SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

PERCEPTIONS OF VASECTOMY AS A FAMILY PLANNING METHOD AMONG MARRIED MEN IN THE AWUTU SENYA EAST MUNICIPALITY

BY

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THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE

JULY, 2019
DECLARATION

I, Felicia Dede Tetteh declare that this submission is the outcome of my own work towards the award of Master of Public Health degree and that, it contains neither material earlier published by another person nor organization which have been accepted for the award of any other degree except where references have been duly made in the work.

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(ACADEMIC SUPERVISOR)
DEDICATION

I dedicate this work to the Almighty God for His love towards me and to my father, Mr. Felix Tetteh- Larbi for his unflinching support throughout all the years of my education coupled with the great investment he made to see me come this far.
ACKNOWLEDGEMENT

I give all the glory to the Almighty God for all the love and protection he bestowed upon me towards a successful completion of this work.

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Special thanks to all lecturers and staff of the Department of Social and Behavioral Sciences for their time and the excellent manner in which they delivered their various lectures. It was very impactful. We cannot thank you enough. God bless you.

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To God be the Glory.
ABSTRACT

Background: Several studies have revealed the essence of family planning especially with emphasis regarding its role to achieving development. Family planning methods have been noted to prevent unwanted pregnancies and prevent maternal and child mortality, however, records emanating from Sub-Saharan Africa indicates a low usage of contraceptives especially vasectomy although there is a high unmet need for family planning. This study aimed at investigating the perceptions of vasectomy as a family planning method among married men in the Awutu Senya East Municipality.

Methods: The study was an exploratory research which employed a qualitative approach. Focus Group Discussions and in-depth interviews were used to gather primary data. Study participants were selected using the purposive sampling technique. The study population consisted of community members from the Awutu Senya East Municipality, precisely married men. Interviews were digitally recorded with the consent of participants. Interviews were transcribed and coded using QSR Nvivo 12 software for thematic analysis.

Results: The study revealed misconceptions about vasectomy. Again, knowledge of vasectomy was low as compared to knowledge of other family planning methods. Few participants had knowledge about vasectomy although they had misconceptions about the method. Religious beliefs, surgical procedure and future uncertainties all influenced participants’ acceptance and perceptions of vasectomy.

Conclusion: The study concludes that there is no enough knowledge about vasectomy among study participants and inadequate knowledge leads to erroneous perceptions. The study advocates that more education be done in the area of vasectomy to clear misconceptions in order to increase acceptance and patronage.
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<td>Acquired Immune Deficiency Syndrome</td>
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<td>ASEMA</td>
<td>Awutu Senya East Municipal Assembly</td>
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<td>FP</td>
<td>Family Planning</td>
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CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Globally, the population of the world has increased as 2018 recorded a total of 7.6 billion people worldwide (PRB, 2018) which undoubtedly renders high population an issue of universal concern. Africa’s population is said to contribute approximately half of the world’s population according to the United Nations Economic Commission for Africa (as cited in Appiah, Agyen, Garti, & Menlah, 2018). In part, this has led to social issues, resource depletion and environmental degradation (Onasoga, Edoni & Ekanem, 2013). In spite of the fact that total fertility rate reduces slowly, it has however been declining globally, especially in developing countries where the usage of contemporary contraception is usually below standard (UN, 2013).

Despite the fact that women in their reproductive years (married or in union), between the ages of 15-49 are those occasionally noted to use contraception in the world (UN, 2017), some methods require the active participation of men (Hardee, Croce-Galis, & Gay, 2016). Universal records in 2017 showed 63% of women in their reproductive age using some form of contraception (UN, 2017). Prior to these records, an international conference had taken place in Kampala, Uganda which was geared towards regulating the rate of births and this was noted to have rekindled the adhesion to family planning (Cates, 2010). Contraceptive use provides couples and individuals the opportunity of realizing their fundamental right to willingly and responsibly decide if, when and how many children to have (UN, 2017).
Essentially, family planning tames poverty and hunger, improves universal education, increase maternal and child health, promotes gender equality and helps combat HIV/AIDS (Cates, 2010). Therefore in their pursuit to control births, countries set reproductive policies to advance the use of contraceptives (Adongo et al., 2014).

Family planning is a method involving the use of contraception that gives couples and individuals their fundamental rights to voluntarily and responsibly decide if, when and how many children they want to have (UN, 2017). There are varied collection of family planning methods including spermicides, oral contraceptive pills, the natural approach and condoms (female/male) representing short term methods. Long term methods comprise intrauterine device (IUD), progestin and Norplant whiles permanent methods also include tubal ligation, voluntary surgical contraception and vasectomy. It is expected that a generous amount of knowledge about these contraceptives will coach service providers and users to take up methods suitable for the user (GHS/RCH, 2013).

Family planning in times past centered greatly on women in the past and this has caused men to act a supplemental role particularly in a setting where male virility and sovereignty is highly significant and is noticeable by procreation. This owes to the fact that women were at the heart of most research and information crusades as a chunk of family planning interventions took place within maternal health and child welfare clinics, aggravating the illusion that controlling for unwanted pregnancies is predominantly the duty of a woman (Onasoga et al., 2013). There have been advocacies to incorporate men into family planning matters, one of which is to make available to couples more alternative family planning methods through the advancement of contraceptive methods for men, for example vasectomy, to nourish men’s involvement in family planning (Adongo et al., 2014).
Family planning methods existing for men are condoms, sterilization and vasectomy (Glasier, 2010). Among these, patronage of vasectomy is greatly affected as the adoption of family planning culture has been canned owing to misconceptions and attitudes of service providers (GHS/RCH, 2013). According to Fainberg & Kashanian (2018), vasectomy is a surgical process of sterilization to avoid future fertility. Usually, sperms are transported by the vas deferens, a thin muscular tube from the testicles into the ejaculate in men. In vasectomy the vas deferens are cut and blocked, making it impossible for sperms to mix with the ejaculate fluid (Fainberg & Kashanian, 2018). There is a worldwide estimation of 42 million couples relying on vasectomy as a family planning method. Out of the 42 million, barely 100,000 couples in Africa are shielded from undesirable pregnancy through vasectomy. A vivid example is seen in Ghana with about one in 1,000 couple relying on vasectomy (The ACQUIRE Project, 2005).

In their quest to boost awareness and expand the reception of vasectomy, the Ghana Health Service, the USAID Mission in Ghana as well as EngenderHealth (under its previous cooperative contract) worked together on a project in the Accra and Kumasi metropolitan areas in 2003. This programme implemented a collective plan employing site interventions that emphasized on value of care and access (supply interventions) with operative and tactical interventions geared towards growing public consciousness on vasectomy (demand side interventions). In 2004 and 2008 the ACQUIRE Project out doored the first and second phases of the projects on vasectomy in that order. Largely, the objective of the 2004 and 2008 communication campaigns aimed at promoting people’s consciousness concerning vasectomy, to escalate their consciousness of the handiness of the services and to assist as a catalyst for men who were making an allowance for vasectomy (The ACQUIRE Project, 2008). Patronage of vasectomy in Ghana is still a low among couples despite the gains made by the ACQUIRE Projects in building awareness about the method (Adongo et al., 2014). Studies have been conducted in Ghana specifically in Accra to
examine the reasons for low patronage of vasectomy including that of Appiah et al., (2018) and Asare, Otupiri, Apenkwa, & Odotei-Adjei, (2017), however little has been done in southern Ghana specifically the central region. An example of a study conducted in the southern Ghana is that of Adongo et al., (2014) to assess community perceptions of vasectomy. Hence this study therefore sought to investigate the perception of vasectomy among married men in the Awutu Senya East Municipality.

1.2 Problem Statement

Primarily, women, in times past have been the focal point of birth control programs globally owing to the necessity to liberate women from immoderate child bearing and to lessen infant, child and maternal mortality and morbidity. There have been little accentuation on male methods of contraception while a great number of family planning services were accessible within maternal and child health centers (Onasoga et al., 2013).

Nonetheless, several efforts have been made in recent years to boost the inclusion of men in issues associated with reproductive health and family planning as governmental and non-governmental organizations acknowledge the importance of considering men in reproductive health issues and decision making (Bunce et al., 2007). Three main methods of contraception are available for men, namely condom, withdrawal and vasectomy (Glasier, 2010).

Worldwide, the prevalence of vasectomy users is estimated at 2.4% (Shattuck, Perry, Packer, & Chin Quee, 2016) whiles sub-Saharan Africa also records not more than one-tenth of 1% women in union who depend on their partner’s vasectomy for contraception despite the fact that it is the most effective method (Bunce et al., 2007). Similarly, Kabagenyi, Ndugga, Wandera, & Kwagala (2014) also adds that uptake of contraception among married men in high fertility countries is low. In Ghana for instance, although knowledge on contraception is almost universal
as 98% of women and 99% of males know about one method (GSS, NMIMR, & ORC Macro, 2004) vasectomy is less common just like other developing countries and is more difficult to obtain as prevalence is less than 0.1% (Asare et al., 2017).

In spite of the many advantages of vasectomy, it is less accepted as a result of widespread misconceptions (Ebeigbe, Igberase, & Eigbefoh, 2011). In a retrospective analysis of 271 instances of vasectomy in Ghana, it was observed that less than half of family planning customers opted for vasectomy. Researchers advocated the need for further studies to be done regarding the reasons and perceptions behind the low patronage of vasectomy in Ghana, Owusu-Asubonteng et al., 2012 (as cited in Adongo et al., 2014). Again, several studies including Appiah et al., (2018) and (Kathpalia, 2018) have mentioned that misconceptions as a result of inadequate knowledge accounts for the low patronage of vasectomy. In the light of the above, this study sought to explore the perceptions of vasectomy as a method of family planning among married men in Awutu Senya East Municipality.

1.3 Justification of the Study

In matters of reproductive health in developing nations, male participation in family planning decisions is a key consideration, much more so if the male decides to settle for vasectomy as a family planning technique. Family planning saves life by reducing maternal morbidity and mortality. It also reduces the stress and frustration of large family sizes, not to the benefit of the couple alone but the society and the nation as a whole.

Population growth which was once a national concern has now come to have global ecological implications due to escalating population (Mahat, Oranut, & Taechaboonsermsak, 2010). The weight is revelatory in developing countries owing to the combined effect of poverty and uncontrolled births. The individual, family and societal benefits resulting from a man’s decision
to opt for family planning cannot be underestimated as it births a more healthier and reproductive work force, enhances saving and reduces pressure on social infrastructure.

In pursuit to increase vasectomy acceptance, evaluating the perception of vasectomy among married men will furnish the researcher with information which could be used to address the low vasectomy uptake. Unmet need which has shielded the family planning programme for years will, to some extent be contended with through the acceptance of an additional family planning method. These are pertinent in reducing maternal morbidity and mortality rate more so to lighten the responsibility carried by women with regards to decision making on family planning methods.

1.4 Research Questions

The study was guided by these research questions:

1. What knowledge do married men have about family planning?
2. What knowledge do married men have about vasectomy as a family planning method?
3. What perception do married men have about vasectomy as a family planning method?
4. What is the reason for acceptance of vasectomy as a family planning method among married men?

1.5 Objectives of the Study

The objectives of the study are categorized into general and specific as shown below.

1.5.1. General Objective

The general objective of the study was to explore the perceptions of vasectomy as a family planning method among married men in the Awutu Senya East Municipality.
1.5.2 Specific Objectives

The specific objectives of the study were:

1. To assess knowledge of married men on family planning.
2. To explore knowledge married men have about vasectomy as a family planning method
3. To assess the perception of vasectomy as a family planning method among married men
4. To determine the reasons for acceptance of vasectomy as a family planning method among married men
1.6 Conceptual Framework

Knowledge of vasectomy
- Vasectomy and its benefits.
- Cost of process.
- Permanent Method.
- Future Complications.

Reasons for acceptance of Vasectomy
1. Religious beliefs.
2. Spousal Influence
3. Surgical procedure
4. Availability of Service.
5. Availability of counseling services

Perceptions of Vasectomy
1. Masculinity does not change.
2. Does not prevent STDs.
3. It is different from castration.
4. Sexual performance is not affected.

Socio-Demographic
1. Age.
2. Educational Level.
3. Occupation.
4. Religion
Figure 1.1 A Conceptual Framework Showing Various Factors That Influence Perception of Vasectomy As A Family Planning Method.

Source: Author’s own construct.

Figure 1.1 is the conceptual framework for the study. Perception of vasectomy is expected to turn positive and eventually an increase in patronage when factors affecting its utilization are duly contended with. Knowledge of vasectomy including its benefits, cost of procedure and the issue of it being a permanent method as well as addressing misconceptions about future complications can expunge the invalid perceptions surrounding the method. This is to say that, adequate knowledge regarding vasectomy has influence on its perceptions. In addition to this, religion, occupational status and educational level of men also have influence on their perception of vasectomy as a family planning technique.

Again, religious beliefs, spousal influence, surgical procedure, presence of adequate counseling services and availability of services influence men’s knowledge and perceptions about vasectomy. These will influence the adoption of vasectomy and the use of vasectomy. In the absence of these, the investigator believes that males can patronize the technique with confidence.

Many individuals, including men, believe that vasectomy is the same as castration, decreases sexual output in men, and potentially perverts the process of ejaculation. More so, other wrongfully preconceived ideas are that it changes the virility of a man. Knowledge of vasectomy influences reasons for acceptance whiles reasons for vasectomy acceptance also influences knowledge. Having knowledge about vasectomy informs the individuals about the procedures involved in getting a vasectomy done, where services are offered and this in turn influences acceptance. On the other hand, reasons for acceptance like, religious beliefs also influence
knowledge of vasectomy. The presence of counseling services allows individuals access to education about vasectomy which in turn influences perception and acceptance. Perceptions such as vasectomy being the same as castration again influences choice to accept the method, hence an effect on the level of patronage. All these and other misconceptions have built general perceptions of vasectomy as a method of family planning and have far-flunged the interest in the method away from choice.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction
This section offers a critical analysis of literature regarding perceptions of vasectomy as a method of contraception. Primarily, it deals with review of works by scholars and researchers on vasectomy, perceptions surrounding the method and its patronage as well as detailed definition of concepts embedded in the study. Consequently this section is split into two sectors. The first attempts to explain and provide various definitions of terms and concepts key to the study whiles the second section reviews works of researchers related to the knowledge, perception and reasons for acceptance of vasectomy as a technique for controlling births.

2.2 Definition of Concepts

2.2.1 Family Planning
There is no anticipation to see populations decline considering the next 30 years, as over population has been the tide in Africa (Appiah et al., 2018). Although the reproduction process prevents against mankind extinction, it comes along with huge risk of maternal and child morbidity and mortality (Onasoga et al., 2013). In a paper authored by Kavanaugh &Anderson (2013), improved birth outcomes for babies, reduced maternal mortalities and morbidities, helping couples and women time and space their pregnancies are some benefits of contraception mentioned.

In order to gain contact with family planning facilities and subsequently adopt a suitable contraceptive method, it is expedient to gain knowledge about contraceptive methods (GSS,
GHS & ICF, 2014). Family planning is a method involving the use of contraception that gives couples and individuals their elementary rights to liberally and conscientiously decide if they want to have children, when and how many. The increasing practice of contraception has led to an improvement in health-related outcomes such as a reduction in maternal and infant mortality as well as an advancement in economic and schooling outcomes, specifically for girls and women (UN, 2017). Spermicides, oral contraceptive pills, the natural approach and condoms (female/male) are examples of short term methods. Long term methods include intrauterine device (IUD), progestin and Norplant whiles emergency methods include the oral pill (WHO, 1988).

In Ghana, family planning has been of essence to the government for many years. The awareness of family planning has risen over time as the Ghana Statistical Service report in 2004 revealed 98% of all women between age 15-49 and 99% of all men age 15-59 who knew no less than one contemporary method of contraception. The common methods among the women were male condoms (95%), injectable (89%), the pill (88%) and female condom (83%). Again, seventy percent of all women had heard of female sterilization (GSS, NMIMR & ORC Macro, 2004).

The 2014 Demographic and Health Survey’s findings on the knowledge of contraception was quite similar to that of 2003. The results revealed that, modern methods were widely known compared to traditional methods. A total of 99% of all women had knowledge of a modern method compared to 85% who knew of a traditional method. In the midst of modern methods, records for the male condom stood at 96%, injectables (92%), the pill (91%) and female condoms (87%). The men also recorded 99% knowledge of male condom, 88% of female condoms, 87% of the pill and injectables 83%. Much as about 7 in 10 women are apprehensive about female sterilization, just about one-third are cognizant about male sterilization yet on the
whole, women exhibit a slightly higher knowledge of family planning methods as compared to men (GSS, GHS & ICF, 2014).

Averagely, women know 8.5 contraceptive methods as opposed to an average of 8.2 methods known among men (GSS, GHS & ICF, 2014). Thummalachetty et al., (2017) in their study titled Contraceptive knowledge, perceptions and concerns among men in Uganda; it was revealed that men had limited accurate knowledge regarding contraceptive methods coupled with fears about complications associated with modern methods of contraception. The study advocated for family planning services in Uganda to be fortified by renewing attempts to concentrate on the understanding, concerns and misapprehensions of men.

Previous literature alludes that male participation can enhance acceptance and prolongation of family planning approaches by improving spousal communication through conduits of improved understanding or reduced male resistance. Despite the increasing proof of the merits of involving men in decision-making on reproductive health, many sub-Saharan nations have been well-known for high fertility rates and family planning needs (Sharan & Valente, 2002).

### 2.2.2 Vasectomy

Vasectomy is a safe contraceptive method and immensely fruitful for couples with the desire to seize childbearing (Shattuck et al., 2016). According to Labrecque, Dufresne, Barone, & St-Hilaire, (2004), vasectomy is executed in two individual steps. The first phase is by bringing and revealing the vas deferens out of the scrotum (isolation), and the second involves occluding the vas. The no-scalpel vasectomy is used to isolate the vas and it is growing among physicians who perform vasectomy in the United States and in developing countries (Labrecque et al., 2004)
According to Shattuck et al., (2016), the NSV involves merely a slight puncture in a man’s scrotum to access the vas deferens, with the client under local anesthesia. Vasectomy is the easiest, benign and most efficient way of definitive fertility control in men (Engl et al., 2017).

Universally, vasectomy use stands at 2.4% according to Jacobstein (2016). The use of vasectomy and its prevalence varies from region to region. As at 2015, North America recorded 11.9% use of vasectomy, Oceania, 6.6%, Europe 3.3%, Latin America and the Caribbean’s, 2.6%, Asia, 2.2% and lastly Africa whose record stood at 0.0% (Jacobstein, 2016). Considering the prevalence of vasectomy in developed countries, a country by country analysis as presented by Jacobstein, (2016) showed that Canada recorded the highest prevalence of 22% followed by the United Kingdom with a prevalence of 21% and New Zealand with 20%. Again in Jacobstein (2016), the United States of America recorded 11%, Australia 9% and the Netherlands, 5%, as these countries have high knowledge and access to family planning coupled with gender equity. In Asia, except for South Korea whose prevalence stands at 17%, India, Pakistan and Bangladesh all record 1.0, 1.2 and 0.3 use of vasectomy respectively (Jacobstein, 2016).

The prevalence of vasectomy in Africa seldom outstrips 0.1% and has continued this way over the previous decade. In this region, vasectomy is noted to be unacceptable among most men and might possibly stay so for a long duration according to some researchers. Notwithstanding, Pile stated the presence of pouches of concern for vasectomy in Ghana, Kenya, Ethiopia, South Africa and Tanzania (Pile, 2008). However in the paper published by Jacobstein, (2016), records from some African countries depicts low or no interest in the method as Kenya, Rwanda, Tanzania, Mali, Nigeria, and Uganda and Malawi all recorded 0.0 and 0.1 use of vasectomy respectively.
In Ghana, the prevalence of vasectomy is less than 0.1% according to The ACQUIRE Project & USAID, (2005). A lesser amount of couples need to reduce future births is met although one in four women expresses their desire of not wanting to have any more children (GSS, NMIMR and ORC Macro 2004). This renders closely 350,000 Ghanaian couples with unmet need to reduce impending births (The ACQUIRE Project & USAID, 2005).

2.2.3 Types of Vasectomy Procedure

In spite of the process of scrotal entry, the maiden phase is to recognize and immobilize the vas through the skin of the scrotum and secondly bring the vas into the open (EngenderHealth, 2002). According to Zini, Grantmyre, & Chan, (2016), the two most common clinical procedures for locating the vas in the course of vasectomy are the conventional incisional technique and the no-scalpel methods. In the conventional method, the clinician uses a scalpel to make either one midline incision or two incisions in the scrotal skin, one overlying each vas deferens (EngenderHealth, 2002). The NSV technique uses a sharp, forceps-like instrument to puncture the skin designed to reduce adverse events like bleeding, infection, and pain (Zini et al., 2016).

Usually, each incision is 1-2cm long and is normally closed with stitches after the vasectomy has been accomplished. Usually with orthodox vasectomy, just the areas around the skin entry site is sedated (EngenderHealth, 2002).

According to EngenderHealth, (2002) the alternate approach, no-scalpel vasectomy (NSV) uses a vassal nerve block formed by first numbing the scrotal skin, followed by creating a deep injection anesthetic along with each vas. This offers an enhanced anesthesia than merely numbing the skin all over the entry point as done in the conventional approach. As an alternative to the scalpel, two specific instruments- a ringed clamp and a dissecting tongs are used. As a
result of this, no sutures are needed since the puncture created with the dissecting forceps on the scrotal skin is so small.

The no-scalpel vasectomy offers a number of merits over the conventional approach as it has fewer complications, minimal pain during the process, timely follow-up period as well as earlier recommencement of sexual activities after surgery. This approach is thought to reduce men’s qualms about vasectomy because it requires no scrotal incisions. It is worth noting that the conventional and the no-scalpel approach are not time consuming however it is described that the vasectomy method time is shorter when experienced providers employ the no-scalpel method (EngenderHealth, 2002).

The utmost common moans are inflammation of the scrotal tissue, bruising, and ache. Even though these symptoms usually go devoid of treatment, ice packs, a scrotal support, and simple analgesics offer relief. Again, possible immediate complications consist of hematoma, wound and genito-urinary infections and traumatic fistulae. Vasectomy failure is however estimated to occur in 0-2% of patients. In the same way vasectomy does not increase the threat of testicular cancer (Awsare, Krishnan, Boustead, Hanbury, & Mcnicholas, 2005).

It is the safest and most effective method available for men and takes about 5-15 minutes to achieve after 5-10 minutes for preoperative preparation and administration of local anesthesia. However, men undertaking vasectomy ought to be given clear directives concerning post-operative care, projected side effects, actions to take if complications happen, places they can access emergency care, the need for post-operative semen scrutiny and the time and place for making a follow-up visit (EngenderHealth, 2002).
2.2.4 The Ghana Vasectomy Initiative

The Ghana Health Service, the U. S Agency for International Development (USAID) mission in Ghana and Engender Health in 2003 commenced an initiative in Accra and Kumasi metropolis to advance approval of vasectomy by connecting site interventions that places emphasis on access and quality (supply-site interventions) with effective and deliberate interventions marked at increasing public consciousness (demand-side interventions). Subsequently, The ACQUIRE Project delivered technical aid to create and undertake the communications crusade and community outreach and to appraise the outcomes of the supply-demand approach. Earlier in 2004, ACQUIRE propelled the initial segment of the demand strategy for vasectomy, by way of a communications campaign called Vasectomy: Give Yourself a Permanent Smile. In order to apprehend the influence of these communications efforts on alertness, knowledge of, and attitudes toward vasectomy, ACQUIRE also organized a board study which included 200 men in Accra. The call for vasectomy services amplified meaningfully closely after the introduction of the campaign (The ACQUIRE Project, 2005).

According to The ACQUIRE Project, (2008) the Ghana vasectomy initiative sought to make available a comprehensive method to addressing the breaches in health care environs by addressing provider biases and the deficiency of availability of services (both supply-side issues) and the low level knowledge about vasectomy, myths and distortion surrounding it (demand side issues). The integrated supply-demand approach centered on a particular number of sites and comprised of these key intervention; strengthening the supply of vasectomy services through training of physicians in no-scalpel vasectomy (NSV), whole site training to create ‘male friendly’ service sites and follow-up training and supervision. The second intervention was to increase the awareness of and demand for vasectomy through community outreach, the
‘Permanent smile’ media campaign oriented to potential clients and instituting of vasectomy telephone hotline.

Comparing figures with the previous year, it was noted that the number of vasectomies increased threefold throughout the first part of the demand strategy in 2004. In 2004, 81 men accepted vasectomies at service sites, compared with 26 in 2003. However, as communications ended in 2004, the number of vasectomy cases fell meaningfully in 2005 and 2006. Then in 2007, concurrent with the additional clinical trainings for new providers, the number of vasectomy cases began to increase again. Once the communications activities commenced, the number of vasectomies more than doubled, increasing from 13 in the latter half of 2007 to 33 in the first half of 2008 (The ACQUIRE Project, 2008).

2.3 Knowledge of Vasectomy as a family planning method

This section seeks to establish from literature what others have discovered with regards to knowledge about vasectomy. Family Planning is a common phenomenon among several societies in the world of which vasectomy is no different. A majority of men and women together know and have heard of family planning. A study by Thapa, (2018) discloses that majority (92.3%) of married women knew about contraception. Similarly, a high level of knowledge of family planning methods is revealed among men in Ogomboslo, southwest Nigeria according to Ogunlaja, Akinola, Aworinde, Ogunlaja, & Bojuwoye, (2017). In spite of their knowledge of the methods, a smaller amount of these men established that, despite their awareness of vasectomy as a technique of contraception, males should be engaged in family planning.

According to USAID, (2008), vasectomy is only popular in a few countries as in countries like Bhutan, Netherlands, New Zealand and United Kingdom, vasectomy is more popular than
female sterilization. Awareness of vasectomy is near to the ground as opposed to awareness of other methods in spite of the high unmet need for family planning. Ninety-eight percent of women and 99% of men in Ghana know of at least one family planning method, however, less than half of women and only three out of five men had heard of vasectomy (GSS, NMIMR & ORC Macro 2004). In Ghana and other parts of the world, research has found that underutilization of vasectomy could be ascribed to four paramount factors, thus: lack of cognizance of vasectomy as a technique for family planning, inadequate and inappropriate information, lack of access to services and provider difference and bias (Pile, 2008).

Inadequate knowledge about the cost of vasectomy is noted to hinder acceptance of vasectomy as a study conducted by Hubert, White, Hopkins, Grossman, & Potter, (2016) to assess the supposed concern of vasectomy among Latina women and their partners revealed that male partners had interest for vasectomy however, they were greatly concerned about the cost of the procedure. The study advocated for counseling and education which will create avenues for interested persons to be enlightened about the method.

It is also revealed in a study by Kısa, Savaş, Zeyneloğlu, & Dönmez, (2017) that vasectomy was common as 39.4% of females and 45.1% of males knew about vasectomy before the survey was conducted. Again, 49.4% of men had no knowledge with regards to whether or not vasectomy was a secure contraceptive technique, females 28.3% and 19.6% males regarded vasectomy as a tough process. In most cases, even in the event that women and men are aware of vasectomy, their information is repeatedly deficient. It is again pertinent to note from a latest study by Iribhobge et al., (2011) that the most prevalent method of contraception among Christian respondents was female contraception as compared to male contraception in Muslim respondents.
In Ghana, a qualitative study done by Adongo et al. (2014) depicted that men and women had heard about the method but had incorrect and incomplete knowledge as respondents mentioned that the basis for their family planning decisions rested on information they received from family members and friends within their society who lacked the expertise to provide them with truthful and comprehensive data for informed choices. In this same study, majority of respondents specified that they had never met or heard of someone who had ever done vasectomy. Again, participants expressed that their knowledge of any vasectomy client could be an encouragement with respect to opting for vasectomy.

Geographical location of individuals is also noted to have influence on knowledge of vasectomy as a study conducted in Dangila, Amhara region northwest of Ethiopia by Temach, Fekadu, & Achamyeleh, (2017) revealed that 75% of married men in the urban centre had ever heard of vasectomy. Basically, the Dangila study was mainly purposed to examine educational status as a factor contributing to men’s knowledge of vasectomy. Undoubtedly, the study reveals that men who were married and had finished secondary education were 4 times more likely to be well-informed about vasectomy as opposed to individuals without any formal training. Cognately, men who had acquired education beyond the secondary level were multiple times bound to be well-educated about vasectomy rather than the individuals who were without formal training. Akpamu, Nwoke, Osifo. Igbinovia & Adisa, (2010) also indicates that poor knowledge of vasectomy affects its acceptance.

It has again been established that, vasectomy is more cost effective (cheaper), quicker and simpler than female sterilization. It offers a more appropriate and effective contraception that men can use instead of or along with condoms and a way to share responsibility for family planning (USAID, 2008). Men and women inclusive wear some iota of fear owing to the fact that
vasectomy is a permanent method as various studies have unveiled several discomforts and strong dislike lodged by respondents.

In Tanzania however, vasectomy clients’ decision circled round the desire to stop pregnancies and births with complications, free their wives from family planning techniques alleged to be capable of harm as well as liberate them from experiencing tubal ligation procedure. One respondent clarified that he was concerned about the wellbeing of his wife as she was already experiencing a deteriorating health state because of child bearing and hence his decision to go in for vasectomy. In this study, half of vasectomy clients precisely expressed their displeasure about a previous birth control technique mainly due to the side effects experienced by their wives. A respondent mentioned that he had to go in for vasectomy because his wife had continuous bleeding as a result of an exposure to a particular family planning method (Bunce et al., 2007).

Undeniably, vasectomy has few complications, however, severe long lasting pains are not common. Among the few problems of the vasectomy procedure are; infections at the incision and hematoma (blood collecting and clotting) in the scrotum (USAID, 2008).

Apparently, in a study by Appiah et al., (2018), respondents opined that vasectomy could lead to prostate cancer. However, over the past two decades, possible physiological impact and long-term sequela of vasectomy has been the issue for broad research and it has been proven that vasectomy has no significant effects on physical and psychological health. Findings of large scale and strategic epidemiological study among men accordantly has demonstrated no unfavorable impact of vasectomy with regards to prostate or testicular malignancy, heart disease, immune multifarious disorder and several others (EngenderHealth, 2002).
2.4 Perceptions of Vasectomy as a Family Planning Method

Several studies have revealed that people carry bad opinions about vasectomy owing to erroneous knowledge and energized by inaccurate suppositions regarding the effects vasectomy has on men (Perry et al., 2016). Researchers have dived into the subject and findings reveal negative attitude towards vasectomy resulting from individual perceptions about the method of which a majority are false. Mahat et al., (2010) expressed that misapprehensions played a major role in men’s refusal to accept vasectomy.

In a study to assess the opinions and attitudes about vasectomy of married couples living in Turkey, Kísa et al., (2017) unveiled that some men perceive vasectomy as a sin and cultural taboo. Respondents also perceived vasectomy to have a negative effect on their marriage as it could affect men’s sexual health negatively. Again, from the same study a 100% of ladies and 35.4% of men believed that vasectomy lowers the position of a man in society. Similar results emerged from a recent study by Asare et al., (2017) to examine vasectomy from the perspective of urban Ghanaian women. Respondents perceived that the masculinity of men could be compromised and hence disapproved vasectomy. Surprisingly, according to Adongo et al., (2014), there is the sensation that undergoing vasectomy would cause men to lose their authority and power over their spouses as referenced in (Perry et al., 2016).

Kísa et al., (2017) again unveils that the greater part of the women believed that birth control decisions are the sole responsibility of women. Findings from this study uncovers that a dominant part of men (88.6%) were not willing to undergo vasectomy. Interestingly, this result corresponds to findings from Akpamu et al., (2010) which showed only 1.6% of male participants who consented to use vasectomy as a method to control births. However more than three fourths of the participants in a research by Mahat et al., (2010) disagreed that contraception
is only the wife’s responsibility. Similarly, in a qualitative study some men and women in Cambodia viewed vasectomy as a path for spouses to partake in FP duties (Perry et al., 2016).

There have been many instances where vasectomy has been likened to castration. According to Bunce et al., (2007), potential vasectomy clients reported rumors that vasectomy was the same as castration and this influenced them to rescind their decision to undergo vasectomy. Interestingly, according to Adongo et al., (2014), respondents feared losing their manhood specifically with the perception that vasectomy is castration. To them, it implied that their spouses may discover sweethearts to fulfill their sexual requests which will eventually lead to a loss of their respect.

According to USAID, (2008) and Perry et al., (2016), a considerable number of men confuse vasectomy with castration with the perception that vasectomy will lead to impotence and worry also that they might not be real men or their wives might be unfaithful. Results from a quantitative study conducted by Otovwe & Okandeji-Barry, (2018) in Nigeria to examine the knowledge and perception of vasectomy among males revealed that a number of men viewed vasectomy as castration. Additionally, qualitative researches conducted by Adongo et al., (2014) and Appiah et al., (2018) unearthed respondents perception of vasectomy as castration. However in castration, there is the removal of the testicles contrary to vasectomy that leaves the testicles whole which does not cease to produce male hormones (USAID, 2008).

Interestingly, it is revealed in Mahat et al., (2010), that a greater portion of participants in that study believed that vasectomy has nothing to do with loss of self-confidence and masculinity yet close to half of the respondents believed that vasectomy makes one weak and impotent. Only 38% were of the view that one can still have an orgasm after vasectomy. A recent study conducted by Engl et al., (2017) among vasectomized men to assess the effect of vasectomy on sexual fulfillment of couples, it was revealed that vasectomy has no negative effect on the sexual
contentment of the affected couple and most importantly, vasectomized men experienced an improvement in sexual satisfaction whiles their respective couples saw no reduction in their satisfaction.

In Asare et al., (2017), some women also perceived that undergoing vasectomy will be a springboard for their partners to become promiscuous which will lead to disrespect on the part of the women and infidelity. Additionally, some participants perceived that their partners will be capable of contracting sexually transmitted diseases after vasectomy when there is sexual intercourse without protection outside marriage. Indeed vasectomy does not prevent against sexually transmitted diseases (STDs) (USAID, 2008). This is coherent with findings from Adongo et al., (2014) as respondents expressed without comfort, the potential impact of vasectomy on the sexual dedication of their partners. Participants saw vasectomy as a certification for men to take part in extramarital affairs since they were not in a good position to impregnate women. Again they believed that the nervousness is capable of leading to marital instability.

Appiah et al., (2018) unequivocally revealed that vasectomy has been made unappealing especially in a low resource setting like Ghana owing to some negative perceptions which has eventually botched the minds of men and the public as a whole. Adongo et al., (2014) concluded that the misconceptions about post vasectomy sexual function, including misunderstandings about the vasectomy procedure in addition to stigma associated with opting for vasectomy accounts for the low uptake of the method.

Contrary to the negative perceptions leveled against vasectomy, it is pertinent to note that vasectomy has no consequence on men’s ability to have sex or their health a whole. In addition,
it is worthy to note that vasectomy does not cause weakness, mental impairments, weight gain, poor vision, general pains and aches (USAID, 2008).

2.5 Reasons for Acceptance

Religion, spousal influence, availability of service, future uncertainties and the surgical procedure all account for reasons that affect an individual’s decision for vasectomy. Specifically, in Muslim countries, religious belief serves as an influence on family planning (Kısa et al., 2017).

Socio-culturally, religion assumes a vital role in the acceptance of vasectomy. According to a study to access knowledge and acceptance of vasectomy as a method of contraception among literate men in Nigeria by Akpamu et al., (2010), not one participant with Islamic belief agreed to any degree of contraceptive use. In spite of the fact that Islam does not forestall the utilization of contraception, some translations continuously seem to clout the utilization of contraception in general (Mahat et al., 2010). In corroboration with this, findings from Adongo et al., (2014) clearly depicts that religion plays a key role in members decision for artificial contraception, even more, the pronounced disapproval of vasectomy. Some respondents in the study believed that vasectomy is a contravention against God which could attract death as a punishment.

In order to see an increase in vasectomy acceptance, Perry et al., (2016) suggested the need to gain the support and public endorsement of religious, community and institutional frontrunners. This, Perry et al., (2016) said had shown to be advantageous in enhancing attitudes towards vasectomy in a number of countries. A typical instance is seen in Tanzania as noted by the ACQUIRE Project, where Seventh Day Adventists were strong advocates of family planning including vasectomy (Bunce et al., 2007).
With respect to spousal influence, Bunce et al., (2007) indicates that both men and women assume a significant role in deciding for vasectomy. In this study it is worthy to note that vasectomy clients chose the method because of concern for their wives especially the desire to stop life threatening pregnancies and births and again to liberate them from contraceptive methods alleged to be possibly damaging. Potential vasectomy clients also expressed disapproval from their wives as a reason for not accepting vasectomy as a result of the desire to have more children and possible instances of infidelity (Bunce et al., 2007). However findings from Adongo et al., (2014) tells that displeasure from wives greatly clouts men’s intent to accept vasectomy or not.

It has been documented that many men and even women have great fear for the unknown future, hence their decision either for or against vasectomy. Bunce et al., (2007) and Adongo et al., (2014) clearly establishes uncertainty about the future as one of the reasons interfering with men’s decision to accept vasectomy. Many participants of this study were concerned about their ability to produce children in the incidence of divorce or child mortality.

Socio economically, the availability of services and trained personnel as well as proper counseling services positively influences the patronage of vasectomy (Perry et al., 2016). According to Bunce et al., (2007), providers availability was a major deciding factor for vasectomy clients. More than quarter of the customers mentioned lack of provider availability as a clarification for having adjourned the technique. Some also expressed difficulty involved in finding the service as some stated that they were not in close proximity to provider centres.

Hubert et al., (2016) in their study also concluded that health communication and affordable vasectomy service were likely to push uptake of vasectomy up among Mexican-origin men after
the study revealed that male partners were willing to get a vasectomy, but had misperceptions regarding the cost and recovery time involved.
CHAPTER THREE

METHODS

3.1 Introduction

This chapter elaborates the techniques and methods employed in this study. It highlights on the study area, population, study design, data collection tools and techniques. In addition, the section gives attention to ethical considerations of the study.

3.2 Study Design

The study employed a qualitative research approach using an exploratory design. Qualitative research is any kind of study that births results devoid of statistical procedures and quantification. It involves the use of naturalistic approach to comprehend phenomena in context-specific settings where the researcher does not try to influence the phenomenon of interest, Patton 2001 (as cited in Golafshani, 2003). A descriptive design was conducted employing a semi-structured interview guide to gather information from participants regarding their perceptions of vasectomy. The motive for choosing this study design was to help obtain in-depth information on the research questions as well as to evaluate respondents’ detailed viewpoints on the issues discussed.

3.3 Study Area

The study area for this research was the Awutu Senya East Municipality in the central region. The Awutu Senya East Municipal Assembly (ASEMA) forms part of the freshly formed Municipalities in the Central Region. The Municipality was carved out of the former Awutu Senya District in 2012 and established as a Municipality by Legislative Instrument (L.I) 2025 with Kasoa as its capital. The rationale was to facilitate government’s decentralization programs
and local governance system. The total population of the municipality stood at 131,543 which is about 4.9% of the Central Region’s population. The people of the municipality are predominantly Guans and speak Awutu, notwithstanding, there is the presence of other settler tribes of different ethnic groups including the Gas, Akans, Ewes, Moshies, Wala/Dagaba, Baseres and other smaller tribes (RGCB, 2018).

Awutu Senya East Municipality is largely urban as records from the 2010 Population and Housing Census indicate that the Municipality has few rural settlements. The Awutu Senya East Municipality is situated in the Eastern part of the Central Region. It has common boundaries with Ga South Municipal Assembly (in the Greater Accra Region) to the East, Awutu Senya District to the North and Gomoa East District to the West and South respectively. The Municipality covers a total land area of about 108.004 sq. km, about 1.1% of the total land area of the Central Region. Kasoa, the Municipal capital, is located at the South-Eastern part about 31 km from Accra, the national capital. The main settlements are Opeikuma, Adam Nana, Kpormertey, Ofaakor, Akweley, Walantu and Zongo (GSS, 2014).

The Municipality has one private hospital, one polyclinic, twenty four (24) Community-Based Health Planning Services (CHPS) zone, four (4) private Maternity homes and twelve (12) private clinics. In addition, all roads linking the major town are tarred except for those linking the rural areas which are un-tarred. Additionally, the municipality has 62.5% of its roads paved whiles 37.5% are unpaved. Records show that most the roads become inaccessible particularly in the wet season eventually disturbing conveyance of farm produce (RGCB, 2018).

On the part of education, the private sector contributes enormously with a total of two hundred and ninety-six (296) kindergarten, two hundred and eighty-five (285) primary schools, two hundred and five (205) junior high schools, eleven (11) private senior high schools and two (2)
There are also twenty (20) kindergarten (KGs), twenty-five (25) primary schools, twenty-four (24) junior high school and one SHS all belonging to the public sector (RGCB, 2018).

Figure 2: Map of Awutu Senya East Municipality
Source: Ghana Statistical Service, GIS
3.4 Data Source

Data for the study was mainly obtained from primary source. Primary data were obtained directly from respondents through the use of a semi-structured interview guide constructed based on themes from existing literature.

3.5 Study Population

The study included married men 18 years and above with two (2) or more children. In an analysis of 10 years of vasectomy programming and research in low resource settings Shattuck et al., (2016) unequivocally stated that vasectomy is not a suitable method of family planning for everyone and discovered from analysis that vasectomy was used among men married men with multiple children and hence the basis for selecting married men with two (2) or more children for the study. As per the 1992 Constitution of Ghana, 18 years and above forms the legal age range for informed consent.

3.6 Sample and Sampling Procedure

The sampling technique adopted for the study was the non-probability method and purposive sampling technique as Creswell, (2014) encourages that participants for a qualitative research should be purposefully selected. Hence participants were selected using purposive sampling. By this, participants were approached, and the objective of the study was explained to them. Introductory letters were shown to participants and upon consenting to participate, they were recruited for the study. It was also emphasized that refusal to participate in the study will not pose any future problems. Two focus group discussions were organized. Each group contained 6 participants. In addition to the focus group discussions, 8 in-depth interviews were also performed.
3.6.1 Inclusion Criteria

The study only included married men 18 years and above with two or more children in the Awutu Senya East Municipality who consented to participate in the study.

3.6.2 Exclusion Criteria

Married men who did not meet the criteria of having two or more children were excluded from the study because according to Shattuck et al., (2016) from review of previous literature, married men with multiple children were the most common vasectomy users. Again, all married men who did not agree to partake in the study were left out.

3.7 Data Collection Tools and Technique

Interview guides were developed and used for the interviews. The guides covered key thematic areas based on existing literature such as knowledge of vasectomy, perceptions built about vasectomy and reasons that affect vasectomy acceptance among married men in the Awutu Senya East Municipality.

Qualitative studies have been conducted in Ghana to assess social factors and perceptions that hinder patronage of vasectomy by Adongo et al., (2014), Asare et al., (2017) and Appiah et al., (2018). In all three studies, focus group discussion was used as a data collection method hence this study replicated the same method. Often times, focus group discussion is used as a qualitative approach to gain in-depth understanding of social issues according to Nyumba, Wilson, Derrick, & Mukherjee, 2018). The meeting presents features defined with respect to the research procedures. Generally, it is characterized by people’s involvement and homogeneity of participants and it is advisable for generating results based on the perceptions of the participants (Freitas, Oliveira, Jenkins, & Popjoy, 1998). Therefore, focus group discussion helped study
participants explain into details their knowledge and perceptions of vasectomy as a family planning method. Aside focus group discussions, the researcher again conducted in-depth interviews also to collect ideas from different respondents on the subject matter. In-depth interview, according to Boyce & Neale, (2006) is a qualitative research technique involved with conducting thorough individual interviews with a small number of respondents to discover their standpoints on a specific idea, program, or situation.

3.8 Data Collection

Data collection was done in one month and the study employed focus group discussion and in-depth interviews for data collection. An interview guide was used to solicit views and responses from participants in order to bring out information regarding the subject matter underpinning the study with the principal investigator leading all discussions. The discussion pattern followed exactly as the questions appeared on the guide. Probing questions were asked in instances where the researcher needed further clarification regarding responses given by participants. Eight (8) in-depth interviews were conducted in addition to two focus group discussions comprising of 6 members each. Field notes were also taken and it helped capture participants’ reactions to the interview, and pertinent observations like the demeanor of the respondent, body language and emotions, that were not captured by the digital recording.

Data collected from these multiple sources makes the data rich and promotes trustworthiness. All interviews were recorded with a digital recorder and notes written down with expressed permission from respondents. The interview guide had main question emanating from the research questions and probing questions to elicit clarification to obtain detailed and accurate information.
Anonymity and confidentiality was ensured by employing pseudonyms instead of actual names of participants which could lead to identification. This was done so that respondents participate in the study without any fear and also to allow participants express themselves well. All interviews lasted between 20-60 minutes in a non-threatening environment where participants will be free to air their views without intimidation. Data saturation was reached when no new information was obtained from any additional participant sampled for the study. One research assistant was employed for data collection whose main task was to take notes. Participants shared their views on their awareness of family planning methods, knowledge of vasectomy, perceptions as well as reasons that may or may not influence them to patronage vasectomy.

3.9 Data Processing and Analysis

All interviews were audiotaped using digital recorders, transcribed verbatim into Microsoft 2013 Word processor by the principal investigator and prepared for data coding. All transcriptions were done in the evening of data collection days. The principal researcher edited transcripts to correct for grammatical errors. A codebook was developed to facilitate data coding processes and this was guided by the objectives, research questions of the study and themes contained in the interview guide. A codebook was generated and contained definitions of major themes and sub-themes taking into consideration the research questions and the objectives of the study which served as a guide in the coding process.

The transcripts were uploaded and coded using QSR Nvivo 12 software for data management and analysis. Each transcript was opened in the Nvivo software and line-by-line reading and coding into nodes of all the statements was done. The coding process involved a critical review of each transcript to identify and code texts into appropriate themes. All themes for the study emerged inductively as they were obtained from existing literature. For the data analysis
technique, thematic content analysis was employed to analyze the data. The process of thematic content analysis means reading through textual data, identifying themes, coding the texts into the themes and then interpreting the content of the themes (Guest, Macquees, & Namey, 2012).

3.10 Establishing Trustworthiness

As indicated by Given & Saumure, (2012), trustworthiness is an essential conception in qualitative research because it gives room for researchers to define the ethics of qualitative terms outside the parameters classically functional in quantitative research. Strategies from Lincoln & Guba, (1985) were used to ensure trustworthiness in this study. The strategies include credibility, transferability, dependability, and confirmability (or neutrality). To achieve credibility, transferability and dependability triangulation was employed, specifically by using focus groups and individual interviews as methods of data collection whiles notes were also taken. Triangulation involves the use of different methods such as observations, focus group discussion and individual interviews for data collection (Shenton, 2004). In Shenton, (2004), it is mentioned that usage of diverse methods compensates for their individual limitations and exploits their respective benefits. To ensure neutrality (confirmability) it is important to note that no personal relationship existed between the researcher and participants of the study.

3.11 Quality Assurance

The study looked at the extent to which the focus group discussion guide provided adequate information to assess the perception of vasectomy as a family planning method among married men.
3.11.1 Training Research Assistants

Prior to the commencement of data collection, a one-day training session was organized for research assistant which aimed at preparing them with the required skills needed for the study. In addition to this, there was a discussion on the purpose of the study, ethical issues, how to take field notes and proper handling of research instruments to avoid damage.

3.11.2 Pre-Testing of Interview Guide

A pre-test of the data collection instruments and methodology of this study was tested in the Ga South municipality of the Greater Accra region of Ghana. Feedback obtained from the activity was used for rewording, reformatting and reordering and of data collection instruments where necessary. Additional probe questions were added to the interview guide after pre-test was conducted. This helped in answering the research question because additional questions enhanced the quality of results obtained. Most importantly, all ethical procedures were duly followed during the pre-test.

3.12 Ethical Consideration

Prior to the inception of data collection, the study proposal was submitted to Ghana Health Service Ethics Review Committee for review and clearance with approval number GHS/ERC 023/04/19. Again, permission was obtained from the Awutu Senya East Municipal Assembly. This helped certify the researcher and assured respondents that the study is solely for academic purposes. Individual consent was obtained from all participants by signing/thumb printing an Informed Consent Form after the objectives and methodology of the study have been explained to them.
Participants were assured that all information provided during the research was going to be treated with strict confidentiality, protected as much as possible and will be purely for research purpose. Again, participants were made to understand that names will not be mentioned in the study and identity of participant will not be taken. Recorded files were stored on a password protected laptop and mailbox to be destroyed after they have been worked with.

The study did not pose any risk to participants as participants were not exposed to any physical dangers. Again, they were made to understand that taking part in the study is voluntary and they can withdraw at their own desired time. Data received from the study was stored solely by the principal investigator and there was no compensation for participants.

3.13 Dissemination of Results

Results from the study were presented in a report and made available to the School of Public Health in the University of Ghana, Legon. The researcher also plans to use findings to write manuscripts for publication in academic journals.
CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of data collected from the study site- Awutu Senya East Municipality. The main aim of the study was to explore the perceptions of vasectomy as a family planning method among married men in the Awutu Senya East Municipality. The result is offered along the study objectives and the conceptual framework used to guide the research. Specifically the results are presented on the socio-demographic characteristics of respondents, knowledge on family planning methods including vasectomy, perceptions of vasectomy as a family planning method and reasons surrounding its patronage.

The chapter entails a qualitative description of results. Two focus group discussions were conducted and in order to ensure validity, triangulation was used as the researcher went further to purposively conduct in-depth interviews. All names employed in the study are pseudonyms and as such any connection to actual persons is only coincidental.

4.2 Socio Demographic Characteristics of Participants

The study recruited 12 participants for two focus group discussions, 6 in each group and 8 individuals for in-depth interviews. All respondents were married and had 2 children which represented the least and 8 children representing the highest among respondents. 6 participants were within ages 30 to 39, 6 fell within ages 40 to 49, 5 within 50 to 59 age range whiles 2 were within 20-29 and 1 above 60 years. Among the respondents, 4 were Muslims, 10 were Christians, 1 was a traditionalist while the remaining 5 said they didn’t belong to any religion as they all held diverse occupational backgrounds. Regarding their educational background, 3 of the
participants had no education, 6 had primary education, 8 fell in the MSLC/JSS whiles 2 had secondary education and 1 with tertiary education.
<table>
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<th>Age</th>
<th>Religion</th>
<th>Number of Children</th>
<th>Occupation</th>
<th>Educational Level</th>
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Table 1: Socio demographic characteristics of participants
4.3 Knowledge on Family Planning

The study commenced with an exploration of respondents knowledge of family planning as a whole. Participants were asked to explain how they understood family planning. Respondents from both FGDs explained how they understood family planning and a common theme that emerged from their responses was spacing. Below are some quotes from Nanaba and Kwodwo (pseudonyms), participants from both FGDs depicting their understanding of family planning.

“So what I know about family planning is that it helps so that the children are spaced in order for parents to cater for them properly” (58 years FGD 1)

“It is something used for protection with regards to birth so that an individual is able to space his children and give birth to a number that he can easily cater for” (53 years FGD2)

Similar to responses from the FGDs, Killy and Nana (pseudonyms) who were employed for individual interviews also shared like understanding with regards to family planning. Below are some excerpts;

“Eeerrrm, what I know about family planning is that, couples decide the number of children they want to have and they use some methods to enable them space child birth which will help them cater for the children properly” (50 years IDI 1)

“Eeerrrm what I know about family planning is that it has to do with spacing your children so that it won’t happen that you give birth to children more than what you want beyond your capacity” (40 years IDI 5)

Moving on, participants mentioned financial leverage, improving health status of women and children as some advantages of family planning. They explained that practicing family planning will help couples control births which will enable them to provide adequately for the few they
are able to bring. Also it was mentioned that giving birth to many children make some women look older than their age and so it is important that family planning is practiced in order to allow the woman to recuperate.

The responses from IDIs were similar to those of the FGDs and excerpts of these responses are represented respectively;

“...Very good. It is good to space children, at least 3 years because within 3 years, not only that the woman would have been back to her original physical strength but emotionally, the first child would be in proper position to be able to ( ). In fact the spacing helps a lot. Again when a woman gives birth to more children within the ages of 40 to 45, the woman starts looking as if she is 50, then the kind of affection and the kind of love that exist between them (the couple), if it was first based on physical appearance, it starts to diminish so it is important” (52 years IDI 2)

“... When the spacing of the children is so close, the man especially suffers a huge financial burden. So when the children are well spaced it helps. It is a very good idea. Some women experience complications after each delivery and so as a man, knowing the condition of your wife you can allow for ample time between the first and subsequent births so that the woman can well recuperate” (53 years FGD2)

It was enquired from participants to mention some family planning methods they knew. Participants were familiar with the pill as some mentioned secure and Postinor 2. Secure was the most common contraceptive pill that respondents knew. Again, implants, injectables, IUDs, condoms and vasectomy were mentioned. All participants in the study both from FGDs and IDIs knew about one method of contraception. Although some participants from both the FGDs and IDIs were not able to mention the names of some methods, they were able to describe them and the researcher per description given by participant found the names of such methods from existing literature.
“There is also another method which I think is the safest. With that method, the man pulls out the penis to release sperms outside the woman and penetrates afterwards” (66 years FGD2)

“Ooooohhhh I can mention about two... I know of postinor 2 and secure. There are other methods but these are all I can mention” (38 years IDI 4)

“I know the one that is inserted in the (participant pointing to the upper arm). And I know another one that is placed in the womb...Yes the permanent one is the men’s method called vasectomy through which the men are castrated” (50 years IDI 1)

Participants also mentioned some side effects linked with practicing some family planning methods. Some mentioned bleeding, dizziness, menstrual disorders and condom breakage. In the IDIs, participants mentioned some side effects which confirmed what had earlier been mentioned in the FGDs

“The condoms tear” (32 years FGD1)

“For instance condoms. Condom is rubber and depending on the ( ) that is taking place at that time there is the possibility for condom to leak. Some condoms are inferior, some are not fragile enough so there is the possibility that they will leak” (52 years IDI 2)

“Some of the women also complain of their heart” (39 years FGD2)

“It has side effects especially on women in a sense that, me my wife went in for the injection and she used to bleed every two weeks and she used to complain of her heart so we went to remove it and tried the injection and that was good for her” (40 years IDI 5)

4.4 Knowledge on Vasectomy as a Family Planning Method

For both FGDs, discussants did not have knowledge on vasectomy. This was affirmed by some responses from IDIs.
“Ooooh no ooo…I don’t know anything like that neither have I heard” (42 years FGD2)

I haven’t heard it before (58 years IDI 4)

Contrary to above findings, earlier responses from some IDI revealed that some participants knew about vasectomy, these are some responses they gave with regards to how it is done and some advantages. Respondents who knew about vasectomy described it as a permanent method that prevents sperms from travelling by intercepting the tubes that carry the sperms. Below are excerpts from Killy and Yaya.

“...And there is this other one for men called vasectomy through which the men are castrated...It’s the name I have heard and what I know about it is that it has to do with men being castrated. So the man can erect and have sex alright only that the tubes carrying the sperms will be blocked and the man can never give birth again…” (50 years IDI 1).

“Vasectomy is the process whereby the tube that transport the sperm is cut and tied so that there will be no release of sperms at all and when that place has been cut and sealed then there will be no production of sperm at all” (52 years IDI 2)

Again they mentioned that the only advantage of vasectomy is that it will prevent the release of sperms which will eventually inhibit the man from having children.

“The only advantage I know is that sperms will not be released” (52 years IDI 2)

“My friend told me it will save him any more children since he already has 7” (38 years IDI 3)

Interestingly, participants opined that vasectomy has many disadvantages despite its merits of preventing a man to have more children. Both FGDs and IDIs revealed some disadvantages about the method. The views of participants are expressed in the statement below;
“Hw333 (A local way of exclaiming) ... What is the advantage about vasectomy? What happens in the event that a man wants to give birth again? Supposing the man gets more money in future and decides to give birth again he cannot because his balls have been removed. There is no advantage about the method” (50 years IDI 5)

“Yeah, the disadvantage I see is that the person will no longer be acting as a human being because I don’t know and I have never been to the hospital to know the real side effect but what I mentioned is just what I think is a disadvantage about the method” (52 years IDI 4)

Apparently the cost of vasectomy was not known by respondents. Additionally it was revealed that participants were not interested in knowing the cost of the method because vasectomy was never going to be an option for them.

“Oh no. I only knew the person from afar so I didn’t even ask question about it. I don’t know how much it cost. I won’t even go near to ask of the price. What profit will it be to me if I should go to a hospital to ask of the cost of vasectomy? What if I get there and they inject me with something and end up castrating me. What will I do? So there is no point getting to know the cost involved because I am simply not interested (Laughs)” (50 years IDI 1)

4.5 Perceptions of Vasectomy as a Family Planning Method

Customarily, perceptions are founded on an individual’s knowledge and beliefs about a phenomenon regardless of the person’s background and location. Participants’ inadequate knowledge about the method revealed some misconception although there were some positive perceptions too.
The researcher sought to know participants views about vasectomy and the masculinity of a man. Interestingly, some participant expressed that vasectomy changes the masculinity of a man whereas others were of the opinion that it does not change anything. Other participants from FGDs also expressed that lack of knowledge in that regard.

“No it doesn’t change it... He is still a man and the man of the house” (52 years IDI 2)

“Ooooh I don’t know anything like that” (42 years FGD2)

Contrary to their statements, another participant revealed that vasectomy changes the masculinity of a man as he expressed,

“Yes it does...Of course...Why won’t you be reduced as a man when one of your balls has been removed and a tube has been cut? It will to some extent” (50 years IDI 1)

About sexually transmitted diseases, participants who knew about vasectomy indicated that vasectomy does not prevent sexually transmitted diseases. This is how they explained it;

“Vasectomy cannot prevent it because not all sexually related acts are connected to sperm production, like for instance if you look at gonorrhea, gonorrhea has nothing to do with sperm because it is a sexual process. Syphilis does not have anything to do with that (vasectomy) so vasectomy is only about how to prevent the flow of sperms so if there is going to be a problem in that direction it has to do with the production, movement and transport of sperms but it is different from sexually transmitted diseases” (tertiary educated, 52 years IDI 2)

“No no no. Not at all... It is only condoms that can be used to prevent sexually transmitted diseases. Even that one it’s a 50-50 affair because it can tear” (50 years IDI 1)
The researcher subsequently sought to know from participants how they perceived vasectomy and castration. Some responses from IDIs revealed participants perception of vasectomy as castration contrary to those from FGDs

“It might cause impotence...” (42 years FGD2)

“It’s true... The only thing is that in vasectomy you haven’t removed the balls but you have still prevented sperms from flowing...” (52 years IDI 2)

In his quest to explain what he said, the respondent narrated:

“Castration is the complete removal of the balls but this one (vasectomy) you didn’t allow the testicles to work so it’s more or less the same thing. I’m not saying it is 100% true but they are similar, even though this one will be able to perform... So if you subject a castrated animal to test and you give the same test to a human being or man that has undergone vasectomy, they are likely to experience the same psychological problem because something has been impaired in their reproductive organ... This one (castration) has been impeded not to work and this one (vasectomy) has been asked to work partially. So they have something in common and that is the reason why a man who has undergone vasectomy tends to look bulky and muscular and tend to look intimidating” (52 years IDI 2).

It was revealed that sexual performance is nowhere affected by vasectomy. Some respondents even went ahead to state that men can still erect and have sex enjoyably like they used to before vasectomy. These results were similar in both FGDs and IDIs as respondents shared related views. One respondent described:

“The family planning will weakness our penile strength” (32 years FGD 1)
In our local culture as Ghanaians, a man is not ceased from birth. Personally I enjoy sex so much so if I opt for this method it will really be a worry to me. I will not be able to perform as I use to” (66 years FGD 2)

“Oh yeah... That one is true. So the man can erect and have sex alright only that the tubes carrying the sperms will be blocked and the man can never give birth again” (50 years IDI 1)

4.6 Reasons for Acceptance of Vasectomy

While other methods of family planning have been understood and been used by men, some also remain unattractive to men, thus vasectomy. Religious explanations, spousal influence surgical procedure and future uncertainty as well as availability of services and availability of counseling have been leveled as reasons for which vasectomy has a low patronage. Views of participants in this study were sought first from their religious perspectives.

Religious stance on family planning was sought from participants’ religion and the Christians were of the view that Christianity speaks against family planning, however they explained that having Christianity speak against family planning is not enough reason to be giving birth to children who will not be properly taken care of. Findings from FGDs corresponded with those of the IDIs. This is how they put it:

“God will punish us. It is a sin. Why should you destroy what God has created?”(39 years FGD 2)

Christianity teaches that family planning is not good. This is because the bible says that we should reproduce, multiply and fill the earth like the sand of the sea shore. This was highly applicable in the early days but now, madam, we can’t go that way. Family
planning is not good though but considering the way things are going now (laughs)... No one will tell you to reduce the number of children you have” (38 years IDI 3)

Another Christian also puts it differently but similar in meaning.

“...yes the bible says we should give birth and multiply on earth (50 years IDI 1)

Although both Christians mentioned that the bible speaks against family planning, they were of the view that Christians are also taught to be wise in their dealings and therefore should be able to bring forth children they can cater for.

“...but that doesn’t mean an individual should bring forth children he can’t cater for...So at some point the bible also mentions how children should be well catered for so if you can’t cater for the children there is no need producing them. Besides the bible says that God has given us wisdom and the ability to make choices as well as decisions. There are ways that a man can use to prevent his wife from becoming pregnant other than these family planning methods. You know it’s not every day that a man should go near his wife sexually. So as a man it will be better to stay away from your wife when you know that if you go near her in a particular time of the month she will conceive. You can do whatever you please when she is in her safe period” (50 years IDI 1)

From the Muslim perspective, this is what was narrated;

According to Islam a woman should breastfeed a baby completely for two years before she conceives another one. Before she starts to prepare for another one the first one must suck the breast for two good years. It is after you wean the baby that is when you start to plan to have another one. So in Islam an average Muslim must has an average gap of three years between children, generally that is how Islam has put it. Secondly Islam supports anything that will bring about the welfare of the family and that of the spouse.
Whatever we can do that will not harm the wife, that will not harm the husband and that will not color the religion, Islam doesn’t forbid that” (52 years IDI 4)

In finding whether religion controls and influence participants acceptance of family planning, this is how they expressed it.

“Oh yeah, because it is written nowhere in the bible that a man should go and cut some parts of his body because his doesn’t want to give birth so I will never do it” (66 years FGD2)

“Actually Islam talks about operations when somebody is sick there are some herbs. If the treatment has to do with herbs treat it… if there is a way to remove that thing to save that person’s life there is no problem” (52 years IDI 2).

He subsequently added by saying that:

...But vasectomy itself, if it is meant to promote something good in that person and that environment, Islam does not frown at anything that is good... Islam does not oppose that as long as the intention is correct and there is no side effect that will not have immediate solution. If vasectomy is done in such a way that at the end of the day people will suffer from it then it is not good because whatever you provide as alternative must have lasting effects that will not have any side effects so as long as that thing will bring another side effect, Islam will tell you, No...that one is not good again...

He further explained as he stated:

“So it may not be a general directive from God that don’t do vasectomy, it could be good for the use of it but where there is alternative to that one it would be better to go for that alternative which would be much more fairer than this one but if there is no other alternative, then you can take this one (vasectomy)” (52 years IDI 2)

Regarding the influence of religion in terms of choosing a family planning method, specifically vasectomy. Respondents narrated
“Personally I will no opt for family planning. Christianity will not force you to do family planning. Christianity allows for individuals to decide by their own choice. It doesn’t force” (50 years IDI 1)

“God will punish us. It is a sin. Why should you destroy what God has created?” (66 years FGD 2)

“My religion to me, from the way I hold my religion, because religion is about how you understand it and how you practice it. Different people are on different levels when it comes to religion... For me, by my religion I do not choose any family planning method but your religion may not forbid it. There are certain things that religion does not forbid but because of the level at which you have reached in your religion you may not want to indulge in it. You understand the situation... But it is not wrong to do it” (52 years IDI 2)

Participants were asked whether their spouses could influence them to get a vasectomy and this was what ensued as all respondents answered negatively. This is however contrary to findings from FGDs as participants had a different standpoint:

“Madam, if we do family planning the penis will never stand, it will always face downwards” (29 years FGD 1)

“If there is any method for men then I would do it but before that there should be elaborate education to know the side effects that accompany such methods before we decide to get it done. I don’t have a problem with my wife telling me to opt for a family planning method but the problem is that immediately I get family planning done I am not going to erect again. The penis will be looking like a head that is bowed. Even when a woman lies naked, the man will not be aroused” (37 years FGD 1)

“I will not” (52 years IDI 2)

In an attempt to explain himself, he recounted:
“I will tell her I want to remain the way I have been created by God... I won’t worry you much. I am not the kind of man that worries a woman with sex. I don’t worry my woman too much... a person who is religious can always tell you that there is no need for vasectomy” (52 years IDI 2)

The researcher probed further to know from the respondent whether he would opt for vasectomy to help her in the event that his wife complains of getting tired of female methods. Apparently the participant stated he would go in for the natural method by observing his wife’s menstrual cycle and knowing her free periods.

In an elaborate manner he narrated:

“I will not (Shakes his head) It all boils down to trust. If you trust me. You know I can do what is right (smiles gently) without producing children (Nods head and smiles) When you tell me “It doesn’t look like I am in my free period, I will opt out... I am not the type of man that forces a woman with sex, if it is twice in a month or three times in a month, we are for each other and that’s why if she tells me (to opt for vasectomy) I will tell her she is the one even creating trouble and problem in the family” (52 years IDI, 2)

In a sharp tone another respondent stated:

“Who should go and do? Me or her... I won’t do it” (50 years IDI 1)

Respondents also were mentioned that vasectomy was a surgical procedure as they explained it differently.

“Yeaaahh it is still surgical (squeezes face a little) Aaaaa there is no way without bringing the sperm duct out of a human being without at least pinching something (laughs)… Even the pinching is still surgical the only thing you are talking about is the degree of the surgery. There are some higher degrees of surgical procedures” (52 years IDI 2)
He further explained:

“\textit{I remember sometime back when I was having this eeerrrrmmmm, what do we call it, appendicitis I was not given any surgical operation and since then I have never heard it. I was only given a pill and the pill went down there and sealed the whole thing, that one is not surgical but if you say you want to remove something from my something (laughs) and say you will draw something out it is still surgical. It is still surgical as long as a hole is drilled and small blood comes out... It is still surgical because you are removing something g or correcting something inside by opening something, that one is surgical}” (52 years IDI 2)

Contrary to this opinion, another participant was of the view that it is not a surgery. Below is how he stated it:

“\textit{No it is not a surgery. They only look for the tube, press it and that ends it}” (50 years IDI 1)

Focus was then shifted to the availability of vasectomy services in terms of where they are offered, their location and the need for counselling services as well as elaborate education. One participant was able to give directions to a facility he knew vasectomy was offered. Findings of IDs were similar to those of FGDs. Again, it was revealed that vasectomy was offered in hospitals. As to whether the facilities can be easily located, another participant mentioned geographical location as a possible barrier to accessing services as he mentioned that individuals in urban areas are more likely to have easy access to these centres and services than those in rural areas. Participants from both FGDs and IDIs stated that counseling services are important as they would educate people about vasectomy, its advantages as well as side effects. The various responses given by participants are exemplified below.
“It can be done in the hospital since the women do theirs in the hospitals” (41 years FGD1)

“Per my knowledge, not every hospital performs vasectomy. I knew one hospital in Accra. I know they specifically handle something that has to do with family planning” (50 years IDI 1)

“In the hospital... In some clinics... In some medical laboratories... In some health center... so it can be done anywhere But it is always much safer to do it in a hospital or a medical institution or proper hospital where the necessary precautions will be taken” (52 years IDI 2)

Then the question was asked about how easily these centers are located and this is what respondents had to say;

“I don’t know” (32 years FGD 1)

“eeerrrrmmmm depending on the area where one is living. People who live in urban areas are closer to those facilities but people who live in rural areas are not close to it so it tells you... it is easy to say therefore that, that is one of the reasons why rural folks produce more children because they don’t have these facilities” (52 years IDI 2)

(Laughs) “I don’t really care to know about something I don’t plan ever doing” (50 years IDI 1)

As to whether counseling services should be provided, participants answered in the affirmative by stating the following:

“Yes...because (long pause) the reason is that counseling offers information that will be beneficial and necessary on things that can lead to effects and defects. So it is not an appeal section or a situation where you are going to make a verdict but it is where
information is supplied so that the individual takes his own decision. So it is all about giving information. It’s part of knowledge. Supply the knowledge to the person let the person take his own decision about it. So counseling on vasectomy is very important not because we want to lure people to be doing it or to tell people to depart from it but it is part of the knowledge that the society need to know so that ( ) We are all human beings, so that if you want to take decision about it you take. Whether it is good or not good is not the function of the counselor. The counselor only has to teach how it is done and the side effects if any, the benefits and all that concerns it” (52 years IDI 2)

Well, they will only be doing their jobs but what I have decided I will never do is final. It wouldn’t even occur to me to opt for vasectomy” (50 years IDI 5)

The researcher probed further to know from participants whether vasectomy will be an option after receiving elaborate education. Views of participants from FGDs were different as compared to those from the IDIs although there were some similarities. As to whether they will accept vasectomy upon elaborate education, these were some responses:

“I will do it only if the education is sound to me” (33 years FGD 1)

“I will not” (Laughs out very loud) I will not because I don’t see myself as a useless human being. I may not engage in sex but I should live as someone who has emotions (52 years IDI 2)

He further explained his initial statement as he said:

“...No oooo. It is as if now I want to be doing what I like. You may be tempted to start sleeping with another person’s wife. You might be promiscuous because now you have given me the liberty to go and be doing all things because it ( ) as long as there is no pregnancy and I can be enjoying myself then my wife alone will be not enough for me at
that time because this time round it’s just for free. not only that, a person who is religious can always tell you that there is no need for vasectomy because one of the only ways that you can run away from it is that, if you are truthful to yourself and honest to the services of your God, your restrictions are enough to prevent you from being promiscuous without undergoing vasectomy” (52 years IDI 4)

No please … I will not... even if I will, I would have to think through very well before I make a decision (38 years IDI 3)

Participants also shared some others substances used for family planning aside the accepted contraceptive methods. Participants from both FGDs and IDIs shared similar ideas in this regard.

“I have a girlfriend and any time I am done “shooting” her (laughs) she takes paracetamol the next day and that will be the end. No need to think of pregnancy. The paracetamol takes care of it” (32 years FGD 1)

“For some women when they experience improper flow of blood during menstruation they buy fanta (soft drink) and add large amount of sugar which propels blood to flow in large quantities so some of them use the same method when they want to do away with an unwanted pregnancy after sexual intercourse without protection” (33 years FGD 1)

“Some of the women also take Guiness (an alcoholic drink). When she does that before sexual intercourse, she will not get pregnant” (29 years FGD 1)

“Ooooo a lot... a lot. My in-law is a herbalist and he has herbs molded in a round shape like palmnut, black in colour. If you swallow two of that, you won’t give birth for two years and it works... Again for this it’s the women who take it” (Laughter) (40 years IDI 3)

“I have heard that before. One Doctor was invited for a radio show and he explained that he had drug which is used by the female prior to sexual intercourse. So the woman
rubs the medicine on her navel and she will be safe from pregnancy. He said that the
drug can work for three days after initial application" (male, 50 years IDI 1)
CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter presents the findings of the study in comparison with literature and the research objectives. Again, this section makes reference to the conceptual framework presented in the first chapter of this work to explain the findings of the research. Vasectomy remains the less patronized method of contraception with a user proportion of about 10% worldwide even though it is the safest, simplest and most definitive form of birth control (Engl et al., 2017). Poor knowledge as mentioned by Appiah et al., (2018), misconceptions (Hubert et al., 2016), and many religious factors as revealed by Kısa et al., (2017) and Adongo et al., (2014) have accounted for the low patronage of vasectomy.

Using focus group discussions and in-depth interviews, the research aimed at exploring the perception of vasectomy as a family planning method among married men in the Awutu Senya East Municipality by investigating the knowledge of married men on vasectomy, the perceptions they have conceived about the method and some reasons that affect acceptance of vasectomy as a family planning method. Twelve (12) married men were engaged in two focus group discussions whiles 8 married men were employed for in-depth interviews.

5.2 Knowledge on Family Planning

All participants in the study had some awareness about the concept of family planning and subsequently went forward to mention some modern and traditional family planning methods used in Ghana, both temporary and permanent as well as those for men and women. This corroborates with findings from the GSS, GHS & ICF, (2014) which reported an 8.2 average of
men’s knowledge of contraceptive methods. Some family planning methods mentioned by participant were the pills (secure and postinor 2), injectables, implants, condoms, withdrawal, vasectomy (not very common among participants), the diaphragm and IUDs.

Respondents also mentioned spacing and positive health outcomes as an advantage of family planning and this corresponds with results of Kavanaugh & Anderson, (2013). However the study also revealed that men had fears about complications associated with modern contraceptive methods, similar to the findings of Thummalachetty et al., (2017) as some declared that usage among women usually causes bleeding and cardiovascular diseases.

5.3 Knowledge on Vasectomy as a Family Planning Method

The study revealed a poor knowledge of vasectomy as majority of respondents did not have enough awareness with regards to vasectomy. This is similar to the findings of Bunce et al., (2007) who conducted a study in Tanzania to investigate factors affecting the acceptability of vasectomy. In the study, poor vasectomy knowledge and understanding was revealed as a factor. In this study, participant who had ever heard of vasectomy added also that vasectomy is a permanent method and they expressed some future uncertainties. These findings are confirmed by that of Shih, Dubé, Sheinbein, Borrero, & Dehlendorf, (2013).

The conceptual framework of shown in chapter 1 of this study projected that socio-demographic characteristics like educational level of participants would influence knowledge of vasectomy in terms of it benefits, cost, irreversibility and future uncertainties. In this study, 3 participants knew about vasectomy. Only one of them had a tertiary level education, this corroborates with results of Temach et al., (2017). In that study it was reported that men who had completed tertiary education were more likely to be well-informed about vasectomy compared to individual who did not have any formal education. Reports from same research on another hand is again
contrary to that of Temach et al., (2017) as findings from this study reveals that, the other respondents who knew about vasectomy all had education up to JSS level. Again, by the conceptual framework guiding this study, the researcher envisioned that knowledge about vasectomy would affect its acceptance. Responses regarding knowledge as given by participants are a clear indication that vasectomy would be less patronized. Majority of participants interviewed in the study did not have ample knowledge about vasectomy such as no knowledge of the cost of vasectomy, knowledge of vasectomy as castration and future uncertainties expressed revealed poor knowledge surrounding the method. This is validated by findings of Appiah et al., (2018) where it was revealed that inadequate knowledge, future uncertainties and the irreversible nature of vasectomy are all factors that account for low patronage of vasectomy. Other works conducted in India and Nigeria have also recounted low knowledge on vasectomy which affects its acceptance as a method of contraception (Mahapatra, Narula, Kalita, Thakur, & Mehra, 2014; Onasoga, Edoni, & Ekanem, 2013).

5.4 Perception of Vasectomy as a Family Planning Method

Several misconceptions have been revealed by a number of studies including that of Appiah et al., (2018) and Adongo et al., (2014). Findings of the study indicated that people had inadequate knowledge which led to the formation of both positive and negative perceptions. This study brought to light some negative perceptions leveled against vasectomy although participants had some positive perceptions as well. Participants who knew about vasectomy in this study expressed that it was the same as castration whiles others had no idea. One of them explained that since castration is the only method performed so that animals are not able to reproduce again then vasectomy is also the same as castration since the man will not be able to give birth again. The above findings were similar to findings from research works conducted by the following
authors (Appiah et al., 2018); (Kısa et al., 2017); (Shattuck et al., 2016); (Adongo et al., 2014) and (Mahat et al., 2010).

Respondents who knew about vasectomy had a positive perception as they expressed that vasectomy does not prevent sexually transmitted diseases. One of them explained that sexually transmitted diseases come about as a result of sexual intercourse and has nothing to do with the production and release of sperms. This research supports findings of USAID, (2008) that makes mention of the fact that vasectomy does not prevent sexually transmitted diseases.

Participants were also asked whether they perceived vasectomy as a method that reduces the masculinity of a man. Similar to the results of USAID, (2008), some participants expressed that vasectomy does not in any way change the masculinity of a man. It is however contrary to findings of Kısa et al., (2017) which revealed participants perception that vasectomy reduces the masculinity of a man although this research had participants who believed that vasectomy reduces who a man is.

Similar to findings of Engl et al., (2017) which revealed that vasectomy has no influence on the sexual contentment of the affected couples, participants in this study also expressed that vasectomy has got nothing to do with sexual performance as they expressed that an individual can erect, have sex and enjoy it alright like he used to do before getting a vasectomy.

5.5 Reasons for Acceptance

Findings from Bunce et al., (2007) suggested that religion impeded the use of vasectomy. Similarly in this study, the Christians were of the view that family planning is not accepted by God and that family planning should not be an option for Christians. This corroborates with the outcomes of Adongo et al., (2014) and (Appiah et al., 2018) although the Christians in this study believe that God does not force Christians but has rather given them the choice. Contrary to the
findings of Kísa et al., (2017), the Muslims in this study were of the view that their religion supports spacing of children as one respondent expressed that there are sections in the Quran where couples are expected to allow some space between the first child and the second.

This study also brought to light participants’ interest in counseling services. One participant expressed that organizing counseling session will contribute to the knowledge base of vasectomy as people will get to know more about the method, its advantages and disadvantages. This is similar to findings of Ochako, Temmerman, Mbondo, & Askew, (2017) as they reported that provider-client collaboration as well as distribution of information through mass media is likely to escalate knowledge and acceptance of modern-day contraceptives.

One participant who knew about vasectomy in this study also expressed that vasectomy is a surgical procedure and had fears about the method. This validates results from Adongo et al., (2014) which suggest that people have fears about the procedure of vasectomy and carried some future uncertainties about the method. Similar to finding of Zini et al., (2016), one however mentioned that vasectomy is not so much of a surgical procedure as it involves only holding and clipping of the tubes to prevent the flow of sperms.

Findings from Ochako et al., (2017) demonstrates that counseling services will improve knowledge on vasectomy. This corroborates with findings from this study as participants were of the view that counseling services will be a source of information and knowledge. Undeniably when knowledge is improved, perceptions will be positively affected to some extent. USAID, (2008) advocates that the presence of good counseling services can raise awareness of vasectomy.
The study again revealed some alternative means and methods of contraception outside what is clinically known and accepted as well as some local analgesics. Participants mentioned the use of paracetamol and APC (analgesics) as their alternative method of contraception. This is validated by findings of Adongo et al., (2014) as it was revealed that cafalgin and panacin which are locally produced analgesics were alleged to have contraceptive abilities and as a result used by men as a substitute to modern contraceptive approaches. Other participants also mentioned the use of herbs as an alternative to modern contraceptive methods. This is validated by findings of Bala, Arya, & Katare, (2014) as it is revealed from their study that several herbs have been verified for their contraceptive activity and they have been found eco-friendly.

5.6 Limitation of the study

The researcher admits that the number of participants sampled for the study could have been increased to receive new ideas from new participants. This however does not affect results presented in this study as data saturation was reached. The researcher was not able to acquire a suitable location for focus group discussions, however this does not in any way impact the worth and reliability of data obtained.
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter provides a summary of findings as revealed by the study and presents conclusions of the results based on the findings. Again, it provides recommendations to appropriate authorities and stakeholders on how to improve knowledge on vasectomy and eventually clear the misconceptions surrounding the method so as to boost patronage.

6.2 Key Findings

1. All respondents were able to explain the concept of family planning and mentioned at least one method.
2. Few of the respondents knew about vasectomy and could describe what it is and how it is done.
3. Respondents had fear about the procedure and were uncertain about the future.
4. Vasectomy is perceived as castration, seen to reduce a man’s masculinity and sexual performance by majority of the respondents.
5. Religious factors were also revealed as reasons for non-acceptance of family planning methods including vasectomy.
6. Locations of vasectomy services were not common to majority of participants however, some respondent mentioned where the services can be found.
6.3 Conclusions

The main aim of the study was to explore the perceptions of vasectomy as a family planning method among married men in the Awutu Senya East Municipality. Specifically, the study sought to explore married men’s knowledge on family planning, the knowledge married men had about vasectomy as a family planning method, explore their perceptions about the method as well as determine the reasons for which they would accept to use vasectomy.

Knowledge of the concept of family planning was high as all participants were able to explain to the researcher, their understanding of family planning and went ahead to mention the family planning methods they knew as well as some side effects. Knowledge of vasectomy was however low as some participants mentioned that they had never heard about the method whiles others had heard about it. For participants who had heard about the method, knowledge was still low as they had no idea about the cost, benefits and procedure of vasectomy.

The study again revealed some wrong perceptions about vasectomy although some positive perceptions were unearthed. Some respondents were of the idea that vasectomy is the same as castration whiles others perceived that the method reduces sexual performance and masculinity in men. Respondents mentioned that vasectomy cannot prevent sexually transmitted diseases.

Religion, spousal influence and the surgical procedure were seen to have great influence on participants’ acceptance and perceptions about the method. Participants advocated for counseling services but were not ready to accept and patronize the method.
The researcher therefore concludes that there is no enough knowledge on vasectomy with respect to its cost, benefits and procedure. Scanty and wrong knowledge leads to erroneous perceptions against vasectomy which then affects its acceptance and patronage.

6.4 Recommendations

The following recommendations are proposed based on the findings of the study to help clear the various misconceptions about vasectomy and to increase patronage.

1. There is the need for health services providers to make available adequate and understandable information on vasectomy.
2. The study also recommends that discussions are organized with policy makers and advocacy groups to ensure the spread of the benefits of vasectomy.
3. Channels of communication such as social media platforms and the media should be used as avenues to spread vasectomy. This should be done by persons or institutions like the MoH who have adequate knowledge about the method.
4. Counseling services should be strengthened to specifically target and educate married men regarding the safety and merits of vasectomy.

6.4.1 Recommendations for further research

1. Quantitative studies are required to measure the level of knowledge on vasectomy among married men.
2. Research could be conducted among religious leaders to elicit their stance on family planning and religion which when done could increase patronage of family planning methods, especially vasectomy.
REFERENCES


**ResearchGate Education for Information.** 22(2), 63–75.


APPENDICES
SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

Appendix A: Participant’s Information Sheet

STUDY TITLE: Perception of vasectomy as a family planning method among married men in the Awutu Senya East Municipality

INTRODUCTION: I am Felicia Dede Tetteh, a student at the University of Ghana, School of Public Health offering a Master’s degree in Public Health. I am conducting a research on the topic “Perceptions of vasectomy as a family planning method among married men in the Awutu Senya East Municipality in partial fulfillment of the award of a Master’s Degree. My contact details are as follows;

Mobile: 0272031039/0552388090

E-mail: fdtetteh001@st.ug.edu.gh

Location: University of Ghana Campus

BACKGROUND OF RESEARCH: Several studies have revealed the essence of family planning especially with emphasis regarding its role to achieving development. Family planning methods have been noted to prevent unwanted pregnancies and prevent maternal and child
mortality, however, records emanating from Sub-Saharan Africa indicates a low usage of contraceptives especially vasectomy although there is a high unmet need for family planning.

**PURPOSE OF RESEARCH:** The study will unearth the various perceptions men have about vasectomy which accounts for its low patronage. It would help policy makers to come up with strategies to involve men in family planning by introducing alternative methods.

**NATURE OF RESEARCH:** The research is a qualitative one and would involve taking part a focus group discussion which will be recorded. The questions involved will be geared towards revealing perceptions surrounding the uptake of vasectomy as a family planning method.

**PARTICIPANTS INVOLVEMENT:** You are being invited to participate in this study to aid the team find answers concerning perceptions of vasectomy. If you agree to participate in the discussion, you will be required to sign a consent form. Discussions are expected to last between 1-2 hours. Participants will be expected to share their perceptions of vasectomy, however they will be at liberty to decide whether to answer a question or not. Discussions would be audio taped with your permission and your participation would be very much appreciated.

**RISKS AND DISCOMFORTS:** The study will not pose any harm because you will not be exposed to any physical danger except for the time that you will spend as a result of taking part in the discussion.

**BENEFITS:** Benefits that may arise will be a greater contribution to the reasons for low vasectomy uptake. The information will also arouse the interest of policy makers to pay more attention to how vasectomy services can be rendered and channel interventions where necessary.

**COST:** The study will not be of any risk or cost to you because the cost have been taken care of and your identity protected as well.
COMPENSATION: The researcher will not pay money to respondents in order to gain their participation for the study to be neither will participants be required to pay any fees so as to take part in the research.

CONFIDENTIALITY: You are assured that all information provided during this research will be taken with strict confidentiality, protected as much as possible and will be purely for research purpose. Your name and identity are not needed in the study. Recorded files will be destroyed after they have been worked with. Nobody will be able to trace any information you will give us in this discussion because all information will be treated as confidential and your names will not be mentioned either verbally or in any written document.

VOLUNTARY PARTICIPATION AND WITHDRAWAL: Your participation in this study is voluntary and you can at any point choose to temporarily or permanently terminate your participation in the discussion. No punishment is associated with your decision to exit. It is not compulsory to answer a question or participate in this study if you do not want to. The research team will still have a good relationship with you even if you decide to opt out of the study and you can still access all medical benefits you are entitled to.

OUTCOME AND FEEDBACK: The data collected will be transcribed and interpreted for the purpose of the research. The data collected will then be discarded some months after the study is entirely completed. The results of the study will be published in journals as well as serve as a basis for further research.

FUNDING INFORMATION: The Principal Investigator solely funded this study.

SHARING OF PARTICIPANTS INFORMATION/DATA: Participants are reassured that the data collected will not be shared with any individual or organization and will be used solely for research purposes by the Principal Investigator.
PROVISION OF INFORMATION & CONSENT FOR PARTICIPANTS: A copy of the Information sheet and consent form will be given to you after it has been signed or thumb-printed to keep.

For further clarifications or questions, kindly contact the following:

Ms. Felicia Dede Tetteh  Prof. Philip Baba Adongo  Ms.Hannah Frimpong
Prin. Investigator  Supervisor  GHS-ERC Administrator
0552388090  0302681109

fdtetteh001@st.ug.edu.gh  pbadongo@ug.edu.gh  f Hannah.Frimpong@ghsmail.org
Appendix B: Participants Certificate of Consent

(A copy of this form will be given to participants)

Perceptions of Vasectomy as a family planning method among married men in the Awutu Senya East Municipality.

I have read through the foregoing information/the foregoing information has been read and interpreted to me in a language I understand (Twi ☐ English ☐). I have been adequately informed about the objectives, benefits, risks and my right to withdraw from the study at any time without any consequences and understand that it would not affect my accessibility to any medical care. I fully understand and I consent willingly to participate in this study by signing/thumb printing.

I voluntarily agree to be part of this research.

Initials of Participant…………………………..   ID Code ……………………………..

Participants’ Signature ...................... OR Thumb Print.............

Date: ....................

INTERPRETERS’ STATEMENT
I interpreted the purpose and content of the Participants’ Information Sheet to the above named participant to the best of my ability in the Twi/ English language to his proper understanding. All questions and appropriate clarifications raised by the participant have been addressed and interpreted to his satisfaction.

Name of Interpreter………………………………………

Signature of Interpreter………………………………..

Date……………………………………………………

Contact………………………………………………...

STATEMENT OF WITNESS

I was present when the purpose and content of the Participants’ Information Sheet was explained to the above named participant to his proper understanding.

I confirm that he was given the opportunity to ask questions/seek clarifications and same were duly answered to his satisfaction before voluntarily agreeing to be part of the research.

Name………………………………………………….

Signature…………………… OR Thumb Print………………………

Date………………………………

INVESTIGATOR’S STATEMENT

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.
Welcome and thank you for volunteering to take part in this Focus Group Discussion (FGD). You are here to participate, as your viewpoint is important. I realize you are busy and I appreciate your time. This FGD is designed to assess your current thoughts or perceptions on vasectomy as a family planning method. The discussion will last with 1-2 hours and will be audio tapped to facilitate recollection. Again, anonymity is assured despite being taped. Also, tapes will be securely stored solely by the principal investigator in an email transcription, word for word, line by line and they will be destroyed after the study has been completed. The transcribed notes will be devoid of any information that will allow individual subjects to be linked with specific information. Try and answer question as accurately and truthfully as possible and also desist from discussing comments of other members outside the group.

Note;

1. One response will be taken at a time.

2. It is expected that members give respect to others.

3. There are no wrong or right answers.
Appendix C: Focus Group Discussion Guide

Section A

Background data of participants

Probes:

1. Age
2. To which of the religions do you belong?
   a. Islam
   b. Christianity
   c. Africa traditional religion
   d. Others
3. Occupation
4. Level of education
   a. No education
   b. Primary
   c. Middle/JSS/JHS
   d. Secondary
   e. Tertiary
5. Marital status
6. How long have you been married?
7. How many children do you have?

Section B
Knowledge on family planning

1. First of all, tell me what you know about family planning?

2. Are there any advantages?
   a. Advantages for men
   b. Advantages for women

3. Family planning methods used in Ghana
   Probe for
   a. Family planning methods used by women in Ghana
   b. Family planning methods used by men.
   c. Tell me some permanent family planning methods you know.

4. Why do people resort to family planning?

5. Do you think there any side effects?
   Probe for
   a. Side effects for men
   b. Side effects for women

6. Do you think family planning will make people promiscuous? Why?

Knowledge on vasectomy as a family planning method

Tell me about vasectomy

Probes:

1. What is vasectomy?

2. Where and how did you hear about it?

3. Tell me the advantages of choosing vasectomy as a family planning method.
4. Do you think vasectomy has any disadvantage?

5. How much is the cost to get vasectomy done

6. Where can the service be found?

7. Can the process be reversed?

8. Future complications you know about vasectomy?

9. Have you done vasectomy?

10. Do you know anyone who has undergone vasectomy?

Perceptions of vasectomy as a family planning method

Probes

1. Do you think vasectomy changes masculinity?

2. Can vasectomy prevent sexually transmitted diseases?

3. Is vasectomy the same as castration? Please explain your answer.

4. Does vasectomy reduce sexual performance?

5. Would you opt for vasectomy upon the advice of your wife? Why?

Reasons for acceptance of vasectomy

Probes

Religion

1. What is your religion’s stance on family planning?

2. What does your religion say about vasectomy?

3. Is your religion a clout in terms of accepting vasectomy as a birth control method?

4. What influence has your religion had on you in terms of choosing a family planning method especially vasectomy?

Surgical Procedure and Future uncertainty
1. Tell me how vasectomy is done?

2. Do you have any fears about the process?

Availability of Service

1. Where are vasectomy services offered?

2. Are these centers easily located?

3. Do you think counseling services should be offered with respect to vasectomy and why?

4. Will you opt for vasectomy should you receive elaborate education? Why?

Do you have any alternatives or have you heard of any way by which pregnancy is prevented aside the modern contraceptives.
Felicia Dede Tetteh  
University of Ghana  
School of Public Health  
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

<table>
<thead>
<tr>
<th>GHS-ERC Number</th>
<th>GHS-ERC 023/04/19</th>
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<td>Project Title</td>
<td>Perception of Vasectomy as a Family Planning Method among Married Men in Awutu Senya East Municipality.</td>
</tr>
<tr>
<td>Approval Date</td>
<td>9th July, 2019</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>8th July, 2020</td>
</tr>
<tr>
<td>GHS-ERC Decision</td>
<td>Approved</td>
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This approval requires the following from the Principal Investigator:

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED.

[Signature]

DR. CYNTHIA BANNERMAN  
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra
LETTER OF INTRODUCTION

FELICIA DEDE TETTEH

I write to introduce to you Ms. Felicia Dede Tetteh, a Master of Public Health Student in the Department of Social and Behavioural Sciences, School of Public Health, University of Ghana, Legon.

Ms. Tetteh is undertaking a project work entitled “Perceptions of Vasectomy as a Family Planning Method among Married Men in the Awutu Senya East Municipality”.

I would therefore be very grateful if she is given the needed assistance towards a successful completion of her project work.

I hope to count on your maximum co-operation.

Thank you.

[Signature]

for: MUNICIPAL CHIEF EXECUTIVE
(ALHAJI MOHAMMED AVONA AKAPE)
MUNICIPAL CO-ORD. DIRECTOR

TO WHOM IT MAY CONCERN