changes their mind after the surgery, what happens?  
\_\_\_\_\_  
\_\_\_\_\_
9. Has there been any client coming to you/ have you gone back with any experienced effects and if yes, what solutions did you offer/were you offered?  
\_\_\_\_\_  
\_\_\_\_\_
10. How about confidentiality and privacy for those seeking vasectomy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. What coping mechanism is available for those who have gone through vasectomy especially if it gets to the public domain against their wish?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Now that you are (Religion) , how did you religious beliefs influence your decision to adopt vasectomy? \_\_\_\_\_  
\_\_\_\_\_

**Thank you.**

## Appendix 4: Narrative and In-depth interview guide

Good \_\_\_\_\_, my name is Evelyne Agingu, a student at the University of Nairobi pursuing a Masters Degree in Gender and Development Studies. In order to fulfil the requirements of the program, I am undertaking a study on “**Knowledge and attitude of men and women towards vasectomy as a family planning method**” The findings of this study will contribute to knowledge in this area; opening up this area for further research.

Would you like to participate? \_\_\_\_\_

### **MEN who have adopted vasectomy**

Name: .....

Occupation .....

Contact ..... Date .....

Age ..... Religion.....

1. How did you find out about vasectomy?

\_\_\_\_\_

2. When and where did you undergo vasectomy?

\_\_\_\_\_

3. At the time what was the availability and cost of vasectomy?

\_\_\_\_\_

4. Did you discuss vasectomy with your partner, how did you introduce the topic to partner? And what was their opinion?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Did/Do your extended family know about your state, and if yes, what has been their reaction?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What was role of your wife in the process; did she accompany you to the clinic for talks and the operation?

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7. Have you experienced effects and if yes where solution provided?

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8. What can you tell those who have not heard or are thinking of having vasectomy (advantages and disadvantages)? Do you discuss vasectomy, if yes to whom, when and where

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9. What coping mechanism is available for those who have gone through vasectomy especially if it gets to the public domain against their wish?

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10. What can you say about confidentiality and privacy for those seeking vasectomy at the clinic?

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11. Now that you are a practising (religion), how did your religious beliefs influence your adoption of vasectomy, does your church know of this and what has been their reaction?

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**WOMEN/SPOUSE OF VASECTOMY CLIENTS**

1. How did you find out about vasectomy?

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2. When and where did your spouse undergo vasectomy?

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3. At the time what was the availability and cost of vasectomy?

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4. Did he discuss vasectomy with you, how did he introduce the topic to you?  
And what was your opinion?

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5. Did/Do your extended family know about this, and if yes, what has been their reaction?

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6. Did you accompany your partner to the clinic for talks and the operation? If not why?

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7. Have you experienced effects and if yes where solution provided?

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8. What can you tell those who have not heard or are thinking of having vasectomy (advantages and disadvantages)? Do you discuss vasectomy, if yes to whom, when and where

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9. What coping mechanism is available for you and your husband especially if it gets to the public domain against their wish?

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10. What can you say about confidentiality and privacy for those seeking vasectomy at the clinic?

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11. Now that you are a practising (religion), how did your religious beliefs influence your husband's adoption of vasectomy? Does your church know of this and what has been their reaction? \_\_\_\_\_

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**Thank you.**

# Acceptor's Voluntary Vasectomy Registration

1 Clinic's ID: \_\_\_\_\_ 2 Acceptor's ID: \_\_\_\_\_ 3 Date of first Visit: \_\_\_\_\_  
Day Month Year

4 Family Name: \_\_\_\_\_ 5 Given Name: \_\_\_\_\_

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

7 Tel. No.: \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell)

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8 Acceptor's Age: \_\_\_\_\_ 9 Date of Birth: \_\_\_\_\_ 10 Partner's Age: \_\_\_\_\_  
Day Month Year

11 Education: \_\_\_\_\_ 12 Employment: \_\_\_\_\_ 13 Occupation: \_\_\_\_\_

14 Union status: \_\_\_\_\_ 15 Union: \_\_\_\_\_ 16 No. of Mistresses \_\_\_\_\_ 17 No. of Children from each union \_\_\_\_\_

18 Religion: \_\_\_\_\_ 19 Ethnicity: \_\_\_\_\_ 20 Reason/s for registration: \_\_\_\_\_

21 Source/s of Influence: \_\_\_\_\_

**Number of:**

22 Living Children: \_\_\_\_\_ 23 Stillborn: \_\_\_\_\_ 24 Miscarriages: \_\_\_\_\_ 25 Abortions: \_\_\_\_\_ 26 Total Pregnancies: \_\_\_\_\_

27 Age of First child: \_\_\_\_\_ 28 Age of Last child: \_\_\_\_\_ 29 Outcome of Last pregnancy: \_\_\_\_\_ 30 How many children did you plan to have: \_\_\_\_\_

31 Reason/s for last abortion: \_\_\_\_\_ 32 Gender of Living children: Boys \_\_\_\_\_ Girls \_\_\_\_\_

33 More children: \_\_\_\_\_ 34 How many more: \_\_\_\_\_ 35 Are you sure? \_\_\_\_\_

36 No. Methods known: \_\_\_\_\_ ( ) 37 Ever-used \_\_\_\_\_ 38 Last/Current Method: \_\_\_\_\_

39 Method/s accepted at visit: \_\_\_\_\_ 40 Is your wife/partner currently pregnant \_\_\_\_\_

41 Primary reason/s for requesting vasectomy: \_\_\_\_\_

42 Date of Procedure: \_\_\_\_\_ 43 \_\_\_\_\_

## Client's Voluntary Consent:

I, \_\_\_\_\_ and currently residing at the address shown on this form, hereby certify that the details of the vasectomy procedure and purpose have been fully explained to me and I now understand that:

- a. Vasectomy is a **permanent** and **irreversible** method of **male sterilization**
- b. If successful I will therefore **not** be able to make any woman pregnant
- c. After the vasectomy, sterilization will be achieved after twenty-one ejaculations or **three months**
- d. Like any surgical procedure, there is **no guarantee** it will work 100%; there is a small risk of failure
- e. I can use temporary methods of contraception **instead** of having a vasectomy
- f. At any time before the procedure, I am **free** to change my mind and decide against having a vasectomy

I declare that I have **voluntarily consented** without **coercion** or **inducement** to the vasectomy and I understand that there are possible risks and discomfort that may be expected from the procedure.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Counsellor: \_\_\_\_\_ Counsellor's Signature \_\_\_\_\_ Date \_\_\_\_\_

### PRE-OPERATION NOTES

Date	Notes	Doctor's Examination		
		Heart	Lungs	Physical Exam

### POST-OPERATION NOTES

42 Date of Procedure: \_\_\_\_\_ (Confirmation)

Date	Notes

### OUTCOME FOR THE CLIENT

44 Post operative complications detected immediately after the procedure _____	
45 Treatment of complications _____	46 Discharge Status _____
47 Laboratory confirmation of vas _____	
<b>Follow-up Information</b>	48 Date of first follow-up visit _____
49 Complications at follow-up _____	50 Treatment of complications _____
<b>Second Follow-up visit</b>	51 Date of second follow-up visit _____
52 Azoospemia confirmed _____	
53 Current condition of client _____	