The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Master in Public Health in the School of Public Health, Faculty of Community and Health Sciences, University of Western Cape.

18 November 2019

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Key Words

Vasectomy

Contraception

Family planning

Drivers

Men

Awareness

Contributing factors

Uptake

Knowledge

Zimbabwe

Acronyms

AM - Any Method

AMM - Any Modern Method

BMREC – Biomedical Research Ethics Committee

CBM – Community-based mobiliser

CBO – Community-based organisation

CPR – Contraceptive prevalence rate

FC - Female Condom

FGD – Focus group discussion

FI – Fascial interposition

FP – Family planning

FS - Female sterilisation

GoZ – Government of Zimbabwe

IEC – Information, Education and Communication

IUCD – Intra-uterine contraceptive device

KI – Key informant

LAM – Lactational Amenorrhea Method

LAPM – Long acting permanent method

MC - Male Condom

MICS – Multiple indicator cluster survey

MoHCC – Ministry of Health and Child Care

MRCZ – Medical Research Council of Zimbabwe

MWRA – Married Women of Reproductive Age

NGO – Non-governmental organisation

NSV – Non-scalpel vasectomy

PSZ – Population Services Zimbabwe

RH – Reproductive Health

SRH – Sexual reproductive health

WHO – World Health Organisation

ZDHS – Zimbabwe Demographic Health Survey

ZNFPC – Zimbabwe National Family Planning Council

Abstract

Background

Currently Zimbabwe has a contraceptive prevalence rate of 67%, up from 59% in 2010-11, among married women of reproductive age (15 t0 49 years). The popular contraceptive method used is pill (41%) and the least being permanent (female and male sterilisation) method (1%). Nationally, vasectomy constitute 0% of the permanent method users with only 0.2% users in Bulawayo, which is the highest compared to all other provinces. Despite Zimbabwe being one of the highest countries with high CPR, permanent method use, mainly vasectomy remains a challenge in-country and regionally. Understanding the perspective of men and women with regards to challenges and what recommendations could be made to improve uptake of vasectomy is important. The current study explored the factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

Methodology

An explorative qualitative study approach was used. Three focus group discussion were conducted and in-depth interviews were conducted with three key informants who are vasectomy service providers. Qualitative data was digitally recorded, transcribed verbatim and subjected to thematic analysis.

Results

The study findings showed multiple factors contributing to low uptake of vasectomy, experienced at individual, spousal/partner, family, religious, community and health systems level. It was evident in this study that knowledge gaps about vasectomy was the main underlying factor, with communities having incorrect and inadequate information leading to myths and misconceptions acting as barrier to uptake of vasectomy method. Some recommendations were made by participants on how to improve vasectomy uptake, that is, using men who had successfully vasectomised as advocates and also conducting vasectomy awareness campaigns.

Conclusion

Based on the findings, increasing vasectomy awareness through information dissemination using various communication methods and strategies is key. Health systems strengthening through service provider capacitation will ensure correct information is given to the community and access

to vasectomy service is increased. In addition, men who had successfully vasectomised and gave positive feedback about vasectomy should be utilised as advocates for improving the uptake of this contraceptive method.

Declaration

I, Patson Ndlovu, hereby declare that this study is a true reflection of my own research, and that all sources that I have used or quoted have been indicate and acknowledged by means of complete references, and that this work has not been submitted for a degree examination at any other institution of higher education.

Signed: 

Date: 18 November 2019

Acknowledgements

I would like to express my profound gratitude to my supervisor, Dr. Anam Nyembezi, of the University of Western Cape for the support he gave me to complete this research. I thank the participants of this study who volunteered to participate in this research. I also thank the Bulawayo City Health management team for the support they gave me during data collection. I finally thank my wife, Maria, for all the support she provided during my studies and as I completed this research.

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CHAPTER 1: INTRODUCTION

1.1 Background

National family planning (FP) initiatives over the past several decades have led to significant gains in contraceptive prevalence rate (CPR), effective spacing of children and achieving desired family size in many countries including developing countries (Perry *et al*., 2016). Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (Zimbabwe Demographic Health Survey, 2011). Family planning methods, also known as contraceptives, include male and female condoms; pills; injectables; implants; intra uterine devices; female sterilisation (tubal ligation) and male sterilisation (vasectomy).

A vasectomy is a permanent form of contraceptive, with a new technique called no-scalpel vasectomy (NSV), requiring no incision but only a small puncture, with no stitches, in a man's scrotum to access the vas deferens (Kokila *et al*., 2018). The semen no longer contains sperm after the tubes are occluded, so conception cannot occur. The testicles continue to produce sperm, but they die and are absorbed by the body (Family Planning Handbook, 2018).

1.2 Worldwide uptake of vasectomy

Use of contraceptive by men varies widely across the globe, with a significant uptake of the method in the United States and other continents besides Africa where it is low. Globally, approximately 60 million couples rely on vasectomy (John, 2019), and by comparison, nearly 210 million couples rely on tubal ligation. North America has 11.9% of married women of reproductive age (MWRA) partners using vasectomy, followed by Oceania at 6.3% with the least being Africa overall with 0.0% (Jacobstein, 2016). In Canada, the United Kingdom, New Zealand, and the Republic of Korea, vasectomy prevalence ranges from 17-22%, comprising 24-31% of modern contraceptive use (Vinluan *et al*., 2019).

A detailed cursory glance at the literature revealed a global picture of vasectomy uptake. Worldwide, nearly 50 million men in the world have opted for vasectomy, with growing evidence that there are no long-term deleterious effects, and more men are choosing this option (World Contraceptive Use, 2011). However, in Africa, the prevalence of vasectomy is very insignificant, with the exception of South Africa and Namibia with a vasectomy prevalence of 0.7% and 0.4% respectively (Shattuck *et al.*, 2014; Emily, 2017; Vinluan *et al.*, 2019). However, despite some individual countries having more than 0.1% users, vasectomy use in Africa as a continent is at 0.0%.

In a study to review published research papers in various African countries, conducted by Shattuck *et al*., (2014), findings revealed that negative attitude towards vasectomy, socio-cultural factors, spousal influence, religion, provider reputation and availability and poor vasectomy knowledge were major factors that influenced vasectomy acceptability among men.

According to World Contraceptive Use Report (2011), the global vasectomy prevalence in 2009 was at 2.4%; Africa at 0.0%; and Zimbabwe at 0.1%. However, according to the current Zimbabwe Demographic Health Survey, (2015) and Zimbabwe Multiple Indicator Cluster Survey, (MICS) (2015), the current vasectomy prevalence for Zimbabwe has dropped to 0.0%, with only Bulawayo and Harare Metropolitan provinces recording 0.2% and 0.1% respectively. In an effort to increase accessibility to comprehensive FP services to women and men in Zimbabwe, the government of Zimbabwe (GoZ), through its Ministry of Health and Child Care (MoHCC) and Zimbabwe National Family Planning Council (ZNFPC), have made huge strides and a collaborated effort with non-governmental organisations (NGOs) and community based organisations (CBOs) in capacity building and FP service provision nationwide (Family Planning Guidelines, 2018). The support by ZNFPC and NGOs to the Ministry in family planning service provision started more than two decades ago. However, despite the various organisations complementing the MoHCC, only one organisation; Population Services Zimbabwe (PSZ), offers vasectomy in Zimbabwe (Moyo, 2018). PSZ's vasectomy contribution feeds into the national system although the numbers are significantly low for the last five-year period.

Despite that, Bulawayo has recorded a relatively high number of males accessing vasectomy, contributing only 0.2% of the total males who have accessed the method nationwide, the contribution is quite insignificant and not as what is expected (ZDHS, 2016). The overall uptake of vasectomy remains at 0.0% nationwide (MICS, 2015), yet the ideal situation is to see an improvement in modern method mix, not skewed towards one particular method, in Zimbabwean case being the pill. Hence, the objective of the Ministry is to improve the uptake of long acting and permanent methods (LAPM) so as to have a healthy method mix. Table 1 below indicates contraceptive prevalence rate for each contraceptive method, including vasectomy, per province in Zimbabwe.

Table 1: Contraceptive prevalence rate per method for each province in Zimbabwe

Region	AM	AMM	FS	Vasectomy	Pill	ICUD	Injectable	Implant	MC	FC	Not
Manicaland	58.7	56.7	0.7	0.0	34.3	0.9	10.4	7.8	2.6	0.2	41.3
Mash Central	66.2	65.1	0.4	0.0	46.5	0.4	7.5	7.2	2.8	0.3	33.8
Mash East	69.9	69.1	0.6	0.0	43.1	0.6	11.3	10.0	3.6	0.0	30.1
Mash West	71.5	70.9	0.6	0.0	48.1	0.4	8.5	9.1	4.2	0.0	28.5
Mat North	67.0	66.3	1.3	0.0	29.3	0.5	18.6	10.6	6.0	0.0	33.0
Mash South	59.8	59.7	0.9	0.1	26.7	0.1	13.4	13.7	4.7	0.0	40.2
Midlands	67.1	66.3	0.7	0.0	39.6	0.2	11.9	10.7	2.8	0.2	32.9
Masvingo	61.2	60.5	0.4	0.0	37.7	0.5	11.4	8.1	2.1	0.4	38.8
Harare	70.8	70.2	0.9	0.1	46.8	1.1	4.4	10.6	6.0	0.0	29.2
Bulawayo	71.9	70.9	3.2	0.2	36.9	1.7	5.8	16.2	6.4	0.0	28.1

**Source:* ZDHS 2016 (Extract)

Key:

AM = Any Method AMM = Any Modern Method

FS = Female sterilisation MC = Male Condom

FC = Female Condom Not = Not currently using

It is against this background that despite the increased effort by PSZ and other organisation, uptake of vasectomy is still lower than 20% that is expected at national level. Therefore, this study explored the contributing factors to general low uptake of permanent modern method of family planning, vasectomy in Bulawayo Metropolitan province. The Metropolitan province was ideal for the study based on the notion that, there has not been research on vasectomy conducted in Bulawayo.

1.3 Problem statement

With the global shift toward a more comprehensive reproductive health strategy (Perry, 2016), there is need to identify factors impeding men from actively participating in all ranges of sexual reproductive health, both as users and promoters, supporting their partners to access the services. Family Planning information and services have been mainly targeted to women neglecting men, yet they play a key role and can also be users of modern contraceptive, mainly condoms or if the couple prefers a permanent method, vasectomy. This has led to men shun anything to do with family planning and not accept vasectomy as contraceptive method. This perception by men that family planning is only for women and that women have to seek permission from their male partners first (Haryanto, 2017), has contributed to unplanned and unwanted pregnancies even among married couples. Moreover, there is little in depth

knowledge on why men are not keen to access vasectomy as their method of choice, general in Zimbabwe.

1.4 Outline of the research

This thesis is comprised of six chapters and appendices. Chapter one provided a brief background of the study by highlighting contraceptive use in Zimbabwe and various contraceptive methods available. Chapter two presents a detailed review of literature related to factors that influence uptake of vasectomy in Zimbabwe and worldwide. The third chapter describes research methods used to carry out the study and further the ethical considerations. Chapter four presents the findings of the focus group discussions with men and women, including couples and in-depth individual interviews with key informants. Chapter five presents discussions of the study findings. Finally, the sixth chapter provides conclusions and recommendations arising from this study.

CHAPTER 2: LITERATURE REVIEW

1.1 Introduction

Family planning is defined by Shah, (2006) as a process enabling individual and couples to attain the desired number, spacing and timing of their children through use of modern or traditional contraceptive methods. Contraceptive methods are classified as modern or traditional. Modern contraceptive methods are those that include female sterilisation, male sterilisation, the pill, the intrauterine contraceptive device (IUCD), injectables, implants, male condoms, female condoms, diaphragm, and the lactational amenorrhoea method (LAM) (Tirfer, 2013), while methods such as rhythm (periodic abstinence), withdrawal, and folk methods are grouped as traditional (Family Planning Handbook, 2018).

Family planning is the responsibility of a couple, to decide how many and when they want to have children. Therefore, male partners should be involved in decision making regarding a contraceptive method of choice. However, the majority of men are not supportive of their partners and they are ignorant of the fact that, their lack of involvement in Sexual Reproductive Health (SRH) issues does not only endanger their partner's reproductive health (RH) but also theirs A study by Kabagenyi *et al*., (2014) in Uganda, for example, identify: lack of time and lack of awareness of the importance of their involvement as affecting men's roles in fertility regulation.

2.2 Vasectomy overview

Vasectomy also known as "male sterilisation", is a surgical process that prevents sperm from reaching the penis from the testicles by sealing, tying or cutting the tubes (Asare *et al*., 2017) as shown in Figure 1. According to Shih, Turok & Parker, (2010), vasectomy is considered to be the most effective long-acting and permanent method available to men. Compared to female sterilisation, it is more effective, cost less and has less complications, including low failure rate compared to other contraceptive methods (Ebeigbe *et al.,* 2011: Perry *et al.,* 2016).

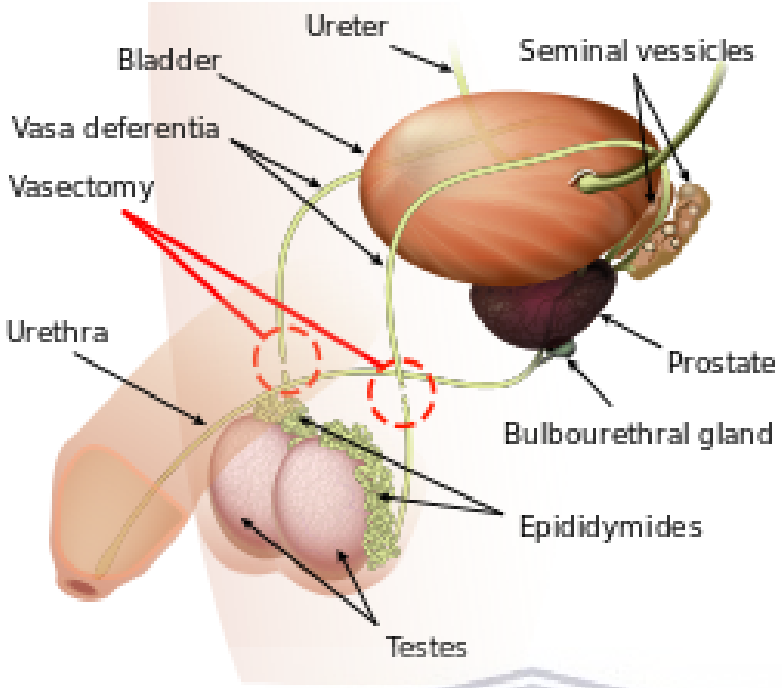

Figure 1: Male reproductive system and vasectomy site

2.2.1 Vasectomy techniques and approach

Vasectomy is performed in two distinct sequential steps: delivering and exposing the vas deferens out of the scrotum, also called isolation, and then followed by occluding the vas deferens (Li *et al.*, 1991: Labrecque *et al.*, 2004) as shown in Figure 2 (A). In order to isolate or expose the vas deferens, two techniques can be used: traditional incisional and non-scalpel techniques (NSV). Traditional technique involves the use of a scalpel to make one or two incisions while NSV uses a sharp, forceps-like instrument to puncture the skin. Jones & Lopez (2014), say NSV technique entails one tiny puncture instead of two larger incisions, one on each side, and has less risks of complications with quicker recovery compared to the other. Zini *et al.*, (2016), say it is a modified technique that requires no incision but only a small puncture with no stitches.

Li *et al*., (1991) state that the NSV technique reduces chances of hematomas, causes less pain and increases chances of acceptance of vasectomy by men. Further to that, according to studies conducted by Zareen *et al*., (2016); and Kokila & Ganapathi (2018), most men would prefer NSV nowadays because the technique is regarded as safe, simple and causes minimal damage to tissues such that it can be performed in low resource settings like Africa. The procedure is ideal in low resource countries like Africa because the countries have poor health systems such that they may not be able to deal with complications of the traditional method, in case it happens.

There are various surgical approaches recommended to occlude the vas deferens after isolation as illustrated in Figure 2 (E). The common approach globally being ligation with suture material and excision of a small vas segment (Labrecque *et al.,* 2004; .Akpamu et al., 2010; Shih *et al.,* 2010). Other effective occlusion methods which have been recommended include cautery of the vas lumen, interposing fascial tissue between the segments of the severed vas, also known as fascial interposition (FI), folding back of one or both vas segments onto itself, excision of a long vas segment, or a combination of two or more of the above techniques (Jacobstein, 2004). Figure 2 shows general steps followed when performing vasectomy procedure.

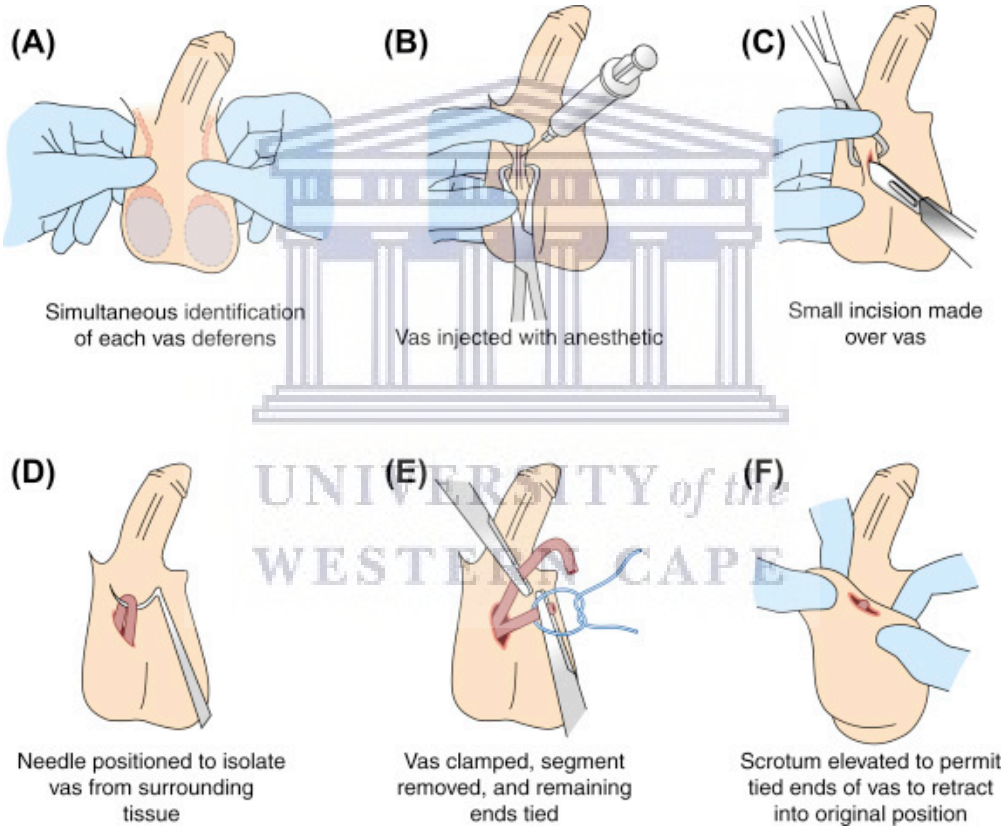

Figure 2: Steps in performing vasectomy procedure

2.3 Effectiveness, advantages and disadvantages of vasectomy

Vasectomy is considered one of the most effective methods of contraception as indicated in Figure 3. It is 99% effective with less than 0.1% failure rate (Family Planning Handbook, 2018). The advantages of sterilisation include effectiveness, safety, convenience and avoidance of high rate of discontinuation. Vasectomy is regarded as the safest and least expensive option of permanent sterilisation (Tijani *et al*., 2013). Compared with tubal ligation, it is less likely to

fail, with less complications and costs and has been reported to be a major contraceptive method in more developed nations. Figure 3 illustrates the effectiveness of various family planning methods. Long acting reversible contraceptive (IUCD and implants) and permanent methods (vasectomy and female sterilisation) are more effective than all other contraceptive methods as indicated in Figure 3.

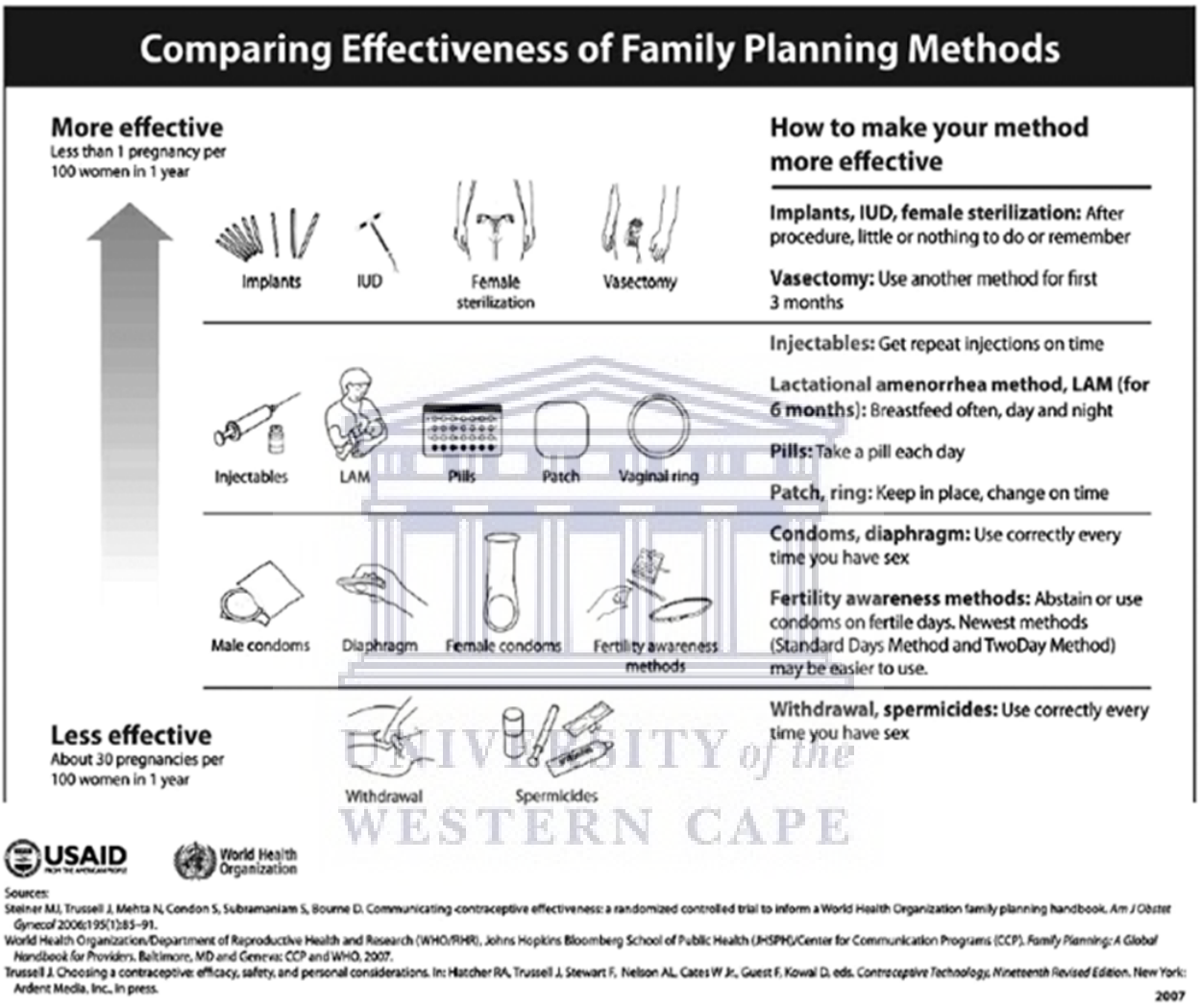

Fig. 1. Abbreviations: IUD, intrauterine device; LAM, lactational amenorrhea method.

Figure 3: Comparing effectiveness of family planning methods

2.4 Drivers to uptake of vasectomy

There are several factors that have been reported as drivers to vasectomy uptake and these are classified as individual, spousal/partner, family, peer, religious and health systems. These are further described in turn.

2.4.1 Individual Factors

The use of any family planning method depends on the person's knowledge of the family planning methods available and the willingness of both partners to participate in the family planning program/activities (Akafuah & Sossou, 2008). Having enough information about a particular family planning method enhances the decision-making process by an individual or a couple, hence access to basic facts about vasectomy could increase vasectomy uptake.

According to study findings by Haryanto, (2017), it revealed that men who have undergone vasectomy procedure as contraception, have presented themselves to their colleagues as agents of positive change. Their personal experience which they share with them have motivated them to consider the method and undergo the procedure as well. It is further alleged that men who accept vasectomy tend to have views different to the rest of their communities thereafter (Haryanto, 2017).

Christiana *et al*., (2015) further argue that the major factors that act as drivers of vasectomy uptake among men was not wanting to risk spouses' health in any way. Men in India perceived vasectomy procedure as easy and not a danger (Kumar, 2007) while a couple of studies in India, perceived vasectomy as a simple and painless procedure (Murthy & Rao, 2003; Scott *et al*., 2011). Such attitudes are likely to be motivators to those men intending to use an effective permanent contraceptive method. Furthermore, a study conducted in Kenya, showed that positive attitudes towards vasectomy were widely discussed by participants (Vinluan *et al.,* 2019). Both women and men alluded to the fact that vasectomy is highly effective and therefore, couples would not have to worry about unplanned pregnancy.

2.5.2 Spousal/partner factors

Spousal positive attitude towards vasectomy is viewed as a driver to uptake of vasectomy by partner. A study conducted in Ghana by Asare *et al.*, (2017) found that some women would approve use of vasectomy if it was to their health benefit or if it would lead to economic gains to the woman. Women who believe that vasectomy is a safe contraceptive method are more likely to encourage their partners to undergo the procedure (Kisa *et al.,* 2017). Women also believe that vasectomy would eliminate the possibility of having a child out of wedlock as they will be unable to make a woman conceive, hence this belief by women can act as a driver to uptake of vasectomy as they would encourage their partners to undergo the procedure (Shattuck *et al.*, 2016).

2.5.3 Family factors

A couple of studies revealed that, the key driver to uptake of vasectomy appeared to be that the man's wife was seen as being too weak or sick to undergo sterilisation herself, hence men will then opt for the contraception (Scott *et al.*, 2011). In one study conducted in India, one man who had undergone the procedure highlighted that he did it because he feared female sterilisation would fail while he believed vasectomy would not fail (Asare *et al*., 2017). The other reason that this man did the vasectomy was because his wife was not well hence, he followed doctor's advice. This was confirmed by Vinluan et al., (2019), in a study conducted in Kenya. Again in this study, men showed great concern about their wives' health such that they would choose to undergo the procedure to avoid burdening their wives health by further exposing her to any form of family planning method including female sterilisation.

Another driving factor according to Vinluan *et al.,* (2019), is the economic hardship faced by the majority of families hence, couples would prefer smaller families which will be easily manageable financially.

2.5.4 Peer Factors

A study conducted by Shattuck *et al.*, (2016) in various African countries showed that in societies where vasectomy uptake has been high, more than 90% of the adopters are men who had discussed vasectomy with other men, who had undergone the same procedure. This is further supported by findings of another study by Vinluan *et al.,* (2019) which revealed that satisfied vasectomy clients can be powerful messengers in motivating more men in the community to undergo the procedure as they can share first-hand information about the experience.

2.5.5 Religious influence

Religion also plays a positive role in some communities. A study conducted in Tanzania showed that, the Seventh Day Adventist church is a strong advocate of contraception; for example vasectomy services are provided at Heri Seventh Day Adventist hospital and contraception is discussed and promoted in Sermons (Bunce *et al*., 2007). In another study conducted in Ghana, churches and mosques were viewed as opportunities for promoting vasectomy as they could be used as a platform for information dissemination (Adongo *et al*., 2014)

2.5.6 Health System Factors

According to the findings of study by Ebeigbe, Igberase & Eigbefoh, (2011), areas where a high number of men were undergoing vasectomy procedures, the men became aware of the procedure through health personnel and at family planning clinics, where comprehensive counselling is provided including addressing myths and misconceptions. This acquired information is then shared with spouses and families at home. Information given and shared is perceived to be key in increasing men/couple's knowledge of vasectomy and consequently its uptake.

WHO (1994) states that comprehensive counselling by health personnel is vital and key in ensuring client satisfaction and possibility of referring another person for the same service. A study conducted recently in Kenya (Vinluan *et al*., 2019) showed that health workers provided comprehensive counselling that include vasectomy. Health workers also used social media to create awareness and demand for the procedure.

2.6 Barriers to vasectomy uptake

Multiple factors contributing to low uptake of vasectomy have been mentioned as barriers and these include individual, spousal/partner, family, community, religious and health systems. These are explained in turn.

2.6.1 Individual Factors

Generally, lack of information about vasectomy by majority of men and women is evident and seen as one of the key barriers to uptake of vasectomy, mainly in developing countries, even if they are knowledgeable about other family planning methods (Ikeako *et al*., 2018). Even those who know about it, the information they have is frequently incorrect or incomplete leading to negative perceptions and attitudes.

In a study conducted in India, men expressed concerns that vasectomy affects manual work; it reduces sexual potency; and has high failure rate (Balaiah *et al*., 2001). Studies in India showed that the majority of men believed vasectomy may cause weakness which will prevent them from doing any manual agricultural work (Bhardwaj *et al.*, 2016; Madhukumar & Pavithra, 2015), hence they were hesitant to undergo the procedure as it will lead to loss of income. It was also perceived that in the case of vasectomy failure, evidenced by a wife's pregnancy, it was proof of extramarital affair by the wife. In the Bhardwaj *et al.*, (2016) study, most men also considered vasectomy unacceptable as it was perceived as causing sexual "weakness".

Another study conducted in Nigeria by Onasoga *et al*., (2013) revealed that, most respondents (82%) showed negative attitudes towards vasectomy and believed that vasectomy should not be done by men and that females should be responsible for family. Furthermore, a study conducted in a rural community of Zimbabwe by Moyo *et al*., (2012) revealed the bitterness of the majority of men towards vasectomy and only 1% of the participants approved the method. They argued that vasectomy is against their cultural beliefs hence, they strongly disapprove of it as one of the participants went on to say "it is the same as castration". In Kenya, men admitted having their own personal fears of exposing their genitals to the health worker and allowing him/her to manipulate them during the procedure (Vinluan *et al.*, 2019).

2.6.2 Spousal/partner factors

Women's knowledge, attitude and perceptions and influence, can be a driver or barrier to the uptake of vasectomy by their spouse/partners. According to Bunce *et al*., (2007, there is evidence that some partners discuss vasectomy and women can have a strong influence on the outcome, however men would resist vasectomy if wives initiate the discussion or try to convince the men. Women also expressed some concern that their husbands would become unfaithful after having vasectomy because they would not worry about getting other women pregnant (Frajzyngier *et al*., 2006). In a study conducted in India, women expressed the fear of reduced sexual performance by their partners, as a result of vasectomy and that a man will be viewed as a "slave to his wife" (Scott *et al*., 2011).

In another study conducted in Ghana, women believed vasectomy may lead to physical weakness and make the men less productive and viewed as "under the control" of his wife (Adongo *et al*., 2014). In addition, in another study conducted in Lagos, the majority (88%) of men confirmed they would not accept vasectomy (even if they wanted it) if their spouses disagree to it and 92% of men who were willing to accept vasectomy would only go ahead if their wives agree (Tijani *et al*., 2013). Such negative attitudes act as barriers to uptake of vasectomy by men, even if they intended to use the method. However, on the other hand, in the same study conducted in Ghana, men believed that the decision on which contraceptive method the couple should use, should be made by men as the head of the family; hence they believe women should be users of family planning and the men the decision makers (Ogunlaja *et al*., 2017).

2.6.3 Family Factors

According to a study conducted in Tanzania by Charles (2014), men believe they may lose control of their families if they engage in decision making regarding their reproductive health goals with their spouses/families. Moreover, they feel it is not necessary for them to be involved in family planning issues and/or use any method of family planning. A study conducted in Ethiopia, revealed that Ethiopians favour large families due to high infant and child mortality rate (Dibaba, 2001). The major benefits of having large families are described as: a source of fulfilment, joy and pride; a source of support for the aging parents; companionship; care for the other children; and a means of continuing the family name (Dibaba, 2001: Shattuck *et al*., 2016) as they prefer to have large families. This has led to an insignificant percentage of men accessing vasectomy in all African countries (Shattuck *et al*., 2016). According to another study conducted in Nigeria, families put pressure on couples to have more male children as it is viewed as important (Ikeako *et al*., 2018). This pressure has led to couples not to consider permanent method of family planning as they keep trying to have more male children.

2.6.4 Community Factors

Myths and misconceptions about vasectomy exists in many communities and this is mainly attributed to poor knowledge and subsequent dissemination of information by individuals with little understanding of the method (Ogunlaja *et al*., 2017). In many communities, particularly in sub-Saharan countries, a man is considered a real man by his ability to father many children. Therefore, if a man undergoes sterilisation, he will never be recognised by his family and community as a real man in the event his wife dies or is divorced, as he will not be able to father a child even if he re-marries (Kols & Lande, 2008; Withers *et al*., 2015).

These negative attitudes are deeply rooted in ancient beliefs about vasectomy as reported in the Population Report (1983) which reports that barriers to uptake of vasectomy is due to community opposition or ambivalence about the method, which is worsened by fears and misconceptions that vasectomy will affect men's sexual performance. This further instils the belief within and across communities that contraception is a woman's responsibility.

2.6.5 Religious factors

Religion can influence acceptance and uptake of contraception including vasectomy. Islamic religion, according to a study conducted in Kenya, promotes polygamous marriages hence they do not approve of permanent method of contraception (Asare *et al.*, 2017). Religious beliefs are also cited as barriers to uptake of vasectomy as most men worry about the impact of

vasectomy on sexual life (Kokila & Ganapathi, 2018). In Tanzania, most men consider use of contraceptives including vasectomy, as a religious taboo which is against faith teachings and commands, hence they would not use contraceptives (Msoka *et al.*, 2019).

2.6.6 Health Systems Factors

These are factors related to the attitude and competencies of the health workers trained and providing vasectomy services, and the general health service delivery system. It entails good customer care by the service provider which, when one client is very satisfied with the service provided, there are high chances that the client will refer other clients (men) to consider accessing the service at a particular health service and the opposite is true. Availability of health facilities providing vasectomy services also plays a key role in increasing the number of men who seek for the services.

In a study conducted by Moyo *et al*. (2012) in Zimbabwe, they highlighted some barriers to accessibility to vasectomy. The non-reversibility of the procedure once it is done and the fact that vasectomy is provided at central hospitals by trained health personnel, who are doctors only, were also mentioned as barriers. The findings of a study conducted in Nigeria looking at the attitudes of gynaecologists towards vasectomy, who provided counselling to their clients, states that the gynaecologists strongly believed that Nigerian men will not accept vasectomy even if they are provided with comprehensive information, while some of them believed that female sterilisation will be a more appropriate permanent method for a couple in Nigeria (Ebeigbe *et al.*, 2011). Therefore, the gynaecologists do not include vasectomy in their counselling because of their own perceptions and beliefs.

In another study conducted in Uttar Pradesh, India, men recommended government hospitals and had confidence in doctors providing services, however some complained of long waiting times and negligence by some doctors (Scott *et al*., 2011). In a quantitative research study conducted in Nigeria, doctors were found to have good knowledge of vasectomy, but the majority of them believed that vasectomy would alter the normal functioning of the testes and impair a man's ability to ejaculate or increase his risk of developing prostate cancer (Perry *et al*., 2016). Further to this, another study done in India, community health workers believe a man loses the ability to do work, become weak and fall sick more often as a result of the vasectomy procedure (Mahapatra *et al*., 2014)).

An interview conducted with primary health care officers, trained nurses and midwives, who are involved in counselling for family planning showed that none of the officers offered routine

counselling or information on vasectomy. The majority of the officers will counsel women on bilateral tubal ligation but very few will talk about vasectomy, as they also believed that Nigerian men will not accept vasectomy (Tijani *et al*., 2013). In a study conducted in Kenya recently, health worker attitude was stated as barrier to uptake of vasectomy (Vinluan *et al*., 2019). The study pointed out that even when couples attended antenatal or postnatal care clinics, they are often not informed about vasectomy and they are rather steered to female contraceptive.

Hence, these beliefs if shared by most doctors and other service providers, become a barrier to counselling clients towards vasectomy. With these beliefs and attitudes the service provider does not realise the need to even mention vasectomy as an alternative contraceptive method that can be used by men or couples. Therefore, to correct this anomaly, it is prudent to aim at improving information dissemination and service delivery by training and re-orientation of health personnel.

2.7. Conclusion

In conclusion, it is apparent that vasectomy has more advantages compared to female sterilisation and other family planning methods. These advantages are perceived to be influencers to the uptake of vasectomy. However, on the other hand, there are several factors considered as barriers to the uptake of vasectomy. Both the influencers and barriers are experienced at individual, spousal/partner and family level while some are related to religious, cultural and health systems factors. Hence, the subsequent chapter gives a broader picture of these factors, based on the views of the research participants.

CHAPTER 3: METHODOLOGY

3.1 Introduction

The study methodology is described in this chapter beginning with the aim and objectives. This is followed by a description of the study design, study setting and study population and sampling process. The data collection and analysis procedures are also outlined in this chapter. The steps taken to ensure rigour as well as the ethics considerations are also presented.

3.2 Study Aim

The aim of this study was to explore attitudes, perceptions and socio-cultural beliefs towards vasectomy of men and women in Bulawayo Metropolitan province of Zimbabwe.

3.3 Objectives

- To explore attitudes and perceptions of men and women towards vasectomy in Bulawayo Metropolitan province of Zimbabwe
- To explore contextual socio-cultural beliefs which promote or hinder uptake of vasectomy among men and women in Bulawayo Metropolitan province of Zimbabwe.
- To explore the views of service providers towards the uptake of vasectomy by men

3.4 Study Design

The study used an exploratory qualitative research design. An exploratory study design was assumed suitable as it is deemed to provide in-depth information about the community's perceptions and attitudes towards vasectomy in the community. The exploratory qualitative study design is flexible and fluid, allowing spontaneous and adaptation of the interaction between the researcher and the participants (Bryman, 1984). More so, Pope & Mays (1995) state that an exploratory qualitative study design solicit meanings, experiences and views of the participants with an aim to answer the questions such as 'what, how and why' aspects of the phenomenon under study. The design is ideal for a study where little is known about the subject, as is the case of vasectomy in Zimbabwe, Bulawayo.

3.5 Study Population and Sample

Makokoba ward 7 is one of the wards in Zimbabwe's second largest city, Bulawayo, which is in the southern region of the country. It is the first black African township to be established in Bulawayo in the early 1900s. The township is characterised by old semi-detached houses with poor water and sanitary facilities. Makokoba is a high density township with a population of 17.910 people, 4.802 household with an average of 6 people per household (Census National Report, 2012). The suburb is characterised by low literacy levels and generally, old people who

are not employed but live on selling various wares, including vegetables in the open market space nearby. The community of Makokoba is served by the third largest national referral hospitals in Zimbabwe, Mpilo Central Hospital, one council clinic and two private clinics owned by medical practitioners. The township share border with Thorngrove industrial sites on the south-west, with an old bus terminus for public passenger transport serving the rural and urban communities on the southern. This is where most of the people from Makokoba earn a living through selling and engaging in casual jobs (Moyo, 2017).

Moule & Hek, (2011), described a sample as a portion of study population, composed of members who become study respondents or elements from which the study information is collected. A sample represent the whole population where it is selected from, however in qualitative research the sample does not necessarily represent the entire or general population statistically but rather represent that population in terms of characteristics and how they view or have experienced a particular phenomenon; a theoretical representation.

In this study, purposive sampling was done to select study participants. The researcher used existing Community-Based Mobilisers (CBM) for family planning (FP) in the ward to select men, women and couples, as they have knowledge of that community, and screen them for inclusion in the study sample. Married men and women, including couples, who met the above criteria were purposively selected from Makokoba ward 7. Purposive sampling allows the researcher to put participants in a group according to a specific chosen criteria or characteristics relevant to a particular research study (Mack *et al*, 2005).

3.6 Description of the study participants

A total of three focus group discussions were conducted for the purpose of data collection, two groups with nine participants each and the third group with seven participants, giving a total of 25 FGD participants. One of the focus group was a mixed group with males and females and the other two groups were composed of men only. There were 7 female and 19 male participants in total. Their ages ranged between 30 to 65 years and the youngest participant being a female. All the participants had at least a child and 15 of them were married, six divorced, one widowed while four were never married. In addition to focus group discussion, in-depth interviews with three key informants were conducted. The key informants were health professionals trained in providing vasectomy services. Two of them were male medical doctors while the other one was a female clinical officer, and all are currently working for the Ministry

of Health and also employed on part-time basis by various non-governmental organisations and the medical doctors run their private practice.

3.6.1 Focus Group Discussion

In this study, men and women (including couples) between the ages of 30 – 65 with at least one child were purposively selected to participate in the study and this was used as the inclusion criteria. This age group was considered to be of childbearing age and were eligible to vasectomy as they at least had a child. Men and women below the age of 30 years were excluded in this study even if they fall under the childbearing age group. A total of three Focus Group Discussions (FGD) were conducted with women and men purposively selected from Makokoba ward 7. Each FGD comprised of 6 – 10 participants.

3.6.2 Key informants

In addition, key informants were identified and recruited to give an independent "expert" view of the phenomenon under study, as it is assumed that their position in the community gives them specialist knowledge about other people and processes in a more detailed and extensive manner than an ordinary person and can provide valuable and rich data (Payne & Payne, 2004). Three key informants were identified and recruited into the study and in-depth individual interviews conducted with them. The key informants were health service providers involved in the provision of vasectomy services from the government and/or private sector including those working for NGOs in Bulawayo.

The selection of key informants was done by the researcher who identified qualified vasectomy service providers in Bulawayo, and employed by the Ministry of Health. The researcher also approached an organisation providing family planning services, including vasectomy and selected the vasectomy service provider to participate in the study. Generally, in Zimbabwe, there are very few health practitioners trained in the provision of vasectomy services hence, the need to target specific institutions for selection of the participants.

3.7 Data Collection

The Focus group discussion data collection method was ideal for this study as they are known to be effective in collecting data on the experiences, perceptions, reasoning, interpretations and beliefs of the participants and the community at large (Patton, 2002). They are useful to explore what people think about a phenomenon and why they think that way, hence by using them as a data collection method, the researcher sought to gain an insight and understanding on how

and why the participants and the community at large view and perceive vasectomy (Kitzinger, 1995; Liamputtong & Ezzy, 2005).

In relation to the FGDs which were conducted, participants were contacted prior to the discussion to agree on time and venue. The discussions were conducted in a place chosen by the participant, community hall, which was convenient and deemed appropriate by them to ensure they were comfortable. The groups were composed of both, married or unmarried, men and women. A semi-structured interview guide, in local language Ndebele, was used. During the discussions, the researcher who facilitated the FGD, was assisted by a research assistant, who was present during the discussions and took notes, including non-verbal cues. After every FGD a debriefing was done between the research assistant and the researcher. The research assistant had experience in conducting focus group discussion and taking field notes. The researcher had also briefed the assistant prior on what she was supposed to do during the discussions.

In relation to key informant interviews, the researcher engaged the key informants and agreed on time and venue for the interview. The interviews were conducted at their private practice (surgery) offices. The key informants comprised of three health professionals trained in provision of vasectomy service. The interviews were conducted face-to-face by the researcher following a semi-structured set of questions or guide and these were conducted in English language. Both FGDs and in-depth interviews were tape recorded and transcribed later on by the researcher and this was fully explained to the participants and a signed consent to that was sought.

3.8 Data Analysis

Thematic analysis methodology was used to analyse data collected. It is a method of data analysis which identifies patterns (themes) within a set of data and it provides a rich description of the data set or a detailed account of a particular aspect (Braun & Clark, 2006). The analysis follows a step-by-step process, starting with the researcher familiarizing with the data during data collection and transcription. When familiar with the data, the researcher start to generate initial codes, made up of a list of ideas of interest. The coded data was further analysed and put into categories or themes. The constructed themes were then further reviewed to ensure they were meaningful. Furthermore, each theme was further analysed in detail, to ensure the themes fit into the broader overall ‘story’ about the data. When the themes were clearly named, final analysis was done and a report was produced.

Analysis started during data collection, where all interviews and FGDs were audio recorded and used later on during transcription as the researcher listened to the audio tapes over and over again. During data collection, the researcher took notes to track the flow of the process and also key points for data analysis. The researcher started analysing data, its content, eliciting recurring themes related to their perceptions and beliefs towards vasectomy. The process of coding and categorizing the content of the data assisted the researcher to bring meaning to the responses and provided the basis for comprehensive content analysis. Both data kept as soft and hard copies will be kept for five years after completion of the study and then destroyed as per standard research ethics practices.

3.9 Rigour

To ensure that the study meets the requirements of rigour or the research is of high credibility and validity, the researcher adhered to approved study protocol. The researcher also ensured that: the study was conducted in accordance with established ethical standards, that is, FGD recordings maintained throughout; data analysed and interpreted using appropriate qualitative analysis methods; and the researcher was well versed with the literature on the subject throughout the study (Fathalla, 2004) through intensive literature review. The researcher used both FGDs and conducted in-depth interviews for key informants to answer the same research question as a way to enhance the validity and reliability of the results by comparing the data obtained from both data collection methods, that is, triangulation. The researcher ensured diligence care in selection of participants and key informants of the study. Systematic data archiving was maintained in form of field notes, methodological and analytical notes as part of audit trail. Audit trail was also achieved through voice recording of all FGDs and interviews as well as keeping a diary of all events taking place throughout the research process.

Trustworthiness

The importance of quality research study was borne in mind throughout all the stages of the research starting with the planning stage right through to the interpretation and dissemination of study findings. This was to ensure credibility, conformability, dependability and transferability of the study findings.

Credibility: involves ensuring that the study findings are believable or credible from the perspective of the study participants (Lincoln & Guba, 1985). In essence, it is checking how accurate participant's views have been represented in the final account. This was done through giving feedback after every FGD and interview with the participants. More so, the researcher

ensured a systematic coherence across the whole design process was maintained and the primary focus was always on the study participants (Creswell & Miller, 2000).

Transferability: is the extent to which the study findings of qualitative research can be generalised or transferred to other settings or context (Lincoln & Guba, 1985). Creswell & Miller, (2000) went on to say this can be ensured by describing the setting, the participants and the themes of a qualitative study in rich detail. However, transferability of qualitative study lies with the person who wishes to "transfer" the results to a particular setting. Therefore, the researcher strived to describe in detail, the research setting and the themes generated from the data collected and all decisions and activities taken during the study were described as well.

Confirmability: is the degree to which the study findings can be confirmed by others who have interest to the same phenomenon. To achieve this, the researcher kept a trail of events by documenting and rechecking data throughout the study. Also, the researcher took the "devil's advocate" role with respect to the results (Lincoln & Guba, 1985), checking every process and ensuring set procedures were followed and documented. The researcher sought the assistance of the supervisor who often reviewed the research process throughout the study.

Dependability: there are various strategies which can be used to ensure we could depend on the study findings. Essentially, it means that, if another researcher conduct the same study, same findings should be obtained. The strategies include member checking, triangulation, researcher reflexivity and collaboration. As the researcher is a health practitioner, the researcher used a research diary to document the entire process to enhance self-awareness. Focus group discussions and in-depth interviews with key informants were used to collect rich data and this was part of data triangulation.

3.10 Ethical Consideration

Ethics approval for the study was obtained from the University of the Western Cape Biomedical Research Ethics Committee (BMREC). The researcher also sought approval from Medical Research Council of Zimbabwe (MRCZ). In respect to the principle of autonomy and respect for the dignity, the researcher sought a signed informed consent from all participants to ensure they participated voluntarily. A participant information sheet with brief explanation of the purpose and nature of the study was provided to the participants and explained in their local language. Participants were informed that they can elect not to participate at all or to withdraw at any stage without negative consequences. Confidentiality was ensured by ensuring the information given by participants is not divulged to anyone outside the study and that the

information was kept in soft copies with encryption. Anonymity was ensured by using study identity numbers rather than names when transcribing the interviews. There is no anticipated harm in this study, however, participants found to be requiring emotional support arising as a result of study processes were to be referred to the nearest Central Hospital, Mpilo for counselling. The hospital offers professional counselling sessions to walk in clients, hence the researcher engaged the personnel and arranged for provision of counselling service when necessary at no cost. Alternative counselling services were also sort from other organisations like Musasa, which provides psychological support to the community.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter presents the findings from three focus group discussions and three in-depth interviews with key informants that were conducted for gathering data on the factors contributing to low uptake of vasectomy. It captures key issues raised by the respondents with regards to vasectomy as a contraceptive method.

4.2 Main themes

The findings of the study are categorized into seven broad themes namely, individual, spousal/partner, family, community, religious, health systems which describes factors contributing to uptake of vasectomy and recommendations made by participants to improve vasectomy uptake as another theme. These themes are listed in Table 2 together with sub-themes which are then described in turn.

Table 2: Themes and sub-themes

Main Theme	Sub-theme
1. Individual factors	1.1 Lack of knowledge about vasectomy 1.2 Incorrect information about vasectomy 1.3 Unwillingness to disclose vasectomy procedure 1.4 Myths and misconceptions about vasectomy procedure 1.5 Advantages of vasectomy
2. Spousal/partner factors	2.1 Poor partner engagement 2.2 Lack of trust
3. Family factors	3.1 Family pressure to have more children 3.2 Poor socio-economic status
4. Community factors	4.1 Ability to have children 4.2 Fear of stigmatization 4.3 Peer influence
5. Religious factors	5.1 Religious beliefs 5.2 Religious practices
6. Health system factors	6.1 Few service delivery points 6.2 Service provider attitude 6.3 Few trained service providers
7. Recommendations to improve vasectomy uptake	7.1 Using satisfied vasectomy client 7.2 Increase vasectomy awareness 7.3 Health systems strengthening

4.2.1 Individual factors

Under the main theme individual factors, lack of knowledge about vasectomy, incorrect information about vasectomy, unwillingness to disclose vasectomy procedure, myths and

misconceptions about vasectomy were mentioned as factors contributing to low uptake of vasectomy. However, advantages of using vasectomy as a method of family planning was mentioned as a driver to uptake of vasectomy.

4.2.1.1 Lack of knowledge about vasectomy

The adage which says "knowledge is power" is important in decision making. People with knowledge are empowered to make appropriate decisions pertaining to their health, including sexual reproductive health and family planning decisions hence, information dissemination in a bid to create awareness of health-related issues plays a key role in people's lives.

In this study, the majority of the FGD participants confirmed that they have no knowledge about vasectomy and they were not aware of the service and how it is done. This was despite the fact that they confirmed having seen and interacted with community-based mobilisers who do door-to-door mobilization and distribution of fliers with information on family planning. However, the mobilisers never mentioned anything about vasectomy. Apparently, they focus mainly on female contraceptives including long acting and reversible methods and short term methods, pills, injectables and condoms.

> "*To be frank, we know nothing about vasectomy, we only have knowledge about female sterilisation only."* (FGD1 P1, 65 year old, male, married)

> *"It is my first time to hear that there is family planning method for men called vasectomy in my life time"* (FGD1 P4, 35 year old, female, single).

> *"…..I have never heard about it in my life, I know about male circumcision, is it the same….."* (FGD 3 P1, 36 year old man, married)

Key informants concurred with what was shared by the majority of FGD participants, that most people are not aware of vasectomy. This was also attributed to general poor health seeking behavior of men. They claim that even if the men visit a health facility they do not seek health information, particularly related to sexual reproductive health hence, they lack basic facts.

> *"The majority of the people are not aware of vasectomy out there, particularly men who generally have poor health seeking behavior…….rarely do they visit a health facility and they do not even want to discuss it with their partners……this is worsened by health personnel who tend to focus on disseminating information on family planning methods for women only" (KI 3)*

4.2.1.2 Incorrect information about vasectomy

The few participants who highlighted that they had heard about vasectomy, had incorrect information about vasectomy and how the procedure is done. Some of the information they described was somehow correct but outdated as they described a vasectomy procedure which was done way before the current one. This suggests that mobilisers are not sensitizing people in the community about vasectomy and the fliers they distribute might not be comprehensive enough.

> *"I am not sure whether what I heard is true or false but what I heard is that they close underneath the testicles so that the man does not produce sperm at all. I also saw a picture of that so-called vasectomy showing where they close"* (FGD3 P6, 37 year old, male, married)

> *"What I heard while I was still at school from friends is that, there is a chemical given to a man which weakens the sperm such that when it gets into a woman's vagina, it becomes useless"* (FGD1 P5, 49 year old, male, divorced).

4.2.1.3 Unwillingness to disclose vasectomy procedure

Participants in the FGDs confirmed that they do not know any man who had disclosed that they had undergone the vasectomy procedure. They related this to the fact that those men who undergo vasectomy feared being stigmatized and labelled as weak men who are castrated. Hence they do not openly disclose because they do not want the whole community to know. They may only disclose to their close friends whom they trust with their information.

> *"I have never heard of or encountered a person who says he has undergone the procedure in my life, this is the first time to hear about vasectomy procedure actual, if there are there, then they must be shy to share with us for they fear people will laugh at them….."* (FGD2 P1, 35 year old man, married)

> *"I believe there might be some men who have done that procedure out there but they do not want to disclose or to be known that they were castrated…….otherwise the community will view them as weak men who could not father children anymore……"* (FGD3 P4, 37 year old man, married)

4.2.1.4 Myths and misconception about vasectomy procedure

When asked about their opinion on how safe they perceive the procedure to be, the majority of participants raised a concern pertaining to safety. The major concern mentioned by participants was the possibility of cutting the head of the penis and/or castration leading to loss of manhood. The concerns were myths and misconceptions which are generally shared by the community due to lack of basic facts about vasectomy.

> *"….these day's doctors are killing people in hospitals, what if they make a mistake during the procedure and they castrate you?"* (FGD1 P5, 49 year old man, divorced)

> *"….it can happen for sure that they make a mistake and the man loses manhood.…..as we try to have sex, he fails to have an erection….."* (FGD1 P4, 35 year old female, single)

Further to that, some participants raised concern about the possibility of having serious complications after the procedure, which could be due to negligence by the vasectomy provider. They narrated that after undergoing vasectomy procedure, one might get sick and never recover from the surgical operation leading to death. This however, indicate misconceptions about the procedure due to lack of correct information.

> *"….what percentage is guaranteed that we are safe……..is there any reference to prove that the person went through the procedure and the person did not die during or after the procedure?"* (FGD2 P4, 39 year old man, married)

4.2.1.5 Advantages of vasectomy as a driver

On the other hand, possible individual drivers to uptake of vasectomy were discussed. Key informants highlighted what could motivate men to undergo vasectomy procedure and advantages of vasectomy were the top possible reasons why men would consider the method. The advantages include: procedure is done once in lifetime, minimal pain, quick recovery and very effective with no major complications. The fact that key informants have vast knowledge and experience of providing vasectomy, they believe that vasectomy is the best alternative contraceptive method for men who no longer want children, hence those men should choose the method based on the advantages of the method.

> "*vasectomy has less complications compared to tubal ligation, hence it is safe and easy to perform…..this could be a motivator to men who intend to use a contraceptive method*…..(KI 2)

4.2.2 Spousal/partner factors

Under the main theme spousal/partner factors contributing to uptake of vasectomy, poor partner engagement and lack of trust by both partners were seen as possible barriers to uptake of vasectomy

4.2.2.1 Poor partner engagement

Participants highlighted that couples do not discuss sexual related issues, including family planning. They concurred that men are not at liberty to discuss with their wives which method of family planning to use as men believe only women can use it. Therefore, the majority of couples do not discuss vasectomy and hence, this is attributed to few men opting for the method.

> *"…..couples do not talk about family planning, use of family planning method is left for women to decide which method to use, mainly oral pills and injectables….."* (FGD3 P7, 35 year old man, divorced)

> *"…..men do not like discussing sexual issues with their wives and they do not want to be seen seeking health information and services with their wives…."* (FGD1 P4, 35 year old female, single)

4.2.2.2 Lack of trust

Lack of trust by partners is also seen as a factor that discourages men from undergoing vasectomy as they may suspect that their wives would have an extra marital affair and have a child with another man. On the other hand, participants mentioned that female spouses may also think that if their husbands undergo the procedure, this will encourage them to be promiscuous since they will be aware that they cannot make their extramarital partner pregnant.

> *"…..couples do not trust each other in marriages and relationships out there…..they would rather prefer either both or none of them to use a permanent method of contraception rather than one of them….."* (FGD1 P4, 35 year old female, single)

4.2.3 Family factors

Under the main theme family factors, family pressure to have more children is described as a barrier to uptake of vasectomy while poor socio-economic status was mentioned as the possible motivator to use vasectomy as a contraceptive method.

4.2.3.1 Family pressure to have more children

Participants highlighted that family members put pressure on couples to have more than one child, yet some couples would want to have only one child. This becomes a hindrance to uptake of a permanent method of family planning by a couple which intends to have one child. Such couples tend to give in and keep trying to have another child even if they are not willing hence they choose to use a reversible contraceptive method.

> *"…..family members sometimes they expect their relatives (couples) to have more children as a way to ensure the family name grows…..in the process such couples cannot choose to use a permanent method of family planning like vasectomy even if they want to….."* (FGD1 P4, 35 year old female, single)

> *"…...relatives of the male partner are the ones who dictate the number of children their son should have in most cases….."* (FGD3 P1, 36 year old male, married)

4.2.3.2 Poor socio-economic status

Participants concurred that economic hardships faced by many families might motivate a couple to consider using an effective long term or permanent method of contraception. This is associated with costs of having to take proper care of a large family in such economically unfriendly environment compared to a smaller family. This is what can make a couple decide that their number of children is enough; hence the man can choose to be in control and undergo vasectomy. This was seen as the time when men can discuss with their partners and agree based on economic reasons.

> *"……one thing for sure is that, things are difficult out there and most families in the African continent are no longer able to cope with large families as compared to the past……...this has led to families realizing the need to limit the number of children they have…..…"* (KI 2)

> *"…..things are now difficult and taking care of many children like what used to happen in the past is no longer easy, hence families may agree to permanently stop having children by using a permanent method*……(FGD2 P8, 43 year old man, married)

4.2.4 Community factors

Under the main theme community factors, the need to have children and ability to reproduce, and fear of stigmatization were mentioned as factors that hinder uptake of vasectomy. These findings are described in turn.

4.2.4.1 Ability to have children

Participants reiterated that in most communities, mainly in Africa, a man is expected to be able to make his spouse pregnant throughout his lifetime, as and when he wants to have a child. They highlighted that for a man to be respected and recognized as a real man in the community, they should have many children of their own and they should be able to make their spouse or a woman pregnant throughout their lifetime. This has put men under pressure to have many children and extra marital affairs or to be in a polygamous marriage. This is the reason that men do not accept permanent family planning methods.

> *"…..in rural areas, elders believe that a man should be able to father children until death, therefore it is considered taboo or against the African culture for a man to undergo a procedure that stops him from fathering a child throughout his lifetime…..what if the men divorces and re-marry?"* (FGD3 P5, 45 year old male, married)

> *"…..in my community, a man is considered a real man by the number of children they have…..not having a child is considered a curse…..hence no man would want to use a permanent method of contraception….."* (FGD2 P4, 39 year old male, single)

4.2.4.2 Fear of stigmatization

Some participants highlighted that men do not seek vasectomy services because they fear to be stigmatized for undergoing the vasectomy procedure because it is a permanent method of contraception. The fear is that once people in the community know that one is no longer able to make his spouse or a woman pregnant following vasectomy, they will label them as castrated and weak men. This was said to be common in rural areas compared to urban areas because of strong cultural beliefs and norms which are upheld by community members.

> *"…..no men would like to tell the public that they have been castrated, as this vasectomy is widely perceived, hence they will be called all sorts of names by others out there….."* (FGD2 P2, 44 year old men, married)

> *"…..I know men are very secretive, no one wants to move around talking about vasectomy…..I don't know whether that is what you call stigma….."* (KI 1)

"…..men fear that once they disclose that they have undergone vasectomy, people will laugh at them as they believe its castration…..they will be labelled as [oxen]….." (KI 3)

4.2.4.3 Peer influence

Key informants indicated that nowadays men motivate each other to use vasectomy. It emerged that men prefer sharing sexuality issues with their peers rather than their spouses or family members. When men who have undergone a successful vasectomy procedure, disclose and discuss it with peers, the peers get motivated to use it as they are reassured that it does not have complications post procedure and it works well as contraceptive method.

"…..…men who have undergone the procedure are motivating others to use it as they disclose and discuss about the experience…." (KI 1)

4.2.5 Religious factors

Under the main theme religious factors, religious beliefs and religious practices were mentioned as factors contributing to low uptake of vasectomy.

4.2.5.1. Religious beliefs

Some participants highlighted that religious beliefs play a key role in making a decision on how to space and limit children and size of the family. They indicated that some religious sectors do not believe in using any non-biological method of family planning as it is against biblical teachings, which say human beings must multiply. Some of the churches promote polygamy and they believe children are a gift from God hence, they can have as many as they can while they are alive.

"….the Johane Masowe church doctrine promotes polygamy, and they respect their doctrine which says, man should multiply…..therefore they do not believe in using any contraceptive method but believe children are given by God, no man shall stop that…." (FGD2 P4, 39 year old male, single)

"….there are some churches which will never allow any form of contraception maybe withdrawal because they do not believe inserting or taking any artificial things into their body system….." (KI 3)

4.2.5.2 Religious practices

The participants confirmed that there are some sections of the community who use natural ways of child spacing and limiting. This practice is widely used as a method of family planning as the congregation believe it works very well for them and that is religiously acceptable among their community more so than to use a modern method which is designed by a human being. The practice was described as jumping shrubs of a particular tree at particular time during the life-time of a reproductive woman. The participants further shared that some religious communities hold a certain ceremony for every woman after giving birth as way of "locking" her ability to conceive and they also do the same when she intends to have a child. The practices ensure that women plan their family size without using artificial modern family planning methods.

> *"…...some communities have specific practices which they use for child spacing like jumping some shrubs to stop conception….."* (FGD2 P4, 39 year old male, single)

> *"…...some people still practice old ways of child spacing as part of their religious beliefs….."* (FGD3 P6, 46 year old male, married)

4.2.6 Health systems factors

Under the main theme health systems factors, few service delivery points, service provider attitude and few trained service providers were also mentioned as factors contributing to low uptake of vasectomy in Bulawayo and Zimbabwe in general. These factors are described further.

4.2.6.1 Few service delivery points

Decentralization of primary health care services is key for increasing accessibility to those services by communities. Participants in the study concurred that there are no public health facilities offering vasectomy services, hence most people are not aware of the vasectomy method. Information dissemination increases awareness of a particular family planning method, and as people become aware and have basic information about the service there are high chances that they will consider using the method. It was apparent in this study that vasectomy is not provided at local government (public) health facilities.

> *"…...all our local clinics do not provide any permanent method of family planning….."* (FGD1 P2, 31 year old man, married)

> *"…...government health facilities do not offer vasectomy services currently, only a few private and NGO facilities offer the services….."* (KI 2)

4.2.6.2 Service provider attitude

Attitude of service providers towards vasectomy was highlighted by participants as one contributing factor to low uptake. Health care providers are supposed to offer routine health education to everyone who visit a health facility including family planning information. Some participants mentioned that they have visited a health facility and attended a health education session where health care workers talk about general health issues and services offered including family planning, but never mentioned vasectomy. This contributes to lack of vasectomy awareness and consequently, low uptake of the service.

> *"…..health service providers never talk about vasectomy and that means they do not provide the service…..so the health system does not promote it….."* (FGD2 P8, 43 year old male, married).

> *"…..health care workers chose to leave out vasectomy topic during counselling and concentrate on pills and other methods of family planning….."* (FGD3 P3, 37 year old male, married).

4.2.6.3 Limited trained service providers

The key informants, who are currently providing vasectomy services, concurred that there are very few professionals trained in providing vasectomy service across the country. Quality service provision can only be provided by a trained and competent cadre, who has confidence and skill to do it. This also create confidence to the client who receives the service as well as the community at large. It is therefore assumed that, because there are very few trained vasectomy providers, those who are not trained do not have confidence to talk about or counsel clients on the method, hence very few men chose the method.

> *"…..there are only three people trained in my organisation to provide vasectomy throughout Zimbabwe…..all based in Harare and Bulawayo….."* (KI 1)

> *"….generally, medical doctors are taught about vasectomy during medical training but they never practice it thereafter, hence they do not offer it at their private surgeries and in hospitals, they are even hesitant to talk about it…..* (KI 2)

4.2.7 Recommendations to improve uptake of vasectomy

Under the main theme recommendations to improve uptake of vasectomy, using satisfied vasectomy client, increasing vasectomy awareness and health systems strengthening were the recommendations made by the participants.

4.2.7.1 Using satisfied vasectomy client

The majority of the participants highlighted that, identifying and using men who have undergone the procedure to advocate and encourage other men to use vasectomy as contraceptive method could yield positive results. Peer to peer influence is considered effective as peers discuss issues that affect them openly and free without fear of being victimized or judged. More so, discussing with those men who have undergone the procedure and are satisfied with the method builds confidence and trust to those who intend to use the method.

> *"…..use men who have done it to be brand ambassador of the procedure…..maybe that would motivate many of us to do the same….."* (FGD2 P5, 41 year old man, married)

> *"…..my humble request is that, may you bring someone who has done it so that we hear from him how he felt and how he handled the whole process…..share experience particularly post procedure….."* (FGD1 P2, 31 old man, married)

4.2.7.2 Increase vasectomy awareness

Increasing awareness and knowledge about vasectomy through dissemination of key information about vasectomy through use of various relevant modes of communication was recommended by the majority of participants. This include mass media; radio, television, social media, bulk messaging, etc.; through arts (drama, street theatre); pamphlets, posters and banners; interpersonal communication through use of community mobilisers. This would also address common myths and misconceptions shared within communities that act as a barrier.

> *"…..the more we demystify myths, the more we talk about vasectomy, the more we have policies that are in the favour of vasectomy…..then we can see more men accessing the service….."* (KI 1)

> *"…..conduct awareness campaigns in form of roadshows in urban areas and rural growth points…..just like what happened to voluntary male circumcision campaigns…..many people are now aware of VMMC….."* (FGD1 P3, 49 year old female, married)

"…..distribution of information, education and communication (IEC) like pamphlets, posters in simple local language also works…..it has to be done by local people….." (FGD2 P5, 41 year old man, married)

4.2.7.3 Health systems strengthening

Strengthening health systems, particularly the public sector in provision of comprehensive family planning services, including vasectomy was also mentioned by the participants. This include capacitating health providers through regular trainings, to ensure they provide correct information on vasectomy during their routine health education talks, and training more vasectomy service providers in government health facilities.

"…..NGOs or donors should support the Ministry of Health by training many health workers in provision of vasectomy across the country….." (KI 3).

"…..health workers should just make it a habit that they talk about vasectomy and other male contraceptive methods during their generic health education talks…..that will go a long way in increasing awareness of vasectomy among men as some visit health facilities for other health issues….. (FGD2 P8, 43 year old man, married).

4.3 Conclusion

The above findings suggest that there are some contributing factors to low uptake of vasectomy service in Bulawayo. The main contributing factors being lack of information about vasectomy among communities as evidenced by the majority of the participants not being aware of the service. Other factors include myths and misconceptions held by community members that hinder men from undergoing the procedure, few health facilities and service providers offering the service and some religious and socio-cultural beliefs which do not allow use of permanent method of family planning. The following chapter discusses these findings against available literature to validate the findings.

CHAPTER 5: DISCUSSION

5.1 Introduction

This study set out to explore factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe. This chapter discusses the findings of the study in relation to available literature. The discussion focuses on the key themes emerging from this qualitative inquiry, which are individual factors, spousal/partner factors, family factors, community factors, religious factors, health systems factors and recommendations made by participants to improve the uptake of vasectomy. The chapter concludes with a discussion of the study limitations.

5.2 Individual factors

In this study, it was noted that there are some factors that motivate men to choose vasectomy as a contraceptive method of choice and those factors viewed as barriers to uptake were also identified. Factors viewed as barriers include lack of knowledge about vasectomy, having incorrect information, unwillingness to disclose, myths and misconception about the procedure while advantages of using vasectomy was viewed as a motivator.

The study findings showed that most participants were not aware of the vasectomy contraceptive method hence, they did not have information or knowledge about the procedure. The results of this study are similar to findings of Shattuck *et al.*, (2016), who reviewed several scientific papers, indicated that there was a general lack of awareness and knowledge about vasectomy procedure among men and women in Africa. Furthermore, in two qualitative studies reviewed by Shattuck *et al*., (2016), that were conducted in Malawi and Nigeria, and they showed that men were less knowledgeable than women about family planning methods in general and about all long acting and permanent methods.

More so, a study conducted in Lagos, Nigeria among men and women, states that there is a positive correlation between lack of knowledge and non-acceptability of vasectomy (Tijani *et al*. 2013). The logic is that, if there is lack of knowledge there is likelihood that one would not realize the purpose and benefits of using vasectomy as a method of contraception, hence they would not consider using it. Further to that, a study conducted in Nigeria among men and women of reproductive age (Akpamu *et al*., 2010), revealed that vasectomy is not known and even where it is known, it still remains unacceptable by most people because of lack of correct information. Lack of information is therefore the underlying cause of all forms of barriers to uptake of vasectomy.

On the other hand, this study showed that men could be motivated to use vasectomy as a method of choice because of its known advantages over other contraceptive methods. Compared to short term and other long acting reversible contraceptive methods, vasectomy is deemed to be cheap over time since its done once in lifetime and the procedure is simple and non-invasive with less to none complications post procedure. However, in this study, only the KI highlighted the advantages of vasectomy and it is not consistent with another study outcome conducted in Malawi among men, where majority of men indicated advantages of vasectomy as being a permanent method, less pain experienced and with less complications post-procedure (Babalola, John & Yinger, 2013).

5.3 Spousal/partner factors

Sexual reproductive health issues involve couples, which makes a family, in addition to children and other extended family members. Therefore, issues to do with sexual reproductive health need to be discussed between couples to ensure they live a healthy sexual life. It was interesting to note in this study, the factors that hinder uptake of male-orientated family planning method mainly, vasectomy include poor partner engagement and lack of trust by both partners.

While spousal influence has been identified as a contributing factor to uptake of vasectomy in other studies (Scott *et al.,* 2011; Vinluan *et al.*, 2019) in this study it was not the case as the findings indicate that men are very secretive and most of them do not disclose or discuss with their partners about vasectomy. Where couples discuss about vasectomy, it was interesting to learn that female partners might have reservations in approving vasectomy as a method of contraception as they suspect the men might be promiscuous knowing they cannot make the other women pregnant. The findings are similar to Adongo *et al*., (2014)'s study which was conducted in Southern Ghana among female and male community members. Both men and women expressed unease on the sexual faithfulness of their partners after vasectomy procedure as it was perceived as a guarantee for men to engage in extra-marital affairs since they were incapable of impregnating a woman. Interestingly, the current study finding differ with a study conducted by Adefalu *et al.,*(2018) in Nigeria among women where more than half (63%) of the respondents disagreed that use of family planning, including vasectomy, promotes promiscuity.

5.4 Family factors

In this study, economic hardships encountered by most families was mentioned as a motivating factor to uptake of vasectomy. The findings concur with those of Asare *et al.*, (2017) where both men and women participants concurred that vasectomy limits the number of children which reduces the financial burden on the family. Again, financial constraints was mentioned as one of the major reason for choosing vasectomy as contraceptive method in another study conducted in Rwanda among married couples who had undergone vasectomy procedure themselves (Shattuck *et al.*, 2014).

On the other hand, the participants mentioned pressure exerted by family members on couples to have more than one children as a factor that inhibit couples who intend to use a permanent contraceptive method of choice. Relatives or family members tend to have their expectations on how many children should a couple have. It emerged that, relatives of the male partner are the ones who put more pressure as to how many children the couple should have. Similar findings were observed in a study conducted among married men in India by Shafi, Mohan & Singh, (2019), where participants mentioned having male children, is considered important by the family and the society. This notion acts as a barrier to uptake of a permanent contraceptive method by potential men or couple, particularly where the couple has female children and they keep trying to have a male one as expected by the family.

5.5 Community factors

In this study, participants mentioned that most communities still believe a man is considered a real man in their communities by the ability to have children until he dies. Men are expected to be able to show his manhood by fathering many children and incase of divorce or death of spouse, they should re-marry and continue to have more children. This was also evident in a study conducted by Moyo, Zvoushe & Rusinga (2012) in Zimbabwe where men were worried about the irreversibility of the contraceptive method, and that it contradicts the “birthright of fertility until death” of a real man. The male participants in that study went on to argue that social norms assign family planning responsibility to women and they can quickly recover from female sterilisation, than in case of male sterilisation, as they do not get involved in labour-intense work like men.

The study findings also showed that there is high possibility of stigma associated with vasectomy in different communities and this could be greatly attributed to lack of basic information about vasectomy procedure and its advantages as a contraceptive method. Fear of

being labelled as weak men who are castrated, was mentioned as a common stigma in this study associated with vasectomy, contributing to low uptake of the procedure. In a study conducted in rural areas of India among men and women, similar findings were noted where respondents of the study highlighted the negative misconceptions and stereotypes associated with vasectomy which lead to community members labelling or stigmatizing a man who has undergone the procedure (Kumar & Prabha, 2015). It then negatively affects even potential vasectomy users, their influencers and the whole community and becomes a hindering factor. Those that have undergone vasectomy are often labelled as *"oxen"*, *"potent"* or *"taking orders from their wives"* hence the majority would not want to disclose that they have done vasectomy even to their wives and relatives.

The study findings also showed that men prefer to discuss with other men and motivate each other to undergo vasectomy procedure rather than discuss with their partners or family members. This is in line with another study conducted by Kokila *et al.,* (2014) which states that peer groups and friends who have undergone the procedure can play a key role in motivating each other to opt for a permanent male contraceptive method.

5.6 Religious factors

In this study it was also apparent that religious norms hinder uptake of vasectomy within certain communities. The study participants mentioned that, one particular religion, the Apostolic section called Johane Masowe in Zimbabwe do not believe in using any form of family planning other than natural birth spacing, which happens only through having faith in God. No other form of modern family planning method is allowed to be used by their congregants and they strongly uphold this norm. Again this was evident in Moyo, Zvoushe & Rushinga (2012) study findings in Zimbabwe where men from Marange Apostolic church confirmed using withdrawal and rhythm only as methods of delaying pregnancy, limiting or child spacing and not any biological or artificial method. In another study conducted in Nigeria among Muslim community, respondents totally disagreed to vasectomy based on their religious culture as well (Akpamu *et al.,* 2010). Adongo *et al.,* (2014) study findings were also in line with this study, where participants of that study viewed vasectomy procedure as an infraction against God, and if done it can attract a death penalty.

5.7 Health systems factors

The study findings revealed that there are no public health institutions currently offering vasectomy services in Bulawayo and in Zimbabwe generally. In fact, the participants in FGDs

alluded to the fact that they are not aware of any health facility or provider offering vasectomy in the country. Key informants, who are vasectomy service providers also concurred that government health facilities do not provide the service. Unavailability of vasectomy services in public health facility is therefore one of the major contributing factor to low uptake of vasectomy because the general populace seek health services in government-owned facilities than in the private. In contrast, in a study conducted in Nepal among men who had undergone vasectomy, the findings showed that most vasectomies were significantly offered in mobile clinics mainly done by non-governmental organisations, rather than government hospitals, particularly in remote areas (Padmadas *et al*., 2014). This meant that the service was largely accessible to those who wanted to use it.

Further to that, results showed that health workers do not provide comprehensive family planning counselling that include vasectomy. This was attributed to lack of information by the service provider, unavailability of trained vasectomy provider or their negative attitude towards vasectomy. Study participants revealed that health care workers tend to focus on female-orientated family planning methods. In contrast, in a study conducted in Tanzania among women, the findings differed with current study findings. The participating women mentioned that healthcare providers provided credible information about vasectomy during routine group counselling sessions (Msoka *et al*., 2019). However, in another study conducted in Nigeria by Ebeigbe, Igberase & Eigbefoh, (2011), the findings showed that service providers choose not to counsel clients about vasectomy and instead they prefer counselling on female sterilisation.

In previous study conducted in Nigeria, shortage of trained and competent vasectomy service providers was noted by key informant participants to be a contributing factor to low uptake of vasectomy (Akpamu *et al.*, 2010). This was also evident in this study as key informants alluded to the fact that very few providers are trained and competent to offer the service. The few trained are providing services in the private sector and not in government health facilities, hence the general public is not aware of the services since they normally seek health services in the public sector than the private sector.

5.8 Recommendations to improve vasectomy uptake

The results of the study suggested that using a satisfied vasectomy user as an advocate or an ambassador to motivate men to use the method could improve uptake. The participants believe that if men can discuss with a man who has undergone the procedure that could give them confidence to consider using vasectomy as a contraceptive method of choice. Similarly,

community members who were participants of a study conducted by Adongo *et al*., (2014) in Ghana believe that a testimony by a vasectomy acceptor could help open their minds and encourage them to accept vasectomy as a method of contraception, hence improving its uptake among wider communities.

Another recommendation made in this study was the need to use various modes of information dissemination to increase awareness of vasectomy service. It was recommended that the material must be in all local languages which are relevant in that particular community. The recommendations of the study were similar to those made in another study where desk reviews were done and showed community and mass media communications can increase awareness and drive demand for vasectomy in low-resource settings (Shattuck *et al*., 2016). Furthermore, while religious beliefs and practices were seen as a barrier to vasectomy uptake in this study, findings of a study by Adongo *et al.*, (2014) showed that some participants suggested using churches and mosques as platforms to promote the use of contraceptives and vasectomy since these platforms reach a wider audience who listens to their religious leaders without questioning their teachings. These recommendations were perceived to be effective in increasing vasectomy awareness among communities over time.

The need to strengthen health systems through capacitating health service providers and increasing number of public health facilities offering vasectomy was also recommended in this study. This entails providing vasectomy training to key health workers like doctors and clinical officers as well as training health professionals on basic family planning counselling. The recommendation was made based on the realization that there are no public health facilities offering the services because there are no government health workers trained on vasectomy hence, they do not even include it during routine health education talks. This recommendation was also made in another study in Nigeria (Akpamu *et al.*, 2015) where participants highlighted that increasing the number of health facilities providing vasectomy services including basic facts on vasectomy, could increase its uptake over time.

5.9 Study strengths and limitations

The strength of the study was that one of the focus group was a mixture of men and women. The discussion of the mixed group was quite interesting as women shared their views and perceptions about vasectomy and that stimulated a constructive discussion with men. However, men seemed to concur with the views of women in the group.

The researcher acknowledges the limitation of the study as the researcher is a student with limited time to conduct the study and that the study was not funded. This led to the researcher selecting only one ward, Makokoba as the study setting hence, the results might not be generalized to the broader population of Bulawayo.

The presence of the researcher during data collection was mostly unavoidable in this qualitative research. Anderson (2010) argues that it can affect the respondent's responses and consequently the quality of data collected. The researcher, therefore, endeavoured to take time to create rapport with participants while also ensuring further clarification of questions, asking a question in different ways and using probing during interviews.

The researcher had been involved in family planning service provision including vasectomy services and this might have formed researcher bias in the study because of prior knowledge and experience in the programme. However, the researcher endeavoured to strictly follow the thesis protocol and conducted the study objectively and continually reflected on his own understanding and perceptions of vasectomy. Also, there was likelihood of social desirability bias, where participants would share what they thought the researcher wanted to hear since the study aim and objectives were explained to them by the researcher.

The study population and sample size was a limitation as the researcher conducted the study in one ward of Bulawayo Metropolitan and only conducted three FGDs. This limited the researcher from reaching saturation, which is ideal for all qualitative studies. The researcher was also limited in terms of wide coverage as this is a mini-thesis project, hence not a fully funded project.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The study sought to determine factors contributing to low uptake of vasectomy in Bulawayo. This study is one of the few studies conducted in Bulawayo and/or Zimbabwe focusing on vasectomy services. Moreover, the study was only conducted in one urban setting, excluding other cities and rural populace hence, there is need for more studies to be conducted at a wider base to support these findings. This section therefore summarizes the study findings and highlights the recommendations to be made to add value to the body of knowledge.

The findings of this study clearly showed that the majority of people are not aware of the vasectomy contraceptive method; even those who are aware, do not have the correct information. This is one of the major contributing factors to low uptake of the service as men could not seek for a service of which they are not aware that can improve their health and lives.

In addition to lack of awareness and lack of knowledge, there are widespread myths and misconceptions within communities which hinder uptake of vasectomy by potential users as they tend to be misled and misguided. This is further worsened by lack of partner support, negative socio-cultural and religious beliefs and norms that discourages uptake or access to certain health services including contraception.

Poor health systems, mainly in the public sector, is another factor identified in this study as contributing to low uptake of vasectomy nationwide. Non-availability of trained vasectomy service providers in public health facilities and often not including vasectomy in counselling sessions and health education talks are the key components of a poor health service delivery system in this regard.

6.2 Recommendations

In view of this study findings and relevant literature, it is evident that there are factors contributing to low uptake of vasectomy. Therefore, the researcher makes the following recommendations that can be considered by program designers, implementers and policy makers to enhance vasectomy uptake in the future:

- Awareness campaigns to be conducted to ensure communities are aware of vasectomy services and that correct information is distributed to address current myths and misconceptions as well as harmful socio-cultural and religious beliefs towards vasectomy and other contraceptives

- Ensure health system strengthening through government partnership with private sector and non-governmental organisations in health service delivery. This include capacity building of service providers, availing resources (human, equipment, information, communication, and education (IEC) material), massive awareness campaigns etc. to increase access to quality vasectomy services.
- Involving satisfied vasectomy users/clients in program design and implementation may also motivate and enhance chances of potential users to undergo the procedure. This may also include involving key or influential community members, chiefs, headman, and religious leaders, to motivate men to consider using vasectomy as a contraceptive method of choice.
- Further research studies on vasectomy to be conducted at a larger scale to gain more understanding of factors underpinning uptake of vasectomy to enhance its programming.

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Appendix 1: Participant Information Sheet – Focus Group Discussion

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INFORMATION SHEET FOR FOCUS GROUP DISCUSSION

Project Tittle: The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

What is this study about?

This is a research project being conducted by **Patson Ndlovu,** a student at the University of the Western Cape. This study is a requirement, in partial fulfilment of the Master of Public Health (MPH) degree, at the University of the Western Cape. The purpose of this research project is to gain an in-depth understanding of the factors contributing to low uptake of vasectomy in Bulawayo Metropolitan Province, Makokoba ward. The information gathered and findings of the study will help in designing effective interventions and strategies to improve uptake of vasectomy in Bulawayo Metropolitan. We are inviting you to participate in this research project because married men and women (including couples) will be included and only those who are between 30 – 65 years and should have at least a child. This age group is considered to be of child bearing age and men of this age-band are eligible to vasectomy.

What will I be asked if I agree to participate?

If you agree to participate in the study, you will be asked to participate in a focus group discussion conducted by the researcher. During the discussion, you will be asked to share your views and perceptions about vasectomy in Bulawayo Metropolitan Province.

. You will be expected to participate in Focus Group Discussions and respond to questions related to your views and perceptions about vasectomy. During the discussions your responses will be tape recorded. You will not be obliged to answer any questions that you feel are inappropriate or insensitive. The discussion will last approximately 60 minutes and will take at a place you are comfortable with.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, we will do our best to keep your personal information confidential. To help protect your confidentiality, we will not put your name on the transcription but instead we will use a pseudonym. This pseudonym will be used by the researcher to link the transcript to your identity and no one, other than the researcher, will have access to this information. The transcripts will be kept in a lockable filing cabinet and we will use password protected computer files. The research will also involve audio-taping. The audio-tapes will solely be used during transcribing and the data analysis process. The audio-tapes will be kept under lock and key no one other than the researcher and the transcriber will have access to them. If we write a report or article about this research project, your identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. All human interaction and talking about self or other carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about views and perceptions of the community of Makokoba towards vasectomy. We hope that, in the future, other people might benefit from this study through improved understanding of street children predicament where the treatment for HIV/AIDS it concerns.

Do I have to be in this research and may I stop participating at any time?

Participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this study, you may also decide to stop participating anytime during the study without any obligation to give reasons to your decision. Moreover, if you discontinue participation, you will not be penalised or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Patson Ndlovu from the School of Public Health at the University of the Western Cape. If there are any questions about the research study itself, please contact Patson Ndlovu at:

+263 77 277 9065

3706371@myuwc.ac.za

patson.ndlovu78@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Appendix 2: Participant Information Sheet – Key Informants

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INFORMATION SHEET FOR KEY INFORMANTS

Project Tittle: The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

What is this study about?

This is a research project being conducted by **Patson Ndlovu,** a student at the University of the Western Cape. This study is a requirement, in partial fulfilment of the Master of Public Health (MPH) degree, at the University of the Western Cape. The purpose of this research project is to gain an in-depth understanding of the factors contributing to low uptake of vasectomy in Bulawayo Metropolitan Province, Makokoba ward. The information gathered and findings of the study will help in designing effective interventions and strategies to improve uptake of vasectomy in Bulawayo Metropolitan. We are inviting you to participate in this research project because as the vasectomy service provider, it is assumed that you have an expert knowledge about vasectomy which can enlighten the researcher in understanding the contributing factors to low vasectomy.

What will I be asked if I agree to participate?

If you agree to participate in the study, you will be asked to participate in an interview conducted by the researcher. During the discussion, you will be asked to share your views and perceptions about vasectomy in Bulawayo Metropolitan Province.

You will be expected to respond to questions related to your views and perceptions about vasectomy. During the discussions your responses will be tape recorded. You will not be

obliged to answer any questions that you feel are inappropriate or insensitive. The discussion will last approximately 60 minutes and will take at a place you are comfortable with.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, we will do our best to keep your personal information confidential. To help protect your confidentiality, we will not put your name on the transcription but instead we will use a pseudonym. This pseudonym will be used by the researcher to link the transcript to your identity and no one, other than the researcher, will have access to this information. The transcripts will be kept in a lockable filing cabinet and we will use password protected computer files. The research will also involve audio-taping. The audio-tapes will solely be used during transcribing and the data analysis process. The audio-tapes will be kept under lock and key no one other than the researcher and the transcriber will have access to them. If we write a report or article about this research project, your identity will be protected.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. All human interaction and talking about self or other carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about views and perceptions of the community of Makokoba towards vasectomy. We hope that, in the future, other people might benefit from this study through improved understanding of street children predicament where the treatment for HIV/AIDS it concerns.

Do I have to be in this research and may I stop participating at any time?

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Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Appendix 3: Consent Form – Focus Group Discussion Participants

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E-mail: soph-comm@uwc.ac.za

CONSENT FORM FOR FOCUS GROUP DISCUSSION - Participants

Tittle of Research Project:

The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand the discussion will be audio-recorded and I may agree or disagree to be audio-recorded without being penalized.

_____I agree to be audiotaped during my participation in this study.

_____I do not agree to be audiotaped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

Appendix 4: Consent Form – Key Informants

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E-mail: soph-comm@uwc.ac.za

CONSENT FORM FOR KEY INFORMANTS

Tittle of Research Project:

The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

_____I agree to be audiotaped during my participation in this study.

_____I do not agree to be audiotaped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

Appendix 5: Focus Group Confidentiality Binding Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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FOCUS GROUP CONFIDENTIALITY BINDING FORM

Project Tittle: The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……..

Participant's signature…….

Date……

Appendix 6: Focus Group Discussion Guide

1. Can you tell me about yourself?

   Prompts

   - Age
   - Gender
   - Level of education work experience

2. Have you heard of vasectomy? *(if participants not familiar with the method, the researcher will explain what it is and how it works)*

   Prompts

   - *Where did u hear about it – radio, TV, newspaper, community mobiliser, health worker*
   - *When was that – week, month, year ago*
   - *Do you know anyone who has undergone the procedure (family member, friends, peers, community member)*
   - *How were their experience after the procedure*
   - *How were their feeling after the procedure*

3. I would like to hear more of your thoughts and opinions about vasectomy.

   Prompts

   - *Do you think vasectomy is a good alternative method of family planning*
   - *What are the advantages*
   - *What are the disadvantages*
   - *Is it safe*
   - *Is it an effective contraceptive*

4. What religious, social and cultural factors that could be contributing to low uptake of vasectomy?

   Prompts

- *Are there any religious constraints to uptake of vasectomy?*
- *Is need for many children as a social factor, a hindrance factor?*
- *What are the myths and misconceptions about vasectomy, what are they?*
- *Is there stigma associated with vasectomy service in your community?*

5. What are the drivers to uptake of vasectomy?

   Prompts

   - *Personal/family health perspectives could be drivers to uptake of vasectomy?*
   - *Is vasectomy seen as an alternative contraceptive?*
   - *Are there key community or health personnel motivating people to use vasectomy?*
   - *Is the information distributed by community mobilisers clear and enough to make people understand the procedure?*

6. What can be done to improve uptake of vasectomy

   Prompts

   - *Is information dissemination done properly and its coverage?*
   - *How is vasectomy service delivery and its accessibility?*
   - *What about community engagement, is it enough?*

Appendix 7: Interview Guide – Key Informants

1. Tell me about yourself

   Prompts

   - Age
   - Gender
   - Level of education work experience

   – Profession, role as a service provider, work experience, organization/NGO etc

2. In your opinion, what are the reasons leading to uptake of vasectomy?

   Prompts *–*

   Do you think the users are satisfied with vasectomy services? What do you think makes men satisfied?

   Do you think users are happy with community mobilisers? What do you think makes them happy about the community mobilizers?

   , spousal approval or encouragement, , clear basic facts about vasectomy, acceptability in the community, ease accessibility of the service, cost of the service, preferences of male or female; doctor or nurse service provider

3. In your own opinion, what could be the barriers to uptake of vasectomy in your community?

   Prompts *– do you think religion is a barrier to uptake of vasectomy?, would you say people lack basic information, is the need to have children a barrier, are there an costs related to the service which may be a hindrance, what about the availability of trained personnel, do service provider have the right attitude or not, is there any stigma associated to the procedure in the communities, are there any myths and misconceptions about vasectomy in the community, what are those myths and misconceptions?*

4. What can be done to improve acceptability and uptake of vasectomy?

Prompts *– could comprehensive information dissemination improve the uptake, improving service delivery model could it improve uptake, addressing myths and misconceptions around vasectomy can it help increase the acceptability of vasectomy*

Appendix 8: uGwalo Lombiko *(Participant Information Sheet - FGD)*

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UGWALO LOMBIKO *(Participant Information Sheet - FGD)*

Isifundo: Ukucubungula imibono lenkolo ezenza ukuthi obaba bengathandi ukwamukela indlela yokuvala inzalo ngokuqunywa imthambo ehambisa inhlanyelo kababa (vasectomy)

Simayelana lani isifundo lesi?

Lolugwalo luyachasisa uhlelo lwezifundo ezenziwa nguPatson Ndlovu oseUniversity of the Western Cape ukuze enelise ukugqiba imfundo zakhe zaphezulu kunhlelo zempilakahle kazulu.

Isizatho socubungululo lolu ngesokuzwisisisa imbangela eyenza obaba bengathakazeleli ukuqunywa imithambo eyindlela yenhlanyelo kababa, njengendlela yokwelamisa lokuhlela imuli koBulawayo, elokitshini leMakokoba. Ngakho siyakunxusa ukuze uphathise kuloluhlelo ngoba obaba labo mama, kuhlanganisa labasemtshadweni, abaleminyaka esqalisa kwengamatshumi amathathu kusiya kwengamatshumi ayisithupha lanhlanu njalo belengane, bazanxuswa kule ingxoxo. Limfundo sikhangelele ukuthi izaphathisa labasebenza kwezempilakahle ukuthi benelise ukukhuthaza obaba ukuthi basebenzise indlela yokuvala inzalo ngokuqunywa imithambo ehambisa inhlanyelo kababa.

Kuyini okuzabuzwa abangena kulesisifundo?

Wonkumuntu ozavuma ukuba lilunga laloluhlelo kuzamele atshengisele ukuthi uzikhethele njalo kancindizelwanga ukuze abe lilunga ngokusayina ephepheni. Imbuzo izabe iphathelene lendaba yokuqunywa kwemithambo ehambisa inhlanyelo kababa. Ingxoxo esizaba lazo zizagcinwa ngumtshina kamabonakude njalo sizaxoxela lapho eliyabe lichelesile khona ukuthi sixoxe. Nxa ungezwa loba nini ukuthi awusenelisi ukuqhubeka ngaloluhlelo, uvunyelwe ukuthi

ungaqhubekeli phambili. Sizabuya njalo sikwazise ngempumela yalezingxoxo ukuze wenelise ukuthola ithuba lokuba lesiqiniselo sokuthi ngempela lokhu okukhulunyiweyo uvumelana lakho. Konke okuzokhulunywa kuzaba yimfihlo njalo akulandlela okungaziwa ngayo ukutho ngubani oyabe ekhulumile. Ngokusemthethweni njalo, nxa singahlangana lolwazi olwezehlakalo ezingekho emthethweni kuzamele sibikele iziphathamandla zomthetho.

Kungabe kulengozi ukuba lilunga lohlelo lolu?

Indaba esizaxoxa ngazo azilangozi eyaziwayo esekeyenzeka phambilini njalo sizazama ngayo yonke indlela ukuthi uzizwe uhlalisekile ngaso sonke isikhathi. Lapho okudingakala khona, sizalazisa lapho elingathola khona usizo olusebangeni eliphezulu.

Isifundo lesi sizanceda ngani?

Kukhangelelwe ukuthi uhlelo lolu luzaveza obala okungabe kubangela ukuhi obaba abanengi bengathandi ukusebenzisa indlela yokuquma imithambo yenhlanyelo kababa ukwelamisa imuli. Lina ngokwenu lingabe lingatholi lutho kodwa kusiya phambili kuzavezeka indlela ezingcono zokukhuthaza obaba ukuthi basebenzise lindlela.

Mele ngenzenjani nxa ngilemibuzo?

Nxa kungabakhona okunye ofuna ukukuzwisisa ngalesisifundo lingadinga u Patson Ndlovu kukheli leli elilotshwe ngaphansi:

+263 77 277 9065

3706371@myuwc.ac.za

patson.ndlovu78@gmail.com

Nxa ungaba lesizatho sokuzwa okunengi ngaloluhlelo langamalungelo akho kumbe kulensolo ofuna ukusazisa ngawo ungadinga u:

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Appendix 9: uGwalo Lombiko *(Participant Information Sheet – Key Informants)*

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UGWALO LOMBIKO *(Participant Information Sheet – Key Informants)*

Isifundo: Ukucubungula imibono lenkolo ezenza ukuthi obaba bengathandi ukwamukela indlela yokuvala inzalo ngokuqunywa imthambo ehambisa inhlanyelo kababa (vasectomy)

Simayelana lani isifundo lesi?

Lolugwalo luyachasisa uhlelo lwezifundo ezenziwa nguPatson Ndlovu oseUniversity of the Western Cape ukuze enelise ukugqiba imfundo zakhe zaphezulu kunhlelo zempilakahle kazulu.

Isizatho socubungululo lolu ngesokuzwisisisa imbangela eyenza obaba bengathakazeleli ukuqunywa imithambo eyindlela yenhlanyelo kababa, njengendlela yokwelamisa lokuhlela imuli koBulawayo, elokitshini leMakokoba. Ngakho siyakunxusa ukuze uphathise kuloluhlelo ngoba njengengcitshi kwezokuquma imithambo yabobaba, kukhangelelwe ukuthi ulolwazi oluphezulu ngendela yokuhlela imuli ngakho kuzaphathisa ekuzwisiseni imbangela eyenza obaba bengathandi le indlela. Limfundo sikhangelele ukuthi izaphathisa labasebenza kwezempilakahle ukuthi benelise ukukhuthaza obaba ukuthi basebenzise indlela yokuvala inzalo ngokuqunywa imithambo ehambisa inhlanyelo kababa.

Kuyini okuzabuzwa abangena kulesisifundo?

Wonkumuntu ozavuma ukuba lilunga laloluhlelo kuzamele atshengisele ukuthi uzikhethele njalo kancindizelwanga ukuze abe lilunga ngokusayina ephepheni. Imbuzo izabe iphathelene lendaba yokuqunywa kwemithambo ehambisa inhlanyelo kababa. Ingxoxo esizaba lazo zizagcinwa ngumtshina kamabonakude njalo sizaxoxela lapho eliyabe lichelesile khona ukuthi sixoxe. Nxa ungezwa loba nini ukuthi awusenelisi ukuqhubeka ngaloluhlelo, uvunyelwe ukuthi

ungaqhubekeli phambili. Sizabuya njalo sikwazise ngempumela yalezingxoxo ukuze wenelise ukuthola ithuba lokuba lesiqiniselo sokuthi ngempela lokhu okukhulunyiweyo uvumelana lakho. Konke okuzokhulunywa kuzaba yimfihlo njalo akulandlela okungaziwa ngayo ukutho ngubani oyabe ekhulumile. Ngokusemthethweni njalo, nxa singahlangana lolwazi olwezehlakalo ezingekho emthethweni kuzamele sibikele iziphathamandla zomthetho.

Kungabe kulengozi ukuba lilunga lohlelo lolu?

Indaba esizaxoxa ngazo azilangozi eyaziwayo esekeyenzeka phambilini njalo sizazama ngayo yonke indlela ukuthi uzizwe uhlalisekile ngaso sonke isikhathi. Lapho okudingakala khona, sizalazisa lapho elingathola khona usizo olusebangeni eliphezulu.

Isifundo lesi sizanceda ngani?

Kukhangelelwe ukuthi uhlelo lolu luzaveza obala okungabe kubangela ukuhi obaba abanengi bengathandi ukusebenzisa indlela yokuquma imithambo yenhlanyelo kababa ukwelamisa imuli. Lina ngokwenu lingabe lingatholi lutho kodwa kusiya phambili kuzavezeka indlela ezingcono zokukhuthaza obaba ukuthi basebenzise lindlela.

Mele ngenzenjani nxa ngilemibuzo?

Nxa kungabakhona okunye ofuna ukukuzwisisa ngalesisifundo lingadinga u Patson Ndlovu kukheli leli elilotshwe ngaphansi:

+263 77 277 9065

3706371@myuwc.ac.za

patson.ndlovu78@gmail.com

Nxa ungaba lesizatho sokuzwa okunengi ngaloluhlelo langamalungelo akho kumbe kulensolo ofuna ukusazisa ngawo ungadinga u:

Prof Uta Lehmann

Director

School of Public Health

University of the Western Cape

Private Bag X17

Bellville 7535

Email: ulehmann@uwc.ac.za

Prof. Anthea Rhoda

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

University of the Western Cape

Private Bag X17

Bellville 7535

research-ethics@uwc.ac.za

Tel: +27 21 959 2988

This research has been approved by the University of the Western Cape's Research Ethics

Committee. (REFERENCE NUMBER: to be inserted on receipt thereof)

Appendix 10: Ifomu lokuvuma – ***(Consent form – FGD)***

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

IFOMU LOKUVUMA ***(Consent form – Focus Group Discussion)***

Isihloko sesichwayiso – Isifundo sokufumana izizatho ezikhokhela enanini eliphansi ekusetshenzisweni kwendlela zokuhlela imuli zabesilisa ukuvalwa kwenzalo kwabesilisa (vasectomy) koBulawayo eZimbabwe

Isifundo/isichwayiso lesi sichasiswe ngolimi engiluzwisisayo. Imbuzo mayelana ngesichwayiso lesi iphenduliwe. Ngiyazwisisa ukuthi ukuphatheka kiso kuzaba ngani njalo ngiyavuma ukuphatheka ngokuthanda kwami lokuzikethela kwami. Ngiyazwisisa ukuthi ubuyimi bami kabusoke buvezwe ngitsho lasemuntwini oyedwa. Ngiyazwisisa njalo ukuthi ngilakho ukumisa kumbe ukuquma ukuxoxisana ngesikhathi engisifunayo kungela sidingo sokuba nginike isizatho njalo ngingela kwesaba kokwehlelwa ngokubi.

_____Ngiyavuma ukuthi zonke impendulo zami zigcinwe kutape rikhoda.

_____Angivumi ukuthi impendulo zami zi tape rikhodwe.

Ibizo lomphenduli/ umhlanganyeli……..

Isignetsha yomphenduli/yomhlanganyeli…….

Usuku……

Appendix 11: Ifomu lokuvuma – ***(Consent form – Key Informant)***

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

IFOMU LOKUVUMA ***(Consent form – Key Informant)***

Isihloko sesichwayiso – Isifundo sokufumana izizatho ezikhokhela enanini eliphansi ekusetshenzisweni kwendlela zokuhlela imuli zabesilisa ukuvalwa kwenzalo kwabesilisa (vasectomy) koBulawayo eZimbabwe

Isifundo/isichwayiso lesi sichasiswe ngolimi engiluzwisisayo. Imbuzo mayelana ngesichwayiso lesi iphenduliwe. Ngiyazwisisa ukuthi ukuphatheka kiso kuzaba ngani njalo ngiyavuma ukuphatheka ngokuthanda kwami lokuzikethela kwami. Ngiyazwisisa ukuthi ubuyimi bami kabusoke buvezwe ngitsho lasemuntwini oyedwa. Ngiyazwisisa njalo ukuthi ngilakho ukumisa kumbe ukuquma ukuxoxisana ngesikhathi engisifunayo kungela sidingo sokuba nginike isizatho njalo ngingela kwesaba kokwehlelwa ngokubi.

_____Ngiyavuma ukuthi zonke impendulo zami zigcinwe kutape rikhoda.

_____Angivumi ukuthi impendulo zami zi tape rikhodwe.

Ibizo lomphenduli/ umhlanganyeli……..

Isignetsha yomphenduli/yomhlanganyeli…….

Usuku……

Appendix 12: Ifomu ngokugcinwa kwemfihlo ngamaqembu okuxoxisana/amaqembu ezifundo

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

IFOMU NGOKUGCINWA KWEMFIHLO NGAMAQEMBU UKUXOXISANA –

(*Focus group confidentiality binding form)*

Isihloko sesichwayiso – Isifundo sokufumana izizatho ezikhokhela enanini eliphansi ekusetshenzisweni kwendlela zokuhlela imuli zabesilisa: ukuvalwa kwenzalo kwabesilisa (vasectomy) koBulawayo eZimbabwe.

Ngiyazwisisa ukuthi ngivunyelwe ukuphuma kulesi sichwayiso/sifundo yiloba yisiphi isikhathi ngingela sidingo sokuchasisa kumbe ukunika izizatho, njalo kungela kwesaba okubi okungangehlela kumbe ukulahlekelwa ngumvuzo. Ngiyazwisisa njalo ukuthi okwemfihlo kuqiniseka nxa abanye abaphatheke emaqenjini okuxoxisana begcine konke okukhulunyiweyo/okuxoxiswane ngakho njengemfihlo.

Ngiyavuma ukugcina yonke imithetho yokugcina imfihlo ngakho konke okwenziwe njalo kwakhulunywa kumaqembu ezifundo njalo lokungavezi amagama alabo abakade beyingxenye yamaqembu ezifundo kumbe abaphatheke kulesi sichwayiso kwabanye abantu.

Ibizo lomphenduli/ umhlanganyeli ……..

Isignetsha yomphenduli/yomhlanganyeli …….

Usuku……

Appendix 13: UWC Ethics Clearance Letter

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

20 March 2019

Ms P Ndlovu
School of Public Health
Faculty of Community and Health Science

Ethics Reference Number: BM19/1/26

Project Title: The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe..

Approval Period: 19 March 2019 – 19 March 2020

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The permission to conduct the study must be submitted to BMREC for record keeping

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

BMREC REGISTRATION NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE

Appendix 14: Medical Research Council of Zimbabwe Approval Letter

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/B/1717 **03 May 2019**

Patson Ndlovu
8 Mahatsula South
Bulawayo

RE: The factors contributing to low uptake of vasectomy in Bulawayo, Zimbabwe

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

1. Completed MRCZ 101 form
2. Full protocol

- **APPROVAL NUMBER : MRCZ/B/1717**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING : EXPEDITED**
- **APPROVAL DATE : 03 May 2019**
- **EXPIRATION DATE : 02 May 2020**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (0242) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement.

Yours Faithfully

.....
MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2019 -05- 03
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix 15: City of Bulawayo Approval Letter

City of Bulawayo

Town Clerk's Office
Municipal Buildings
Fife Street
P.O.Box 591
Bulawayo

All Communications
To be addressed to the
Town Clerk

Tel: (263-9) 75011
Fax: (263-9) 69701
Email: tcdept@citybyo.co.zw
Website: www.citybyo.co.zw
Facebook: The City of Bulawayo
Twitter:@CityofBulawayo
Call Centre: 08084700 (Econet,)
08004700 (Telone) (09) 71290

REF: JBM/MZ.74-00-00

23 April 2019

Mr Patson Ndlovu
84 Mahatshula South
P.O. Box Mahatshula South
Bulawayo

Dear Mr/Mrs/Miss Ndlovu

RE: REQUEST FOR PERMISION TO CARRY OUT RESEARCH ON COUNCIL PREMISES: The factors contributing to low uptake of research by Bulawayo Municipal

Your letter on the above matter refers.

Please be informed that Council acceded to your request to carry out research within Bulawayo City Council premises subject to the following conditions:

a) You should submit a copy of your research findings after completing the research exercise.
b) Council is to be indemnified against any accident/mishaps, which may occur during the conduct of the research.

Accordingly you may approach any of Council's Service Departments as appropriate for assistance.

Yours faithfully

TOWN CLERK

CITY OF BULAWAYO
HUMAN CAPITAL DEPT.
10th FLOOR MUNICIPAL
23 APR 2019
TOWER BLOCK, L. TAKAWIRA AVE./
J. TONGOGARA ST.
P.O. BOX 558 OR 559, BULAWAYO
TEL. +263 (9) 75011