UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF NURSING SCIENCES

FACTORS INFLUENCING VASECTOMY ACCEPTABILITY IN KABWATA TOWNSHIP LUSAKA DISTRICT - ZAMBIA

BY

Miyanda Nzobokela

Bsc. Nursing, RM, RN

A Dissertation submitted to the University of Zambia in Partial fulfilment of the requirements for the Degree of Master of Science in Nursing

SEPTEMBER, 2013

DECLARATION

I Miyanda Nzobokela declare that this Dissertation represents my own work and that all the sources I have quoted have been indicated and acknowledged by means of complete reference. I further declare that this dissertation has not previously been submitted for a degree or diploma or other qualifications at this or other university. It has been prepared in accordance with the guidelines for Master Degree in Nursing Sciences dissertations of the University of Zambia.

Signed …… Date ……

Candidate

Signed …… Date ……

Supervisor

Signed …… Date……..

Supervisor

CERTIFICATE OF APPROVAL

The University of Zambia approves this dissertation on Factors Influencing Vasectomy Acceptability in Lusaka District in a partial fulfilment of the Master Degree in Nursing Sciences.

Examiner`s Signature…… Date……..

Examiner`s Signature…… Date……..

Examiner`s Signature…… Date……

DEDICATION

I dedicate this study to my late father Anderson, and to Uncle Justin for their support and encouragement rendered to me throughout my life.

To my mother and my sisters for their continued support.

My beloved children Jennipher, Joseph and Lisa for their undivided love, support and prayers to enable me complete this study successfully.

To all my grand-daughters, nephews and my sister-in-law Inonge for every support each one of them rendered to me.

ACKNOWLEDGEMENTS

My heartfelt gratitude goes to Dr Catherine Ngoma my Supervisor and Dr. M. C. Maimbolwa, Co Supervisor for the tireless efforts rendered to me for this study to be successfully completed.

I also want to thank the following:

Ministry of Health for sponsoring me during my training.

The staff of Lusaka District Medical Office for permission to conduct this research.

The staff of Kabwata Health Centre for a lot of support rendered during data collection.

My classmates, for their advice and constructive critical analysis of my study.

My beloved children for their encouragement.

To also various people who contributed in anyway including all examiners who spared their time and efforts to have this document complete.

Above all the ALMIGHTY GOD for inspiration and everything.

ABSTRACT

The study aimed at identifying factors affecting vasectomy acceptability among men. It sought to answer the research question: What are the factors that may be associated with vasectomy acceptability among men?

This was a cross section study that was conducted in Kabwata Township in Lusaka. Data were collected using a semi-structured interview schedule and a focus group discussion guide. The respondents who were interviewed were selected by a systematic sampling method and those for focus group discussions were purposively selected. A total of 245 respondents were interviewed and the response rate was 100%. In addition, 13 participants took part in the focus group discussions.

Quantitative data were analysed using SPSS version 16.0. The Chi-square test and Fisher`s test were used to determine associations between the independent variables with the dependent variable. Qualitative data were analysed using content analysis.

The findings revealed that the majority of the respondents 180 (73.5%) indicated that vasectomy was not culturally right and that men must not undergo vasectomy. The majority of the respondents felt that family planning was a woman's responsibility and men should only give support to women by allowing them to go for family planning. Most of the respondents 128 (51.8%) stated that men should not be involved in matters concerning women, and 209 (85.4%) indicated that family providers influenced client's choice of vasectomy as a method of family planning.

The findings revealed that 152 (64%) of the respondents had a negative attitude towards vasectomy as they believed that it was not culturally right in the community. In addition, most of the focus group participants were of the view that if a man undergoes vasectomy the man was no longer able to function as a man because sexual activities would be reduced. The study showed that 80.9% of the respondents did not know where vasectomy services were obtained, and 225 (91.8%) said that vasectomy services were not accessible.

Most 209 (85.4%) of the respondents indicated that health workers did not receive people who sought vasectomy services well, and 215 (87.8%) stated that the attitude of family planning providers on vasectomy was poor.

The Majority of the respondents indicated the need for increased sensitization on vasectomy and other family planning issues through the private and public media. Therefore, there is a need to design a programme to promote awareness about vasectomy. Information and education materials on vasectomy should also be supplied to the communities. Vasectomy services should be scaled up in the provinces to enable easy access to the service by many clients.

In conclusion, there are factors that influence vasectomy among men. The study also concluded that participants knew little is known on vasectomy

Key Words: Factors, Vasectomy, Acceptability

TABLE OF CONTENTS

CONTENT **PAGE**

CHAPTER TWO

Literature review

3.0 RESEARCH METHODOLOGY

CHAPTER 4

Data analysis and presentation

CHAPTER 5

Discussion of findings

LIST OF APPENDICES

List of figures

List of tables

LIST OF ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome
CSO – Central Statistics Office
DHO – District Health Office
FGD – Focus Group Discussion
FP – Family Planning
MoH – Ministry of Health
NGO – Non Governmental Organisation
NSV – No Scalpel Vasectomy
SPSS – Social Sciences Statistical Package
UN – United Nations
UNFPA – United Nations Population Fund
USAID– United States Aid
UTH – University Teaching Hospital
WHO – World Health Organisation

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Vasectomy is male sterilization by surgical excision of the vas-deferens, the thin duct that carries sperm cells from the testicles to the prostate gland and penis. Vasectomy is a permanent method of family planning that is simple, safe and effective. This gives vasectomy an advantage over other methods as it is effective. The safety of an individual after the procedure is assured. This is because services are provided in big hospitals mostly with adequate equipment and skilled personnel. Side effects for vasectomy are mild and not permanent (transient) (USAID, Johns Hopkins and WHO, 2007).

After undergoing vasectomy, a man can still have an erection and ejaculate semen, but the semen no longer makes a woman pregnant because it has no sperm. Vasectomy is very effective as a method of family planning after twenty (20) ejaculations or three (3) months after the operation (Cook et al., 2004).

The vasectomy procedure can only be performed by qualified medical personnel. It does not prevent sexually transmitted diseases/infections including HIV and AIDS (Cook et al., 2004). Reversal of vasectomy is difficult, expensive and not available in most areas of the world and success cannot be guaranteed (USAID, Johns Hopkins and WHO, 2007).

There is also no possibility that the reverse can always lead to pregnancy. Therefore vasectomy is considered as a permanent method of family planning.

The surgical intervention method of contraception has shown to be accepted by women than men. Despite the fact that vasectomy is safer, simpler and effective, it is underutilized and relatively unknown in Zambia. For quite some time in Zambia family planning has targeted women yet the population growth rate is still high. While reports show men in developing countries to make most of the decisions regarding family information (Bankole & Singh, 1998), research has also shown that men need information and want to be involved in reproductive matters (PIP, 1994). This

opportunity can be taken to involve men and make male methods of contraception be utilized. Throughout the world, vasectomy is one of the least used and least known method of contraception (Jacobstein and John, 2007) whereas female sterilization is twice as common as male sterilization in the developed world, in Asia, it is eight (8) times more common and in Latin America and the Caribbean it is fifteen (15) times more common (Bob's Blog, 2007). In Sub-Saharan Africa the rate of male sterilization are too low for accurate comparison. Worldwide tubal ligation accounts for more than five (5) times as many procedures as vasectomy (PBR, 2002). In Africa the prevalence of vasectomy is zero percent (0.1%) (Bunce et al, 2007) and has remained relatively stable throughout the past decade.

In Zambia, vasectomy services are offered at the University Teaching Hospital (Tertiary Hospital). These services have been put in place by the Zambian Ministry of Health in order to encourage people to undergo vasectomy. There is also training of more surgeons who will among other services help to conduct vasectomy. This is one way of encouraging men to participate in family planning. The Government family planning policy is to make the services available, affordable, and accessible to both men and women. Until policy makers consider strategies that address both family planning demand creation and supply of services, progress in Zambia and the rest of sub-Saharan Africa will continue to lag behind the rest of the world. It is therefore worthy to consider vasectomy as one of the effective methods of family planning. This study therefore, investigated the acceptance of vasectomy as a male contraceptive method among married men in Kabwata Township in Lusaka, Zambia.

1.2 PROBLEM STATEMENT

In many developing countries including Zambia, male acceptance of fertility regulation is substantially lower than of women as men often think that fertility regulation is women`s affair (Keremat, et al, 2011). However, it is important to change this practice so that women are no longer left alone in matters of fertility regulation, but work in partnership with men. The continuation of male negative attitudes towards fertility regulation has a negative effect on women`s health, as many women are dying from

childbirth (Saudi, 2002). Women must be protected from unnecessary deaths due to child birth. Furthermore, making women the focus of family planning activities has marginalized men and left male attitudes towards fertility control unchanged (Saudi, 2002).

Male participation in family planning especially by accepting and utilizing vasectomy is crucial. It can help the government attain Millennium Development Goal (MDG) number five (5) which aims at reducing maternal death by three quarters (¾) by the year 2015. Government and Non-Governmental agencies and international health organizations have recognized the need to include men in reproductive health matters and services (Network, 2004; UNFPA, 2003; WHO, 2002). This recognition should give impetus to governments to encourage males' participation in family planning. One way to foster male involvement in family planning is to give couples more contraceptive choices through promotion of male orientated methods such as vasectomy.

Vasectomy as a family planning method is still underutilized world-wide, especially in developing countries (Bunce, et al., 2007). The estimated number of couples using vasectomy worldwide in 2001 was forty-three (43) million. In 2002, vasectomy was made up only seven percent (7%) of all modern contraceptive use world-wide (Population Reference Bureau, 2002). The same report indicates that in Africa vasectomy use is zero percent (0.1%). In Zambia statistics show that vasectomy prevalence is ten percent (10%) (CSO, 2006), and tubal ligation among women is sixty-four percent (64.6%) (CSO, 2006). This shows that women participate far more than men in permanent methods of family planning.

In Lusaka District, thirty-six (36) men obtained vasectomies between 2003 and 2009, whereas one hundred and ninety-six (196) women received tubal ligations between 2007and 2009. These statistics indicate that vasectomy is not a popular method of family planning among men. Therefore, there is need to determine factors affecting vasectomy as a method of family planning with the view of increasing men participation in family planning services.

1.3 FACTORS INFLUENCING ACCEPTABILITY OF VASECTOMY AMONG MALES

Factors influencing acceptability of vasectomy among males may be classified into two broad categories: service-related factors and socio-cultural/economic factors.

1.3.1 Service related factors

Availability and Accessibility of service

Vasectomy services must be made available for people to be able to utilize them. People must know what services are there and where to find them. Poor accessibility of the services for vasectomy may hinder or prevent people from using vasectomy services. Some men live far from where the services are and fail to access them when they need them. This is because currently this service is mainly offered at the University teaching in Lusaka. This makes it impossible for the rural people to travel from rural to UTH where vasectomy services are provided. Some people do not use these services because there is no privacy.

Qualified health practitioners

Vasectomy requires a qualified person to do it and these qualified people may not be readily available. Most of the facilities in Zambia are badly hit by critical shortage of required staff.

Attitudes of staff

Attitude of staff available must be positive towards clients and the services that clients need to get. If staff attitudes are negative, they will not provide information that will encourage people. This may make people shun the services. The staff must also have knowledge about vasectomy to give to clients who seek vasectomy services.

Referral system

The referral system is also not effective enough to allow people who want to have vasectomy done reach the available services. Health centres and hospitals that do not have vasectomy services must refer clients to where they will be able to get the services. The referral system must be clear and known by all users to promote service delivery and avoid confusion.

Cost

Vasectomy services may be provided at a cost which may make people not to afford to have it done.

1.3.2 Socio-cultural and economic related factors

Myths, fears and misconceptions

Myths, fears and misconceptions about the vasectomy procedure may influence acceptability of vasectomy among men. Many people believe that men cannot function as men sexually or won't have an erection after the procedure. These beliefs, however, are not true and can be misleading to people who want to have vasectomy done as a permanent method of family planning. They may lead to stigmatization of clients who undergo vasectomy. Fears or myths and misconceptions must be cleared so that men can utilize this method without fear.

Lack of knowledge

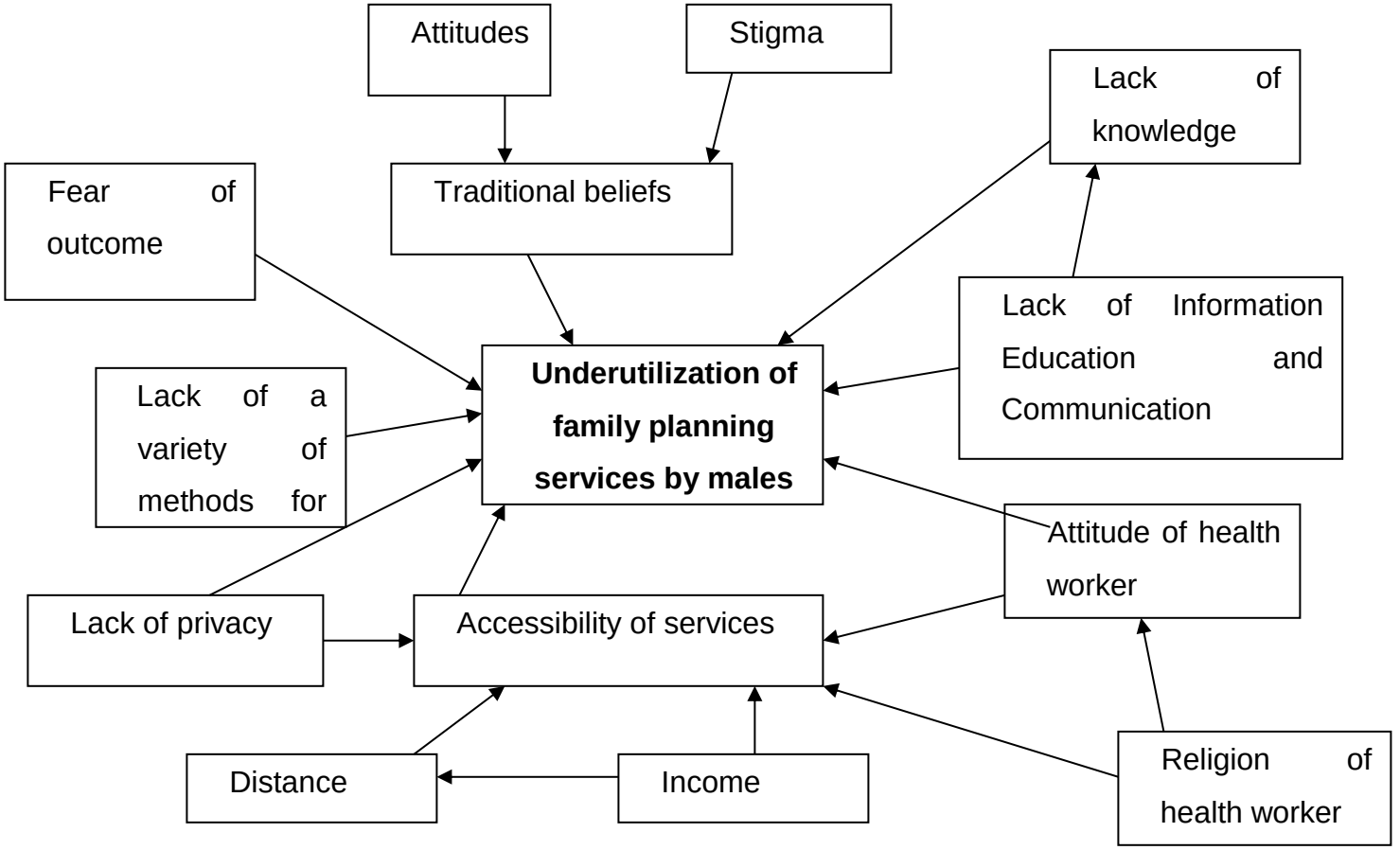
Lack of knowledge on vasectomy may also hinder people from getting the services. People need to have the knowledge about vasectomy in order to utilize vasectomy services available for them. Traditionally, family planning is believed to be an activity or affair for women only. Men therefore shun family planning. There is a need therefore for partnership in family planning utilization. Service providers also must be knowledgeable about vasectomy.

Religious beliefs of worker/client

Religious beliefs of the health care workers may also be a barrier to family planning services.

For example, if the health worker is a strong Roman Catholic who believes that artificial family planning is not good and should not be practiced, these beliefs will be a barrier to acceptance of vasectomy. The client also may belong to the Roman Catholic Church which advises their church members not to use family planning because it is believed to be another way of ending human life. It is important to explain that vasectomy is not a method that involves any killing because sperm is not able to meet the ovum and cannot make a baby.

PROBLEM ANALYSIS DIAGRAM



1.4 THEORETICAL FRAMEWORK USED FOR THE STUDY

To answer the research question, the Health Belief Model (HBM) provided a conceptual framework on which this research was based. The HBM is developed to provide a framework to explain why some people take specific actions to avoid illness while others fail to protect themselves (Polit & Beck, 2004). The HBM postulates that health-seeking behaviour is influenced by a person's perception of the threats posed by a health problem and the value associated with the actions aimed at reducing the threat.

According to the HBM, an individual will take a health related action if that person feels that a negative health condition can be avoided, has a positive expectation that by taking a recommended action, the negative health condition will be avoided and believes that one can successfully take the recommended action. Based on these assumptions, it could be concluded that without men's perceptions of having many children as threat, there could be no resultant prevention action (undergoing vasectomy).

In terms of the HBM's roots in value-expectancy theory, attitudes are developed and modified based on assessments about beliefs and values. Sensitivity to risks depends on many factors. It depends on behaviours such knowledge of vasectomy and its benefit, cultural beliefs and values.

1.5 JUSTIFICATION OF THE PROBLEM

Currently the maternal mortality rate in Zambia is five hundred and ninety-one per thousand (591/100,000) live births (CSO, 2008). This figure is very high. In addition, there are five thousand (500,000) live births every year in Zambia and the total fertility rate is about six (6.2) (MOH/CSO, 2008). Together with other nations, Zambia has made commitments to achieving Millennium Development Goal five (5) to reduce the maternal mortality rate by three quarters (3/4) by the year 2015. One of the ways of reducing the maternal mortality rate is by encouraging men to participate in reproductive health matters including family planning. It is clear that involvement of men in family planning by encouraging them to undertake vasectomy could contribute

to the reduction in maternal mortality and morbidity and in turn lead to improved maternal and neonatal health. This is because the number of women who die from pregnancy related complications will reduce. Vasectomy reduces pregnancy rates.

This study therefore attempts to investigate factors affecting acceptability of vasectomy among men with a view of improving the uptake of vasectomy. Furthermore, not many studies have been conducted on this topic in Zambia. This study will therefore, assist by generating data that can be used as a basis for subsequent studies and investigations. It is hoped that the findings of this study will be utilized by policy makers, health care workers providing family planning services, Non Governmental Organizations (NGOs) and all concerned stakeholders to form effective strategies on how to promote vasectomy and to improve service delivery.

1.6 RESEARCH QUESTION

What are the factors that may be associated with vasectomy acceptability among men?

1.7 RESEARCH OBJECTIVES

1.7.1 GENERAL OBJECTIVE

To determine factors influencing vasectomy acceptability among men in Kabwata Township, Lusaka, Zambia.

1.7.2 SPECIFIC OBJECTIVES

1. To assess men`s level of knowledge on vasectomy.
2. To identify socio-cultural factors that influence vasectomy acceptability among men.
3. To determine between knowledge on vasectomy and willingness to undergo vasectomy.

1.8 CONCEPTUAL DEFINITION OF TERMS

1.8.1 **Acceptability**: This is when a man agrees that vasectomy is good and that people must be encouraged to have it done willingly (USAID, JOHNS HOPKINS, WHO, 2007).

1.8.2. **Vasectomy**: A surgical procedure made to block the sperm so that the man cannot make the woman pregnant and used as permanent method of family planning (USAID, JOHNS HOPKINS, WHO, 2007).

1.8.3 **Family planning**: This refers to spacing of births of children to enable one to have children when they are ready (USAID, JOHNS HOPKINS, WHO, 2007)

1.8.4. **Men**: Adult males (Collins Pocket English Dictionary, 2005)

1.8.5 **Factors**: Elements contributing to a result (Collins Pocket English Dictionary, 2005).

1.9 OPERATIONAL DEFINITION OF TERMS

1.9.1 Knowledge: This variable was measured by using seven (7) “Yes and No” items, for instance, heard about Vasectomy, Source of information, seen or know a person, who has vasectomy done, definition of vasectomy, vasectomy services accessible, where to access them and whether vasectomy is beneficial). Knowledge level was categorised into high level (scores between 5 and 7), medium level (scores between 4 and 3) and low knowledge levels (scores below 2).

1.9. **Acceptance**: This was ascertained by three (3) “Yes and No” items on the interview schedule such as vasectomy is good, people must undergo vasectomy, and willing to undergo vasectomy.

1.9.3 **Traditional beliefs**: This was measured by five (5) items on the interview schedule. Respondents were to mention how people in the community look at a

person how has vasectomy done, whether men should participate in family planning matters, whether they discussed family planning openly, whether they think it is cultural right for a man to have vasectomy done).

1.9.4 **Attitudes**: Attitudes of health providers were measured by two (2) items on the interview schedule. Respondents' were asked to state whether health care providers' received clients who sought vasectomy services well and whether family planning providers gave information, education and communication on vasectomy.

1.10: VARIABLES AND INDICATORS

Table 1: Variables and indicators used in the study

VARIABLES	INDICATORS	CO	INTERPRETATION
INDEPENDENT VARIABLES			
Participant`s knowledge on vasectomy	If one gets 7- 5 marks	1	High
	If one gets 4-3 marks	2	Medium
	If one gets below 2 marks	3	Low
Attitude of Health Providers towards vasectomy			
	Positive	1	In favour of vasectomy
	Negative	2	Not in favour of vasectomy
Traditional beliefs associated with vasectomy			
	Present	1	Within the respondents reach
	Not Present	2	Out of the respondents' reach
DEPENDENT VARIABLE			
Acceptability of vasectomy	Yes	1	Wants to have vasectomy done
	No	2	Does not want to go for vasectomy

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Chapter two provides information on the literature review. The review focuses on studies conducted on vasectomy acceptability. Sources of literature include books, articles from professional journals, and the internet. The purpose of literature review was to establish what is known about the topic and to identify if there are gaps in the existing literature. The literature review is organized according to studies at the global, regional, and national levels.

2.2 GLOBAL PERSPECTIVE

The estimated number of couples using vasectomy worldwide in 2001 was forty-three (43) million. In 2002, vasectomy was made up of only seven (7%) of all modern contraceptives use worldwide (Population Reference Bureau, 2002). The same report indicates that in Africa vasectomy use is zero percent (0.1%). Whitehead in his study stated that although vasectomy is a simple, effective, safe and cost effective method of family planning it is more common in the developed than developing world. For instance, in the United States of America, about one out of six (1/6) men who are thirty-five (35) years and above, have had vasectomy done Whitehead (2002).

Whitehead (2002) conducted a study in the United States of America to determine the prevalence of vasectomy among the male folk. The study showed that ninety percent (90%) of the participants who were educated had vasectomy. The study showed a significant association between the prevalence of vasectomy, education and income.

A cross sectional study conducted by Ringheim (2003) in the United States of America indicated eighty percent (80%) of participants interviewed reported that family planning matters were for women and only five percent (5%) of men went for family planning. This shows that, men do not equally share the responsibility of fertility regulation with women. The responsibility of fertility regulation efforts has been exclusively towards women.

It is documented that there are some individual societal factors that affect vasectomy acceptability among men. For example a comparative and cross sectional study in the United States of America showed that ninety percent (90%) of men who had vasectomy were whites and only nine percent (9%) were blacks. It was noted that the prevalence of vasectomy was nine (9) times greater among whites as compared with blacks (Magnani, 1999). The purpose of this study was to determine the prevalence of vasectomy between whites and blacks. This study suggests that race could have an influence on vasectomy uptake.

In a study by USAID (2005) it was revealed that public motivation sixty-seven percent (67%), method twenty percent (20%), perception elven percent (11%), cultural tolerance five percent (5%), financial status and information available had some influence on vasectomy acceptability. The study concluded that if men were well informed about the effectiveness, safety and benefits they will be able to accept vasectomy and utilize it. In another cross sectional study Bankole and Sigh (2001) it was concluded that men need information on vasectomy. This study implies that male involvement in family planning could play a vital role fertility regulation and in improving women`s health.

A study done in New Zealand by Terry and Braun (2011) revealed that ninety percent (90%) of men were opting for vasectomy because of their desire to take their turn in family planning, eighty percent (80%) were going for vasectomy because of satisfied parity and seventy percent (70%) because of pressure from their wives. Only very few men, two (2) out one thousand (1,000) who have had vasectomy requested reversal of the procedure. This study shows that vasectomy is accepted and well utilized in other countries compared to Zambia where only zero percent (0%) of men utilize the service.

According to Philliber and Philliber (2006) the likelihood of sterilization increases with lower socioeconomic status in Bangladesh and India, while higher socioeconomic

status was associated with greater likelihood of sterilization use in Latin America and the Caribbean. In the United States, female sterilization use was more likely among those of lower socioeconomic status, whereas male sterilization use was more common among couples of higher socio and economic means. Philliber and Philliber (2006) also reported that sterilization was common among high parity couples. Couples in Asia and Latin America who used sterilization were those with the average of 4-5 children.

Scot et al., (2011), conducted a participatory ethnographic evaluation research study to understand the low prevalence of vasectomy in Uttar Pradesh, India. A total thirty-nine (39) women and twenty-nine (29) men participated in the study. The study showed that men and women reported negative attitudes toward vasectomy. Fears about weakness resulting from the procedure were common among both men and women and served as one of the main barriers to acceptance of vasectomy. Worry about the impact of vasectomy on men's sexual performance served as another barrier to use of the method and was more frequently expressed by women. Most participants didn't know that sexual performance would not be affected and feared the procedure, believing that only a courageous man would go for vasectomy. It was also noted that men would not tell other people if they had been sterilized, fearing being shamed and taunted by the community members who might refer to them using words as "***nomard"*** (meaning infertile). Women also worried that a sterilized man would be thought of as a "slave to his wife".

2.3 REGIONAL PERSPECTIVE

In Africa, vasectomy acceptability is low. For instance, in a survey done on vasectomy acceptability by Wilkinson (2006) in Kenya it was found that only two hundred and fifty-five (255) men had vasectomy done in sixteen (16) years despite continued sensitization. This indicates that more needs to be done to motivate men to go for vasectomy. The findings in the same study showed that vasectomy was actually being mistaken for castration. A study by Headman et al., (2009) in Kenya found that giving

information on vasectomy to men helps them to make informed decisions on vasectomy.

A study done in Tanzania by Bunce et al., (2007) revealed that factors contributing to vasectomy decision-making processes were economics thirty percent (30%), spousal influence ten percent (10%), religion, provider reputation and availability, uncertainty about the future twenty-three percent (23%), and poor vasectomy knowledge and understanding thirty-five percent (35%). The same study concluded that spousal discussions are important in the decision to have vasectomy done, but these discussions should be initiated by the male partner. Programs need to educate men about contraceptive options, including vasectomies. Detailed, culturally relevant knowledge of the barriers and facilitators individuals experience during their decision-making process will enable vasectomy promotion programs to more successfully target appropriate populations. However, in 1993 the first family planning centre for males opened in Kenya, Nairobi to provide counselling, and reproductive health and vasectomy services for men. The number of men who used vasectomy services rose sharply after sensitization. The men showed that they did not want children they could not care for (Admasu et al.,2012). This may have made them accept to undergo vasectomy to avoid having more children.

In Ghana, a pilot study was conducted to educate men on no scalpel vasectomy (NSV) and also to increase access to quality NSV (Engender Health, 2004). The study also intended to test whether vasectomy could become a viable contraceptive in a country where misconceptions and myths are common. It was noted that lack of information on vasectomy lead to myths and misconceptions eight-five percent (85%) which had in turn contributed to misgivings about using vasectomy method. Providers also did not know how to provide vasectomy services and were biased against doing so. The project after vasectomy awareness proved to be successful.

Evidence from another study in Ghana demonstrated that research can lead to change if there is meaningful involvement of stakeholders and if it is immediately

followed by action to implement recommendations (Malarcher, 2007). A program whose main objective was to expand vasectomy services was introduced in Accra and Kumasi. To spark the demand for vasectomy, a communication initiative was designed to serve as a catalyst for men considering vasectomy. The results showed an increase by thirty-five percent (35%) in the number of men requesting for the service.

A similar program was also introduced in South Africa Morocco and Zambia and the programme was reported to have been successful (Muhondwa, et al, 2007). These studies suggest that making the services accessible and raising awareness will help men to utilize the service.

The evaluation of the family planning program in Zimbabwe in showed that addressing men`s fears and concerns about family planning reduced their resistance to it (Ricco & Samson, 2002). The finding also revealed that men were not involved in family planning due to lack of knowledge and information on planning, religious and traditional beliefs which favoured men having large families, existing structures that hindered men`s access to reproductive health information and laws and regulations (Ricco & Samson, 2002). However, Zimbabwe took up the challenge of addressing the above mentioned issues by improving Information, education and communication (IEC) about family planning, providing services that meet the men`s needs and advocating policies that encourage men to participate in family planning programs (Ricco & Samson, 2002).

Although vasectomy is safer, simpler, and less expensive than female sterilization, sterilized women outnumber sterilized men by five to one, and vasectomy remains one of the least-known and least-used contraceptive methods. This is particularly true in Africa, where barely one thousand (100,000) couples use vasectomy (United Nations, 2006). In Tanzania, for example less than one percent (1%) of the population uses male sterilization.

The underutilization of vasectomy in Africa has often been attributed to men's lack of interest in family planning. However, research has confirmed that men in many African countries do in fact care about avoiding pregnancy and want to share the responsibility for family planning with their partners (Admasu et al., 2013; Drennan, 2001). Furthermore, evidence suggests that lack of access to vasectomy information and services is the principal reason for vasectomy underutilization (Vernon et al., 2003, Wegner et al., 2005).

An Ethiopian study by Admasu et al., (2013) revealed that majority of the participants eighty-two percent (82.9%) in their study never heard about vasectomy as a contraception method. Their knowledge about vasectomy was generally very poor as large proportion of the respondents did not know how it worked, its effectiveness and its effect on their asexual performance. None of the respondents had ever used vasectomy as a modern male contraception method. Misleading information towards its impact on sexual performance/desire was reported as a main reason not to use this method. Among others need of more children, unavailability of services, lack of information, spouse refusal and religious concerns were mentioned as a potential reason for their negative perception towards vasectomy. The study showed that lack of awareness, myths and rumours, limited access to services and indifference and bias on the part of the providers about vasectomy limited its popularity. The main aim of the study was to investigate the awareness about practice and practice of men towards vasectomy among workers in Dashen Brewery, Ethiopia. A total of one hundred and eighty-seven (187) randomly selected participants were included into the study.

2.4 NATIONAL PERSPECTIVE

In line with the Reproductive Health policy frame work, Zambia is now encouraging male involvement in reproductive health matters. For example, the policy emphasizes on male involvement in family planning since men are decision makers in most families. The policy addresses among other things the importance of variety of methods for clients to make a choice. It also emphasizes the importance of

accessibility and affordability of family planning services. In spite of this, very few couples in the nation have opted for vasectomy as a family planning method.

According to two collaborative surveys conducted by Muvundi et al., (2002) in the Copperbelt Province, on factors affecting vasectomy, ninety percent (90%) of reproductive health services still focused on Maternal and Child Health and family planning was utilized mainly women and children. Many men were still not utilizing male family planning methods as anticipated. Therefore, equipping men with knowledge on family planning may encourage male involvement in family planning.

In another development, the population reports (2004) revealed that Zambia had zero percent (0%) population using vasectomy as a family planning method by 1996; while a study done in 1997 showed that at least 5 men had vasectomy the previous year though the demand remained low. On the other hand, thirty-three percent (33%) of men interviewed were aware of vasectomy as a family planning method (CSO, 2003).

In a study conducted by Shikupa in 2000 in Lusaka urban district on knowledge and attitudes of men on vasectomy, fifty-four percent (54%) of the respondents had positive opinions about vasectomy and fifty-eight percent (58%) felt that vasectomy should be encouraged. Contrary to these positive views, when asked whether they could have vasectomy, sixty percent (60%) of the men declined the method because they felt that the method was not of the Zambian culture as it values having many children while others feared being impotent. Others said it is against God's will (Shikupa, 2000; Sianchapa, 2005). Shikupa 's study recommended that the Government through the Ministry of Health should to expand method mix for family planning methods, provide continuous information education and communication and to offer guidance to men.

Evidence from Malawi, Zambia and Ghana demonstrate that uptake and sustained use of modern family planning methods including vasectomy can occur in even most poor, resource stripped and large rural countries (Malarcher, 2007). This implies that

Zambia, even if poor, can still make use of modern family planning methods including vasectomy.

Until policy makers consider strategies that address both family planning demand creation and supply of services, progress in Zambia and the rest of sub-Saharan Africa will continue to lag behind the rest of the world. It is therefore worthy to consider vasectomy as one of the effective methods of family planning.

2.5 CONCLUSION

The literature clearly shows that most of the countries worldwide are supporting the uptake of vasectomy following the idea of male involvement in reproductive health matters. This is evident in measures taken such as introduction of male family planning projects and clinics to create awareness and provide vasectomy services. However, despite all these efforts put in place by those countries to ensure the successful implementation of the vasectomy programmes, the uptake of vasectomy is still very low in Africa (not in the U.S. and Australia according to your review). This means that there may be still problems in how the programmes are run and delivered. The study may help to reveal some of these shortfalls.

Furthermore it is also evident that most of the studies include other methods of family planning and not specifically putting emphasis on vasectomy. Very few studies have been done on vasectomy acceptability in Zambia. Therefore, the investigator wishes to find out the factors that influence acceptability of vasectomy.

CHAPTER THREE

3.0 METHODOLOGY

3.1 INTRODUCTION

Chapter 3 discusses the methodology used in this study. It describes the research design, research setting, study population, sample selection, inclusion and exclusion criteria, sample size, data collection tools, data collection technique, validity and reliability, pre-test and ethical consideration.

3.2 RESEARCH DESIGN

In this study, a mixed method study design which employed both qualitative and quantitative approach was used. This research design was chosen because little is known about the problem (Geri LoBiondo-Wood and Judith Habber, 2002). The study was exploratory because rather than observing and describing it investigated the factors that are related to the study. The purpose of the exploratory analysis was to gain an insight into factors that influence vasectomy acceptability among men of between forty-five (45) and seventy-five (75) years of age. It was aimed at exploring and describing in depth information on acceptability of vasectomy among men. This study was cross-sectional because it involved the collection of data at one point in time. The study phenomena were captured during one data collection period (Geri LoBiondo-Wood and Judith Habber, 2002).

3.3 RESEARCH SETTING

The research setting is the physical location and conditions in which data collection takes place (Bassavanthappa, 2007).

The study was undertaken in Kabwata Township, a medium density area Township in Lusaka urban district (Zambia) in the homes of the respondents.

3.4 STUDY POPULATION

A study population is a well-defined set that has certain specific properties (Basavanthappa, 2007). The study population was men who were between forty-five (45) and seventy-five (75) years of age and living in Kabwata Township who were

eligible and agreed to participate in the interviews. It was assumed that men of this age group had at least enough or more than enough children and may no longer want to have any more.

3.4.1 TARGET POPULATION

The target population is the total group of individual people or things meeting the designated criteria of interest to the researcher (Basavanthappa, 2007).

The target population were all men between forty-five (45) and (75) years of age who no longer wanted to have any more children.

3.4.2 SAMPLE SELECTION

Sample selection is the process of selecting a portion of population to represent the entire population (Polit et al., 2001). In order to obtain a representative sample of the population selected for the study, the sample was obtained from the target population. The total population for Kabwata township was 761,170 (CSO, 2008). The population of men in Kabwata township was 372,973 and men above 45 were 111,892 (CSO, 2008).

Kabwata Township was purposively selected. The Researcher obtained a list of households in Kabwata Township from the Lusaka city council. The township is divided into 10 residential sections. Six residential sections were selected using simple random selection and the sample size was determined proportionally based on the number of household in the 6 residential sections. Forty-one respondents were drawn from each section and this number was obtained by dividing the sample size by the number of residential sections (245 divided by 6 = 40.8). The sampling interval was calculated by dividing the number of households in each section by the number of households the researcher decided to visit every day (40 divide by 10). Each house was counted as a household. The first house was selected randomly using a table of random numbers and from there on subsequent households were selected using every fourth household. Respondents were selected purposively (because of the age specifications required). **Those who were not present at the time of the interview a**

second visit was made the following day or by appointment before being replaced. Similarly, female headed household where there were no males living there were replaced.

Two focus groups discussions were conducted. The focus group participants were purposively selected. The participants were the same age range as those who were interviewed but the investigator made sure that they were not the ones who have been interviewed. So they were picked from other parts of Kabwata where the interviews did not take place. Participants were picked by sampling interval which was every 5th house.

3.4.2.1 Inclusion criteria

The following were included in this study because they met the inclusion criteria set by the researcher:

(a) Only men who were between forty-five (45) years and seventy-five (75) years with satisfied parity in the sampled township were included.

(b) Only men who consented were included in the study because participation was by consent.

3.4.2.2 Exclusion criteria

The following were excluded from the study because they did not meet the inclusion criteria:

(a) Men below 45 years and above 75 years of age. Men below 45 years of were excluded from the study because they still needed children and vasectomy is a permanent method while those above 75 years were assumed to have satisfied parity.

(b) Men above 45 who did not consent to participate in the study because participation in the study was voluntary.

(c) Men who stated that they did not father any child. This was because only men who had children met the inclusion criteria for this study.

3.5 SAMPLE SIZE

The sample size was calculated using the Epi - info version 6.0 statistical software. This constituted the population size.

Population size = 111,892 (This is the number of the population of the target from which the researcher drew the number of participants to be interviewed)

Expected frequency = 80%

Worst acceptable = 75%

Confidence interval = 95%

n (number of respondents) = 200

With the addition of 10% non - response rate, the final sample was adjusted as follows: 10/100(241) = 45. Therefore, the sample interviewed individually was:

n =200+45=245

3.6 DATA COLLECTION TOOLS

The data collection tools that were used in this study a semi-structured interview schedule and a focus group discussion guide.

3.6.1 Semi - structured interview schedule

A semi - structured interview schedule (Appendix IV) comprised of questions that were both open and closed ended. Open ended questions permitted free responses (explanations are given) and therefore information was more and valid.

Closed questions allowed answers to be recorded `quickly and were not time consuming. The semi - structured interview schedule was used collect data because it was assumed to be the most efficient way of gathering data. The advantage of using this tool was that it was accurate since, it allowed the interviewer to probe and clear misunderstanding of questions during the interview. Interviews were appropriate for the respondents in this study because some of respondents were illiterate and could not fill out a questionnaire, but could participate in interviews. The other advantage of using this tool is that the interviewers were able to observe the respondents non-verbal cues and this helped to validate the information being collected. It also ensured that questions were answered.

However, the instrument had a drawback for instance; the presence of interviewers may have led to not giving precise and correct answers.

The semi-structured interview schedule comprised four sections. Section A consisted of questions on the respondents' socio- demographic data. Section B comprised questions eliciting information on vasectomy knowledge and section C had questions on whether the respondents accept vasectomy or not. Section D elicited information on traditional beliefs and values and Section C had questions on the attitudes of the health provider.

3.6.1.1 Validity and Reliability of the semi-structured interview schedule

To ensure validity of the research tool, the researcher conducted an exhaustive literature search in order to have adequate content coverage. The researcher also consulted the Reproductive Health Specialist in the Ministry of Health, and the Research supervisors. The sequencing of the semi- interview schedule was same for all the respondents. A statistician was also involved in the formulation of the research instrument.

Reliability was ensured by conducting a pilot study before the main study to pre-test the research instrument. The research assistants were trained in data collection methods. Reliability was also ensured by the use of different data collecting methods and triangulation of data.

3.6.2 Focus group discussion guide

A focus group discussion is a method that allows the researcher to examine the points of view of a number of individuals in a group as they share their opinions/concerns about a topic (Fraser, 2004). A focus group discussion guide (Appendix V) was used to ask questions to the participants. This procedure allowed more revelations and new ideas were generated on the topic. An advantage of focus group discussion is that it allows illiterate participants to participate in the discussion and in - depth information may be obtained.

A disadvantage may be that people may be uncomfortable to express their views in front of others.

3.6.2.1 Trustworthiness of qualitative data

Trustworthiness of the qualitative data was ensured through addressing transferability, credibility, dependability and conformability of the results. Transferability was ensured through thick description of the participants' characteristics, the research setting and processes of the inquiry. Credibility was ensured through asking participants to provide their opinions about vasectomy. To ensure dependability, the researcher documented all the raw data.

3.7 DATA COLLECTION TECHNIQUES

3.7.1 Face to face interview

Data collection technique is a procedure of collection of information needed to address a research problem (Basavanthappa, 2007). The data collection technique used in this study was face to face interview.

The interviews were conducted from 14th to 24th August, 2010. They were conducted in such a manner that each client was interviewed privately. The interviewer introduced himself to the respondents and explained the purpose of the study. Respondents were reassured of confidentiality. After putting the respondent at ease, the interviewer then proceeded with the interview.

Questions that were not clear to the client were repeated, and rephrased while ensuring that the meaning of the question was not changed. The clients were asked to ask questions at the end of interview. The interviewer thanked the clients for their time and participation, and then ended the interview.

The procedure for the interview was as follows:

Three research assistants were engaged to assist with data collection.

Introduction of self to participant was done in order to make the participant feel at ease.

The purpose, benefits and risks of the study were explained to the participant.

The participants signed a written consent form before being interviewed.

Interviews were conducted where and in a manner that privacy and confidentiality

Questions were read carefully to the participant to avoid cross-examination and questions not understood were repeated without showing direction or clue to the answer.

The interviewers used follow up probes when questions were not fully answered by the participants.

All the responses were immediately noted down on the interview schedule to avoid missing out any information.

The interview was conducted at an agreed time and 15 minutes were spent on each participant.

Each participant was thanked for participating at the end of the interview.

3.7.2 Focus group discussion

Focus Group Discussions were also used to collect data in this study. The procedure that followed during the focus group discussions is described below. Two health workers who were trained in data collection methods were recruited as research assistants and they were assigned different roles. One research assistant acted as a recorder and the other one was a time keeper. The researcher was the facilitator.

The researcher and research assistants introduced themselves. The tape recorder was shown to the participants and its purpose explained and permission sort from participants to use it in the discussion. Confidentiality was ensured. The purpose, risks and benefits of the study were explained. Each participant was requested to sign a consent form.

Using the focus guide, the researcher initiated the discussion and participants were given chance to express themselves in the discussion. The discussion took 30 minutes. Each participant was thanked for participation in the discussion.

3.8 PRE-TEST

The purpose of the pre test is to elicit flaws in the data collection tools, such as ambiguity and illogically sequenced questions and make revisions to strengthen the methodology (Basavanthappa, 2007). The pre test was also used to determine the predictability of the data collection (Basavanthappa, 2007). Pre testing of the data collection tools was conducted on a sample of people which had similar characteristics as the actual study sample.

The pre-test study was conducted to assess feasibility of the study so as to make necessary adjustments to the questionnaire so that it is valid and reliable. It also helped the researcher to determine the reactions of the clients to the research procedure that the investigator watched for during the study.

After the pre-test, questions number 9 was modified to read “do you know anyone who has had a vasectomy done”. Previously the question was “Have you seen or know a person who has undergone a vasectomy”. Question number 18 was modified to read as “Do you agree that men must undergo vasectomy. From “Do you agree that people must undergo vasectomy”?

3.9 ETHICAL CONSIDERATION

Ethics is defined as a system of moral values that is concerned with degree to which research procedures adhere to professional, legal and social responsibilities to the study participants (Basavanthappa, 2007). Ethical approval and permission was sought from the University of Zambia Biomedical Research Ethics Committee.

Reproductive health matters are culturally sensitive and greatest care must be taken on the values and beliefs of the participants. The research assistants were male nurses so that participants were able to talk freely. The investigator found out and learnt about traditions and respected them.

Confidentiality during the interview was assured to participants and they were interviewed in a private room. They chose a room which was private in their house. Nobody else was allowed in the particular room except interviewer and the

interviewee. Research assistants were trained to ensure that they maintain confidentiality. The participants' names were not written on the interview schedules and no other person apart from the researcher was allowed to access the collected data. The participants were not subjected to any physical harm, as the research did not involve any invasive procedures. To ensure further confidentiality, all questionnaires were kept under lock and key after interviews.

CHAPTER FOUR

4: 0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4: 1 INTRODUCTION

This chapter discusses the analysis and presentation of findings. The aim of the study was to determine factors influencing vasectomy acceptability in Kabwata Township in Lusaka district.

4: 2 DATA PROCESSING AND ANALYSIS

4.2.1 Quantitative data

Data analysis is the systematic organization and synthesis of data (Basavanthappa, 2007). Data analysis is done to reduce, organize and give meaning to the data. The analysis of data from quantitative research involves descriptive and exploratory procedures to describe study variables and the sample and statistical techniques to test proposed relationships.

Data were collected using a pre-tested semi-structured interview schedule and a focus group discussion guide. After data was collected, it was coded and entered into SPSSS version 16 statistical package. The chi-square test was used to test associations of categorical variables. The variables included acceptability, knowledge, traditional and cultural beliefs and attitudes on vasectomy by health care providers. The cut off point for statistical significance was set at five percent (5%), only p value less or equal to 0.05 were considered statistical significant thereby rejecting the null hypothesis.

4.2.2 Qualitative data

Data from the focus group discussions was collected to compliment data collected from the interviews. Qualitative data was analysed using content analysis. The audio recordings and field notes were transcribed verbatim for analysis. The information was read to identify meaningful segments and units and then the segments were reviewed. Finally themes and categories were identified.

4: 3 PRESENTATIONS OF QUANTITATIVE DATA

4.3.1 Quantitative data

In this study, findings were presented according to the sequence of questions and categories in the interview schedule.

Frequency tables, pie charts and graphs were used to present quantitative data because they are easy to read, understand and give a rough idea and picture about findings even before reading the discussion of findings. They are also useful to combine information on two or more variables in order to arrive at a positive explanation of the problem.

4.3.2 Qualitative data

Data was presented in narratives according to what the respondents stated. The narratives are presented according to themes that emerged during the discussion.

SECTION A: SOCIO DEMOGRAPHIC DATA

This section presents the respondents demographic characteristics. The demographic characteristics include age, marital status, years of marriage, religion, educational level and income.

TABLE 2: DEOMOGRAPHIC DATA (n= 245)

Variable	Frequency	Percentage
Age range 45-55	151	61.1
56-75	94	38.4
Total	**245**	**100**
Marital status		
Single	14	5.7
Married	153	62.5
Divorced	28	11.4
Separated	27	11.0
Widowed	23	9.4
Total	**245**	**100**
Years spent in marriage		
Below 2 years	12	5
2-3 years	20	8.1
4-5 years	116	47.3
Above 5 years	97	39.6
Total	**245**	**100**
Religion		
Christian	234	95.5
Moslem	4	1.6
Hindu	1	0.5
Buddhist	2	0.8
Others (specify)	4	1.6
Total	**245**	**100**
Educational level		
None	43	17.7
Primary	45	18.4
Secondary	68	27.7
College	67	27.3
University	22	8.9
Total	**245**	**100**
Income		
Above K1,000,000	85	34.7
K 500,000- K1,000,000	82	33.5
Below K500,000	78	31.8
Total	**245**	**100**

Table shows that of the 245 respondents, majority were between 45 and 55 years of age 151 (61%) and 94 (38.4%) were between 56 and 75 years of age. The mean age of the respondents was 50 years.

A total number of the153 (62.2) respondents were married, 28 (11.4%) were divorced, 27 (11.0) were separated, 23 (9.4%) were widowed and 14 (5.7) were single.

The majority of the respondents 116 (47.3%) were married for a period of between 4-5 years and 97 (36.6%) were married for more than 5 years. Majority of the respondents were Christians 234 (95.5%) Muslims were 4 (1.6%) and other religions were also 4 (1.6%).

The maximum literacy level attended was secondary school 68 (27.8%) had attained secondary education, followed by college education 67 (27.3%), and primary education 45 (17.6%) whereas 43 (17.6) respondents had never been to school and 22 (9.0). Only 85 (34.7%) respondents earned a monthly income greater than K1, 000,000, 82 (33.5%) earned between K500, 000 -1,000,000 and 78 (31.8%) earned a monthly income less than K500, 000.

SECTION B: KNOWLEDGE OF VASECTOMY

Section B presents the respondents knowledge levels on vasectomy. The variables measured were have heard about vasectomy, source of information, benefit of vasectomy, accessibility of vasectomy services, location of services and men to undergo vasectomy.

Figure 2: Have Heard about Vasectomy (n=245)

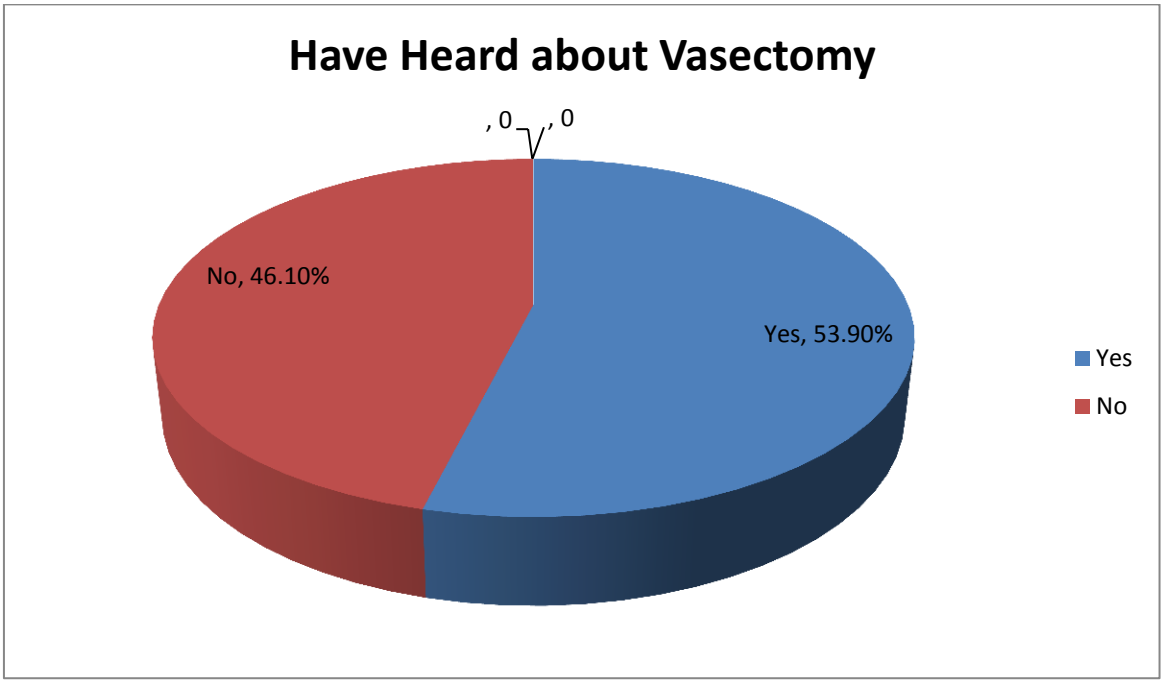


Figure 2 shows that majority of the Respondents 132 (53.9%) had heard of vasectomy and 113 (46.1%) had not.

Table 3: Source of information (n=245)

Source of information	Frequency	Percentage
Media	186	75.9
Health provider	46	18.8
Relatives	7	2.9
Friends	6	2.4
Total	**245**	**100**

Table 3 shows that the majority of Respondents 75.9% said that their source of information on vasectomy was from the media, 18.8% from health providers, 2.9% from relatives and 2.4% from friends

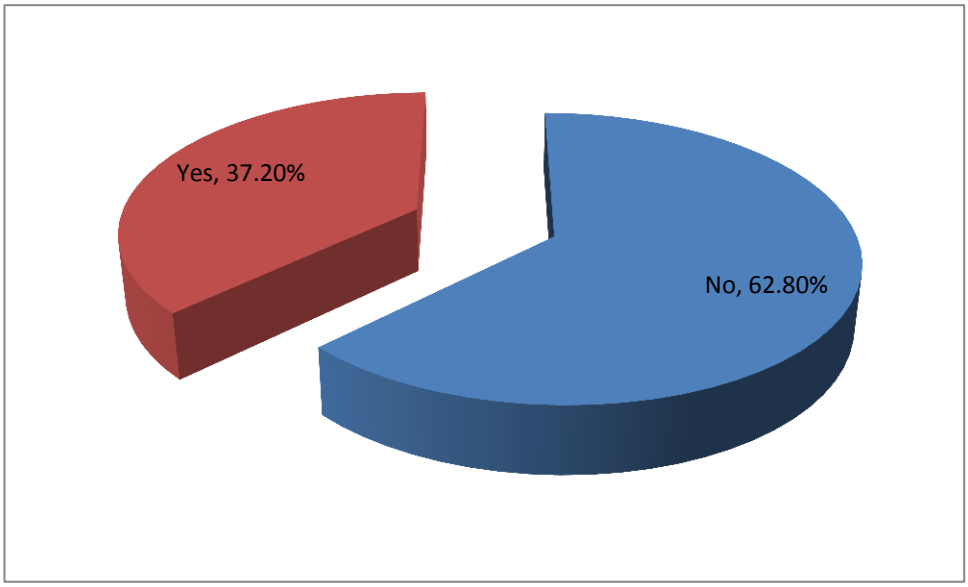
Table 4: Knowledge of vasectomy and vasectomy services

Variable	Frequency	percentage
Knows a person who has had vasectomy done		
Yes	**66**	**28**
No	**179**	**72**
Total	**245**	**100**
Knows the definition of vasectomy		
Yes	**41**	**16.7**
No	**204**	**83.3**
Total	**245**	**100**
Vasectomy services are accessible		
Yes	**47**	**81.1**
No	**198**	**80.9**
Total	**245**	**100**
Knows the location of vasectomy services		
Yes	**20**	**8.2**
No	**225**	**91.8**
Total	**245**	**100**

Table 4 shows that most respondents 179 (72%) stated that they did not know anyone has had a vasectomy done while 66 (28%) knew. Many of the 204 (83.3%) respondents did not know the definition of vasectomy while 41 (16.7%), 198 (80.9%)

reported that vasectomy services were not accessible and 47(18.1%) reported that they are accessible. Table 4 shows that 225 (91.8%) of the respondents responded that they did not know where vasectomy services were found and 20 (8.2%).

Figure 4: Vasectomy beneficial (n=245)



The figure 4 shows that 62.8% of the respondents stated that vasectomy is not beneficial and 37.2% reported that it was beneficial.

SECTION C: ACCEPTANCE OF VASECTOMY SERVICES

Table 5: Acceptance of vasectomy services (n=245)

Variable	Frequency	Percentage
Good		
Yes	58	23.7
No	187	76.3
Total	245	100
Willing to undergo vasectomy		
Yes	100	40.8
No	145	59.2
Total	245	100

As indicated in table 5, 187 (76.3%) of the respondents stated that vasectomy was not good and 58 (23.7%) stated that it was good. Most respondents' 145 (59.2%) stated that they were not willing to undergo vasectomy while 100 (40.8%) were willing.

Figure 5: Men to undergo vasectomy (245)

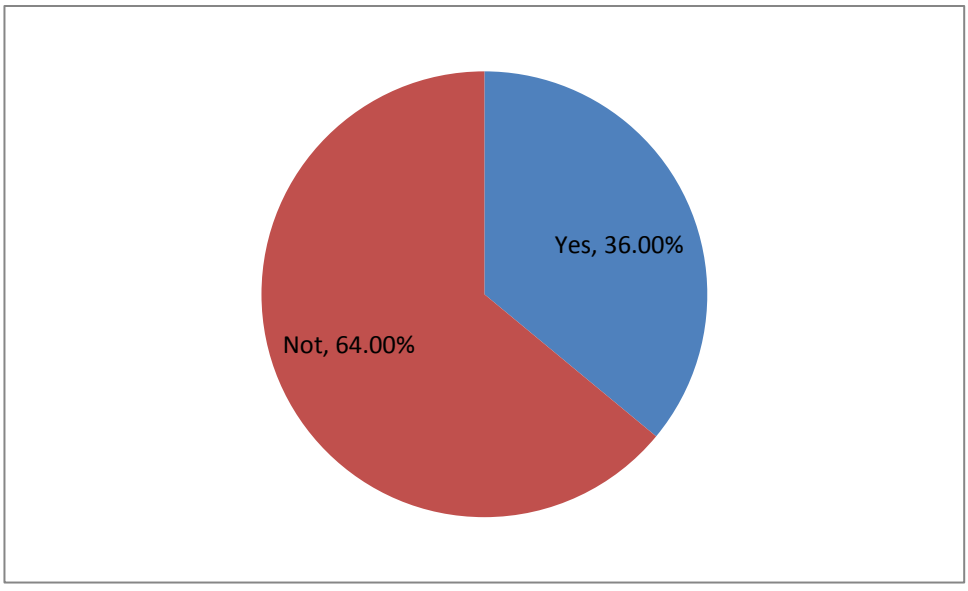


Figure 5 shows that 152 (64%) of the respondents said that men should not undergo vasectomy and 48 36% stated the opposite.

SECTION D: TRADITIONAL AND CULTURAL VALUES ON VASECTOMY

Table 6: Traditional and cultural values on vasectomy (245)

Variable	Frequency	Percentage
Community perceptions about vasectomy		
Positive	26	10.6
Negative	219	89.4
Total	245	100
Whether men should participate in family planning		
Yes	128	51.8
No	117	47.7
Total	245	100
Openly discussed vasectomy		
Yes	24	9.3
No	221	90.7
Total	245	100
Culturally right for vasectomy		
Yes	65	26.5
No	180	73.5
Total	245	100
Taboo to discuss family planning with Partner		
Yes	221	90.7
No	24	9.3
Total	245	100

As indicated in Table 6, many respondents 219 (89%) had negative perceptions about a man who has had a vasectomy done 26 (10.6%) had a positive perception. Majority of Respondents127 (51.8%) reported that men should participate in family planning matters and 117 (47.7%) said that they should not, 221 (90.7%) stated that they did not openly discuss matters related to vasectomy while 24 (9.3%) did. The data presented in Table 6 shows that 180 (73.5%) respondents stated that it is not culturally right for a man to undergo and 65 (26.5) stated the opposite, 221(90.7%) said that it was taboo to discuss family planning issues with spouse while 24 (9.7%) said that it is not.

SECTION E: ATTITUDES BY HEALTH PROVIDERS

Table 7: Attitudes by health providers

Variable	Frequency	Percentage
Reception		
Good	36	14.6
Poor	209	85.4
Total	245	100
Provide adequate information		
Yes	215	87.8
No	30	12.2
Total	245	100

Table 7 shows that the majority of the respondents 209 (85.4%) said that Health workers did not receive clients who sought vasectomy services well and 36 (14.6%) said that Health workers received clients well. The majority of the respondents 215 (87.8%) reported that the family planning providers did not provide adequate information to men on vasectomy and 30 (12.2%) respondents said they did.

SECTION F: ASSOCIATIONS BETWEEN THE DEPENDANT AND THE INDEPENDENT VARRIABLES

Table 8: Association between level of education and willingness to undergo vasectomy (n=245)

Educational level	Yes	No	Total	Percent	P-value
No education	4	35	39	22.5	0.000
Primary	4	35	39	22.5	
Secondary	30	38	68	25	
College	18	37	55	23	
University	7	14	12	7	
Total	**88**	**157**	**245**	**100**	

Majority of the respondents attained secondary school education 30 (44.1%) and those who attained college education 18 (32.7%) were likely to have vasectomy done than those without formal education (P- value = 0.000 significant). There is an association between education level and willingness to undergo vasectomy.

Table 9: Association between willingness to undergo vasectomy and whether it is culturally right for a man to have vasectomy (n=245)

		Culturally right for a man to have vasectomy		Total	P value
Willingness to undergo vasectomy		No	Yes		
	Yes	13(26.5%)	11 (29.2%)	24(28%)	0.74
	No	36 (73.5%)	26(70.2%)	62 (72%)	
Total		49 (57%)	37(43%)	86(100%)	

Table 9 illustrates the association between willingness to undergo vasectomy and whether it is culturally right for a man to have vasectomy. Majority 36 (73.5%) of the respondents who said that vasectomy was not culturally right and 26 (70.2%) were not likely to undergo vasectomy than those who said vasectomy was culturally right (P-value = 0.74, not significant). There is no association between willingness to undergo vasectomy and whether vasectomy is culturally right.

Table 10: Association between willingness to undergo vasectomy benefits (n=245)

		Vasectomy beneficial		Total	P-Value
Willingness to undergo vasectomy		Yes	No		
	Yes	63 (56.3%)	0 (0%)	63 (35.8%)	0.000
	No	49 (43.3%)	64 (56.6%)	113 (64.2%)	
Total		112 (63.3%)	64 (36.4%)	176 (100%)	

Table 10 shows that majority of the respondents 64 (56.6%) who stated that vasectomy was not beneficial were not likely to undergo vasectomy than those who stated that it was beneficial (P-Value = 0.000, significant). There is association between willingness to undergo vasectomy and knowing whether vasectomy is beneficial.

Table 11: Association between willing to undergo vasectomy and reception of clients who services by health providers (n=245)

		Reception of clients who seek vasectomy services		Total	P-Value
willingness to undergo vasectomy		Good	Poor		
	Yes	9 (15.2%)	50 (28.4 %%)	59 (28%)	0.000
	No	25 (16.7%)	126 (71.7%)	151 (72%)	
Total		34 (23.3%)	176 (86.7%)	210 (100%)	

As it can be seen from table 11, majority of respondents 126 (71.75) who reported that the reception of health providers at the health facilities were poor were not likely to undergo vasectomy (P- value = 0.000, significant). This result is statistically significant.

4.4 PRESENTATION OF QUALITATIVE DATA FROM THE FOCUS GROUP DISCUSSION

Data collected from focus group discussions were summarized in narrative form. The findings were interpreted and most useful quotations that emerged from discussions were selected to illustrate the main ideas.

4.4.1 SOCIO DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

All the participants who participated in the focus group discussions resided in Kabwata Township in Lusaka. There were eligible for the study and were recruited purposively. Two focus group discussions were held in two different locations within Kabwata Township. Each group comprised of 8 participants. The first group included 5 participants between ages 45 - 55 years and 3 participants aged between 56 - 75 years. Three of these men had attained college education, 3 never went to school and 2 attained secondary school education. The majority of participants were businessmen getting income of between K500, 000 - K1, 000,000. Most of the participants 5 were married, 2 divorced and 1single. 2 had 7 children each, 3 had 5 each and 3 had 6 each and 2 had 4 each.

The second group included 6 participants. The majority of participants had attained primary school education and 1 had completed university level education. Four were married, 1 was single, and 1 was widowed. Three participants were in formal employment getting an income of between K500,000 - K1, 000,000, 2 were businessmen getting an income of K1, 000,000 per month and 1 relied on daily piece work and earned less than K500,000 per month. All the participants had children ranging between 4 and 9 years of age.

Ideally focus groups should be homogenous however; the focus group members in this study were heterogeneous with respect to some variables such as educational level, marital status and income level. In order to enable all group members talk freely, the researcher with the help of group members created ground rules that bound all

group members during the discussion. For example, emphasis was put on the importance of democracy, specifically the importance of giving every person space to share their views and respect every group member's contribution. Every member of the group was given responsibility of ensuring that everyone got involved in the discussion.

4.4.2 PARTICIPANTS KNOWLEDGE OF VASECTOMY

Participants were asked what they knew about family planning. Most participants had an idea and stated that family planning is spacing children to allow growing of children. Some said it is stoppage of bearing children. Others said it is when a woman rests in bearing.

Participant 1 said; *"that family is resting from child bearing done by women".*

Participant 2 said; *"family planning is spacing of pregnancy to allow growth of already born baby".*

Participant 3 said;" *it meant family planning*".

However most of them said it was spacing children to allow growing of children.

Participants were also asked what vasectomy is. Majority of the respondents reported that it was castration of a man to make man not function as a man. Some said it was cutting of tubes to make a man not function as a man. One of them said it was done to make a man useless.

Participant 1; said *"it means cutting off male tubes.* He further went on to say *"a man will fail to perform his duty to his wife".* Meaning when the tubes are cut, the man loses his manhood and won't perform sexually".

Participant 3 said "*he knew very little and was happy to be involved in the discussion because he has learnt something about vasectomy".*

Another participant said*;" vasectomy is cutting of male tubes to make erection stop so that the male no longer produce."*

4.4.3 TRADITIONAL/CULTURAL BELIEFS AND VALUES ON VASECTOMY

Participants were asked if there were any traditional/cultural values and beliefs on vasectomy.

One of the participants said "*men should not even be involved in family planning as It is for women alone. Women are the ones who fall pregnant. So why should men come into these issues."*

Other participants also came in to support their fellow participant`s contribution.

Another participant said *"it is not culturally acceptable that men should participate in vasectomy issues."*

Participant 3 said" *if a man participates in family planning matters, it must be to allow the wife to go for family planning and can even escort her if he has time*." This was supported as well by most of the participants

One of the participants who sat quiet for sometime spoke up and said men who go for vasectomy are controlled by their women and are not mentally right. This could be attributed to the factor family planning is perceived to be a woman's affair.

4.4.4 ATTITUDE OF HEALTH PROVIDERS TO CLIENTS WHO SOUGHT VASECTOMY SERVICES

Participant 4 said "*most health providers do not talk about vasectomy and usually clients are not even received well."*

Another answered and said" *they don`t explain so that we can have information on vasectomy"*

Another one said" *may be they don`t have information as well*"

One said" *sometimes they sound very hash and put us off."*

4.4.5 ACCESSIBILITY OF VASCTOMY BY THE RESPONDENTS

Many (6) said they did not know where the services are found. Only 2 participants said that they knew where to find them. This is reflected in the narrative below:

One participant stated" *services are there at UTH*."

4.4.6 SUGGESTIONS FOR INCREASING ACCEPTABILITY OF VASECTOMY

When participants were asked to give suggestions on how to create awareness on vasectomy among men in the community.

All of them said "*there must be programmes on the media to educate the community on vasectomy.*

Another participant said "*health workers must change their attitude towards vasectomy*."

Another one said *"health providers must take time to explain and give information on vasectomy."*

The other recommendations included:

Traditional leaders must also be actively involved since there are cultural values/beliefs attached to family planning especially vasectomy.

Vasectomy like HIV and AIDS, circumcision must be considered to be discussed publicly so that men can make informed choice.

Emphasis on vasectomy must be made by family planning providers and the government.

Traditional leaders must also be actively involved since there are cultural values/beliefs attached to family planning especially vasectomy.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 INTRODUCTION

This discussion focuses on the respondents' socio demographic characteristic, knowledge of vasectomy, and factors that influence vasectomy among men in Lusaka district.

The major findings of this study are that slightly above half of the respondents had heard about vasectomy but their knowledge levels of vasectomy was limited. The majority of the respondents reported that they did not know any who had done a vasectomy, vasectomy services were not easily accessed and that vasectomy was not beneficial. Most respondents stated that vasectomy is not good and that men must not have a vasectomy done and many of them were not willing to undergo vasectomy. The majority of the respondents reported that the community was negative about men who decide to have a vasectomy done and that the health workers had a negative attitude towards men who sought vasectomy services.

5.2 SOCIO DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

The demographic characteristics of the respondents which were relevant to this study included age, marital status, religion and education and income levels. The information on the demographic characteristic was essential for interpretation of the findings. A total number of 245 respondents were interviewed yielding a response of one hundred percent (100%).

Of the respondents interviewed most of them 100 (40.8%) were aged between 45 - 55 years (Table 2) and those aged between 56 – 75 years old were 60 (24.2%). Most of the respondents were married (62.2%) and were in the current marriage for more than 5 years (47.3%). Many respondents in this study were married because marriage is considered to be universal in many African societies including Zambia and that society expects every normal male or female to get married and raise a family. Most of the respondents in this study were Christians 234 (95.5%). This is because Zambia is Christian nation and individuals have freedom of association.

The study revealed that majority of the respondents had attained secondary school education 68 (27.7%) followed by those who went up to college 67 (27.3). This may be an indication that people in urban areas value education. Furthermore, there are many secondary schools in urban areas which increase the opportunities to attend school.
Regarding the respondents income, 34.5% earned an income above K1, 000,000 (Table 2). This could be an indication that income levels in this country are low.

5.3 RESPONDENTS KNOWLEDGE OF VASECTOMY

The results showed that slightly above half 132 (53.9%) of the respondents had heard of vasectomy (Table 3). This could be attributed to the Information, education and communication given on the media considering the factor that a large number of the respondents' source of information in this study was the media 186 (76.0%). Information on vasectomy is necessary in order to motivate more men to have vasectomy done. However, many men in Sub-Saharan Africa except Ghana, Kenya, Malawi and Uganda have not heard of vasectomy (Bunce et al., 2007). In addition, evidence suggests that lack of access to vasectomy information and services is the principal reason for vasectomy underutilization (Apamu, et, al, 2010; Olawepo and Okedare, 2006). This finding is similar with previous findings from studies conducted by Bunce et al., in Africa which revealed that lack of information, misunderstandings and rumours about vasectomy process contributed to many people's reluctance to choose vasectomy.
The present finding is in contrast with studies in Ghana where three in five men have heard of vasectomy (Ministry of Health, Ghana, 2003).

From the findings of this study, it is evident that vasectomy is not a commonly done procedure as majority of the respondents 179 (72%) said that they did not know anyone who had undergone vasectomy operation (Table 4). This scenario may be attributed to the fact that vasectomy is considered to as castration by many men. The majority of men fear that they will become impotent if they have a vasectomy done (Engender Health, 2002).

In this study, the respondents were asked to give a meaning of the term vasectomy. Eighty–three percent (204) of the respondents did not know the definition of vasectomy (Table 4). Similarly, the focus group discussion participants were also not aware of the definition of vasectomy as many thought that it referred to castration as indicated by this narration by one participant "*vasectomy is cutting of male tubes to make erection stop so that the male no longer produce."*These findings support those of a multi stage study in Iran conducted by Alfsaneh between 2005 and 2007 which found that 84% of the respondents in their study had no knowledge of vasectomy.

For a family planning program to meet the needs of its clients and achieve program goals, its services must be accessible to everyone who wants to use them. The easier it is to obtain the services, the more likely it is that people will use them (UNFPA, 2003). However, in the finding of this study as indicated Table 4 shows that majority of the respondents 198 (80.9%) stated that vasectomy services were not accessible. This scenario could explain why many people are not utilizing the service. In addition, many respondents 225 (91.8%) did not know where the services were located. Regarding the location of health services including family planning, these should be located as close to the family as possible for them to be utilized.

The benefits of family planning to couples are numerous cannot be over emphasized for instance, it helps to improve the future by allowing parents to better plan their lives. Through family planning individuals can obtain a greater prosperity and security for the family because they can have a better chance at receiving an education and devoting more time to earning an income. However, many respondents (62.8%) did not know the benefits of vasectomy as a family planning method (figure 4). This suggests the need for increased health education on the subject.

5.4 ACCEPTABILITY OF VASECTOMY SERVICES BY THE RESPONDENTS

A large number of the respondents 187 (76.3%) in this study indicated that vasectomy was not good (Table 5). This could be attributed to myths and misunderstanding surrounding vasectomy.

In addition, the focus group discussion participants clearly stated that vasectomy reduced a man`s power and should not be practiced. Their fears were same as fears revealed by studies in Kenya and Tanzania on vasectomy (Bunce et al., 2007; Wilkinson, 1990). The fear that strength of manhood could be compromised was strongly expressed.

In this study, the respondents 152 (64%) did not support the idea that men must not have vasectomy done (Figure 5). This could be due to the fact that family planning matters are believed to be a woman's business (UNFPA, 2003; WHO, 2005) and myths surrounding vasectomy. Most health institutions visited by the researcher in the country including UTH showed that family planning is mostly used by women. Very few men access family planning services. Previous studies have shown that men in many African countries do in fact care about avoiding pregnancy and want to share the responsibility for FP with their partners (Drennan, 2001).

When asked whether they can have a vasectomy done, many 145 (59.4%) respondents were not willing to do so. These findings are higher than those reported by Central Statistics Office (2006), which showed that uptake of vasectomy among men was 10%. The findings are inconsistent with findings from other studies done worldwide which revealed a low vasectomy utilization rate (WHO, 2005 & Magnani et al., 1999).

These finding are supported by the low vasectomy figures reported at UTH urology Clinic (UTH Urology clinic register, 2009). The Department of Urology sees many clients (close to a thousand every month) but only very few come for vasectomy. Shikupa (2000), also found that 60% of the respondents in his study indicated that vasectomy was good but declined to accept to have vasectomy done.

5.5 RESPONDENTS TRADITIONAL/CULTURAL BELIEFS AND VALUES ON VASECTOMY

Cultural beliefs and values can influence use of family planning services including vasectomy. As indicated in table 9, majority of the respondents 219 (89%) reported

that the community was negative about men who decide to have a vasectomy done. Educating both clients and community leaders can help improve attitudes towards vasectomy.

The majority 230 (93.8%) of the respondents indicated that men should not participate in family planning matters. Similarly, focus group participants expressed the same sentiments as suggested by the following narrative" *men should not even be involved in family planning as family planning is for women alone. Women are the ones who fall pregnant. So why should men come into these issues."* The current study has revealed that most 221(90.7%) respondents did not discuss matters related to vasectomy openly (Table 11). These findings are in accordance with a previous study by Ringhein (2003). This suggests that in African society family planning matters are regarded private.

In many cultures, contraception is resisted by women, men or the community at large. A high number of the respondents 180 (73.5%) in this study said that it was not culturally right and not acceptable for a man to have a vasectomy (Table 12). Similar sentiments were expressed by participants in the focus group discussion as shown in this narrative "*it is not culturally acceptable that men should participate in vasectomy issues."*

About ninety-one percent of the respondents 221(90.7%) indicated that it was taboo to discuss family planning issues with partner/spouse (Table 13). Several possible explanations could account for this finding, but the most plausible explanation is that family planning matters are regarded private and that men are decision makers in a home and do not need to consult the wives on such matters. The findings agree with that of Bunce et al., (2007) in Kenya where 81(92%) of the respondents in their study held a similar view. Spousal discussions are important in the decision to get a vasectomy, but these discussions should be initiated by the male partner.

5.6 ATTITUDE OF HEALTH WORKERS ON VASECTOMY

The respondents 209 (85.4% in this study reported that health workers did not receive people who seek vasectomy services well (Table 14). If clients do not feel welcome when they seek services, they will shun that particular service. In addition, the majority of the respondents 126 (71.75) who reported that reception of health providers were poor, were not willing to undergo vasectomy. More than three quarters of the respondents 215 (87.8%) indicated that the attitude of family planning providers did not give adequate information on vasectomy (Table 15). Similarly, participant in the focus group discussions were of the view that health workers did not receive people very well at the health facilities as indicated by this participant "*most health providers do not talk about vasectomy and usually clients are not even received well*."

These findings are contrary to the results of an Iranian study that showed that health workers has a positive attitude towards clients seeking vasectomy services and were the main source of information on vasectomy.

5.7 ASSOCIATIONS BETWEEN THE DEPENDANT AND THE INDEPENDENT VARRIABLES

Although not many vasectomy studies have been conducted worldwide, the few that have been done especially in Africa indicated that there are traditional beliefs associated with vasectomy. Willingness to undergo vasectomy may be influenced by traditional beliefs. However, in this study, there was no significant association found between willingness to undergo vasectomy and whether vasectomy is culturally right (P-value = 0.74) as indicated in table 16.

The study found a significant association between willingness to undergo vasectomy and knowing whether vasectomy is beneficial (P-Value = 0.000, significant). Majority of the respondents 64 (56.6%) who stated that vasectomy was not beneficial were not likely to undergo vasectomy than those who stated that it was beneficial (Table 17).

The present study revealed a significant association between vasectomy acceptability and reception of clients (P- value 0.000). Majority of the respondents 126 (71.75) who reported that reception of health providers were poor, were not likely to undergo

vasectomy (Table 18).There was a significant association between the respondents' educational level and willingness to undergo vasectomy (P- value = 0.000 significant). Majority of the respondents attained secondary school education 30 (44.1%) and those who attained college education 18 (32.7%) were likely to have vasectomy done than those without formal right (Table 19).

5.8 IMPLICATIONS FOR NURSING

Providing information about vasectomy to men is important in increasing knowledge vasectomy and vasectomy acceptability. The study findings suggest that health care health providers play a pivotal role in motivating men to accept vasectomy and utilize the services. Most of the family planning health providers are nurses. Receiving of clients is also very important part of care.

5.8.1 Nursing education

The present study has revealed a knowledge deficit on vasectomy among clients .This implies that nurses do not give adequate information on vasectomy to clients. It is most likely that health care providers lack knowledge on vasectomy as well as hence they are not able to give adequate information to clients regarding the same. The General nursing Council if Zambia in conjunction with the Nursing Schools therefore need to strengthen the component of family planning in the curriculum.

5.8.2 Nursing practice

The current study has revealed that nurses providing family planning providers services at the health facilities did not receive clients well and did not provide them with adequate information on vasectomy. This can discourage clients from utilizing the service they need. Nurses can make a difference by changing their attitude towards clients. It does not cost money to smile at client. There is a need to reinforce clinical protocols in this area and to ensure that Nurses provide Information, Education and Communication to clients.

5.8.3 Nursing administration

Vasectomy services in Zambia including Lusaka city are not readily available. Nurse Managers can advocate for integrated Vasectomy service so that clients can receive the service at the same time with other services. This study has shown that men lack information about vasectomy. Nurse Managers should regularly supervise nurses providing family planning services to ensure that they give health education to family planning clients. Nurses should also be provided with adequate Information, Education and Communication materials plus other supplies to enable Nurses to provide quality care. Staffing levels should also be adequate.

5.8.4 Nursing Research

Studies have been conducted on vasectomy globally, regionally but no research has been conducted locally on factors affecting vasectomy acceptability among men in Zambia. Therefore, a more rigorous study with a larger sample should be done to enable generalization of the findings to other settings.

5.9 LIMITATIONS OF THE STUDY

This study has several limitations. The results of the study may not be generalized to other settings because the study was done in Lusaka. Another notable limitation could interviewer bias. Respondents may give incorrect information because of the presence of the interviewer. In addition, information obtained through face to face interviews has been shown to be distorted especially in sensitive information to make the responses socially acceptable.

5.10 CONCLUSION AND RECOMENDATIONS

The main objective of the study was to determine factors affecting vasectomy acceptability among men. The factors influencing vasectomy acceptability among men in Kabwata Township include the respondents' level of knowledge on vasectomy, tradition beliefs/myths and values, religion, perception by the community, availability of services, and attitudes by family planning health providers. These findings are very important because they provide insight to the problem of vasectomy acceptability.

Accepting vasectomy may help improve the health of mothers and children in the communities.

5.16 RECOMMENDATIONS FOR INCREASING VASECTOMY ACCEPTABILITY

Recommendations for increasing vasectomy acceptability have been made based upon the findings of the study.

Vasectomy services should be strengthened and made accessible by the government through Ministry of Health so that clients who require the method can easily access like other methods of family planning. This can be done by scaling up vasectomy services to provincial hospitals rather than UTH alone

1. To increase coverage the media should be utilized to educate couples on the benefits of vasectomy.
2. The District Health Offices and Hospitals must also make efforts to talk to clients about vasectomy and its benefits so that couples can use it.
3. Service providers must change their attitudes towards clients who seek vasectomy services by receiving clients well and providing them with necessary information on vasectomy.

5.17 RECOMMENDATIONS FOR FURTHER RESEARCH

There is a need to duplicate the study to more geographical areas in the country to enable a good response to vasectomy acceptability and utilization as it prevents more pregnancies than other methods. Future research should continue to probe into the attitudes of providers and should make use of multiple data collection methods to strengthen the quality of data.

REFERENCES

Admasu, E., Chekol, N.,Chekol, T., Shewmene, Z., Eteffa, Z. (2013). Factors affecting vasectomy acceptability in Ethiopia. ***International Journal of Pharmaceutical Sciences and Research***; 4(4); 1561-1564.

Alfsaneh, N. (2007). Family, Body, sexuality and Health, Enclocpaedia of women and Islam: the morning after, Travails of sexuality and love in modern Iran. ***International Journal of Middle Eastern studies,*** Volume 36, pp. 367-385.

Aradhya, A.R. (2007). Vasectomy is a viable contraception in Africa: Evidence from Ghana. ***International Family planning Perspectives***, Volume 20, Number 2, pp.134 -138.

Atkins, B., Jezowski, T. (2003). Report on the First international Conference on Vasectomy. ***Studies in Family Planning***, 14:89-95.

Akpamu U., Nwoke, E.O, Osifo, U.C., Igbinoula E.N., Adiso A.W., 2010: Knowledge and Vasectomy Acceptability. Africa Journal May, 2010. PP 153-156

Banda, H.N, Bradley, N and Hardees, C. (2004). Policy Report. Lusaka. Zambia.

Bassavanthapa. (2007): Nursing Research. Nigeria

Bunce, A.,Guest, G., Searing, H, Frajzyngier, V., Riwa, P., Kanama, J and Achwal, I. (2007). Factors affecting vasectomy acceptability in Tanzania. ***International Family Planning Perspectives***, Volume 33, No. 1, pp. 13 – 21

Centers for Disease Control and Prevention (CDC). (1999). Family planning methods and practice: Africa. Second Edition. Atlanta, Georgia: United States Department of Health and Human Services, Centre for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health.

Central Statistics Office (CSO). Zambia Demographic Health Survey. (2003). Central statistical Office, Ministry of Health and Macro Internal Inc., Maryland, USA.

Central statistics Office (CSO). (2006). Zambia Demographic Health Survey. Central statistical Office, Ministry of Health and Macro Internal Inc. Maryland, USA.

Clark, S. and Flavier, J. (2008). Asian Social Science and Medicine. Nepal. Indonesia.

Collins Pocket English Dictionary. (1993).New Edition. HarperCollins Publishers. Great Britain. ISBN 000433632-1

Cornell, D. (2009). Having second thoughts about vasectomy: Available at URL: http//www.articlesphere.com. Accessed 29/05/09

Drennan, M. (1998). Reproductive health: New perspectives on men's participation. Population reports, series J, No 46. John Hopkins University School of Public Health, Population information Program, Baltimore.

Engender Health, 2004. Factors influencing sterilization use: Contraceptive sterilization. Engender health.

Family Health International. (2004). Involving men. ***Network***, Volume 23. No. 3, pp. 29 – 30.

Geri L.W. and J. Habber,(2002): Nursing Research Methods: Critical Appraisal for Evidence Based Practice. Eisavier. Mosby.

Headman, H., Bankel, I., Salend, L and Von Couswant, C. (2000). Factors influencing vasectomy. Available at URL: http//www.popline.org.docs. Accessed 29/05/09.

Klass, H. et al. (2005). ***Human Reproduction Health,*** Volume 1, number 20. Berlin.

Landry, E., and Ward, V. (1997). Perspectives from couples on the vasectomy decision: A six-country study. In beyond acceptability: Users perspectives on contraception, London Reproductive Health Matters, pp. 58-67

Lynam, P., Dwyer, J., Wilkinson, D., and Laundry, E. (2006).Vasectomy in Kenya: The First steps, AVCS working paper number 4, May.

Magnani, R.J., et al. (2003). ***American Journal of Public Health***. Volume 89, Issue 2, pp.192- 94

Malarcher, R. (2007). USAID Sponsored Meeting for Experts. USAID. Washington DC.

Menintrye, J. (2005). Reproductive Health Matters. WHO. Geneva.

Ministry of Health (Ghana). (2003). Ghana Demographic and Health survey . Calverton, MD, Noguchi memorial Institute for Medical Research and ORC Macro.

Muhondwa, E., Rutenberg, N., & Lusiola, G. (2001). Effects of vasectomy promotion project on knowledge, attitudes and Behaviour in Dar es Salaam, Tanzania and Nairobi, Kenya: Population Council.

Ndubani, P. (2003). Towards Implementing Reproductive Health Policy in Zambia. ***Medical Journal of Zambia***, Vol 13- 14, Jan- March, pp. 11-12

Nigam, S., K., Malik, S., K., Das, H., C., (1994). A profile to acceptors of no scalpel vasectomy. ***Journal of family welfare***, 40:19-21.

Population Information Program (PIP). (1994). Population reports. Center for communication programs. The Johns Hopkins School of Public Health, Baltimore, Maryland, U.S.A. Volume XXII, Number 1.

Population Reference Bureau (PRB). 2002. Family planning World Wide: 2002 data sheet. Washington. DC: PBR

Population Reports. (2004). Information Project Centre for community programmes. Men`s Surveys, Series M, number 18, pp. 34-39.

Ricco, R., J. and Samson, A.K. (1996). Better together: A Report on the African Regional Conference on men`s participation in Reproductive Health, Harare, Zimbabwe.

Ringheim, K. (1996). Factors that determine prevalence of use of contraceptives methods for men. ***Studies in family planning***, 24:87-89

Ross, J.A., Hong, S., and Huber, D.H. (2002). Vasectomy. ***International Family Planning Perspectives***. Vol. 28, no 1, pp. 45-50.

Sianchapa, B., N. (2005). A study to determine views on vasectomy in Choma District. University of Zambia (unpublished).

Sinclair, C. (1993). Attitudes towards surgical contraception in four districts in Kenya. ***Studies in Family planning*** 20 (5): 281-287.

Terry, G & Braun, V. (2011). I'm committed to her and the family: Positive accounts of vasectomy among New Zealand Men. ***Journal of Reproductive and infant Psychology***, 29; 276-291.

United Nations Population Fund. (2003). It takes two; Partnering with men in sexual and reproductive health. United Nations Population Fund. New York

Uys, H., H., M and Basson, A., A. (2002). Research Methodology, Kagiso Tertiary, Cape Town.

Van, et al. (1993). Barriers to vasectomy use in Kenya, ***East African Medical Journal***, 1999, 76 (3):121–123.

Vernon, R. (1991). Making vasectomy services acceptable to men. ***International family planning Perspectives,*** 17: 55-60

Wegner, N., M., Laundry, E., Wilkinson, D., and Tzanis, &. (1998). Men as partners in Reproductive health: from issues to Action. ***International Family planning Perspectives***, volume 24, Number 1, March.

Wilkinson, D. (1990). Man-myths: some perceptions from Kenya: Reproductive health attitudes and behaviour in three sub-locations. AVSC international, New York.

Whithead, D., E. (1992). Current Operative Urology. J.B Company. Philadelphia

World Health Organization. (1991). Meeting of Experts. Geneva, Switzerland.

APPENDICES

APPENDIX 1: INFORMATION SHEET

Title of Study: Factors affecting Vasectomy Acceptability among men in Lusaka District.

My name is Miyanda Nzobokela; a student of Masters of Science in Nursing at the University of Zambia who is kindly requesting for your participation in the research study mentioned, because it is important to identify the factors that influence vasectomy acceptability among men. The participation in this study is voluntary. If you are not interested in participating in this study you are free to do so. Even after you have joined the study you are free to withdraw as you wish, and that will not affect your health services at this centre**.**

If you are willing to participate, you will be asked to sign a consent and agreement to participate, will not result in any immediate benefits. Please ask where you do not understand.

PURPOSE OF THE STUDY

The study will identify the factors influencing vasectomy acceptability among men. The information obtained will help the policy makers and implementers of the programme in the MOH to re- direct programme implementation in order to improve the vasectomy acceptability and utilization in Zambia.

PROCEDURE

The study involves a face-to-face interview with the research assistant who will ask you a set of questions using a structured questionnaire. After signing the consent form, the research assistant will proceed to ask you the relevant questions and your responses will be recorded on the questionnaire. The interview will take about 30 minutes.

RISKS AND DISCOMFORTS

There is no risk involved in this research though part of your time will be utilized to answer some questions. Some questions may seem to be sensitive and personal. If you will need further discussion, it will be offered to help you understand the topic more.

BENEFITS

There is no direct benefit to you by participating in this study, but the information which will be obtained will help the policy makers to take measures that will ensure that men also participate in permanent method of family planning by accepting to undergo vasectomy. No monetary favours will be given in exchange for information obtained, but education will be given on benefits of vasectomy as a permanent method of family planning.

CONFIDENTIALITY

Your research records and any information you will give will be confidential to the extent permitted by law. You will be identified by a number, and personal information will not be released without your written permission except when required by law. The Ministry of Health, the University of Zambia Research Ethics Committee or the School of Medicine may review your records again but this will be done with confidentiality

APPENDIX 11: INFORMED CONSENT FORM

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that:

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary.

I_____

(Names)

agree to take part in this study.

Signed: _____ Date: _____

(Participant)

Participant's signature or **thumb print**

Signed: _____ Date: _____

(Witness)

Signed: _____ Date:_____ (Researcher)

PERSONS TO CONTACT FOR PROBLEMS OR QUESTIONS

1. Miyanda Nzobokela, University of Zambia, Post Basic Nursing Department, P.O. Box 50110, Lusaka. Cell: 0977108783. email mnzobokela@yahoo.com

2. The Head of Department, University of Zambia, Department of Nursing Sciences, P.O. Box 50110, Lusaka. Telephone Number 252453.

3. The chairperson, University of Zambia, Biomedical Research Ethics Committee, University of Zambia. P.O. Box 50110, Lusaka.

APPENDIX 111: BUDGET

BUDGET CATEGORY	UNIT COST (ZMK)	QUANTITY	TOTAL
1. STATIONERY			
a) Flash Disc	140,000.00	x1	140,000.00
b) Bond paper	30,000.00	x10	300,000.00
c) Pens	100,000.00	x10	10,000.00
d) Pencils	500.00	x10	5,000.00
e) Rubbers	1,000.00	x5	5,000.00
f) Note book	8,000.00	x1	8,000.00
g) Tippex	10,000.00	x1	10,000.00
h) Bag for interview schedules	150,000.00	x1	150,000.00
i) Stapler	50,000.00	x1	50,000.00
j) Staples	75,000.00	x1	75,000.00
k) Lap- top	10,000.00	x1 Box	10,000.00
	3,500,000.00	x1	3,500,000.00
SUBTOTAL			**5,523,000.00**
2. PERSONNEL			
a) Lunch allowance			
Principal researcher	50,000.00	x1 x 30 days	1,500,000.00
Research assistant	30,000.00	x3 x 30 days	2,800,000.00
SUBTOTAL			**4,300,000.00**
3. SERVICES			
a) Ethics committee	250,000.00	1	250,000.00
b) Data entry	500,000.00	1	500,000.00
c) Data analysis	1000,000.00	1	1,000,000.00
d) Photocopying proposal	250.00	320 pages	64,000.00
e) Photocopying questionnaire	250.00	10 pages x 3	33,000.00
f) Photocopying report	250.00	3	80,000.00
g) Binding	250.00	3	250,000.00
	60,000.00	0	300,000.00
		400 pages	
		5 copies	
SUBTOTAL			**2,177,000.00**
TOTAL			12,000,000.00
CONTIGENCY FUND10%			1,200,000.00
GRAND TOTAL			**13,200,500.00**

JUSTIFICATION FOR THE BUDGET

STATIONERY

The 10 reams of bond paper will be used for the research proposal development and the final report. Paper will also be required to make extra copies of the proposal for submission to the Research Ethics committee and the board of graduate studies. In addition the interview schedule will consist of 90 pages which need to be photocopied.

The bag for interview schedules is for the researcher to ensure that the interview schedules are kept safe.

The flash disc is for copying, storage and safe keeping of research data.

The lap-top is to facilitate typing and easy information storage for the investigator.

Other accessories such as pens, pencils rubbers, stapler and staple and note books are required for the routine collection of research data.

PERSONNEL

Data collection will be conducted through out the day as such the researcher will need lunch allowance. The research has been allocated 30 days to allow adequate time for administration of interview schedules and for observations.

SECRETARIAL SERVICES

Funds for photocopying services and binding of the proposal and report will be needed. The charge for photocopying implies that one copy will be printed and the rest photocopied to cut down on the cost. The researcher will need five copies of the proposal to submit to Post Graduate Research Committee for dissertation and dissemination.

CONTIGENCY

Contingency fund which is 10% of the budget is required for any extra costs due to inflation and for any eventualities.

APPENDIX IV: DATA COLLECTION TOOL

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF NURSING SCIENCES

STRUCTURED INTERVIEW ON FACTORS AFFECTING VASECTOMY ACCEPTABILITY AMONG MEN

DATE OF INTERVIEW : _____
PLACE OF INTERVIEW : _____
NAME OF INTERVIEWER: _____
SERIAL NUMBER : _____

INSTRUCTIONS FOR THE INTERVIEWER

1 Introduce yourself to the respondent.
2 Explain the reason for the interview.
3 Assure the respondent of confidentiality and anonymity
4 Do not write the name of the respondent on the interview schedule.
5 Fill in the most appropriate response to the question on the space provided.
6 Provide time for the respondent to ask questions at the end of the interview.
7 Refer the respondents to a person who can answer the questions you are not sure of.
8 Thank the respondent at the end of each interview.

SECTION A: DEMOGRAPHIC DATA

1. Age at last birthday {age}
    1.45 – 55years
    2. 56+ years
2. Marital status (marital)
    1. Single
    2. Married
    3. Divorced
    4. Separated
    5. Widowed

3. Years in present marriage
    1. below 2 years
    2. 2 – 3 years
    3. 5 years
    4. above 5 years.

4. Religion (Relig)
    1. Christian
    2. Moslem
    3. Hindu
    4. Buddhist
    5. Others specify_____

5. Educational Level (Educal)
    1. None
    2. Primary
    3. Secondary
    4. College
    5. University

6. Income (income)

1. above K1, 000,000
2. between K500, 000- K1, 000,000
3. below K500, 000

SECTIOB B: KNOWLEDGE OF VASECTOMY

7. Have you heard of vasectomy?

1. Yes
2. No

8. Do you know a person who has undergone vasectomy?

1. Yes
2. No

9. If yes, which is your source of information? (Tick all appropriate) (info soc)

11. Media

2. Health personnel
3. Relatives
4. Friends
5. Others specify_____

10. What is vasectomy? ……...
……

11. Are vasectomy services accessible?

1. Yes
2. No

12. Do you know where to find them?

1. Yes

2. No

13. Do you think vasectomy is beneficial?

1. Yes
2. No

SECTION C: ACCEPTANCE

14. Do you think vasectomy is good?

1. Yes
2 No

15. Do you agree that men must undergo vasectomy?

1. Yes
2. No

16. Would you be willing to undergo vasectomy?

1. Yes
2. No

SECTION D: TRADITIONAL/CULTURAL VALUES/BELIEFS ASSOCITED WITH VASECTOMY

17. In your community how do people look at a person who has had vasectomy?

…….

……

18. Do you think men participate in family planning matters?

1. Yes
2. No

19. Do you openly discuss matters related to vasectomy openly?

1. Yes
2. No

20. Do you think it is culturally right for a man to undergo vasectomy?

1. Yes
2. No

21. Is it taboo to discuss family planning issues with your partner?

1. Yes
2. No

SECTION E: ATTITUDES BY HEALTH PROVIDERS

22. In your opinion do health care providers receive clients who seek vasectomy services well?
    1. Very well
    2. Sometimes
    3. Not well
23. Do family planning providers provide adequate information on vasectomy to clients who seek the service?
    1. Yes
    2. No
24. Kindly give suggestions on how to create awareness on vasectomy in our Community

    ……
    ……
    ……
    ……

End of the interview and I thank you for your co-operation.

APPENDIX VI: FOCUS GROUP DISCUSSION GUIDE ON FACTORS INFLUENCING VASECTOMY ACCEPTABILITY BY MALES WHO HAVE HAD VASECTOMY

Number of participants……

Composition of participants……..

Language to be used during discussion……

Date…….

Duration ……

Place …….

INSTRUCTIONS

1. Welcome the participants
2. Introduce yourself, show the recorder and explain the use to the participants
3. Allocate numbers to participants.
4. Explain the purpose of the discussion
5. Obtain verbal consent from the participants to continue with the discussion.
6. Assure the participants of confidentiality and anonymity and encourage them to participate freely.
7. Respect each participant's views.
8. Thank the participants at the end of the discussion.

QUESITIONS

1. **Knowledge on vasectomy**
   (a) What do you know about vasectomy?
   (b) What is done to the man during vasectomy?
   (c) Can someone who had vasectomy have children again?
2. **Associated traditional/cultural beliefs**
   (a) Should a man participate in family planning matters?
   (b) Is it culturally acceptable for a man to have vasectomy done?
   (c) How is a person who has had vasectomy perceived in the community?
   (d) How do we as individuals look at or perceive vasectomy?

3. **Attitudes of Health Providers on vasectomy**
   (a) How do the health providers receive you when you seek information on the vasectomy services?
   (b) Do the health providers take time to provide information on vasectomy?
4. **Suggestions for increasing acceptability of vasectomy**
   (a) What do you think may be done to create awareness of vasectomy among men in the community?
   (b) Who should be in the fore front to spearhead the awareness programme to promote vasectomy acceptability?

We have come to the end of our discussion. Thank you very much for your contributions and for participation as well as your time.

APPENDIX VII: LETTER TO THE DISTRICT MEDICAL OFFICER

The University of Zambia
School of Medicine
Department of Nursing Sciences
P.O Box, 50110
LUSAKA.

28th April, 2010.

The District Medical Officer
Lusaka District Health Office
LUSAKA.

UFS: The Head of Department
Department of Post Basic Nursing
School of Medicine (UNZA)
LUSAKA.

Dear Sir/Madam,

RE: REQUESTING FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN LUSAKA DISTRICT

I am a student at the above mentioned institution pursuing a Master of Science in Nursing degree.

In part of fulfilment of this programme, I am required to conduct a research study. My topic is Factors affecting vasectomy acceptability among men. The study will involve interviewing men who are legible for vasectomy aged 45 and 75 years. It will be conducted in the Kabwata Health Centre catchment area.

The study will be undertaken from April to May, 2010.

Your consideration of my request will be highly appreciated.

Yours Faithfully,

Miyanda E. Nzobokela (Ms).