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**COMMUNITY PERCEPTIONS OF MALE STERILIZATION AS A
BIRTH CONTROL METHOD IN THE LA DADEKOTOPON
MUNICIPALITY, ACCRA**

BY

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
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DECLARATION

I, Emma Afari declare that, except for references to other people’s work which I have duly acknowledged, this dissertation was the result of my original field work, and that this dissertation, either in part or completely has not been presented elsewhere for another degree.

.....

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(Student)

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Dr. Phyllis Dako-Gyeke Date

(Academic Supervisor)

DEDICATION

This dissertation is dedicated to the Almighty God and the members of my family Mr. George Agama my husband, my children, Emmanuel, Patrick, and Paul Agama and to a supportive course mate, Mr. Thomas A. Ahoto and Stanley Alor.

It is dedicated to my family members whose financial and moral support over the years has brought me this far.

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ABSTRACT

Background

Male sterilization is a simple, safe and less expensive method of birth control, equally effective as other forms of permanent birth control measures, yet least known and patronized. Vasectomy does not only provide health benefits to the user and his direct family, but to the whole population, by reducing and regulating it. Therefore the study sought to explore the community perceptions, level of knowledge on male sterilization, availability of services and reasons for use or non-use in the La Dadekotopon municipality, Accra.

Method

A qualitative exploratory study was conducted with the use of phenomenological approach in the LaDadeKotopon municipal area, Accra. Data was collected through 3 focus group discussions with 10 participants in each group. The selection and recruitment for the FGD was done through snowballing for only the population of men 20 years and above and women in their fertile age, who have resided in that community for more than 3 years and have children.

There were 14 Key Informant Interviews. The interviews and focus group discussions were audio-taped, hand written notes taken on the facial expressions and gestures with the expressed permission from participants. Recorded data were transcribed verbatim and immersion in data to identify themes using the content analyses manually.

Results

The study revealed that male sterilization is still perceived by some people to be synonymous to castration and can lead to sexual weakness and impotency. Four themes emerged as factors contributing to their negative perceptions and low patronage included are inadequate knowledge, negative perceptions / thoughts, future uncertainty, and proximity of services. The religious were identified to be of the view that, vasectomy would hinder God's command on marriage and procreation. Most of the participants in the study used other forms of family planning because information on them was clear and understandable. The health workers in the study did not have accurate information on male sterilization as a birth control measure. The findings clearly showed that proximity of the health facilities did not influence men's readiness to take up vasectomy. There was a finding that swallowing 2 tablets of paracetamol before or after sexual intercourse prevents pregnancy .

Conclusion

The socio-demographic data of the participants did not have any impact on their perception, choice or use of vasectomy, except educational level of 3 men who were university graduates who really supported and explained the difference between castration and vasectomy to the FGD members but rather the severe lack of accurate, adequate and enough information on vasectomy services. Therefore, it is recommended that, health care providers should build up their capacity and FP education and services should be their daily activity. The chapels and mosques which are religious platforms should be used for the education on vasectomy; also individual counseling and the use of

vasectomized clients as satisfied clients (role models) for health promotion and education activities to popularize vasectomy and promote its uptake.

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LIST OF ABBREVIATIONS

CHN	Community Health Nursing
CHPS	Community-based Health Planning and Services
CYP	Couple Years Protection
FGD	Focus Group Discussion
FP	Family Planning
GSS,	Ghana Statistical Service,
NMIMR	Nouguchi Memorial Institute Medical Research
HBM	Health Belief Model
IUD	Intra Uterine Device
KII	Key Informant Interview
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
NGO	Non-governmental organization
PMO	Principal Midwifery Officer
PHN	Public Health Nurse
UNICEF	United Nations Children Educational Fund
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Knowledge	Factual information that a person knows
Perception	A way of conceiving something
Reasons	An explanation of the cause of some phenomenon
Surgical operation	An incision with instruments; performed to repair damage or arrest disease in a living body
Vas deferens	A duct that carries spermatozoa from the epididymis to the ejaculatory duct
Vasa deferentia	The two ducts that carry the spermatozoa from left and right epididymis to the ejaculatory duct.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

The contraceptive method mix in Ghana has only two main types of modern contraceptive methods for men, these include male condom and male sterilization known also as vasectomy, defined by the Ghana Health Service family planning service protocol, is a minorsurgical procedure done,under localanesthesiaon a male to locate, block,or tie and cut the Vasadifferentia to prevent him from having children(GHS, 2007).

Human beings ordinarily take health, for that matter reproductive health for granted until something goes wrong. Reproductive health is a state of physical, social and mental wellbeing of an individual and not merely the absence of disease or infirmity in all aspects or matters of reproduction (WHO,2008).

In view of this,Family planning issues are surprisingly among the most common problems affecting society's health today in both developed and developing countries. In Ghana,problems such as overcrowding, armed robbery, head pottering, high maternal mortality and child morbidity, all seem to be associated with not practicing family planning.(GSS and ICF Macro 2009) However, male sterilization has become popular in North America, Europe and Asia. Successful vasectomy programs also have been launchedin Africa, Latin America and the Middle East.Acceptors are from a broad range of cultural and religious backgrounds (Trollope, Fisher & Naidoo, 2009).

The 1990 summit for children addressed the role of couples in family planning and one of the goals were, to make family planning services available to every couple to prevent unintended pregnancies (UNICEF,1994). Also the 1994 International Conference on population and development held in Cairo heightened the role of men in matters of birth control. It was declared that, male involvement in family planning should be made attractive to encourage couples to have easy access to and fully participate to prevent unplanned pregnancies (Ringheim, 1996). An informed choice is sometimes jeopardized, when undue emphasis is placed on particular methods of contraception. Clients should receive information about all the available options before a choice is made (Subramanian et al.,2010). Despite the advantageous positions of men in the family as the heads, their roles in family planning largely remains unrecognized and unutilized concluded by (Nte,et al. 2009).

1.2 Problem Statement

Although male sterilization is equally as effective, it is the least known and least used method (Jacobstein & Pile, 2007). Users of vasectomy globally are about 42.7 million, and in Africa one percent (WHO, 2008) in Ghana one percent (GSS, 2008). Accounting for the fact that, knowledge on contraceptives in general, in Ghana is almost universal, 98% of women and 99% of men know at least one method of contraception. However, fewer than half of women and only three in five have heard of vasectomy (GSS, NMIMR & ORC Macro, 2004) hence, only one percent of men are using the male sterilization (GSS, 2008). As evidence to that percentage, La General Hospital, in the La Dadekotopon municipality in Accra, documented performed only 61 male sterilizations

from 2010 to 2014, surprisingly, out of the male population of 62,415 aged 20 years and above, only one person came from the Lamunicipality. The remaining 60 cases came from all over Accra and its surrounding towns and villages (GHS, 2014).

In a review of 271 vasectomies performed in 2009 in three healthcare facilities in Ghana, from which this study area was included, the researchers recommended the exploration of the reasons and perceptions resulting in the low uptake (Owusu-Asubonteng, Dassah, Odoi, Frimpong and Ankobea, 2012). Some other researchers also suggested that it was possible to explore people's perceptions of vasectomy and change them to increase the use of vasectomy, those researchers also iterated that, despite several advocacy strategies on vasectomy country wide, the acceptance rate was still low at one percent (Jacobstein et al. 2005). In this context, the researcher explored community perceptions of male sterilization as a birth control method to answer the research questions.

1.3 Justification of Study

Family planning saves lives. The stress, frustration, irresponsibility, that is experienced when one has a large family size cannot be over emphasized. There is economic hardship and mental agony for the whole family, exerting pressure on social amenities. The high unmet need in family planning can be averted when couples are motivated to practice the permanent or long term methods of birth control. Therefore findings of this study will serve as a documentation which will reflect the state of vasectomy in FP within the municipal, it will aid in Policy making and national Programming of appropriate strategies towards vasectomy education to assist FP service

providers, like nurses and midwives, to have a better understanding of how to meet, as well to improve the quality of motivation and education on the services about male sterilization. It also sought to increase awareness on vasectomy and to encourage limiters in sexual and reproductive health to make an informed choice of contraceptives within the study area.

It will serve as a source of reference for future researchers within the La Dadekotopon municipality. Finally, in the long term, it may be one of the most cost-effective developmental investments to achieving the Millennium Development Goals (Cates, 2010).

1.4 General Objective

The main objective of the research is as follows:- to investigate the Community Perceptions of male sterilization as a birth control method within La Dadekotopon municipality.

1.5 Specific Objectives

1. To explore the level of knowledge of male sterilization as a birth control method.
2. To ascertain reasons for use or non-use of male sterilization as a birth control method.
3. To examine the level of knowledge on the availability of the male sterilization services, in particular hospitals as a birth control method

1.6 Research Questions

1. What is the community's perception, about male sterilization as a birth control method?
2. What is the level of knowledge, of male sterilization as a birth control method?
3. What are the reasons for the low patronage?

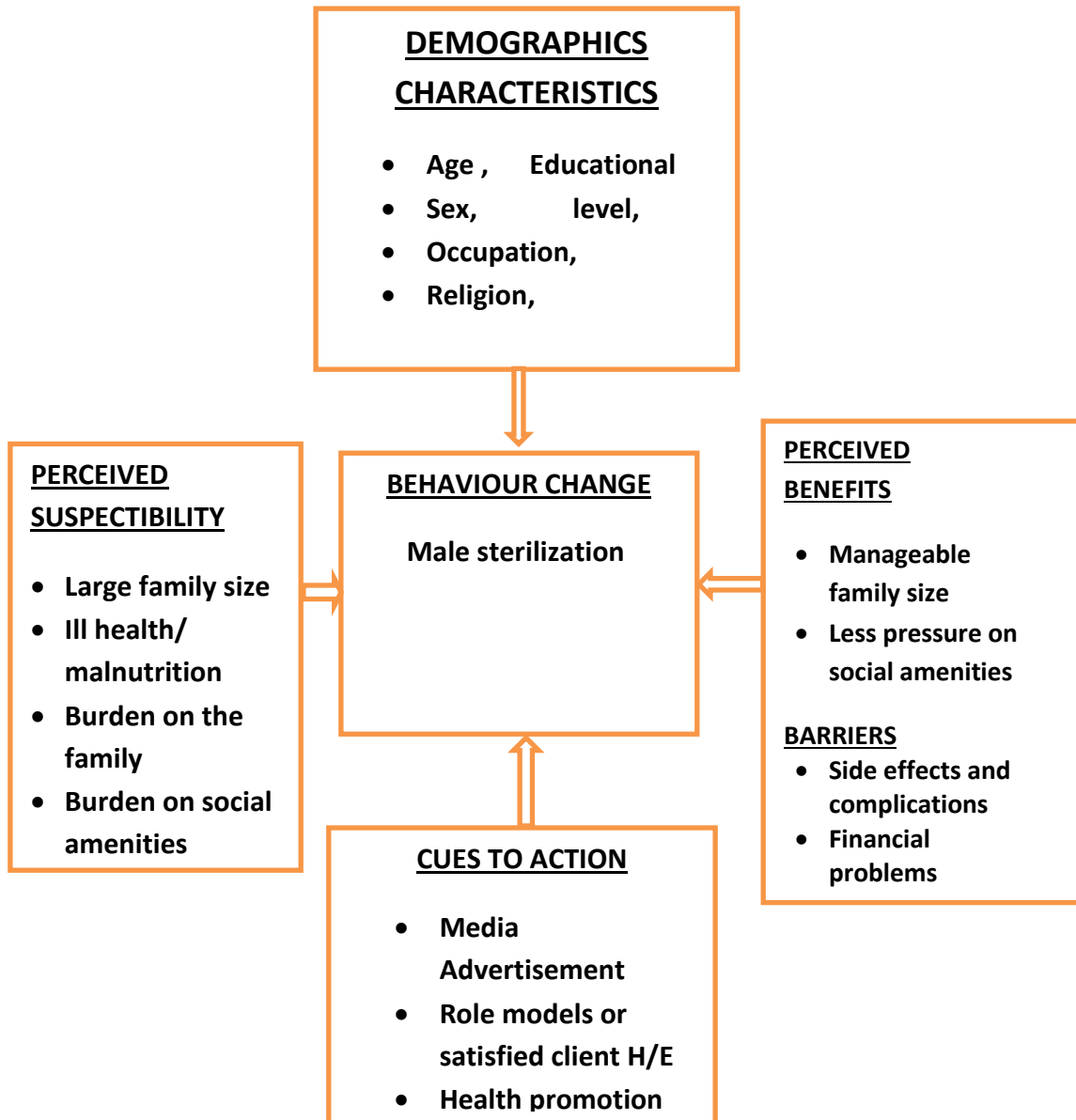
1.7 Theoretical Framework

Development of the framework for this study is guided by the health belief model. The HBM is one of the longest established theoretical models, designed to explain health behaviors by understanding peoples' perceptions or beliefs about health.(Hochbaum, Rosenstock & Kergels, 1950s). Originally, it was articulated to explain why individuals participate in health screening and immunization programmes. It can be applied to other types of health problems. At its core, the model suggests that the likelihood of an individual taking action for a given health behavior or problem is based on the interaction between 4 types of belief. The model predicts that individual will take action to protect or promote health if:-

1. They perceived themselves to be susceptible or at risk for a condition or problem.
2. They believe it will have potential serious consequences for them.
3. They believe a course of action is available which will reduce their susceptibility or minimize the consequences.
4. They believe that the benefits of taking action will outweigh the cost or barriers.

The study will employ all the themes of the model except self- efficacy. The Health Belief Model is a psychological model that explains and predicts health behavior, was developed by a group of psychologists in the US Public health services unit, in response to the failure of a health screening program.

The individual would need to believe that they are at risk of having many children and to conceive that, there are consequences of having lots of kids. These beliefs may lead the individual into the realization of the threat ahead, if action is not taken and whenever there are supportive cues to action, such as media advertisement or publicathjions, the use of role model example satisfied vasectomy clients in family planning health education. It may trigger a response to opt for male sterilization. Considering that the benefits of vasectomy outweighing the potential barriers, then individuals or couples will think and trust their ability to take effective action to accept or opt for male sterilization to limit childbearing. In summary individual's perception of the risk, consequences, benefits, barriers or challenges of the condition or situation also depends on demographic characteristics such as age, sex, education, income and religion. Promoting change in belief or perception may lead to changes in health behavior that contributes to improved health systems. Hochbaumetal.,(1950s).

FIGURE .1 CONCEPTUAL FRAMEWORKS -THE HEALTH BELIEF MODEL

Hochbaum, Rosenstock & Kergels (1950s)

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The previous chapter looked at the background of the research, the research purpose and questions, as well as the significance of undertaking this study. It also briefly highlighted the structure of the entire work. This chapter critically reviews the literature on the topic community perceptions of male sterilization as a birth control method. The literature reviewed literature on male sterilization, related studies on levels of knowledge about male sterilization as a birth control method, and reasons for use or non-use of male sterilization as a birth control method.

2.2 Overview of Male Sterilization (Conventional and No-Scalpel Vasectomy)

According to the Centre for Disease Control and Prevention (CDC) “sterilization means the use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacteria endospores (Engenda health, 2003). Sterilization is a permanent birth control method. Whilst sterilization procedures for women are called tubal occlusion, the procedure for men is called vasectomy (Bankole, A., & Singh, S. 1998) Male sterilization is done to keep a man’s sperm from going to his penis, so his ejaculate would not have any sperm in it that can fertilize an egg. Male sterilization is a simple, minor surgical procedure that is performed by entering the scrotum through a small incision or puncture (E H, 2002) the procedure usually takes 5—15 minutes to perform, after 5—10 minutes of preoperative preparation and administration of local anesthesia (E H, 2002) discovered that vasectomy is one of the safest and most effective

family planning methods and one of the few contraceptive options available for men. Failure rates are commonly quoted to be between 0.2% and 0.4% among men.

According to Engender Health, (2002) no reason has been established medically that absolutely restricts a man's eligibility for vasectomy. However, WHO, (2011) reported on 'improving access to quality care in family planning: Medical eligibility criteria for contraceptive use' "states that certain precautions should be taken before vasectomy is done. Among these precautions are localized problems such as inguinal hernia, large hydrocele or varicocele, cryptorchidism, and previous scrotal injury, conditions such as diabetes, coagulation disorders, or AIDS. In cases such as systemic infection, gastroenteritis, or filariasis, the provider is advised to delay performing the vasectomy until the condition is resolved (WHO, 2003).

The Centers for Disease Control and Prevention and EngenderHealth, (2002) identified two approaches to Male Sterilization and these are Conventional vasectomy and No-scalpel vasectomy. According to Engender Health (2002, p164), in conventional vasectomy, "the clinician uses a scalpel to make either one midline incision or two incisions in the scrotal skin, one overlying each vas deferens. Each incision is usually 1—2 cm long and is routinely closed with sutures after the vasectomy has been completed. In general, with conventional vasectomy, only the area around the skin entry site is anaesthetized"(Engender Health, 2002 p, 164). On the other hand No-scalpel vasectomy was developed and first performed in China in 1974 (AVSC, 1998). This technique uses a vashjal nerve block, created by first anaesthetizing the scrotal skin and then making a deep injection of anesthetic alongside each vas deferens(EH, 2002). This provides better anesthesia than simply anaesthetizingthe skin around the entry point.

Bibi, et al.2005). Instead of a scalpel, two specialized instruments—a tined clamp and a dissecting forceps (a sharp, curved haemostat) are used. Because the scrotal skin puncture made with the dissecting forceps is so small, sutures are not needed (EH, 2002).

Comparatively, No-scalpel vasectomy offers several advantages over conventional vasectomy (EH, 2002). These include, fewer complications, less pain during the procedure, early follow-up period, and earlier resumption of sexual activity after surgery (AVSC Int,1997;). Because it requires no scrotal incision, no-scalpel vasectomy is believed to decrease men's fears about vasectomy (AVSC,1997). Neither the conventional nor no-scalpel vasectomy is time-consuming (EngenderHealth, 2002), but it has been stated that the vasectomy procedure time is shorter when skilled providers use the no-scalpel approach (Li et al., 1992).

2.3 Use of Male Sterilization as a Birth Control Method

The use of sterilization as a method of birth control has been adopted at varying levels in various countries with female sterilization gaining more popularity than male sterilization. Ross J., Mouldin W., & Miller V.C.(1993) observed that the increasing popularity of sterilization as a method of birth control among married couples who have completed their childbearing underscores the need for knowledge about sterilization as a birth control method. Thus, this section compares the use between men and women. Data from the 1991 National Survey of Men in the United States indicated that about 12% of married men aged 20-39 have had a vasectomy as a birth control method and about 13% are married to a woman who has been sterilized. A recent statistic on male sterilization indicated that it was the most effective and the only long-acting form of

contraception available to men in the United States and has progressed steadily from 6.2% between ages 15-44 to 15.1% between ages 40-44 (UNICEF, 1994). However, in India the prevalence of female sterilization exceeds that of male sterilization by a factor of 37 to 1 with a current rate of 4.4%. Although majority of respondents in a study (54.0%) indicated an approval for vasectomy, only 1% of men were actually practicing vasectomy (Tauseef Ahmed, 1993). In India sterilization, particularly female sterilization was the major birth control method and the practice of vasectomy was minimal (3%). Although the method had been available since 1952, according to Presser et al, (2006) the pendulum swung from an emphasis on female to male and then back to female sterilization over the next few decades, reflecting programmatic changes (Srinivasan, 1995; Presser, 1970). Comparatively, statistics on the use of vasectomy by men in the United States is far higher than in India.

In the case of Africa, Caldwell and Caldwell, (2002) reported vasectomy to be unacceptable to most African men and probably will remain so for a very long time. A study in Nigeria, which targeted literate, married men confirmed Caldwell and Caldwell's, (2002) study to reveal that vasectomy is underutilized in Nigeria and that those who might have accepted the procedure would do so conditionally. A study by M. Mandara, (2012) found that there is low acceptance of vasectomy among Nigerian men. Again, a study by Owusu-Asubonteng et al, (2012) which examined the trends, client profiles and clinical and surgical practice in 8 hospitals in Ghana from 3 hospitals, revealed that less than 0.5% of Family Planning clients opt for vasectomy, that both

male professionals and semi-skilled workers opted for vasectomy, that the mean age of acceptors was 40.7 years and that each had 3 or more children.

In China and Puerto Rico, sterilization has been the practice since 1947 where female sterilization dominated that of the male until after 1982. In 1947-48, close to seven per cent of all ever-married women in Puerto Rico, either in consensual or legal unions, were sterilized (Atkins, & Jezowski, 1983). By 1965, the prevalence of sterilization rose to 34 per cent of all mothers aged 20 to 49 (Scharping, 2003). In China male sterilization increased modestly from seven per cent in 1982 to 10 per cent in 1992, then declined to eight per cent in 1999 (Scharping, 2003). Statistics showed a low rate for both male and female. Sterilization was far less frequent in Japan, that is, only six per cent of married women chose sterilization while the men scored zero (National Institute of Population and Social Security Research, 2003). In Russia, sterilization remains rare because it was outlawed for decades and only delegalized in the 1990s (Hollander 1997; RAND 2002: Schehl 2002). In 1992, sterilization focused more on women than on men to the extent that less than one per cent of women of reproductive age were sterilized (Popov 1996), and there is no suggestion in the literature of a marked increase thereafter (Presser et al., 2006).

With increasing frequency, married couples who have finished bearing children are liable to raise the matter of sterilization (as opposed to contraception) with their family doctors and gynecologists. In view of this, Presser, Hattori, Parashar, Raley & Sa (2006) noted that, heavy reliance on sterilization as a means of birth control is a major response in most countries of this world. Again, comparatively developed countries are far ahead of developing countries as far as the use of both male and female sterilization is

concerned. In Africa, the trend is worse with respect to sterilization. According to Shattuck, Wesson, Nsengiyumva, Kagabo, Bristow, Zan, and Ngabo (2014), in spite of the fact that vasectomy is safe and highly effective, it remains an underused method of family planning (FP) in Africa. The rate of male sterilization in sub-Saharan Africa is very low (Atkins, Jezowski, 1983).

From the review, it is clear that sterilization methods have focused primarily on women in developing countries and in some advanced countries as well. While female sterilization is twice as common as male sterilization in the developed world, in Asia it is 8 times more common and in Latin America and the Caribbean it is 15 times more common (Rutenberg & Landry, 1993).

2.4 Knowledge of Male Sterilization as a Birth Control Method

Thus, this section sought to establish from the literature what others have discovered with regards to knowledge about male sterilization. In some countries, knowledge about male sterilization was found to be very low where men were virtually unaware about the method. For example, in Bangladesh, a study conducted by Islam, Padmadas & Smith 2006 to determine contraceptive knowledge among men found that while “contraceptive knowledge was universal in Bangladesh, the degree of knowledge differed among certain subgroups”. The study reported that about 19% of younger men knew of 4-5 Modern methods and that older, educated and those who were currently using modern methods were more likely to have reported a high degree of knowledge. This study did not specifically mention which modern methods, in other words the study lumped all the modern methods into one. A more specific study in Nagpur, India revealed that

knowledge level on vasectomy was low (54.0%) and 13.0% had no knowledge. Char, Saavala & Kulmala, (2009) revealed that the only source of information for men concerning birth control was mainly from the mass media. (However, they raised a concern that they would like to have information, through discussions from or with knowledgeable sources) their findings also indicated that men saw family planning and contraception as two different issues. They viewed family planning as synonymous to female sterilization, whereas they considered contraception as referring to birth spacing methods only, and some did not know the difference between male sterilization and castration. This study concluded that awareness was insufficient.

The association of knowledge on vasectomy, level of education as well as occupation among men and was found to be significant in (Saoji, Gumashta, Hajare, and Nayse's 2013) study. Another group of researchers found that around 62% of men thought a man's sexual performance was affected after male sterilization and 77% did not have any idea about the time required to resume normal work and sex after the procedure. The authors concluded that poor knowledge and wrong perception could be one of the main reasons for poor male participation in the family planning process in India (Mahapatra, Narula, Kalita, Thakur, and Mehra, 2014) furthermore, the awareness and perception of men exposed their level of knowledge with regard to male sterilization.

For instance, Saoji et al. (2010). Researched into the awareness and perception of vasectomy among antenatal women at a teaching hospital and canvassed that vasectomy is safer, simpler, less expensive and as effective as female sterilization. Yet, in India the number of women who had tubectomy was about 95.6% (2010-2011). Advocacy

strategy was found to be 94.5%, but knowledge was 67.5%, 81% of the women approved of vasectomy, but surprisingly would not agree for their spouses to use it. Almost all those women refused to give reasons why they would not agree for their partners to do it. Some women also said religion and culture prohibits vasectomy for fear of sexual dysfunction. It was the opinion of all the antenatal women that birth control should be a decision of both husband and wife. In a similar study.....

Generally, the case in Africa concerning knowledge of family planning methods found in the literature is quite encouraging. A study by Mbizvo et al. (1991) which described knowledge, attitudes, and practices in family planning among males in Zimbabwe found that males' knowledge of various family planning methods was high in that country, as was approval and use of family planning. Attitudes toward family planning information, accepting methods, communication between couples, and family size were also investigated. It also obtained that, programme efforts should move beyond an emphasis on child spacing to focus on family size limitation.

They also found that in East and North Africa and Asia, more than 90 percent of men knew of at least one contraceptive method, with the exception of Pakistan and Tanzania, where only 79 and 86 percent of the men, respectively, knew of a method.

In the case of Ghana, the proportion of men who knew of at least one method exceeded 90 percent and this was somewhat lower in West Africa (Mbizvo et al. 1991). In other Western African countries surveyed, knowledge of a contraceptive method ranged from 66% in Mali to 85% in Niger. In all but two countries, Burundi and Mali, a greater percentage of men knew of a modern method as opposed to a traditional method. However, in Nigeria, knowledge of vasectomy was found to be poor among the

studied population due to misconceptions, and incomplete and incorrect information about vasectomy (WHO, 2011).

Bangladesh researchers, Schuler, Hashem & Jenkins, (1995) examined the family planning strategy of using female community-based family planning service providers distribute contraceptives and information to those in need in their homes. Findings indicated that, the strategy was good and increased the prevalence, but failed to provide adequate and educative information to support users.

2.5 Perceptions about Vasectomy

Perceptions formed with regards to contraceptive use among women and men in Africa demonstrate their level of knowledge as regards male sterilization. For instance Dyers et al, (2012) discovered from Ethiopia how perceptions of community norms differentially shape contraceptive use among men and women. Women and men whose current number of sons is lower than their perception of the community ideal had lower odds of reporting contraceptive use, while women and men whose personal ideal number of sons is lower than the community ideal had greater odds of reporting contraceptive use. Dyres et al, (2012) reported from another research conducted in Kenya, that both sexes were influenced by their perception of the social network's approval of family planning than by their own approval of family planning. Results spotlighted the importance of place, conceptualized as the place-specific perceptions of fertility ideals, when doing reproductive health research (Dyres et al, 2012). In Ghana, the perception that a birth control method is significant, safe and effective motivated its use (Aryeetey et al., 2010).

In the United States, perception of male sterilization as a birth control method circles around some racial populations. For instance, the Latino population in the United States has a lower prevalence of vasectomy than the non-Hispanic white population. However, a body of research has considered that cultural perceptions about masculinity might explain why Latinos are less likely to undergo vasectomy (Hubert, White, Hopkins, Grossman, 1998).

On issues of perception of male sterilization as a birth control method, Africa has a lot of interesting views about male sterilization. For example, a study in Tanzania by Bunce et al. (2012) identified that regarding vasectomy decisions, wives had a strong influence on the outcome, and that both sexes held many misconceptions about vasectomy, including fear of decreased sexual performance. Similar research in Ghana by Adongo et al. (2014) looked at the social and cultural factors that affected the uptake of vasectomy and identified that vasectomy is perceived as an act against God, which is punishable either by death or answerable on Judgment Day. They also found that vasectomy is believed to be a form of castration, which can make a man sexually incapable and weak, leading to marital conflicts. Burns et al, (2012) discovered that Panacin tablets and Cafalgin analgesics were perceived to have contraceptive abilities and were used in place of modern contraceptives. This supported the findings of (Adongo et al. 2014).

Owusu-Asubonteng et al. (2012), in their study, researched the trends, client profiles and clinical practice in 8 hospitals in Ghana but canvassed from 3 hospitals, that less than

0.5% of Family Planning clients opted for vasectomy. They also said that both professionals and semi-skilled workers opted for vasectomy, and that the mean age of acceptors was 40.7 years and they had 3 or more children each.

Thus Bunce et al. (2012), Adongo et al, (2014) and Shih et al. (2011) concluded that the misconceptions about post vasectomy sexual function, including misunderstandings about the vasectomy procedure in addition to the stigma and misconceptions regarding vasectomy account for the low uptake of vasectomy.

2.6 Reasons for Patronizing or Not Patronizing Vasectomy

A scan through the literature revealed many reasons why male sterilization is used by some men and why it is not. Economic, social and cultural factors were stated as reasons why male sterilization is used and why it is not used. For instance, Shih et al, (2011) states that male sterilization, is the most efficacious, permanent category of birth control obtainable to male adults in the United States. They further stated that male sterilization is more economical, cheaper and has lower risks or complications than female sterilization.

Vasectomy is a cost-effective outpatient technique for men which can aid in achieving the millennium goals (Cates, 2010). In other words, these authors considered the economic aspect of the desire by males in the use of vasectomy. The social context factors, according to Shih et al. (2011) is that vasectomy decision-making among racially diverse populations found that couples' reasons for opting for vasectomy included a desire to care well for their families, share birth control responsibility, and be faithful to each other. On the other hand, lack of information, fear of impotence,

incorrect and incomplete information about vasectomy and ignorance among men are no doubt the reasons for its low prevalence. The ACQUIRE Project,(2006) had revealed barriers posed by lack of knowledge and incorrect or incomplete information concerning vasectomy. Some of these barriers include fear of impotence, the equation of vasectomy to castration, wives' concerns about sexual functioning and physical strength of their husbands after vasectomy, lack of access to vasectomy provision sites, age, religion, level of education and the community one belongs to.

Shrivastava, Shrivastava, & Ramasamy, (2013) have noted that irrespective of the multiple benefits associated with vasectomy, acceptance rates among clients have been extremely poor in different settings. For instance, according to Shih et al. (2011), less than half the number that utilize tubal ligation opt for vasectomy in the United States, most especially among black and Latino populations, who generally prefer to use bilateral tubal ligation.

Furthermore, Grady et al, (1996) found that multiple socio-demographic and health care delivery factors have been attributed to the poor acceptance rate of vasectomy among the general population. Some of the factors included lack of awareness and fear of possible loss of children due to death or divorce, adoption of other contraceptive measure by spouse, myths and misconceptions related to vasectomy that is, fear of irreversibility, pain, and/or inability to indulge in future sexual intercourse; risk of postoperative complications, loss of efficiency at work, and/or its perceived synonymy with castration, poor educational and socio-economic status, psychological limitations and religious difficulties, acceptance rates among gynecologists and physicians' perception that male patients will never adopt the surgical procedure, spousal impact,

and accessibility and availability of trained doctors (Bunce, Guest, Searing, Frajzyngier, Riwa, & Kanama, 2007;) Owusu-Asubonteng, Dassah, Odoi, Frimpong, & Ankobe, 2012). Vasectomy is not selected because it is associated with barrenness, infertility, loss of manhood, and irreversibility.

Balaiah et al, (1999) investigated three thousand and seventy-two married men, with special emphasis on the reasons for not accepting male methods in Maharashtra, India. The study revealed that the majority of them not only had no idea of family spacing, but they had no intention to improve their knowledge or acceptance of the methods for men. Men who had some knowledge on birth control methods possessed little and inaccurate knowledge of the consistent and correct use of vasectomy, 53.7% had positive views about their role in family planning, while 66.2% of them emphasized the need to improve the acceptance of male methods by providing adequate knowledge and information through the media, and door-to-door campaigning. In addition, 30% of them said providers needed to improve the access and quality of services. This study confirmed a pressing need for effective intervention at the community and the health facility level, backed with efficient counseling, and motivation in the rural areas.

Black and Latino respondents referred to the perceived ease of reversibility of female sterilization and lack of social support around vasectomy as reasons not to choose it. They added that counseling sessions are not helpful, so should be made better,correcting the misconceptions,others argued that the lack of readiness on the part of medical doctors or physicians to train in no-scalpel vasectomy is the reason many do not want to try vasectomy, (Shih et al., 2011).

Shattuck et al., (2014) investigated three Rwandan physicians who were trained in no-scalpel vasectomy in 2010, and revealed that their readiness has led to over 2,900 vasectomy clients from February 2010 to December 2012. In most cases, men over 40 years who had met their desired family size, either married or living with their partners, had little wealth, and sought to avoid side effects from hormonal methods (for wives) were a fundamental influence on the vasectomy uptake. They said ‘until after their training, the vasectomy projects in sub-Saharan Africa was viewed as unrealistic’. In all these decisions, a study in Tanzania by Bunce et al. (2012) noted that in deciding to go for a vasectomy, wives had a strong influence on the outcome. In summary to the literature review, the misconceptions and inadequate knowledge of this procedure may be the overriding factors in vasectomy apprehension among most men in Africa and some parts of the world.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Area

The La Dadekotopon Municipality was the site for this study. According to the GHS's DHIMS' 5-year cumulative family planning report, prevalence of male sterilization is very low, only one man underwent the procedure out of 61 men as documented by the La general hospital at the end of 2014 and as a recommendation by a group of researchers to assess the perceptions of community members on the male sterilization as a birth control measure within the area. LADMA, shares boundaries with Ayawaso Sub-Metro on the north, Osu-Clotey Sub-Metro on the East, Ledzokuku Municipality on the west and Gulf of Guinea to the south. It has a projected population of 231,166 inhabitants, with the adult male population of 62,415 and the WIFA /WIRA population of 69,350, and a growth rate of 4.4%, according to (GSS, 2008).

For administrative purposes, the municipality was divided into 3 zones, namely; Tenashie, La South and La North. The Police hospital is under Tenashie zone while part of the 37 military hospitals is within the La South zone and part of Ayawaso sub-metro. Kotoka International Airport and trade fair are within the La North zone. It is a predominantly a Ga speaking area.

The ethnic groups, mainly resident in the area are Gas, Akans, Ewes and Fantis. The inhabitants are mainly fishermen, and migrants from other fishing communities. It has many estate houses and renovated houses which are very congested or over crowded. The La Dadekotopon Municipality has a total of 16 health facilities made up of 1

District Hospital, a Quasi-government hospital, a Quasi-government clinic, 2 private maternity homes, a private hospital, 10 private clinics and 3 urban CHPS zones.

3.2 Research Design

The study was a qualitative exploratory research with the use of phenomenological approach in data collection through, 3 FGD, one FGD in each of the 3 zones of the municipality with peculiar features such as; group size was 10 participants for each group, Tenashie zone featured the all female group, whilst La South hosted the both sexes group, and La north had the all men's group. There were 14 KII with family planning service providers working in the municipality. Focus group discussion and key informant interview Guides were used in each zone. Duration of FGD was 1 -2 hours at a venue that participants were comfortable with. KII took about 20 -30 minutes per provider.

3.3 Research Sampling Technique

Participants were purposefully snowball sampled, this means that the selection of participants was goal-directed or according to the inclusion criteria, the researcher approached the potential interviewee and explained the purpose of the research, stressing that refusal will not affect any future discussion, introductory letters were shown to participants. FGD participants were from 3 to 6 communities which were nearby to the centre of each zone, Kakramadu for Tenahie zone, Agyman for La South zone and Wireless for La North zone. All these were achieved through the efforts of the community stakeholders.

3.4 Themes for the Study

The themes explored in the study included, perceptions of the community about male sterilization as a birth control method, knowledge of male sterilization as a birth control method and reasons for the patronage or non-patronage of male sterilization.

3.5 Data Collection

The study employed phenomenological approach to data collection. Data collection occurred in three phases or 3 FGDs on separate dates from May to June 2015 and 14 KIIs were conducted, using the piloted KII and FGD guides to solicit views and responses from the 30 participants that were divided into the 3 groups and 14 family planning service providers were interviewed due to data saturation.

Both procedures were audio taped with expressed permission from the participants. This enabled the researcher to get information on the various themes of perception,

knowledge and reasons for patronizing or non-patronizing of vasectomy. The recordings were done on a notepad, alongside audio recordings. The FGD had two moderators to facilitate each section a day.

3.6 Selection and Recruitment of Participants

Community entry was conducted; this was done by going to see the assemblyman of the area to seek his consent. He led us to the chiefs and elders or the heads of the Clan houses. He then helped us in the selection and recruitment of participants, women in their reproductive age and men who have children and has resided in the community for 3 years or more, were selected through snowballing to participate in the FGD till the required group size of 10 was reached in each of the 3 zones. Venue, time, date, and duration, were discussed. Two moderators as research assistance were used for each FGD on separate date and days, an insider moderator conducted the discussion and an outsider who was an observer took notes of useful terms. Both moderators were individuals who were well versed in the Ga and Twi languages used and practices of the people, they also assisted in explaining both the verbal and the non-verbal languages of the people. The principal investigator controlled and supervised both the moderators and the participants to focus on the subject matter. All the family planning service providers in both private, Quasi and government health facilities participated in the KII until the researcher was data saturated (meaning researcher started receiving same or almost the same answers from 3 -5 respondents) and decided to stop.

3.7 Data Processing and Analysis

Demographic data from participants were presented in a descriptive form and they were continually coded in a book, with major features that surfaced well noted and contents well analyzed. Taped recordings from the FGD and KII allowed the researcher to clearly immerse in the data to understand the points that were raised.

There was little meaning to the audio recordings so it was later played over and over, listened to attentively whilst transcribing. Immersion in data to identify or look for recurring response to use as themes using the content analyses manually and with the help of Microsoft word, coded word by word and line by line and a hand typed written version was created. This involved the systematic, organization and interpretation of textual ideas or materials, concepts and categories uncovered in the data. Data has been stored in the principal investigator's email inbox and on a CD until 3-6 months after transcription and then would be destroyed. Names or other information that could identify participants were not included in the typewritten work to arrive at the necessary outcomes. The findings has been outlined, discussed, with conclusion drawn and recommendations given and copies submitted to the School of Public Health, would be disseminated to stakeholders of the La Dadekotopon municipal health directorate and assembly for action to be taken, after graduate school has accepted it.

3.8 Quality Assurance

Quality control was ensured by training qualified research assistants who were properly motivated to perform the tasks and participants were recruited into the study. The

research assistants were supervised to ensure that they perform correctly as assigned them.

3.9 Ethical consideration

Ethical clearance was sought and approval granted from the Ghana Health Service ethical review committee. Introductory letters were collected from the School of Public Health, University of Ghana to the study area.

Anonymity and confidentiality were assured. Introductory letters from La Dadekotopon municipal health directorate to the zones were collected. Participant's consent was sought and a copy given to each person. Participants' demographic details were taken, on participant's arrival and were collected at the end of the discussion or interview. All participants were informed about the following. Recording the discussion allowed the researcher to clearly immerse in the data and understand the points that were raised in FGD and KII. The participant could request that the recording be stopped at any time or temporarily as appropriate during the session. The researcher is the only person who knows and has access to the recordings, transcriptions and electronic versions of the document. The recordings would not be used for any purpose other than the study alone. No names or other information that could be used to identify participants were included in the hard and electronic work. Anything that could possibly indicate their identification was excluded or was disguised.

CHAPTER FOUR

4.0 FINDINGS

4.1 Background Characteristics of Participants

This chapter presents the findings of this study. A total of forty four (44) participants were involved in the study. Fourteen (14) of them who participated in the KII were family planning service providers working in the various health facilities within the La Dadekotopon Municipality, whilst the remaining 30 who participated in the FGD lived in the communities within the municipality. The majority of participants in the FGD were between the ages of 20 and 30 years while in the KII, the majority of participants were less than 41 years. There were 15 females and 15 males in the FGDs, with 13 females in the KII. The majority of the participants, numbering 20, were married and the remaining were involved in other forms of relationships. Twenty participants in the FGD and 10 in the KII were Christians while other participants were Muslims. All 14 participants in the KII were educated to the training college and tertiary levels whilst only 3 participants in the FGD were tertiary graduates. In terms of occupation, the majority of participants in the FGD 13 were fishermen and traders whilst all the participants in the KII were public servant workers.

4.2 Awareness on General Family Planning Methods

The study observed a general knowledge of family planning. The responses from the participants in all the focus group discussions were in unison indicating they had information on family planning. Participants mentioned that they had heard a lot about family planning methods and some of their responses are recorded below:

“I know the one that they inject the women and some of them take pills.” (Male, 38years, Mixed, FG)

“Also the women have a loop, female condoms and the men have a vasectomy and condoms.” (37years, Male FG)

‘We have natural way of planning our family, by using the menstrual cycle.’ (Male, 27years mixed FGD)

The responses from the participants showed that they did not only have knowledge of the various modern contraceptive methods and the sexes that used the various types, but some participants also used some of these family planning methods as follows:

“I am using the one that last for 12years.” (Female,47years, Mixed FG)

Rear and imagined method that a participant alleged she uses *‘i often tooktwo tablets of paracetamol and pure water before or after sex,my child is 5years now’*

(Female,34years, Mixed FG)

“I use condoms when I go out because my wife is old ”(56years, Male FG)

*“I use my wife’s safe period to prevent her from getting pregnant.”
(Male, 42years, Mixed FG)*

4.3 Knowledge of Male Sterilization as a Birth Control Method

Some of the participants had heard of vasectomy whilst others had not. Only three participants from the men only focus group could give a vivid description of the procedure and others who said they had heard of it were not able to describe it. Key

informants for the study were FP service providers who were health workers and had some level of knowledge on vasectomy. Unfortunately, some of these health workers were also not able to explain the procedure in detail. Below are some quotes confirming the above assertion?

“I counsel men on vasectomy but I can’t give details to them to convince them to accept it the information. What I have on it is what I give them” (CHN, 28 years, KII)

“It is a procedure that is carried out in the hospital by a doctor. Your scrotum is cut open and the tube that stores your semen is cut and tied. Three months from the day of the procedure, you can have sex with your partner but you can’t impregnate her.” (Male, CHN 27 years, KII)

Below is an indication of statements of poor knowledge about vasectomy.

Included was a participant who had heard of the method, but he could not give the right description of the method and even mention the right sex that can use the method.

“You don’t hear nurses or people talk about it and also when you introduce it in your counselling, client reaction towards it tells you they have never or not much information about it.” (CHN, 28 years KII)

“Vasectomy? I don’t know or never heard of this family planning method before” (40 years, female FG)

“It is the one that they cut the inner part of the woman’s upper arm and fix something there (Male, 49 years MG)

The above responses show that information on vasectomy was inadequate and inaccurate.

4.4 Perceptions of Vasectomy

Perceptions are mostly based on one's knowledge and beliefs about something irrespective of the person's background and location. The participant's shared different sentiments which were either negative or positive perception of vasectomy. Following are some of the negative comments from the participants:

“In our local language ‘saa’ or ‘asaale’ means to castrate an animal, so if vasectomy is also called ‘saa’ in some local languages, in my view, then it is human castration and need not be accepted” (47 years, Male G)

“If you have sex and you don't ejaculate then you are blocking God's command on marriage and procreation, then why have sex because the essence of sex is the feeling you get ” (Male, 53 years, Mixed group)

“For me, I think when you do vasectomy, you will not enjoy sex like before and maybe the man will become impotent.” (CHN, 37 years, KII)

However, there were a few positive perceptions that were mostly influenced by people's beliefs, knowledge or educational levels as well as age (maturity) levels. In some cases,

living standards(income or occupation). For instance, a participant explained the differences between vasectomy and castration to other members of the group as follows:

“In castration of animals, the balls are removed from the scrotum, but in vasectomy the duct that carries the sperm is cut and ties and does not lead to impotence. (Male, 49years, mixed group).

“The fact that you will never have to worry about giving birth, it will give you peace of mind if you do a vasectomy, so it is good.”(27years, Male FG)

“I think it is a good thing for the men to do, because, men never stop giving birth, even at sixty, so it’s good for them.” (59yrs, Female FG)

4.5 Reasons for Use or Non-use of Vasectomy

Despite the realization that men have embraced the concept of family planning methods, it is not all the methods that have been accepted. Some methods have been fully understood and widely practiced by men. Yet others still seem new or probably unattractive to men as a birth control measure. One of such methods is vasectomy. The themes that emerged under the objective of use and non-use during the analysis included the possibility of use or non-use due to economic reasons, health reasons, educational level and future uncertainty. The study indicated that most participants would not like to use vasectomy because of the negative thoughts or perceptions such as those that participantssshared below:

“Personally, I am on a method, so I will not advise my husband to opt for it; I think my FP method is working perfectly. I don’t want him to be sexually weak” (CHN, 35yrs, KII)

“There is nothing I like about this method, I will use condoms, I am afraid! I may be impotent” (40yrs, Male FG)

The study also gathered a few positive intentions about the use of vasectomy as a birth control method such as, “because they will not have more children than they already have, they will be able to cater for the existing ones very well”. A man in the male focus group was prepared to modify his religious belief and opt for vasectomy because of economic hardship.

“If you have a lot of children you can’t pay their school fees, I want to give my children the highest of education. I did not go to school to a higher level, so...” (Male participant, 34yrs, FG)

“Most of the clients who accept vasectomy readily have read extensively about it before coming to the FP clinic. Most of them have made up their minds already before they come and so with the little counseling they accept the method.” (CHN, 28yrs KII)

However, some participants had mixed feelings, were uncertain of what the future held for them after taking up a vasectomy. Most women held the opinion that because vasectomy just prevents the men from impregnating a woman, the men may become promiscuous and bring home STIs especially HIV and hepatitis B infections, which could affect the health of both the man and all the women in his life.

Most of the participants expressed the above fears and concerns. Also, some study participants showed interest in the procedure till they found out that it is permanent and not reversible. The participants had the fear that the condition under which they made the decision to take up the procedure could change, for example, the death of a child. Participants also cultivated the fear that vasectomy could cause some health conditions or problems in the future, for example, a distended abdomen. As professionals providing FP services, some were not able to give concrete reasons for not allowing their partners accept vasectomy.

4.5 Knowledge on the Availability of the Male Sterilization Services in Particular Hospitals

Access is a direct determinant of use. As indicated earlier, the availability and source of information on vasectomy gave an indication of the level of accuracy and sufficiency of knowledge. Some hospitals and health centers may have the capacity for undertaking vasectomy, but if this information is not known by clients or men in the vicinity, they will not patronize the facility formal sterilization or birth control. The study sought to find out if the participants had knowledge of health facilities where vasectomy services were provided and how easily they could access those centers for their services. Below are some responses:

“We don’t know where to get the vasectomy services.”(Unison)

Almost all the participants did not know where vasectomy services were provided within Accra. Except only (3) three of the participants from the three focus groups had

knowledge of some of the health facilities that provide the services and below is their responses

“I know La General Hospital, Karle-Bu and Ridge Hospital provide the service. As I said earlier, I wanted to do it, but I realized my wife was in her menopause, so I did not continue to-doit, the nurse gave me the names of these health facilities.” (Male 49yrs, Mixed FG)

“I know police, hospital, La General Hospital. They are the two hospitals I know that you can get vasectomy services.”(53yrs, Male FG)

‘I do know every hospital should provide this service, but I prefer to go Elsewhere for the services, because many of my people may meet or see me there’ (male 45years, mixed group)

Some of the participants who were ready to accept vasectomy were of the opinion that because there are other facilities that provide the method too, if the need arises, they would go elsewhere to do it for fear of stigmatization. These findings clearly showed that nearness of the health facilities did not influence men’s readiness to take up vasectomy.

‘vasectomy acceptors can get the services from La General Hospital the main vasectomy training site for doctors, Karle- Bu teaching hospital, Police Hospital and two NGO s; Marie Stops International(MSI) and Planned Parenthood Association of Ghana (PPAG)’. (PHN, 45years KII)

The study indicated that, most non-health workers had poor knowledge of the facilities where vasectomy services could be obtained, but on the other hand, almost all the health workers knew where the services could be obtained in Accra

CHAPTER FIVE

5.0 DISCUSSIONS

5.1 Introduction

This study was designed to explore community perceptions about vasectomy and in what ways these perceptions might influence the use of the male sterilization in the La Dadekotopon Municipality, Accra.

5.2 Knowledge of male sterilization as familyPlanning Method

The study revealed that, some participants and key informants had heard about vasectomy, but were not able to give detailed information which is similar to the findings of Char, Saavala & Kulmala, (2009), there was not much knowledge about vasectomy and it was evident and clear that the low acceptance of vasectomy is not completely due to resistance from men to the method, but because of the inability of health workers to make information accessible and available to the public.

Though knowledge played an important role in the uptake of vasectomy, the study revealed that the actual decision for acceptance of the method was a household one as mostly husband and wife had to decide as Saoji et al. (2010) also found out that wives were concerned with the possible outcome of the act which they feared could result in poor sexual performance. The above assertion was looked into by some participants who were educated, had in-depth knowledge about vasectomy as compared to those with low level or no formal education, this was also revealed by a family planning project in Ghana (Pile JM, et al. 2009).

5.3 Perceptions about Vasectomy

The health belief model suggested that it is likely that an individual would take an action, such as opt for vasectomy, based on the interaction between his beliefs. The findings of the study showed that people had inadequate knowledge which has led them into both the negative and positive perceptions about vasectomy. Negatively, male sterilization was still perceived or equated to castration, which leads to sexual weakness and impotency, as the term castration has a lot of negative connotations in our Ghanaian communities. Castration is only known to be a practice linked to male animal; hence a man who is vasectomized is likely to be seen as such. Participants had other negative thoughts and feared the future uncertainty. The above findings were similar to the findings from researches conducted by the following researchers: Adongo et al. (2014); (Bankole, Singh, 1998); (Rutenberg, & Landry 1998) and (AQUIRE Project, 2008); which indicated that some communities understood male sterilization to be castration of men. In addition the fear of sexual weakness made women take strong positions against vasectomy as were similarly found by (Ross, Karen, Elisabeth et al, 2002). Both men and women feared vasectomy may lead to divorce as it would be difficult for couples to stay together when the man is sexually weak. This perception made the decision of men to accept vasectomy a difficult one as women were quick to make their voices heard on this decision as they are direct beneficiaries or otherwise of the outcome. This was similar to the findings of Bounce et al. (2012).

The health belief model also predicted that, action would be taken to protect or promote a man's health if he perceived himself to be susceptible or at risk for consequences of large family size, ill health, malnutrition, burden on family and on social

amenities. Certain times the demographic characteristics influence the individual judgment or assessment of issues. If adequate information is given to couples through all forms of media and the use of satisfied vasectomy clients in health education and promotion activities and they take into consideration the perceived benefits and perceives less barriers, their perception and behavior would change to accept male sterilization. Many frontline health workers with whom the public comes into contact often lack the required information. These challenges increased unwillingness of men to accept the method. Apart from the thought that vasectomy was painful, it did not prevent sexually transmitted infections; hence many men who were interested in prevention of sexually transmitted infections would not see vasectomy as a preferred method. This findings are almost nearly the opposite to Bounce et al.'s (2007) report that men and women of Tanzania believed that male sterilization would result in decrease sexual act hence prevents the occurrence of the STI's. Most couples in the study used other forms of modern contraception but there was a real and imagined use of 2 tablets of Paracetamol before or after each sexual act as contraception, which is similar to the findings of Adongo et al. 2014 in part of Ghana and Bounce et al. 2012 in Tanzania. In Ghana, the involvement of men in contraception does not seem to be very well documented, because family planning is mostly perceived to be associated with women, and this made men perceive vasectomy to be a way of reducing their masculinity, hence men preferred condom use to vasectomy.

There were few positive perceptions about vasectomy. Most of the participants agreed that with the current economic situation, vasectomy could be the best birth control method as the number of children one has could have a direct impact upon their

economic well-being. Most participants who would have liked to have accepted vasectomy if they had had enough children and accurate information would also have accepted the method, provided that their potency and strength after the procedure was assured. Some participants whose educational levels were up to the tertiary were able to outline the differences between vasectomy and castration. Some of them believed that the benefits of taking action would outweigh the cost or barriers which would enable the individual to opt for vasectomy. These details suggested that provision of knowledge and demonstrations or simulation of the procedures to the public could influence their perception about vasectomy.

5.4 Availability and Use of Vasectomy Services

Access is a direct determinant to use, and as indicated earlier, the availability and nearness of a service centre may influence the uptake. Some hospitals and health centers may have the capacity for undertaking vasectomy, but if this information is not known by clients in the vicinity, they will not patronize the facility for male sterilization. Almost all the participants in the FGDs did not know where specific vasectomy services were provided within Accra, except 3 people had knowledge of some of the health facilities, but because of stigmatization would not like to use La General Hospital, which is nearer to them, but preferred other hospitals. These findings clearly showed that proximity to the health facility did not influence couple's or partners' readiness to take up vasectomy as a birth control method. These findings differed from (AQUIRE Project 2006, & 2008), (AVSC 1998); (Pile JM, Barone MA 2009), who found several other reasons for non-vasectomy participation, except the above-mentioned one.

Almost all the health workers knew where the services could be obtained in Accra, but the non-health workers had poor knowledge of the facilities where vasectomy services could be obtained. A clear signal has been given that health promotion is not effective on this issue. Whenever the individual received supportive cues to action, such as media advertisement or publications, the use of the role models example satisfied vasectomy clients in family planning health education to trigger a response to opt for male sterilization. In summary, the individual's perception of the risk, or consequences, benefits, barriers or challenges of the condition or situation also may depend on demographic characteristics such as age, sex, education, income /occupation and, religion. Promoting change in belief or perception, may lead to changes in vasectomy acceptance which in turn could contribute to improved health systems.

5.5 Study Limitations

There were few restrictions to note, the FGDs and KIIs were conducted in the local languages, Twi and Ga. Hence, data transcription into English posed a lot of problems and there could be few biases, which could affect the original meanings. The principal investigator rectified the shortcomings during the transcription and revised them when necessary to arrive at the overarching themes for analysis.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This section outlines the conclusion of the study based on the findings and discussions and makes recommendations for improvement of the current situation. Conclusively, male sterilization is still perceived to be synonymous to castration which is a negative perception. Certain factors were identified as contributing towards the negative stands, such as knowledge inadequacy, fear of the unknown in the future, and misconceptions.

Despite all these concerns raised, there was willingness of some men to undertake the procedure if it is properly explained to them. The stand of the religious (30Christians and 14Muslims) in the study indicated thereis much to be done in the mosques and chapels concerning vasectomy. Though the use of vasectomy is not as high as other methods whose informations are clear and well understood, thereisthe hope of its acceptance, as men who have undergone the practice couldbe used as,health educators to share their experiences , to express positive views about the safety and the benefits of vasectomy.

6.2 Recommendation

To improve male sterilization uptake, there is the need for health service providers to build up capacity and make available, adequate, and understandable information and services on male sterilization to all couples / partners to prevent unintended pregnancies and family planning should be integrated into the daily activities of every health worker. To discuss with policy makers and advocacy groups, in the propagating of the good

news about vasectomy. Also use social platforms for health education because they have large number of followers and listeners.

Since the study also indicated that their proximity to health facility does not influence readiness of men to accept vasectomy, but rather promote stigmatization it is recommended that social gatherings should be used to dispel myths, misconceptions and to prevent stigmatization.

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APPENDICES

Appendix 1: Informed Consent Form

Title of Dissertation: Community Perceptions of Male Sterilization as a Birth Control Method--Study within the La Dadekotopon Municipality, Accra

This informed consent form has two parts:

1. Information sheet (to share information about the study with you); and
2. Certificate of consent (for signature should you choose to participate in the study)

You will be given a copy of both to keep

Part 1: Information sheet

Institutional Affiliation:

School of Public Health,

College of Health Sciences,

University of Ghana, Legon.

Background and Personal Introduction:

Name of Principal Investigator is Emma Afari, amaster's student of the Applied Health Social Science Department of the above school. Tel. 0244574998. Email: efari13@yahoo.com this study is for academic purpose and requirement for the award of Master of Science Degree in Applied Health, Social Science Degree and supervised by Dr. Phyllis Dako-Gyeke of School of Public Health University of Ghana, Legon.

Procedure:

Participants would be in two groups for the FGD and KII. The community members 18years and above would be expected to give demographic details verbally and answer focus group discussion guides Family Planning service providers would be expected to answer the Key Informant Interview guides.

The discussion would be tape recorded with your permission; it will last for 1-2 hours, and 20-45mins respectively. Your participation would be so much appreciated.

Possible Risk or Benefits:

There will be no invasive procedure, so the study will not pose any harm to the participant. There will be no incentive attached for participation in this research, whilst the benefits that may arise include a greater contribution to vasectomy knowledge.

Right to Refuse: Participation is voluntary you can choose to temporarily or permanently terminate the discussion, whenever you like, no punishment is associated, but since your opinions are important we need your co-operation and full participation.

Anonymity and Confidentiality:

You are assured that whatever information you provide will be taken with strict confidentiality and will be purely for research purpose, Data collected and storage would be done by Emma Afar the principal investigator.

Before taking Consent:

Do you have any questions that you want addressed now or later? Or any other clarification regarding the research, please do not hesitate to contact the principal

Investigator on phone - number above and email. Contact for additional information if you have any information as a participant or feel you were not treated fairly, you can call the phone number of the review board of the Ghana health Service Nana Arena Kwaa Addai Donkoh at 0244712919.

Part 2: Participant's Certificate of Consent

I, have been adequately informed about the purpose, process, and declare that the purpose, including risk and benefits of this study have been thoroughly explained to me and I have read the purpose including risks and benefits of this study thoroughly. I hereby agree to take part in the study.

Signature.....or

Thumbprint.....,date.....

Interviewer's Statement: I have explained the process to be followed in this study to the participant in a language that he/she understands best and he/she agreed to participate in the study.

Name of Interviewer.....

Signature of Interviewer.....

Date.....

INSTRUCTIONS FOR FOCUS GROUP DISCUSSION WITH A GUIDE

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, knowledge and reasons for use or non-use, of male sterilization as a birth

control method. The discussion will take not more than 2 hours. I may audio tape the discussion to facilitate its recollection. Anonymity despite being taped, I would like to assure you that, the discussion will be anonymous. The tapes will be securely kept and also stored in an email transcription, word for word, line by line, and then they will be destroyed 2 months after the study. The transcribed notes of the discussion will contain no information that will allow individual subjects to be linked to specific statements even with the type written one. You should try to answer or comment as accurately and truthfully as possible. We will all appreciate it, if you would refrain from discussing the comments of other members outside the group. Full participation is required in all questions raised

Ground Rules;

1. Only one person speaks at a time.
2. You do not have to speak in any particular order, but with respect for others
3. There are no wrong or right answers

APPENDIX 2. Focus Group Discussion Guide

SECTION A

Background/ Demographic data characteristics of participants (please tick appropriately)

1. Age
2. Sex -: Male () F ()
3. What is your religious affiliation?
 - a. Christianity ()
 - b. Islam ()
 - c. African traditional religion ()
 - d. Others (specify) ()
 - e. No religion ()
- 4 Income/occupation
- 5, educational Level

SECTION B

Knowledge on vasectomy as a birth control method

4. What is family planning?
5. Do you know of any birth control method for men? Mention them?
6. What is vasectomy?
7. How and where did you hear about vasectomy?
8. Who told you about vasectomy?

9. Mention some side effects or complications of vasectomy?

SECTION C.

Perception of vasectomy as a birth control method

10. What do people say about vasectomy?

11. What do you think about vasectomy?

12. What are your perceptions about vasectomy?

13. What are peoples; opinion about it?

SECTION D

Reasons to patronize or not to patronize vasectomy

13. How much does vasectomy cost?

14. Which hospitals or clinics provide vasectomy services?

15. Who can utilize vasectomy?

16. For how long can it be used?

SECTION E

FOCUS GROUP DISCUSSION NOTE TAKING FORM

Instructions: Please use this form to record the proceedings of the focus group. Notes should be extensive and accurately reflect the content of the discussion, as well as any salient observation of non-verbal behavior, such as facial expressions, hand movement, group dynamics etc.

Please specify which focus group you are recording (please tick one)

- 1. Tenashie zone { }
- 2. La North zone { }
- 3. La Southzone { }

DateLocation

Name of Note Taker

NOTES:.....

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INSTRUCTIONS FOR KEY INFORMANT INTERVIEW with GUIDE

- (a) Explain the purpose of the interview to the health worker
- (b) Administer consent before proceeding with the interview
- (C) Make sure all questions are answered
- d) Please answer honestly to the best of your knowledge
- (f) Ask for clarification wherever necessary.

GUIDE FOR KEY INFORMANT INTRVIEW FOR FP SERVICE PROVIDERS

GUIDENumber { }

Date:

Name of health facility:

Municipal/ district/ sub metro:

Educational Status

Religion.....

A.KNOWLEDGE ON VASECTOMYAS A BIRTH CONTROL METHOD

1. Do you know of any birth control method for men? Name them?
2. What is vasectomy?
3. What do you know about vasectomy?
4. What do you think about vasectomy?
5. Where did you first hear about vasectomy?

B. PERCEPTION ABOUT MALE STERILIZATION AS A CONTROL METHOD

6. Have you ever heard about vasectomy?
7. What are your perceptions about vasectomy?
8. What do think about vasectomy?
9. Do you know any other place where it is performed apart from here?

C. REASONS FOR USED OR NON-USED

10. Have you done vasectomy?
11. If yes, what is your motivation for doing it, if no why?
12. Would you like your husband, partner or relation to do vasectomy? Explain?
13. During FP clinics do allow clients to make an informed choice? Or you choose for them?
14. Do you know of any vasectomy sideeffects or complications?
15. What are your impressions about those who opt for vasectomy?
16. How can the uptake be increased in the La Dadekotopon municipality?