FACTORS INFLUENCING MALE ATTITUDES TOWARDS VASECTOMY IN KILIFI DISTRICT, KENYA

BY

MUSA LUGWE KIDZUGA

Research Project Report Submitted in Partial Fulfillment of the Requirement for the Award of degree of Master of Arts in Project Planning and Management of the University of Nairobi

2012

DECLARATION

This research project report is my original work and has not been presented for a degree or any other award in any other University.

11/11/2012

Musa Lugwe Kidzuga **Date**

Registration Number: L50/65296/2010

This research project report has been submitted for examination with my approval as the University Supervisor.

11/11/2012

Dr. Anne Aseey **Date**

Lecturer, University of Nairobi

DEDICATION

This project report is dedicated to my family. My mother Margaret Kidzuga and my brother Hassan Kidzuga for being my greatest blessing and source of encouragement throughout the research work. May God bless them always.

ACKNOWLEDGEMENT

I am grateful to the Almighty Allah the most Merciful for his unfailing love, provision, protection and unmerited mercy. My sincere thanks go to all lecturers and staff of University of Nairobi, Nairobi Extra Mural Center for their support throughout the Master's program in general and in particular this project.

Special thanks to Dr Anne Aseey for her unwavering support and advice as my supervisor. Her effort and sacrifice really challenged and encouraged me. Special thanks go to all my colleagues in the Masters class especially Group 7 members (Jecinta Anyiso, Joram Kihumba, Isaac Kariuki and Anne Misiko) for their encouragement and support. To all, may the Good Lord bless you abundantly.

ABSTRACT

Vasectomy is unique among the modern methods of contraception as it enables the male partner to take primary responsibility for fertility control; its availability broadens the choice of methods for family planning users and contributes to promoting male involvement in family planning. This therefore led to the need of undertaking a study of the factors that influence the male attitudes towards vasectomy in Kilifi District. Specifically the study assessed how independent variables like education level, economic factors, cultural and religious factors and reproductive health service providers and had an influence on the male attitudes towards vasectomy in the district which is the dependent variable. Descriptive survey design was used and a sample of 3 health centers was selected through purposive sampling methods. Reproductive health service providers' and men from different parts of the division formed the study respondents. Questionnaires with both closed and open ended questions were used to collect data as well as an interview guideline. The study findings identified the main factors influencing male attitudes is culture, low education levels, ignorant educated men and health service providers bias. The study findings recommend vasectomy sensitization campaigns, training of service providers and long term commitment of government, donors and other stakeholders towards vasectomy programs in terms of leadership and resources.

TABLE OF CONTENTS

CONTENT **PAGE**

LIST OF TABLES

CONTENT **PAGE**

LIST OF FIGURES

CONTENT **PAGE**

ABBREVIATIONS AND ACRONYMS

CHAK	-	Christian Health Association of Kenya
CHW	-	Community Health Worker
ECP	-	Emergency Contraception Pill
FP	-	Family Planning
FPAK	-	Family Planning Association of Kenya
FPPS	-	Family Planning Private Sector
MYWO	-	Maendeleo ya Wanawake Organization
NCPD	-	National Council for Population and Development
STIs	-	Sexually Transmitted Infection
TBA	-	Traditional Birth Attendant
TFR	-	Total Fertility Rate

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Vasectomy is unique among the array of modern methods of contraception as it enables the male partner to take primary responsibility for fertility control, (Kincaid et al., 1996). Its availability broadens the choice of methods for family planning users and contributes to promoting male involvement in family planning, (NCPD, 2004). Furthermore, vasectomy is highly effective in preventing pregnancy independent of subsequent behavior modification by the vasectomized man and the non scalpel vasectomy procedure is convenient and safe for the client and simple to perform, (FHI, 2002). While sterilization is the most widely used family planning method worldwide, in most settings the number of women sterilized for contraceptive purposes far exceeds the number of men, (NCPD, 2004).The lowest rates of sterilization in the world are found in Africa where fewer than three percent of married women of reproductive age rely on sterilization to avoid pregnancy and male sterilization is negligible, (Ross and Frankenberg, 1993).

Male attitudes are often blamed for the underutilization of vasectomy method, (Wilkinson et al., 1996).Frequently cited examples of attitudes which discourage the use of vasectomy include men's lack of interest in or responsibility for avoiding pregnancy, the association of vasectomy with castration, and fear of the procedure, (FHI,2002). However, some advocates of vasectomy believe more than negative attitudes among potential male adopters underlie the low levels of use, (Liskin, Benoit, and Blackburn, 1992).

The use of vasectomy in the world varies significantly by region and country. Almost three-fourths of the 37 million couples who use vasectomy† live in Asia, with China and India alone accounting for more than two-thirds of this total, (NCPD, 2004). Four and one-half million men in the developing world outside of these two countries use vasectomy. Vasectomy use in Latin America has increased four-fold in the past 10 years.

Prevalence remains less than 1% in most of the region, with the exception of Brazil, 14 Colombia, 19 Guatemala, 7 and Mexico, 12 where programs benefited from donor support in the 1980s and early 1990s, (FHI, 2002). Vasectomy rates in almost all of Africa are 0.1% or less, although vasectomy services have been introduced within a number of Sub-Saharan African countries, such as Kenya, Ghana, Malawi, and Tanzania, (NCPD, 2004). Still, vasectomy has been adopted by at least some men in every country where it has been introduced. Vasectomy, which can be provided in a variety of primary care settings, has a potentially important role to play in helping individuals and programs meet the ever-growing family planning and reproductive health needs outlined above, especially as donor support declines and national family planning programs increasingly need to focus on cost-effective services and methods, (Ross and Frankenberg, 1993).

One major shortcoming in the current national effort in Kenya is with regard to male involvement towards FP. For a long time, FP has been packaged and directed primarily at women. The success achieved to date in reducing the Total Fertility rate (TFR) is attributed to the involvement and use of contraceptives by women, (FHI,2002). As in other countries, when modern family interventions began in Kenya, women became the immediate focus of programmes and services, resulting in minimal or no minimal participation, (FHI, 2002). The women bear the biological responsibility of pregnancy and childbirth, that the female anatomy seems easier to accommodate a wider range of contraception's options, that FP was and continuous to be justified as a women's health issue and most FP services are based in health facilities seldom used by men, have combined to perpetuate the emphasis on female contraception, (FHI, 2002). Thus while culture and traditions expect men to decide on issues of fertility and family size, FP has been directed mainly to women who now constitute 99% of modern FP users in Kenya, (NCPD, 2004).

1.2 Statement of the Problem

The exclusion of men in FP programmes has resulted in ignorance about the need and means for modern contraception, leading to suspicions and misgivings about the motives and intentions behind FP, (FHI,2002).Consequently, male support for FP has suffered

greatly. Men have not seen their role in jointly discussing and deciding on FP issues with their spouses and the limited range of modern male contraceptive methods has constrained their wider acceptance and utilization, (NCPD, 2004) thus there is need for research on male attitudes and participation on family planning.

Despite the various factors affecting male uptake of vasectomy, there is limited research in the area. No local or international study has been carried out on the factors that influence male attitudes towards vasectomy in Kenya. This has negatively impacted the success of vasectomy programmes and direct involvement of men in family planning, (NCPD, 2004). There is need for realization of the significance of strong direct male involvement in family planning, because of the high population growth rate in Kenya, (NCPD, 2004). This research seeks to investigate the factors that influence male attitudes towards vasectomy.

1.3 Purpose of the Study

The purpose of this study is to investigate factors influencing male attitudes towards vasectomy in Kilifi district, in Kenya.

1.4 Objectives of the Study

The major objective of this study was to investigate factors influencing male attitudes towards vasectomy in Kilifi district. The specific objectives were:

1. To explore the extent to which education level influences male attitudes towards vasectomy in Kilifi district.
2. To establish how economic factors influence male attitudes towards vasectomy in Kilifi district.
3. To examine the extent to which cultural and religious factors influence male attitudes towards vasectomy in Kilifi district.
4. To investigate the influence of reproductive health service providers on vasectomy services in Kilifi district.

1.5 Research Questions

The overall research question for this study was to investigate factors influencing male attitudes towards vasectomy. In order to answer the research question the study sought to answer the following specific questions.

1. To what extent do education levels affect male attitudes towards vasectomy in Kilifi district?
2. What is the extent to which economic factors influence male attitudes towards vasectomy in Kilifi district?
3. How do cultural and religious factors influence male attitudes towards vasectomy in Kilifi district?
4. What is the extent to which reproductive health service providers influence male attitudes towards vasectomy in Kilifi district?

1.6 Justification of the Study

The study creates awareness of the vasectomy method in a time of reduced resources for family planning and of growth in the numbers of couples who want to limit their families.

The study addresses the sense of equity and choice in matters of family planning by establishing vasectomy as a routine option among family planning method choices.

The study provides a source of reference for future studies on vasectomy. It will also act as a source of literature for academics in the field of family planning.

1.7 Scope of the study

The study was done in Kilifi district, and this gave an opportunity of carrying out research in both urban areas such as Mtwapa and rural areas, therefore providing comprehensive report on the factors that influence male attitudes towards vasectomy in Kilifi district.

1.8 Limitation of the Study

The limitation involved the issue of confidentiality. This was overcome by sending the questionnaires together with the introductory letters with specific information on the purpose of the research and the confidentiality of information provided to the chiefs and community heads of the area. The researcher, with the assistance of community leaders facilitated questionnaires at agreed convenient time with households and individuals and carried interviews with service providers at agreed time over a two weeks period.

1.9 Delimitations of the study

The study was delimited to a representative sample drawn from the target population in Kilifi District to save on time and money.

1.10 Definition of Significant Terms.

The following are concepts used in the study:

An attitude: is a favorable or unfavorable evaluation of something. Attitudes are generally positive or negative views of a person, place, thing, or event.

Family planning: is the planning of when to have children, and the use of birth control.

Family planning services: are defined as: "comprehensive medical activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.

Tubal ligation or tubectomy): is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked, or severed and sealed, either method of which prevents eggs from reaching the uterus for fertilization. Tubal ligation is considered a permanent method of sterilization and birth control.

Vasectomy: a minor surgical procedure which stops sperm from being released when a man ejaculates.

Reproductive health service providers': Medical personnel who inform, educate, communicate and provide Sexual and Reproductive Health services in the area of family planning.

1.11 Organization of the study

The study is organized into five chapters. Chapter One provides a general background into the subject of study. The chapter also provides focus on the objectives of the study with specific questions to be answered. The objectives and questions developed provide a precursor to better understanding and articulation of the significance of the study.

Chapter Two presents available works and literature done on factors influencing male attitudes towards vasectomy by scholars who have studied the subject in other vasectomy contexts. The chapter provides a conceptual framework which outlines the relationship between the dependent and independent variables identified in the subject of study.

In Chapter Three, the researcher presents the research design, target population, data collection instruments and methodologies used in the study.

Chapter Four presents analysis and interpretation of the data collected from the field. Both Quantitative and Qualitative methods were used in the analysis of the collected data.

Summary of the key findings from the study as per the set objectives and discussion of the findings and recommendations developed thereof, including suggestions for further research, are provided in Chapter Five.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to provide a review of the existing literature perceived to be relevant in discussing male attitudes towards vasectomy. The aim is to identify issues that are key to understanding male attitudes towards vasectomy.

The chapter also presents a conceptual framework reflecting the relationship between the identified dependent and independent variables.

2.2 Education Level of Men in Relation to Vasectomy

Knowledge and approval rates of vasectomy method have been observed to vary considerably by various demographic and socioeconomic characteristics, (Posner and Mbodji, 2009). Consistent with findings from female interviews, both knowledge and approval rates have been observed to be highest among the younger, higher parity, better educated men and those in professional/skilled occupations, (Posner and Mbodji, 2009). Isiungo-Abaninhe (2003) found that educated men in Nigeria preferred significantly smaller families. Relative to men with no formal schooling, those with primary and secondary education were about twice as more likely to want no more children. A family planning survey in Senegal singled out education as the most important factor affecting desired family size and subsequent contraceptive use (Posner and Mbodji, 2009).

Knowledge of contraceptives in sub-Saharan Africa varies from country to country, (Gachango, 2003). Furthermore, knowledge varies with age and place of residence. The differences are most pronounced in West Africa. Urban residents have more knowledge of contraceptives than the rural residents, young people more knowledgeable than older people, and educated men more knowledgeable than uneducated men, (Oni and McCarthy, 2001). The differences in usage of contraceptives in Nigeria reflect education and regional differences. For instance, only 2 percent of women without education were using contraceptives, while 30 percent of women with secondary education use a method.

The regional differences are also glaring, with only 1 percent of women in the northeast using contraceptives, against 15 percent of women in the south west, (Kim Y M, 2001).

2.3 Economic Factors in Relation to Vasectomy

In Burkina Faso, males predominantly discussed the financial implications of having many children, especially in urban settings where large families are viewed as being too expensive, (Ntozi, 2003). In the Kenyan study, both users and non users were found to have positive dispositions toward modern contraceptives. They both perceived users as people who have come to terms with economic realities and are trying to minimize financial difficulties by having small families, (McGinn et al., 2009). The study suggests that messages to easing of financial worries and promoting of good health and happiness for the whole family would be acceptable to most couples. This is consistent with the suggestion that policy makers should not dwell excessively on changing male attitudes since, as in Burkina Faso, male attitudes in most African countries may be more positive than supposed, (Ntozi, 2003). FP is advantageous to men too and they can be relied on to recognize its benefits such as easing their economic load and contributing to healthier family (McGinn et al., 2009).

A survey carried out in Tanzania shows economic hardship was the most frequently mentioned reason for vasectomy acceptance, (Stover 2001). Respondents commented on the general economic benefits of a smaller family, and anticipated problems covering the basic needs of many children, including adequate food, health care and education. One participant explained: "When we were increasing the generation, we found that we did not get any progress in life even buying soap was a problem; seeing that the children we had were enough, we decided to accept the services. By this time we had five children."- Vasectomy client, Kibondo, (Green, 2004).

The ability to afford to educate one's children was the most frequently mentioned economic motivation for vasectomy, , (Stover 2001).Many respondents said that education is a necessity for both males and females, and that smaller families allow parents to send all of their children to school, which in turn will allow them to advance in

life, (Khasiani,2001).One respondent explained it this way: "For example, if you cannot educate your child if she is a female, you may cause her to be selling oranges or to become a sex worker. If he is a male and you can't give him education, expect him to be a hawker. Those are the consequences I was trying to look at, and decided that the family I had by that time of five children was enough." -Vasectomy client, Kigoma, (Mbizvo and Adamchak, 2001).

2.4 Cultural and Religious Factors in relation to Vasectomy

When looking at attitudes, one aspect of male role is particularly important to understand – that men culturally have been socialized to be decision makers in their relationships, (NCPD, 2004). Some men oppose FP for fear that it will undermine their authority as household heads. This is particularly so in the case of vasectomy, which clouded by many far reaching misconceptions. The most common misconceptions are that 'vasectomy may affect one's health and disturb one's work and that a man is not sterilized (Lam, 2003). Many people associate vasectomy with castration.

Generally, men who oppose vasectomy have a wide variety of reasons influenced by cultural beliefs about birth control, most of them erroneous, (NCPD, 2004). Some believe that if their wives used FP, they would become unfaithful, while others worry about contraceptive side effects, erroneous beliefs about physiology, the mode of action of contraceptives, and traditional beliefs, (NCPD, 2004). Accomplishing FP goals in the face of male resistance to such involvement is likely to take a very long time. Undoubtedly, the real change will come about only when more fundamental changes take place in society as a whole. In the meantime, we are convinced that programmes based on realistic but compassionate understanding of men and their cultural roles are important steps in the right direction, (Rappaport, 2001). Family planning programmes should remain sensitive to the reasons why men are put off by FP responsibility and formulate relevant strategies to fight these barriers, (NCPD, 2004).

Vasectomy is one of the least known and the least popular modern FP methods in sub-Saharan Africa thanks to largely cultural beliefs, (Khasiani, 2001). This unpopularity has

been attributed to the association of vasectomy with loss of manhood and respect, being permanent and irreversible, seen to represent castration which is only suitable for bulls and is associated with retention of protein in the blood causing allergies (Khasiani, 2001). Despite being simple and highly effective, overwhelming negative attitudes overshadow the positive aspects of vasectomy. Most countries in sub Saharan Africa have vasectomy prevalence rates well below 1%. A male fertility survey in Uganda observed that vasectomy had never been used by any of the respondents, (Ntozi, 2003). In Tanzania too, vasectomy prevalence among males interviewed was observed to be neglible. A disappointing low of 0.5% of the respondents stated intending to use the method in future (BSPC, 2003).

Surveys in Kenya have similarly shown vasectomy to be as low as 0.3% (Gachango, 2003). In a baseline survey of men in Nairobi and Mombasa, only 2 out of 618 men interviewed had undergone vasectomy. However, 22% of the respondents were observed to be potential vasectomy clients (ICS.JHU/PCS, 2002). The 2003 KDHS finding showed that despite reasonably high awareness levels of vasectomy among Kenyan men (56%), the proportion using this method was negligible. The future of vasectomy is not brighter either, with only 0.5% of men intending to use the method in future (NCPD, 2004).

Many people are still conservative in accepting the male responsibility concept in family planning because of their cultural background. Psychologists have long noted the extraordinary assistance of males to seeking any kind of assistance when in physical or emotional distress, (Rappaport, 2001). The rigid culture role requirement in that men appear tough, objective, strong, achieving, unsentimental and emotionally unexpressive makes self-disclosure of any kind of masculinity. This problem is particularly intense in the area of sexuality and sexual relationships. The male role is so rigid that for many men, especially adolescents, asking for health about anything sexuality is an open discussion of sexual naïveté and failure. It places in the class of 'weak men' disapproved of by male peers and unattractive to women (Rappaport, 2001). This social prejudice against the expression of feelings presents enormous barriers to providing effective counseling to male clients, (FHI, 2002).

The Catholic Church has been opposed to contraception for as far back as one can historically trace, Chandra,(2001).Many early Catholic Church Fathers made statements condemning the use of contraception and various other, The Catechism of the Catholic Church specifies that all sex acts must be both unitive and procreative, In Hershberger, Anne K (2000). In addition to condemning use of artificial birth control as intrinsically evil,_non-procreative sex acts such as mutual masturbation and anal sex are ruled out as ways to avoid pregnancy.

Anglicanism, the Church of England accepted birth control in the 1930 Lambeth Conference, Meyendorff, John (1975). In the 1958 Lambeth Conference it stated that the responsibility for deciding upon the number and frequency of children was laid by God upon the consciences of parents 'in such ways as are acceptable to husband and wife' Meyendorff, John (1975).

Lutheranism, The Evangelical Lutheran Church in America allows for contraception in the event the potential parents do not intend to care for a child, Zion, William Basil (1992). Other Lutheran churches or synods take other positions, or do not take any position at all. For example, in 1990 the Lutheran Churches of the Reformation passed a resolution titled "Procreation" stating that birth control, in all forms, is sin, although they "allow for exegetical differences and exceptional cases (casuistry)", for example, when the woman's life is at risk, Meyendorff, John (1975).

Methodism, the United Methodist Church, holds that "each couple has the right and the duty prayerfully and responsibly to control conception according to their circumstances," Kotva Jr., Joseph J. (2002). Its Resolution on Responsible Parenthood states that in order to "support the sacred dimensions of personhood, all possible efforts should be made by parents and the community to ensure that each child enters the world with a healthy body, and is born into an environment conducive to realization of his or her potential." To this end, the United Methodist Church supports "adequate public funding and increased

participation in family planning services by public and private agencies," Christopher West, (2000).

Presbyterianism, the Presbyterian Church (USA) supports "full and equal access to contraceptive methods," Kotva Jr., Joseph J,(2002). In a recent resolution endorsing insurance coverage for contraceptives, the church affirmed that "contraceptive services are part of basic health care" and cautioned that "unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity, and threaten the economic viability of families," Gordon B. Hinckley,(2002).

Birth control is permissible according to Islam, which recognizes that the sexual act is more than just a means of procreation, but permanent methods that include, Vasectomy in males and Tubecotomy in females, all the scholars unanimously agree that permanent methods of family planning are prohibited since they involve changing human physiology, (William Basil, 1992). Modern temporary methods such as pills are allowed, especially in circumstances like, the woman may rest between pregnancies, if either partner has a transmittable disease. For the sake of the woman's health, for example if she is already breast-feeding a child it would be damaging for both her and the child to have another pregnancy and if the husband cannot afford to support any more children, William Basil (1992).

2.5 Reproductive health service providers' influence on vasectomy

The attitude of FP providers to male methods, particularly vasectomy, is a crucial ingredient to family planning services to men (Gill, 2001). Since counseling is a critical component of vasectomy service, well trained counselors must be employed in clinics offering the service. Rappaport (2001) noted that one mistake that is made in hiring personnel for male programmes has been to assume that "any man" will do. Even though his motivation may be good (useful role model for clients and staff), merely being a man does not make a good counselor for men. What is required is a man who is both committed to ending sexist roles in himself and other men and, at the same time, feels real compassion for men and the trained and absurd situations they are forced into by this

role. For women counselors, it is crucial that such work be assigned to women who want to genuinely do this kind of counseling (Forde, (2001). Training should there focus on instilling these desirable qualities in a counselor. Some health personnel providing family planning services still hold the traditional belief that "Family planning is a woman's responsibility" (Khasiani, 2001). This attitude needs to be changed through appropriate training before such personnel can be effectively involved in FP services for men.

A major impediment to men's utilization of vasectomy is provider bias, (Stover 2001). Some providers assume that men are not interested in family planning while others are poorly informed regarding male contraceptive methods, while may share the same misconceptions as their clients, (Stover, 2001). Common indicators of provider bias against male involvement include the fact that: providers may not offer male methods or may provide inadequate information about them; providers may present male methods negatively; other providers may make men feel uncomfortable visiting clinics and seeking more information on family planning (Donald, 2006).

It is essential that all family planning programmes, whether male or female oriented, emphasize appropriate training for their personnel and responsible and through counseling at its clinics if they are to be successful, (Khasiani,2001).Some health personnel are not well informed about available family planning methods and cannot, therefore, be expected to offer satisfactory services. In a family planning KAP study among health centre personnel in western province of Kenya, (Terefe, 2009) observed that, while clinical based staff (clinical officers and community nurses) had good knowledge of family planning procedures, to the field staff (traditional birth attendants, family health field educators, community health workers (CHW) and public health technical staff), whose work is mainly educational and motivational, the procedures were less clear. This situation is particularly damaging for vasectomy, a procedure that is already shrouded in serious misconceptions. The study concludes that to improve family planning programs in the province, health personnel need more training on family planning, (Green, 2004).

2.6 Conceptual Framework

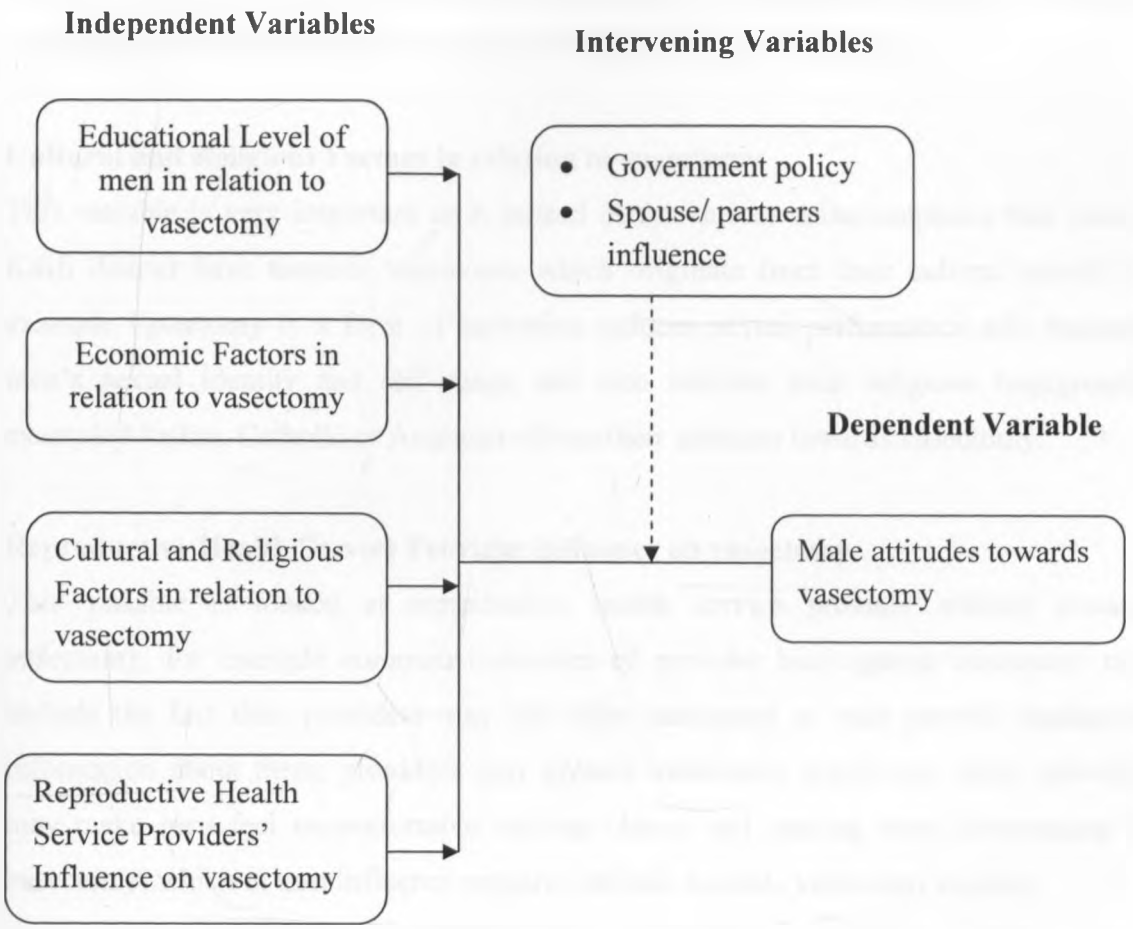

Figure 2.1: Conceptual framework

Independent variables

The male attitudes towards vasectomy is influenced by; education level, cultural factors, reproductive health service provider and religious factors.

Education Level of Men in relation to vasectomy

This variable looked at how men with different educational levels are opinionated towards vasectomy. It gives insight whether education background really affects men attitude towards vasectomy.

Economic Factors in relation to vasectomy

This variable looked at economic realities like income level of respondents and their number of children, whether financial implications of having many children is making men in Kilifi district have positive attitudes towards vasectomy or not.

Cultural and Religious Factors in relation to vasectomy

This variable is very important as it looked at the various misconceptions that men in Kilifi district have towards vasectomy which originate from their cultural beliefs for example vasectomy is a form of castration reduces sexual performance and threatens men's sexual identity and self-image and also whether their religious backgrounds example Muslim, Catholic or Anglican affects their attitudes towards vasectomy.

Reproductive Health Service Provider influence on vasectomy

This variable is looked at reproductive health service provider attitude towards vasectomy, for example common indicators of provider bias against vasectomy may include the fact that: providers may not offer vasectomy or may provide inadequate information about them; providers may present vasectomy negatively; other providers may make men feel uncomfortable visiting clinics and seeking more information on vasectomy, which in turn influence negative attitude towards vasectomy on men.

Dependent Variable

The dependent variable is male attitudes towards vasectomy. The study looked at particularly Kilifi District because of major towns in this area such as Mtwapa known for its night life and rural areas such as Kikambala. This is to improve our understanding of the degree or extent of male attitudes towards vasectomy in both urban and rural areas. The extent of male attitudes was measured by looking at their education levels, cultural factors, reproductive health service provider influence and religious factor.

2.7 Summary of the Literature Review

From the foregoing review, the importance of direct male involvement in family planning especially having vasectomy could not be overemphasized. Most of the literature on vasectomy however highlighted the need to have the family planning programs incorporate men not to emphasize family planning on women alone. Male attitudes towards vasectomy are dependent on many other variables which come into play. This study set out to assess these factors that might influence male attitudes towards vasectomy in Kilifi District.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research design, study variables, target population, sample size and sampling procedure, research instr000ument data collection procedure and data analysis.

3.2 Research Design

The study used both qualitative and quantitative research paradigms. Qualitative research involves several methods of data collection, such as focus groups, field observation, in-depth interviews and case studies. In all of these methods, the questioning approach is varied. In other words, although the researcher enters the project with a specific set of questions, follow-up questions are developed as needed (Wimmer and Dominick, 2003).

The study adopted descriptive survey design to assess the factors influencing male attitudes towards vasectomy in Kilifi district. Descriptive survey design is used in preliminary and exploratory studies to allow the researcher gather information, summarize, present and interpret it for the purpose of clarification (Orodho 2002). Kothari (2003) also recommends descriptive design as it allows the researcher to describe, record, analyze and report conditions that exist or existed.

The design allowed the researcher to generate both numerical and descriptive data that can be used in measuring correlation between variables. Descriptive survey research was intended to produce statistical information about aspects of male attitudes towards vasectomy that interest stakeholders such as policy makers. The location of the study was Kilifi District.

3.3 Study Variables

The research variables are the factors that are manipulated to achieve different outcomes and hence determine the findings of a study. Variables will therefore assume different

values when conducting research analysis. Variables can be classified as dependent and independent. Independent variables forms the core part of the research and are aligned to the research objectives. The dependent variable shows the outcomes at different levels of manipulation of the independent variable.

In this study, the dependent variable was clearly inclined towards influence of male attitudes towards vasectomy. The independent variables which have been identified in this study according to the research objectives and questions included: education level, economic factor, religious and cultural factor and reproductive health service providers'.

3.4 Target Population

Kombo, K. and Tromp (2006) define a population as a group of individuals, objects or items from which samples are taken for measurement. The study was done in Kilifi District in coast Province of Kenya. The target population was 135 people drawn from the males in the community and the reproductive health service providers.'

Table 3.1: Target Population

Category	Source	Target Population	Percentage (%)
Reproductive health service providers	3 Registered health centres.	15 (5 officials per health centre)	20
Males.	6 divisions	120 (20 males per division)	80
Total		135	100

3.5 Sample Size and Sampling Procedure

According to Orodho and Kombo (2002) sampling is the process of selecting a number of individuals or objects from a population such that the selected group contains elements representative of the characteristics found in the entire group.

In this study, the sampling method to be used will be purposive sampling. This technique allows the researcher to use cases that have the required information with respect to the objectives of the study (Mugenda and Mugenda, 2003). This is because although Kilifi District has total of 73 health facilities distributed across the district. Accessibility of health services is, however low. The doctor patient ratio stands at 1:100,000 which in itself a manifestation of staff shortages in the District. There are only 3 centres in Kilifi District that have well established family planning services and have staff providing family planning. These health facilities are Kilifi District hospital, Vipingo health centre and Mtwapa health centre. Purposive sampling will still be used on each of the health centres to identify 5 health services providers that are well informed on family planning services.

The study adopted cluster sampling when it came to sampling males in Kilifi district. There are 283, 807 males according to 2009 census results in Kilifi district but due to vastness and sparsely population of the district, 20 households were clustered per division each household a purposive sample of one man was done bringing a total of 20 men per division, this reduced field costs as a result of saving of travelling time and distance covered, because there are six divisions in the district this translated to a target population of 120 men

3.6 Research Instruments

Data refers to all the information a researcher gathers for his or her study. The study used both primary and secondary data sources. Quantitative data was gathered through open and close ended questionnaires for the men sampled in the communities. A quantitative method is defined by Kasomo (2006) as that which yields data which is quantifiable. Qualitative data was collected by in depth interviews of all the reproductive service providers. In depth interview is distinguished as a method that allows the researcher to explore the deeper structure of ideas and also verify the ideas presented (Stylianou, 2008). An interview guide was used to get in depth answers from the respondents. The researcher sought maximum co-operation from respondents by establishing a friendly

relationship prior to conducting the interviews. They were assured of confidentiality of information given.

3.6.1 Validity of the Research Instruments

Mugenda and Mugenda (1999) contend that the usual procedure in assessing the content validity of a measure is to use a professional or expert in a particular field.

To ensure the validity of the research instrument the researcher sought opinions of experts in the field of study, the service providers for example clinical officers and the researcher's supervisor. This facilitated the necessary revision and modification of the research instruments thereby enhancing validity.

3.6.2 Reliability of the Research Instruments

Reliability is a measure of the degree to which a research instrument yields consistent results after repeated trials, (Mugenda & Mugenda, 1999). This was ensured through pilot testing. The researcher used test-retest technique of evaluating reliability of the questionnaires. The same instrument was re-administered to the same respondents after one month to test whether similar responses would emerge. The two scores of the respondent was checked to analyze the consistency of responses. Scores from the first test were correlated with scores from the final test.

3.7 Data Collection Procedures

Data was collected though questionnaires and interview schedules so as to get data on the set objectives of the study. The questionnaires (open and close ended questions) and interview schedule were tested for validity and reliability through piloting. The respondents were administered questionnaires and interviews carried out in person at the health centres and in the communities.

3.8 Data Analysis

The data collected was analyzed using descriptive statistics. Quantitative data was coded manually, organized, and analyzed using percentages and frequencies. In order to save time and money, while increasing accuracy of the results, computer Statistical Program for Social Sciences (SPSS) was used for processing data. The results were presented in tabulated form for easy interpretation.

Qualitative data generated from questions were organized into themes, categories and patterns pertinent to the study. This helped to identify information that was relevant to the research questions and objectives. Data was tabulated and classified into sub-samples for common characteristics with responses being coded to facilitate basic statistical analysis. Orodho (2003) argues that the simplest way to present data is in frequency or percentage tables, which summarizes data about a single variable. Both Microsoft Excel and the Statistical Package of Social Sciences (SPSS) was used to analyze the data which will be presented using frequency tables.

3.9 Ethical Considerations

The research maintained utmost confidentiality about the respondents. All the respondents were given a free will to participate and contribute voluntarily to the study. Necessary research authorities were consulted and permission granted while due explanations were given to the respondents before commencement of the study.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents the findings of the data collected from the sampled reproductive health service providers and males in Kilifi district coast Province, Kenya on factors influencing male attitudes towards vasectomy. Out of 135 respondents that the study targeted there were 129 respondents. This is 95.5% of the target group. The data was interpreted according to the research questions. The analysis was done through descriptive statistics and findings of the study were presented in form of frequency tables. The discussion of the outcomes is based on the outputs from Statistical Package for Social Sciences (SPSS).

The chapter provides results and discussions of the findings and data analysis of the study. The discussion is linked to the questions of the study and research objectives in accessing the factors influencing the male attitudes towards vasectomy in Kilifi District.

4.2 Response Rate

Table 4.1: Questionnaires Response Rate

Male Respondent per division.	Questionnaires issued per division.	Questionnaires returned per division.	%	Response rate as per questionnaire issued.
Vitengeni	20	20	16.7	100%
Bahari	20	20	16.7	100%
Chonyi	20	20	16.7	100%
Kikambala	20	20	16.7	100%
Ganze	20	20	16.7	100%
Bamba	20	20	16.7	100%
Total	**120**	**120**	**100%**	

The study targeted 135 respondents of this 120 was supposed to be males in the community comprising of 20 males from each of the 6 divisions and 15 reproductive health service providers from 3 health centers. 120 questionnaires were administered to the males in the community and each of them returned thus a total of 100%. The Tables 4.1 shows the response rate on the males sample in the community

Table 4.2: Interview Response Rate

Health Center	**No of health service provider targeted**	**No. of service provider interviewed**	**%**
Kilifi District Hospital	5	3	20
Mtwapa Health Center	5	3	20
Vipingo Health Center	5	3	20
Total	**15**	**9**	**60**

A total of 15 reproductive health service providers from 3 health centers were supposed to be interviewed, 5 service providers from each of the health Centre but the researcher got 3 service providers from each of the health Centre bringing a total of 9 reproductive health service providers thus a total of 60%, this is because of shortage of health service providers in the district. The Table 4.2 above show the response rate on the health service providers.

4.3 Demography of the Respondents

The study targeted males of 18 years and above and reproductive health service providers of the three major health centres in Kilifi district.

4.3.1 Age of the Respondents

Table 4.3 records the age distribution of the respondent.

Table 4.3: Age of Respondents

Age	Frequency	Percentage
18-25	25	20.8
25-30	33	27.5
31-35	17	14.2
Over 35	45	37.5
Total	**120**	**100.0**

Table 4.3 above reveals that, majority of the respondents 37.5% were over the age of 35 while 14.2 %, 27.5% and 20.8% were 30-35 years, 25-35 years and 18-25 years respectively

4.3.2 Ethnical Grouping of the Respondents

The researcher asked the respondents their ethnic group because it will be the basis of cultural factor which is one of the main objectives of this research. Cultural opinions originate from one's ethnical group and it was therefore important to ask respondents their ethnical background.

Table 4.4: Ethnical Grouping of the Respondents

Tribe	Frequency	Percentage
Mijikenda	110	91.7
Kikuyu	4	3.3
Kamba	5	4.2
Meru	1	0.8
Total	**120**	**100.0**

The study was done in Kilifi district which is inhabited mainly by Mijikenda people and they comprise majority of the respondents at 91.7% followed by Kamba 4.2%, then 3.3% Kikuyu and lastly 0.8% Meru as shown in Table 4.4 above.

4.3.3 Marital Status of Respondents

Respondents were asked to state their marital status.

Table 4.5: Marital Status of Respondents

MaritalStatus	Frequency	Percentage
Single	40	33.3
Married	74	61.7
Divorced	4	3.3
Widowed	2	1.7
Total	**120**	**100.0**

Table 4.5 shows majority of respondents are married with 61.7% followed by single people 33.3% then divorced and widowed who were 3.3% and 1.7% respectively.

4.3.4 Education Level of Respondents

The respondents were asked to indicate their education levels

Table 4.6: Education Level of Respondents

Level	Frequency	Percentage
Primary	52	43.4
Secondary	36	30.0
Tertiary	19	15.8
No Formal Education	13	10.8
Total	**120**	**100.0**

Table 4.6 above shows primary level respondents are majority 43.4%, followed by secondary at 30.0%, tertiary level is 15.8% and no formal education is 10.8%. Education level of respondents was important demography for the researcher as it is the objective of the study

4.3.5 Religious Affiliation

The respondents were asked to indicate their religious affiliation since religion is the main objective of the study

Table 4.7: Religious Affiliation

Level	Frequency	Percentage
Muslim	35	29.2
Catholic	26	21.7
Protestant	46	38.3
No Religion	13	10.8
Total	**120**	**100.0**

The table 4.7 shows there are more Protestants to the study 38.3%, followed by Muslims 29.2%, then Catholic 21.7% and lastly respondents who said they had no religion or (atheists) were the least at 10.8%.

4.4 Education Level of Men

Kilifi District has 230 primary schools. To cope with the increasing population in this age group, there is need to improve the facilities in the schools, a lot of infrastructure needs to be done to build more primary and secondary but there is the notorious problem of school drop outs in Kilifi district, most kids drop out of school when they finish primary and become beach boys in the hope of getting a rich white woman, a get rich quick scheme where most end up indulging in drugs and getting HIV/AIDS infection.

4.4.1 Vasectomy Awareness

The researcher asked the respondents whether they heard about vasectomy, this was to know whether the respondents basically were aware of the vasectomy procedure, surprisingly majority of the respondents even men who had no formal education 84.6% of the men are aware there is a vasectomy procedure only 15.4% with no formal education said they have never heard of the male vasectomy. This was surprising considering low

levels of education and poverty in Kilifi where most people do not have television sets but majority of them said they have heard about vasectomy from the radio. These shows how radio is a powerful communication channel and therefore radio can be used as a mass communication channel to create awareness in rural areas.

Table 4.8 illustrates the distribution as per the response.

Table 4.8: Vasectomy Awareness

Education level	**Frequency**			**Percentages**		
	Yes	No	Totals	Yes	No	Totals
Primary	46	5	52	88.5	11.5	100
Secondary	31	5	36	86.1	13.9	100
Tertiary	17	2	19	89.5	10.5	100
No formal education	11	3	13	84.6	15.4	100
Total	**105**	**15**	**120**			

4.4.2 Vasectomy is a good family planning method?

The researcher asked the 105 respondents who had said yes they have heard about vasectomy whether vasectomy is a good family planning method, the researcher wanted to get the attitude towards vasectomy from the respondents whether it is positive or negative.

Table 4.9: vasectomy a good family planning method

Education level	**Frequency**			**Percentages**		
	Yes	No	Totals	Yes	No	Totals
Primary	15	31	46	32.6	67.4	100
Secondary	10	21	31	32.3	67.7	100
Tertiary	6	11	17	35.3	64.7	100
No formal education	1	10	11	9.1	90.9	100
Total	**32**	**73**	**105**			

Table 4.9 illustrates how majority of the respondents said vasectomy is not a good family planning method including respondents who have tertiary education majority 69.4 % of them said they do not think family planning is a good method showing there is generally a negative attitude towards vasectomy among all male respondents regardless of one education level. This make the assumption of men with higher education would readily accept vasectomy quite wrong.

4.4.3 Respondents that have undergone Vasectomy

The study also sought to establish whether respondents had undergone vasectomy as presented in Table 4.10.

Table 4.10: Respondents that have undergone the vasectomy procedure

	Frequency	Percentage
Yes	2	1.9
No	103	98.1
Total	**105**	**100.0**

Table 4.10 shows the respondents that have undergone vasectomy procedure are only two people. Surprisingly the two vasectomized respondents have no formal education. They had the same characteristics both were in advanced age, have elderly children and both were convinced to undergo vasectomy procedure by colleagues who had medical backgrounds.

The researcher also asked the respondents if they can consider having a vasectomy in the future

Table 4.11: Respondents that can consider the vasectomy procedure in the future

Education level	Frequency			Percentages		
	Yes	No	Totals	Yes	No	Totals
Primary	15	32	47	31.9	68.1	100
Secondary	11	20	31	35.5	64.5	100
Tertiary	4	13	17	23.5	76.5	100
No formal education	1	9	10	11.1	88.9	100
Total	**32**	**73**	**105**			

Table 4.11 illustrates majority said they cannot consider vasectomy procedure in the future including respondents who have tertiary education of which majority 76.5% said they cannot have a vasectomy in the future, this information confirms Table 4.9 above

when respondents were asked if they think vasectomy is a good family planning and majority gave out a negative response and therefore if vasectomy awareness programs are carried out then they should target males of all education backgrounds including those with tertiary education for them to be successful.

4.4.4 Personal Opinion about Vasectomy from the Respondents.

The researcher was interested to find out how respondents opinions about vasectomy. Majority of the response was generally negative with most respondents saying vasectomy was like castration, others said they are against it because it is a permanent method, others cited that it is against African culture and others said it is against their religious faith.

4.5 Economic Factors

Economic factor can influence any one attitude towards family planning. People have generally embraced family planning so as to have small families to ease their economic load and have a healthy family. The researcher wanted to establish whether men can accept vasectomy due to economic hardship.

4.5.1 Income earning levels of Respondents

The study explored the influence of current economic and financial environment to males access to sustainable livelihood in Kilifi. Males interviewed through questionnaires confirmed that they engage in varied economic activities as part of their livelihood strategy namely; business and employment i.e. running grocery 'kiosks', tailoring/ dress making, working as domestic workers, undertaking food vending, casual work at construction sites, working in restaurants, perform acrobats in hotels , as security guards, sell second hand clothes and shoes, boda boda operators, subsistence farmers, police officers, drivers, making of art crafts and some are jobless.

The researcher sought to understand respondents' levels of income from the different income sources as illustrated in Table 4.12

Table 4.12: Income earning levels

Earning levels	Frequency	Percentage
1,000-4,999	10	11.7
5,000-9,999	14	15
10,000-14,999	58	51.7
15,000-19,999	9	9.2
20,000 and more	3	4.1
No earnings/jobless	8	8.3
Total	**102**	**100.0**

Table 4.12 shows that the statistical mode earnings amongst males in Kilifi is between Kshs. 10,000 and 14,000 from either casual employment or business. Fewer males in Kilifi earn amounts above Kshs. 15,000. Given the low income levels, males reiterated that they are not able to make any savings as expenditures in most cases surpass their income levels. These groups of males live below their livelihood thresholds as their disposable income is significantly low.

4.5.2 Family planning to ease financial worry

The researcher asked the respondents generally if they believe in practicing family planning to have a smaller family to ease your financial worry, they responded as shown in Table 4.13.

Table 4.13: Family planning to ease financial worry

Do you believe in practicing family planning to have a smaller family to ease your financial worry		
	Frequency	**Percentage**
Yes	86	69.2
No	19	15.8
No response	15	15.0
Total	**120**	**100.0**

The response was positive with majority of the respondents 69.2% they believe family planning eases financial worry of one having a family that he can manage. This shows majority of the respondents know the importance of family planning in terms of having smaller families that they can manage.

4.5.3 Basic Needs

The researcher asked the respondents if they can have a vasectomy to maintain a small family to ease their financial worry of providing adequate food to their children the basic need of every family. They responded as shown in Table 4.14

Table 4.14: Ease of financial worry on providing food

Can you have a vasectomy so as to maintain a small family to ease your financial worry of providing adequate food to your children		
	Frequency	**Percentage**
Yes	32	26.7
No	73	58.3
No response	15	15.0
Total	**120**	**100.0**

4.5.4 Opinions about Economic Factor

The researcher was interested to find out why majority of the male respondents believe in practicing family planning to have a smaller family to ease their financial worry while they cannot take a personal responsibility themselves of having a vasectomy. Majority of the respondents cannot have a vasectomy they prefer their spouses or wives to be sterilized instead of them having a vasectomy, or the wife continues to do the temporary methods of family planning. The researcher noted that most of the men took family planning as women's responsibility therefore lack of male involvement in family planning is the biggest hindrance to vasectomy acceptance.

4.6 Cultural Factors

The vasectomy procedure is clouded by many far reaching misconceptions. The most common misconceptions are that 'vasectomy may affect one's health and many people associate vasectomy with castration. The researcher posed questions that are common misconceptions about vasectomy in order to gauge the understanding of respondents in

relation to their cultural background. The respondents were to say whether they agree or disagree with the statements.

4.6.1 Vasectomy a Form of Castration

One of the biggest cultural misconceptions of vasectomy is that vasectomy is a form of castration. The researcher asked the respondents whether they think vasectomy is a form of castration. Table 4.15 illustrates the response.

Table 4.15: Vasectomy a Form of Castration

	Frequency	**Percentage**
Agree	60	50.0
Disagree	36	30.0
Unsure	9	5.0
No Response	15	15.0
Total	**120**	**100.0**

Unfortunately, majority of the respondents 50% in Kilifi district think vasectomy is castration those saying vasectomy is not castration were only 30% those unsure were 5%, no response were 15%. The researcher notes that this can be blamed on the low awareness levels of the vasectomy procedure and the low education standards in the district. The reproductive health also said that vasectomy being categorized as castration is the biggest hindrance of low uptake of vasectomy services in Kilifi district.

4.6.2 Vasectomy affects a Man Sexual Ability?

The researcher asked the respondents whether vasectomy affects a man sexual ability or libido. Table 4.16 illustrates the distribution per response

Table 4.16: Does Vasectomy affect a Man Sexual Ability

	Frequency	Percentage
Agree	53	44.2
Disagree	28	23.3
Unsure	24	17.5
No Response	15	15.0
Total	**120**	**100.0**

Majority of the respondents 44.2% think that vasectomy affects sexual ability; only 23.3% said they do not think vasectomy affect, 17.5% of the respondents were unsure and 15% did not respond. The scientific fact is vasectomy does not affect a man sexual libido at all, the man continues to function as normal. This is one of the misconceptions that make men fear vasectomy and it can be addressed by educating men and increase their level of awareness.

4.6.3 Vasectomy affects a Man's Respect?

The researcher asked the respondents the question whether vasectomy affects a man's respect. Table 4.17 illustrates the distribution per response

Table 4.17: vasectomy affects a Man's Respect

	Frequency	Percentage
Agree	63	50.0
Disagree	35	29.2
Unsure	7	5.8
No Response	15	15.0
Total	**120**	**100.0**

Majority of the respondents 50% agree that vasectomy affects a man's respect, those who disagreed were 29.2%, those unsure at 5.8% and those who did not respond were 15%. These information shows how culture is a major influence on male attitudes towards vasectomy, men fear talking about vasectomy among fellow peers as they see their friends will think less of you if they hear you have been vasectomized.

4.6.4 A man cannot ejaculate after a Vasectomy Procedure

The researcher asked the question if a man cannot ejaculate after a vasectomy procedure.

Table 4.18 illustrates the distribution per response

Table 4.18: A man cannot ejaculate after a Vasectomy Procedure.

	Frequency	Percentage
Agree	33	27.5
Disagree	20	16.7
Unsure	52	40.8
No Response	15	15.0
Total	**120**	**100.0**

Majority of the respondents were unsure at 40.8%, 27.5% of the respondents agreed that a man cannot ejaculate after a vasectomy procedure, 16.7% disagreed with the statement while those who did not respond were 15%. This information was a confirmation to the researcher that most of the respondents are not fully aware of the details or facts of the vasectomy procedure. The scientific fact is one can still ejaculate after the vasectomy procedure.

4.7 Religious Factor

Religion is a very important factor that can influence male attitudes towards vasectomy. One faith may influence his or her attitudes towards contraception. Religious denominations have different opinions for example the Catholic church is well known for its opposition towards modern contraception methods, Muslims are against permanent methods of contraception specifically vasectomy in men and tubal ligation in women while generally most protestants churches such as Anglicans have no problem with contraception.

4.7.1 Vasectomy against your Religious Faith?

The researcher asked the respondents whether vasectomy is against their religious faith. Table 4.19 illustrates the distribution per response.

Table 4.19: Vasectomy against your Religious Faith

	Frequency	Percentage
Agree	41	34.2
Disagree	51	40.8
No Response	28	25.0
Total	**120**	**100.0**

The response had a slight difference. The majority disagreed at 40.8% while those who agreed at 34.2% and who did not respond at the question were 25%. Those who did not respond were people who are not aware about vasectomy or had no religion.

The table below shows how different religious affiliations responded to the question; Table 4.20 illustrates the distribution as per the response.

Table 4.20: Religious Faith

Religious affiliation	**Is vasectomy against your religious faith**					
	Frequency			**Percentages**		
	Yes	No	Totals	Yes	No	Totals
Muslim	22	10	32	66.7	33.3	100
Catholic	7	15	22	46.7	53.3	100
Protestant	14	24	38	36.8	63.2	100
Total	**43**	**49**	**92**			

Majority of Muslim respondents 66.7% said vasectomy is against their religious faith giving reasons such as vasectomy is a sin and it is against the teachings of the Holy Quran. Surprisingly most of the Catholic faith respondents 53.3% said vasectomy is not

against their faith, although their church advocates for natural family planning methods. The Catholic faith respondents said they see no bad reason with the vasectomy procedure because of the economic difficulties of raising many children, just like their women counterparts practice family planning regardless of their church standing and others said having a vasectomy is a personal decision and their religious faith is least of their concern. The Protestants respondents as assumed majority of them 63.2% said vasectomy is not against their religious faith.

4.8 Reproductive Health Service Providers

The study sought to establish the influence of reproductive health service providers on vasectomy services in Kilifi district and they were interviewed by the researcher guided with an interview guideline.

4.8.1 Training of the Officers

The reproductive health service providers comprised of mainly registered nursing officers in the three health centers namely Kilifi district hospital, Mtwapa health Centre and Vipingo health Centre except only one clinical officer in Mtwapa health Centre. The researcher was not able to get a medical doctor from the three medical centers even in Kilifi district hospital. Medical doctors are usually notified when there is a complicated case especially which requires surgery. There are no gynecologists in Kilifi district; one has to be notified from the nearby Mombasa district occasionally when there is a complicated surgery to be undertaken. There only 3 nurses in the family planning unit in Kilifi district hospital only assisted by student nurses serving a large population of patients. This confirms the World Health Organization report of 2009 that there is shortage of medical staff in Kilifi district.

In Kilifi district hospital the three nurses the researcher interviewed have no training on vasectomy therefore they cannot perform a vasectomy procedure. They can only provide counseling services to a vasectomy client thanks to the training they got during the four years period in Kenya Medical Training College (KMTC). This was also the same case in Vipingo health Centre. When asked if they require training vasectomy services, all the

service providers said they had no interest as there is no demand of vasectomy services. The researcher noted already there is a negative attitude towards vasectomy in both Kilifi district and Vipingo health Centre.

In Mtwapa health Centre the two nurses and one clinical officer have been trained on performing a vasectomy procedure. The researcher found out they received on job training of one month from Marie Stopes a non-governmental organization which had set an outreach center in Mtwapa. They were also trained by Marie Stopes to counsel vasectomy clients.

4.8.2 Facilities for Providing Vasectomy

Both Kilifi district hospital and Mtwapa health Centre have a theatre and all necessary facilities of providing vasectomy but both have not provided any vasectomy procedure for the last one year.

Surprisingly Mtwapa health Centre has not provided any vasectomy procedure even with occasionally presence of Marie Stopes outreach Centre due lack of sensitization of the vasectomy procedure to the public. Marie Stopes did not have any sensitization programmes although they provided the services. The service providers also confessed that they do not discuss the vasectomy method with women.

Vipingo health Centre has a theatre but does not have the necessary facilities to provide vasectomy. This shows the negative attitude towards vasectomy services by the health Centre itself where no facilities are provided for the vasectomy procedure even if there is a potential vasectomy client, then he cannot be provided the service.

4.8.3 Attitudes of Men towards Vasectomy

The researcher asked the service providers the attitudes of men towards vasectomy and family planning generally. The service providers said the major problem is culture which confirms the information from the male questionnaires that most men attitudes are affected negatively by culture. The service providers noted most men do not participate in

family planning because they see it as a women's responsibility. In fact there are many cases where women have to get permission from their husbands to practice family planning. Male chauvinism is rampant in the district that's why service providers do not see the need to undergo vasectomy training as they see it is a waste of time, because of no demand for the vasectomy service.

According to the service providers' men prefer their wives to be sterilized but not them citing reasons of vasectomy is like castration, he may develop erectile dysfunction problems or he may gain weight. Service providers noted that low education levels contributes to negative attitude towards vasectomy, but they also noted sometimes low education level is an advantage because low educated men regard them with high esteem and therefore if they explain to them a new medical procedure they readily agree, another disadvantage they explained highly educated men can be ignorant and therefore very hard to convince to accept a vasectomy procedure.

The researcher asked the service providers if other factors such as economic levels and religious factor affects attitudes towards vasectomy among males. The service providers' response was the two factors do not have major impact such as culture. For a factor such as religion they said most women even Catholics do come for family planning therefore they see religion no hindrance when it comes to men having a vasectomy. About economic factor the service providers pointed out that men who understand the importance of family planning in having smaller families due to economic hard times still cannot accept vasectomy due to negative cultural tendencies associated with vasectomy, they will prefer their wives to do family planning but not them, this information collaborates with the information the researcher got from the male questionnaires where men agree to practice family planning to ease their financial worry but the men themselves cannot accept to have a vasectomy procedure.

4.8.4 Obstacles towards Vasectomy Service and Solutions

One of the major obstacles towards vasectomy acceptance the reproductive service providers noted is lack of government support towards vasectomy service. They gave an example of whereby in the 1990s' the NORPLANT procedure one of the female planning methods was virtually unknown but in 2004 when the government started supporting it the NORPLANT procedure is one of the most well-known and widely used procedure by women in the country. Another problem is cultural tendencies of men, which quickly the reproductive health service providers say the problem starts from the policy level where family planning programs are skewed towards women which fuels cultural tendencies of men to think family planning is women responsibility.

Low levels of education are also a problem which brings a negative attitude towards vasectomy as it compounds the problem of cultural tendencies of men. The district officer informed the researcher that the Kilifi education office is trying to solve the problem by carrying out education awareness to curb early marriages, reduce child labour and reduce the number of drop outs. The solutions advocated by the service providers is sensitization of the vasectomy service in the Kilifi district especially through the mass channels such as radio as most households have radios.

The service providers advocated first for community health workers to be educated about the vasectomy procedure then later various chief barazas or community forums to be held in the district targeting men with the educated community health workers spearheading the sensitization of men about vasectomy during this barazas. The service providers advocated for door to door strategy whereby the community health workers go in and each every house holds targeting men and sensitizing them about vasectomy. The service providers who were not trained especially in Kilifi district hospital and Vipingo health centre advocated for them to be trained only when there is an indication that vasectomy sensitization programmes will be carried out in the district.

4.9 Summary

The researcher has presented in this chapter an analysis and interpretation of the data collected and the key findings from the field based on the objectives that were set in Chapter one. In the succeeding Chapter Five, summary and discussion of the findings, recommendation, conclusion to the study and suggested area for further research will be presented.

CHAPTER FIVE
SUMMARY OF THE FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the summary of the findings; conclusions reached and then give the recommendations as per the responses from the respondents. This is in relation to education level, economic factors, cultural and religious factors, and lastly reproductive health service providers. The chapter also looks at the conclusions and recommendations as deduced from the study findings. Finally the chapter points out the areas the researcher thought would require further research in related fields.

5.2 Summary of findings

This section highlights the key findings from the study.

5.2.1 Education Level of Men

The study revealed that majority of men even those who are highly educated have negative attitude towards vasectomy. The assumption was educated men especially those with tertiary education will have a positive attitude towards vasectomy. This assumption was proved wrong when the researcher asked the respondents if they think vasectomy is a good family planning method majority of the respondents said they do not think vasectomy is a good family planning method including respondents who had tertiary education 69.4 % and secondary educated respondents 67.7% said vasectomy is not a good method. The study further revealed majority of the respondents in all education levels cannot consider vasectomy in the future. The tertiary educated respondents 76.5% and secondary educated respondents 64.5% said they cannot have a vasectomy in the future confirming the negative attitude towards vasectomy even by educated men.

Majority of the respondents negative attitude even the highly educated was founded by the belief that vasectomy is like castration which gave the impression how cultural beliefs is very strong in our African societies regardless of education backgrounds. Other

respondents gave out reasons such as vasectomy is against their religious backgrounds or they cannot have a vasectomy because it is a permanent method.

5.2.2 Economic Factors

On economic factors the study revealed generally majority of men 69.2% are aware of the significance of practicing family planning to have smaller families because of the financial difficulties of having a large family. This was good news considering the fact majority of the respondents earnings 51.7% are between the bracket 10,000 and 15,000 which is significantly low.

The study also revealed majority of the respondents still cannot have a vasectomy even when faced with economic hardship. This was accounted by majority of the respondents 58.7% who said they cannot have a vasectomy even when faced with challenges of providing food, education, shelter and other basic needs for their children. The respondents said they would encourage their wives to practice family planning but them personally as men cannot take a personal responsibility.

5.2.3 Cultural and Religious factors

Findings from this study reveal culture is a big hindrance to vasectomy acceptance. Majority of the respondents 50% think vasectomy is a form of castration, only 30% saying they do not think vasectomy is a form of castration shows how culture contributes mostly negative attitudes towards vasectomy. Majority of the respondents 50% were also worried that vasectomy affects sexual desire and desire with only 30% saying they do not think so while the other 20% were unsure, the fact is vasectomy does not affect sexual desire or libido which shows many people are not aware the details about the vasectomy procedure.

On religious factor the study revealed that religious denominations have different attitudes towards vasectomy. The researcher asked the respondents whether they find vasectomy is against their religious faith, majority of Muslim respondents 66.7% said yes vasectomy is against religious faith giving reasons such as vasectomy is a sin and it is

against the teachings of the Holy Quran. Surprisingly most of the catholic faith respondents 53.3% said no to the question although their church advocates for natural family planning methods. The Catholic faith respondents said having a vasectomy is a personal decision and their religious faith is least of their concern. Respondents from protestant churches majority of them 63.2% said vasectomy is not against their religious faith. This latter information confirms that most Protestants churches support family planning.

5.2.4 Reproductive health service providers'

The study reveals reproductive health service providers bias against the vasectomy method. In Vipingo health Centre and Kilifi district hospital the service providers have no training in carrying out a vasectomy with the exception of Mtwapa health centre providers. Vipingo health Centre does not even have the facilities of providing a vasectomy procedure. The researcher noted the service providers were assuming men are not interested in family planning as most of them saw no need of undergoing vasectomy training.

The study also reveals service providers do not talk about vasectomy option at all even with the women clients in the family planning clinics, this brings the assumption the service providers in take family planning as women's responsibility. Service providers are also faced with challenges of lack of vasectomy sensitization awareness being carried out in the district. The service providers revealed that community health workers the people responsible to sensitize the communities about various family planning methods are not trained about vasectomy procedure. The study reveals lack of sensitization and service providers who are not trained is the reason why there has no vasectomy procedure that has been done for the last one year.

5.3 Discussion of Findings

This section provides a contrast and comparison analysis of the findings in reference to works undertaken by other scholars on male attitudes towards vasectomy.

This study reveals that majority of the highly educated men also have negative attitude towards vasectomy. This is total contrast of (Posner and Mbodji, 2009) who said knowledge and approval rates of vasectomy have been observed to be highest among the younger, higher parity, better educated men and those in professional/skilled occupations. Majority of the highly educated men even those with tertiary education in this study revealed that they do not think vasectomy is a good family planning method and they cannot consider having a vasectomy even in the future. The researcher was surprised when they also argued vasectomy is like castration or it may affect their sexual desire which shows that educated men can exhibit strong cultural tendencies regardless of their exposure to education.

Majority of the respondents seemed to be generally aware of the significance of practicing family planning to have smaller families because of the financial difficulties of having a large family, but the same respondents still cannot have a vasectomy. Most men prefer their wives to do family planning but they cannot take personal responsibility of having a vasectomy themselves even in times of hardship. This is because men take family planning as women's responsibility. If men realize the importance of family planning in reducing economic hardship (McGinn et al., 2009) suggested that vasectomy sensitization campaigns can use economic motivation for vasectomy acceptance explaining how vasectomy can be relied on to recognize its benefits such as easing their economic load and contributing to healthier family

The study identified cultural factor as the biggest contributor of male negative attitude towards vasectomy. Educated men with tertiary education exhibited cultural misconceptions of vasectomy that it is like castration, one loses sexual desire or one may gain weight after the procedure. This establishment is mirrored in the study by (Khasiani, 2001) who acknowledges that vasectomy is the least popular modern family planning methods in sub-Saharan Africa thanks to largely cultural beliefs. This explains why the study found out in the 3 major health centres in Kilifi district no vasectomy procedure for past several years. This information corresponded in the study by (Khasiani, 2001 who

says most countries in sub Saharan Africa have vasectomy prevalence rates well below 1%.

Findings from the study reveal that religious factor is not a big hindrance to vasectomy acceptance except Muslims. Most muslim respondents said vasectomy is against their religious faith. This finding resonates with the assertions of William Basil (1992) in the study he implies Muslim scholars unanimously agree that permanent methods of family planning are prohibited in Islam since they involve changing human physiology. The catholic respondents said they can have a vasectomy regardless of the church standing which advocates for natural family planning methods giving reasons such as family planning is an economic reality in this harsh economic environment. The protestant respondents as assumed do not see vasectomy is against their religious faith, this establishment is mirrored in the study by Kotva Jr., Joseph J. (2002) in the study he implies most protestant churches have no problem with artificial contraception most have a religious that "each couple has the right and the duty prayerfully and responsibly to control conception according to their circumstances."

Reproductive health service providers are bias towards the vasectomy procedure. This is shown by how the service providers except Mtwapa health centre but of the two major Centre's; Kilifi District hospital and Vipingo health Centre have no training on providing a vasectomy procedure. Vipingo health Centre does not even have the facilities of providing a vasectomy procedure. The researcher also noted that the service providers see family planning as a women's' responsibility as they did not see the need to undergo vasectomy training, creating a situation is particularly damaging for vasectomy, a procedure that is already shrouded in serious misconceptions. Scholar (Khasiani, 2001) emphasizes that it is essential that all family planning programmes, whether male or female oriented, emphasize appropriate training for their personnel and responsible and thorough counseling at its clinics if they are to be successful. If all health reproductive health service providers are not trained on how to perform and counsel potential vasectomy clients then it will have a negative impact on the vasectomy service.

5.4 Conclusions

The study establishes that male attitudes towards vasectomy in Kilifi district are generally negative. This negative attitudes emanate from strong cultural tendencies by men who believe family planning is a woman's' responsibility. This problem is compounded by reproductive health service providers' bias towards the vasectomy procedure. Other challenges include low education levels, ignorance from highly educated individuals, and religion in the case of Muslims.

5.5 Recommendations

Based on the findings of the study the following recommendations were made:

Reproductive health service providers should be trained in providing vasectomy and counseling services. The training objective will be to make providers be able to perform vasectomy procedure, be able to provide adequate counseling on vasectomy clients; be able to present vasectomy positively; be able to make men feel comfortable visiting clinics and seeking more information on vasectomy.

There are very serious misconceptions about vasectomy; in view of this a wide variety of communication channels should be used to disseminate accurate information about effectiveness, safety and benefits of vasectomy. Mass media campaigns using community health workers, physicians and satisfied vasectomy clients should be created to address myths and misinformation.

To enable vasectomy sensitization campaigns to be effective. Community health workers have to be educated about the vasectomy procedure. They have to be well aware of its advantages, disadvantages and all the details about the vasectomy service. They should be trained on how to devise culturally relevant approaches and maintaining good interpersonal relations with men.

Sensitization campaigns should highlight the economic benefits of smaller family size to make vasectomy more attractive to men. For example, a media campaign might convey the notion of a "satisfied spouse," who no longer has to be concerned about problematic

childbirths, is sexually satisfied and has a family that is financially secure and well provided for. Such messages may resonate among women, as well as among men who are concerned about their spouse's health.

Given a spouse's potential role in the decision-making process promotional efforts should be directed toward women as well as men. Women could receive education regarding vasectomy in maternal and child health clinics. Mass media programs such as radio dramas can provide role models for couples discussing vasectomy. Reproductive health service providers should routinely discuss the option of vasectomy with female clients interested in long term methods.

Family planning services should be tailored towards men needs. Existing clinics should consider offering broader men's reproductive health services to enhance the appeal of family planning to men. Clinics can include male only settings to support vasectomy programs and integrated services with separate hours for men. The latter may offer broader men's reproductive health services, such as urology, infertility treatment, testing for and treatment of sexually transmitted infections and counseling for sexual problems.

To ensure consistent levels of vasectomy service provision, it is recommended that vasectomy outreach services should be regularly scheduled (example on a weekly basis), and linked with community outreach and mobilization. Each facility should always be stocked with the necessary equipment and supplies, so that services can be performed whenever the provider is on-site.

"Change takes time," especially in medical settings, which are generally conservative, hierarchical, and change resistant. This is even more the case when the change entails adoption and provision of an unknown or widely misunderstood procedure, such as vasectomy. It is recommended that the government, donors, policy makers and other stakeholders to have a long term commitment towards the vasectomy programs in terms of sustained attention, leadership and resources.

5.6 Suggestion for further studies

The following are recommendations for further research;

1. Barriers facing vasectomy services and their impact on men attitudes in Kenya.
2. The effectiveness of vasectomy mass media communication strategies on men attitudes in developing countries.
3. Influence of spousal/partners communication on men attitudes towards vasectomy in Kenya.

REFERENCES

Bureau of Statistics, Planning Commission (BSPC), (2003). *Tanzania Demographic and Health Survey* 1991/92. Dares Salaam: Bureau of Statistics, Planning Commission.

Chandra, A; Martinez GM, Mosher WD, Abma JC, Jones J. (2001). *"Fertility, Family Planning, and Reproductive Health of U.S. Women:* Data from the 2002 National Survey of Family Growth" (PDF). *Vital Health Stat* (National Center for Health Statistics) **23** (25). Retrieved 2007-05-20.

Christopher West (2000). *Good News about Sex and Marriage: Answers to Your Honest Questions about Catholic Teaching*. Servant Publications. pp. 88–91. ISBN 1-56955-214-2.

Donald C. (2006). *Synthesizing Research; A guide for Literature Reviews* (3rd Ed) Sage: Thousand Oaks.

Family Health International (FHI), (2002). *"Men and Family Planning," Network* 13 (1), 1995 "Undeserved Groups," Network 15 (3).

Forde E., (2001). *"Male Participation in Family Planning in Sierra Leone,"* PPASL *Three Year Plan*, 1984-1986.

Gachango, G. W., (2003). *"Some factors Affecting Husband Contraceptive Acceptance and Fertility Preference in Kenya,"* Unpublished postgraduate diploma project, PSRI, University of Nairobi.

Gill G. (2001). *"Needs Assessment in Men with Sexually Transmitted Diseases and AIDS."* Paper prepared at a workshop on Male Involvement in Banjul, The Gambia. Nov. 25-29.

Gordon B. Hinckley, (2002). *"If I Were You, What Would I do?"* BYU 2002-2003 Fireside and Devotional Speeches, September 20, 19, p.11

Green C. P., (2004). *"Male Involvement in Reproductive Health and Family Planning,"* Program Advisory Technical Paper. New York: UNFPA.

Hershberger, Anne K (1989). *"Birth Control".* Global Anabaptist Mennonite Encyclopedia Online. Retrieved 2006-08-17.

Innovative Communication Systems and John Hopkins University Population Communication Services (ICS.JHU/PCS), (2002). *Baseline Family Planning Survey of Men in Mombasa and Nairobi, Kenya.* Nairobi: ICS.JHU/PCS.

Isiugo-Abanihe U.C., (2003). *"Fertility, Family Size Preference and Value of Children among Nigerian Men."* Paper presented at the Annual Meeting of Population Association of America, Cincinnati, Ohio, and April 1-3.

Khasiani S. A., (2001). *"Family Planning KAP among Health Centre Personnel in Western Province of Kenya." Journal of obstetrics' and Gynecology of Eastern and Central Africa* 9 (1):30.

Kim Y. M, (2001). *"Counseling and communicating with men to promote family planning in Kenya and Zimbabwe,"* paper presented at the W HO Meeting of Regional Health Advisors on Programming for Male Involvement in Reproductive Health, Washington, DC, and Sept.5 7.

Kincaid D. L., A. P. Merrit, L. Nickerson, M.P.P. DeCastro and B.M. Castro, (2009). *"The Mass Media Vasectomy Promotion Campaign in Brazil: Impact on Clinic Inquires, Attendance and Performance," International Family Planning Perspectives* (forthcoming).

Kombo, K. and Tromp, L. (2006). *Proposal and thesis writing, an introduction*, Nairobi: Paulines Publications Africa

Kothari, C.R. (2008). *Research Methodology,-Methods and Techniques,* New Delhi: New Age International (P) Ltd Publishers.

Kotva Jr., Joseph J. (2002*). "The Anabatist Tradition: Religious Beliefs and Healthcare Decisions"* (pdf). *Religious Traditions and Healthcare Decisions*. Park Ridge Center for the Study of Health, Faith, and Ethics. Archived from the original on 2006-07-06. Retrieved 2006-10-0

Lam, P., (2003). *"Family Planning Association of Hong Kong (FPAHK) Male Responsibility Promotion: Male Involvement in Family Planning Program Initiatives."* Paper prepared for the IPPF staff consultation, pp.97-111.

Liskin L, Benoit E, Blackburn R, (1992*). Vasectomy: new opportunities*. Population Reports Series D, No 5. Johns Hopkins University Population Information Programme, Baltimore.

Mbizvo, M. T. and D. J. Adamchak, (2001). *"Family Planning Knowledge, Attitudes and Practices of Men in Zimbabwe."* Studies in Family Planning *22(1):31-38.*

McGinn, T., A. Bamba and M. Balma, (2009). *"Male Knowledge, Use and Attitudes Regarding Family Planning in Burkina Faso,"* International Family Planning Perspectives 15(3):84-87

Meyendorff, John (1975). *Marriage: An Orthodox Perspective*. Crestwood: St. Vladimir's Seminary Press. p. Ch. 13. ISBN 0-913836-05-2.

Mugenda M. O. and Mugenda A. (1999). *Research Methods: Qualitative and Quantitative Approaches*, African Centre for Technology Studies, Nairobi, Kenya.

National Council for Population and Development (NCPD), (2004). *Kenya Demographic and Health Survey 1993*. Calverton, Maryland: NCPD, CBS and Macro International.

NTOZI J. P. M., (2003). *The Role of Men in Determining Fertility among the Banyakore of South Western Uganda, Kampala:* The Institute of Applied Statistics and Economics, Makerere University.

Oni, G. A. and J. McCarthy, (2001). *"Family Planning Knowledge, Attitudes and Practices of Males in Ilorin, Nigeria,"* International Family Planning Perspectives 17(2):50-54.

Orodho, A.J. (2003). *Essentials of educational and social science research methods*. Nairobi: Masola Publishers.

Posner, I. K. and F. Mbodji, (2009). "*Men's Attitudes about Family Planning in Dakar, Senegal,"* Journal of Biosocial Science 21:279-91.

Rappaport, B.M., (2001). *"Family Planning Helping Men Ask for Help,"* Men and Family Planning, pp.245-259.

Ringheim, K., (2003). *"Factors that Determine the prevalence Use of Contraceptive Methods for Men."* Studies in Family Planning 24(2):87-99.

Ross K and Frankenberg Tree, (1993). *Male Participation in Family Planning:* A Review of Program Approaches in Africa, London: International Planned Parenthood Federation (IPPF).

Salway, S., (2004). *"How Attitudes towards Family Planning and Discussions between Wives and Husbands Affect Contraceptive Use in Ghana,"* International Family Planning Perspectives 20(2):44-47

Stover, J. and M. Bravo, (2001). *"The Impact of AIDS on Knowledge and Attitudes about Condoms as a Contraceptive Method in Urban Mexico,"* International Family Planning Perspectives 17(2):61-64

Strader, M.K., M. L. Beaman and McSweaney M., (2007). *"Effects of Communication with Important Social Referents on Beliefs and Intentions to use Condoms,"* Journal of Advanced Nursing, 17:699-703.

Terefe, A., (2009). *"Modern Contraception Use in Ethiopia: Does Involving Husbands Make``a Difference?"* American Journal of Public Health 83(11):1567-71.

Vernon, R., G Ojeda and A. Vega, (2001), *"Making Vasectomy Services More Acceptable to Men,"* International Family Planning Perspectives 17(2):55-60.

William Basil (1992). *Eros and Transformation: Sexuality and Marriage: An Eastern Orthodox Perspective*. Lanham: University Press of America. p. Ch. 7. ISBN 0-8191-8647-3.

Wilkinson, D., et al. 1997. *Improving vasectomy services in Kenya: Lessons from a mystery client study.* Reproductive Health Matters No. 7, pp. 115–121.

Wimmer, R.D. and Dominick, J.R. (2003). *Mass Media Research*: an introduction. Belmont: Thomson Learning Inc.

APPENDICES

APPENDIX I: LETTER OF INTRODUCTION

University of Nairobi,
College of Extra Mural studies,
School of Continuing and Distance Education,
Nairobi Center.

The Management
……..
Health Centre
Box……
Kilifi District
Dear sir/ madam.

RE: **Academic Research**

I am a student of University of Nairobi pursuing a Masters Degree in Project Planning and Management. Am conducting an academic research on factors influencing male attitudes towards vasectomy in Kilifi district.

Your health facility has been chosen to provide information relating to reproductive health service provider influence towards vasectomy. The information that you will give is confidential and will be used only for the purpose of my academic research. Thank you in advance.

Yours faithfully,

Musa Lugwe Kidzuga
L50/65296/2010

APPENDIX II: MALE QUESTIONNAIRE

TODAY'S DATE_____

My name is **Musa Lugwe.** *I am a postgraduate student at the University of Nairobi. I am conducting research in Kilifi district. The purpose of the study is to learn the factors that influence male attitudes towards vasectomy. This information will be used to determine the level of male perception towards vasectomy with the aim of incorporating men in family planning programs in future.*

Regarding this I would ask you some questions. Some of these questions are personal but the answers you give will not be shown to anyone. This is ***CONFIDENTIAL DATA*** *that will only be treated with utmost confidence and shall only be used for research purposes only*

Section A: Background Information

1. How old are you
   a) Under 25 yrs ☐
   b) 26 – 30 yrs ☐
   c) 31- 35 yrs ☐
   d) Over 36 yrs. ☐

2. Which tribe are you?
   a) Mijikenda ☐
   b) Other (Specify).....

3. What is your occupation?
   .....

4. What is your marital status?

   a) Single ☐
   b) Married ☐
   c) Divorced ☐
   d) Widowed ☐
   e) Separated ☐

5. What is your religious affiliation?

   a) Muslim ☐
   b) Catholic ☐
   c) Protestant ☐
   d) Other (Specify).....

6. What is your education level? ☐

   a) Primary ☐
   b) Secondary ☐
   c) Tertiary ☐
   d) No formal education ☐

7. a).Do you have children?

   Yes [ ] No [ ]

   b).If yes please specify how many.....

Section B: Education Level

8. Do you know anything about family planning?

   Yes [ ] No [ ]

9. Have you heard about male methods of family planning?

   Yes [ ] No [ ]

10. Do you know anything about vasectomy?

    Yes [ ] No [ ]

11. Do you think it is a good family planning method?

Yes [ ] No [ ]

12. Have you undergone the vasectomy procedure?

Yes [ ] No [ ]

13. If not vasectomized, can you consider vasectomy in the future?

Yes [ ] No [ ]

14. What is your personal opinion about vasectomy?

.....

.....

.....

.....

Section C: Economic Factors

14. What is your income earning level?

[ ] 1,000-4,999

[ ] 5,000-9,999

[ ] 10,000-14,999

[ ] 15,000-19,999

[ ] 20,000 and more

[ ] No earnings

15. Do you believe in practicing family planning to have a smaller family to ease your financial worry?

Yes [ ] No [ ]

16. Can you have a vasectomy so as to maintain a small family to ease your financial worry of providing adequate food to your children?

Yes [ ] No [ ]

If no why.....

17. Can you have a vasectomy so as to maintain a small family to ease your financial worry of providing healthcare to your children?

Yes [ ] No [ ]

18. Can you have a vasectomy so as to maintain a small family to ease your financial worry of providing adequate education to your children?

Yes [ ] No [ ]

19. Can you have a vasectomy so as to maintain a small family to ease your financial worry of providing adequate shelter to your children?

Yes [ ] No [ ]

Section D: Cultural and Religious Factors

No.	**Questions and filters**	**Coding Categories**		**Skip to**
	State whether you agree or disagree with the following statements	Agree	Disagree	Unsure
20.	Is Vasectomy a form of castration	☐	☐	☐
21.	Does vasectomy affect a man sexual ability	☐	☐	☐
22.	Does vasectomy affect a man sexual desire	☐	☐	☐
23.	Does vasectomy affect a man's respect	☐	☐	☐
24.	A man cannot ejaculate after a vasectomy procedure	☐	☐	☐
25.	Having a vasectomy will make your wife become unfaithful	☐	☐	☐
26.	The vasectomy procedure causes a man to gain weight.	☐	☐	☐

27. Is vasectomy against your religious faith?

Yes [ ] No [ ]

(a) If yes why?

.....

.....

.....

.....

(b) If no why?

.....

.....

.....

.....

The End

Thank you.

APPENDIX III: INTERVIEW SCHEDULE FOR SERVICE PROVIDERS

1. What are your medical Qualifications?
2. Have you been trained to provide vasectomy services for potential male vasectomy clients?
   a) If yes where and how long was the training?
   b) If no, do you require the training?
3. Have you been trained to provide counseling for potential male vasectomy clients?
   a) If yes where and how long was the training?
   b) If no, do you require the training?
4. Do you provide vasectomy services?
5. Would you recommend vasectomy services to male clients?
6. Kindly tell me in figures the number of men who come for this services like per month/year?
7. In your opinion what is the attitudes of men in Kilifi towards vasectomy?
8. In your opinion what are the factors that influence male attitudes towards vasectomy?
9. a) In your opinion what are the obstacles towards vasectomy service?
   b) What are the solutions to these obstacles you have mentioned?
10. What are the communication strategies used in this clinic to promote vasectomy?
11. What has been the response of the community?
12. Is there a need of more sensitization?
13. In your opinion which other channels can be used for vasectomy promotion?