

**'Get a Permanent Smile'—  
Increasing Awareness of,  
Access to, and Utilization of  
Vasectomy Services in Ghana**

December 2005



**USAID**  
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

## ACQUIRE Report

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December 2005



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# Contents

Acknowledgments .....	v
Foreword .....	vii
Executive Summary .....	ix
Introduction: Situation Analysis of Vasectomy in Ghana .....	1
The Vasectomy Intervention .....	3
Addressing Barriers to Vasectomy “Supply” .....	3
Addressing Barriers to Vasectomy “Demand” .....	5
Project Results .....	11
Service-Delivery Statistics .....	11
Quality of Services .....	12
Comfort Talking with Clients about Men’s Reproductive Health .....	13
Evaluating the Impact of the Communications Campaign .....	14
Hotline Call Volume and Information Requests .....	20
Profiles of Vasectomy Acceptors, Hotline Callers, and Information Seekers .....	21
Discussion and Lessons Learned .....	23
Factors for Success at the Site Level .....	23
The Whole-Site Training Approach .....	23
Role of the Communications Campaign .....	24
Coordinating the Timing of Project Components .....	25
Where Are We Now? .....	25
Recommended Next Steps .....	26
Conclusions .....	29
References .....	31
<b>Appendixes.....</b>	<b>33</b>
Appendix 1: Training Overview.....	35
Appendix 2: Clinic Intake Form .....	37
Appendix 3: Summary of Campaign Components and Television Advertisement Photo Boards .....	39
Appendix 4: Media Flow Chart .....	51
Appendix 5: Hotline Questionnaire .....	53
<b>Tables</b>	
Table 1. Gaps in the Supply and Demand of Vasectomy Services and Interventions for Closing the Gaps .....	3
Table 2. Key Message Analysis of Campaign Components.....	7

Table 3. Results Reported from Project Monitoring and Measurement Tools and Data Sources Used .....	11
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## Figures

Figure 1. Number of Vasectomy Procedures Performed at EngenderHealth-Supported Sites .....	11
Figure 2. Number of Vasectomies Performed and Program Interventions, by Quarter, 2002–2004 .....	12
Figure 3. Percentage Distribution of Respondents, by Level of Agreement with Statements on Services for Men, Pretest and Posttest .....	13
Figure 4. Percentage of Providers Strongly Disagreeing with Statements Presenting Misconceptions About Vasectomy, Pretest and Posttest .....	13
Figure 5. Percentage of Men in Panel Study with Knowledge of Selected Vasectomy Characteristics, Baseline and Follow-Up .....	16
Figure 6. Percentage of Men Agreeing about Positive Aspects of Vasectomy, at Baseline and Follow-Up .....	16
Figure 7. Percentage of Men Agreeing about Potential Disadvantages of Vasectomy, at Baseline and Follow-Up .....	17
Figure 8. Percentage of Men Who Would Consider Having a Vasectomy in the Future, at Baseline and Follow-Up .....	17
Figure 9. Percentage of Respondents Who Could Recall Selected Components of the Vasectomy Campaign (N=216) .....	18
Figure 10. Percentage of Men Who Were Aware of Vasectomy, According to Whether They Recalled/Were Exposed to Selected Campaign Components (N=149) .....	18
Figure 11. Percentage of Men Who Knew of a Source of Vasectomy Services, Baseline and Follow-Up .....	19
Figure 12. Percentage of Men Who Reported Taking an Action as a Result of Exposure to TV Advertisement (N=94) .....	20
Figure 13. Number of Hotline Calls Received per Week, Relative to Timing of TV and Radio Advertising .....	20
Figure 14. Number of Hotline Caller, by Information Source (N=429 Callers) .....	21
Figure 15. Number of Hotline Caller Who Sought Information on Various Myths Related to Vasectomy (N=425) .....	21
Figure 16. Number of Vasectomies Performed, 2002–2005, by Quarter .....	26

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## Foreword

Vasectomy is safer, simpler, and less expensive than female sterilization, and is just as effective a contraceptive method, yet in many countries it remains one of the least-known and least-used methods. Worldwide, an estimated 42 million couples rely on vasectomy; by comparison, nearly 210 million women rely on female sterilization. In Africa, barely 100,000 couples are protected from unwanted pregnancy through vasectomy. Ghana is typical in this respect, with only about one couple in 1,000 relying on vasectomy.

Why is vasectomy so underutilized, both in Ghana and in other African nations? For many years, the relative underutilization of vasectomy has been attributed to men—that they do not want to take responsibility for family planning. Yet experience suggests otherwise: Men do care about avoiding pregnancy and want to share the responsibility for family planning with their partners (Drennan, 1998; Salem, 2004). Many people simply do not know about vasectomy; negative myths and rumors about the procedure abound; no provider skilled in vasectomy may be anywhere nearby; and many providers may not care about the method or may be biased against it. Because men lack full access to both information and services, they cannot make informed decisions nor take the active part in family planning that their attitudes indicate they may be willing to take.

Researchers have suggested that vasectomy is unacceptable to most African men and probably will long remain so (Caldwell & Caldwell, 2002). Yet similar predictions in the late 1980s that female sterilization would never be an acceptable method (Caldwell & Caldwell, 1987) proved unfounded (Dwyer & Haws, 1990; EngenderHealth, 2002). Thirty years ago, “experts” and providers said that men in Latin America would never accept vasectomy—and they have been proved wrong. Vasectomy use in Latin America has increased four-fold in the past 10 years (The ACQUIRE Project, 2005).

In 2003, the Ghana Health Service, EngenderHealth, and the U.S. Agency for International Development Mission in Ghana collaborated on a pilot program in Accra and Kumasi metropolitan areas to explore whether vasectomy is a viable contraceptive choice when site interventions that focus on issues of quality and access are coupled with effective and strategic interventions aimed at demand awareness. The aim was to make this method available and put the choice into the hands of Ghanaian couples. This report, which describes the results of the project, demonstrates that it is possible to change people’s perceptions of vasectomy and increase the use of this method; we hope that the findings will inspire other countries and agencies to adopt similar approaches to increase the acceptance of underutilized family planning methods.

Vasectomy is an excellent method, and though it will not meet the needs of all couples who do not want any more children, its advantages over other family planning methods—in terms of safety, simplicity, and cost—will become very important in the coming decades.

Lynn N. Bakamjian  
Director  
The ACQUIRE Project





## Executive Summary

In Ghana, vasectomy has been a relatively “invisible” contraceptive method. Prevalence is less than 0.1%; a total of only 18 vasectomies were performed in Ghana in 2003. A review of research on vasectomy services and perceptions of the method by both providers and potential vasectomy users in Ghana identified four main barriers to vasectomy utilization: inadequate access to and quality of services; bias against the method on the part of providers and clinic staff; low awareness of the method; and the prevalence of myths and misinformation about the method, both among men and among the general public.

In 2003, the Ghana Health Service and EngenderHealth initiated a project to introduce and expand vasectomy services in a range of public- and private-sector health facilities in metropolitan Accra and Kumasi. Supported by the U.S. Agency for International Development (USAID), the project was designed to address both the supply-side and demand-side issues that have contributed to the underutilization of vasectomy among couples potentially interested in a permanent family planning option. Meridian Group International, Inc., provided technical assistance to the design and implementation of demand-side interventions. Evaluation of the initiative was undertaken by the ACQUIRE Project, a collaborative project funded by USAID that involves both EngenderHealth and Meridian.

Seven providers were trained in no-scalpel vasectomy (NSV), and facility staff at seven sites were oriented to vasectomy and trained in male-friendly services, to increase their ability to work with men and their comfort level in doing so. Concomitantly, a communications initiative was designed both to serve as a catalyst for men considering vasectomy to take that final step and access services and to raise awareness of vasectomy as a contraception option and dispel rumors. Clinical and community health nurses organized community outreach events at each site. With technical assistance from Meridian Group International, Inc., a campaign was designed based on qualitative research with men, women, and providers in target communities. The campaign, which was anchored in the slogan “Vasectomy...Get a permanent smile” and featured satisfied vasectomy users, aired via two television advertisements, a television documentary, two radio advertisements, posters, brochures and flyers, and public relations efforts. A telephone hotline was also set up, with trained staff to answer calls during the project months. The hotline was promoted in all campaign materials and in community outreach and mobilization events.

Facility staff were oriented in 2003 and 2004. The media campaign was launched and outreach activities began at the end of February 2004, and both ran for four months through June 2004. The direct cost of the intervention, including the media time purchased, was \$180,000. (This does not include the cost of the project evaluation.)

Initial results indicate that the project was a success. After the program was launched in early 2004, the number of vasectomies performed quadrupled over the volume provided in the prior year. A total of 81 men requested and received vasectomies at service sites in 2004, compared with an annual total of 18 in the preceding year. This service volume was 6.6 times higher than the average number of procedures provided in the 10 years prior to the project (1994–2003). In addition, 425 callers received information from the hotline counselors during its working hours. Other men and women sought (and continue to receive) information from the telephone’s automated 24-hour prerecorded information menu of answers to frequently asked questions about vasectomy.

A final component of the project was to assess the extent to which the project produced fundamental changes in the barriers to vasectomy utilization in Ghana. Special studies were conducted to gauge the impact of training on the quality of services and the impact of the communications campaign on people's knowledge and perceptions of vasectomy. Pretest and posttest measurement of providers' attitudes showed that their knowledge about and attitudes toward providing services to men both improved substantially. A mystery client study revealed some gaps in service provision, although all men who sought services were able to get the information they needed. The service level at these sites was thus considerably improved over the levels of access to services and information that existed prior to the project.

A panel study conducted in metropolitan Accra prior to and following the campaign among married men with three or more children showed that the number of men who were aware of vasectomy had nearly doubled. Fifty-six percent of the men who were interviewed recalled and were able to describe at least one element of the campaign, and more than half of the men who reported seeing the campaign television advertisements took action as a result, visiting a doctor or health center to discuss vasectomy, discussing vasectomy with their partner/wife, and/or discussing vasectomy with colleagues. More than half of these men also were able to name a specific site where vasectomy services are offered. The men's "intention to consider vasectomy" also doubled, with the proportion willing to do so increasing from one in every 10 men at baseline to one in five at follow-up.

Data from the first quarter of 2005 suggest that demand for vasectomy is higher than it was prior to the campaign. Thirteen vasectomies were performed at program sites in the first quarter of 2005, compared with zero and seven during the same quarter in 2003 and 2002, respectively. Also, men still call the project hotline with questions. The ACQUIRE Project and EngenderHealth/Ghana staff will continue to monitor service statistics to track the project's longer-term impact. However, follow-up activities on both the supply side and the demand side should be undertaken if this positive momentum is to be sustained.

Recommended next steps include the following:

#### ***Site-level support***

- ◆ Continue periodic whole-site training of facility staff, to combat misconceptions concerning vasectomy, to expand their knowledge base, and to increase positive attitudes concerning vasectomy
- ◆ Expand referral systems and possibilities for inreach among men and women in other health care services, referring interested clients to sites where services are offered
- ◆ Periodically utilize mystery clients to assess the quality of both clinical services and counseling services and review the results with providers to identify any problem areas that should be addressed
- ◆ Identify champions at each site who will devote sustained effort and energy to the vasectomy initiative
- ◆ Focus on a small number of skilled providers and support expansion of access through those providers who perform well

#### ***Demand and client communications***

- ◆ Repeat the media campaign in short, concentrated periods at least twice a year, to continue to improve awareness, knowledge, and use of the method and to support men considering vasectomy to take that final step and seek services

- ◆ Run a hotline during and for at least three months after the campaign bursts, to serve as an intermediate action that interested men can take to get further, personalized information
- ◆ Maintain the program's use of interpersonal communications channels (e.g., hotline, counseling opportunities, and community outreach) and time community-based interventions to coincide with the media campaign bursts
- ◆ Conduct a follow-up workshop with participating clinic staff and other project stakeholders to pool their ideas and add them to a scaled-up project



# Introduction: Situation Analysis of Vasectomy in Ghana

In Ghana, one in four married women say they do not want any more children, yet less than half of their need to limit future births is being met (GSS, NMIMR, & ORC Macro, 2004). This translates to nearly 350,000 Ghanaian couples having an unmet need to limit future births. The prevalence of vasectomy, however, is less than 0.1%.

Vasectomy has been more difficult to obtain in Ghana than other family planning methods. The 1996 Ghana Situation Analysis (GSA) noted that fewer than 5% of physicians had performed a vasectomy, informed a client about vasectomy, or referred a client for vasectomy in the past three months. Moreover, two out of five providers said they would not recommend vasectomy for couples who did not want any more children (GSS, 1998).

Even if vasectomy services are available, health care providers may devote little or no attention to vasectomy or to permanent contraception in general when they discuss family planning options with clients. Though permanent contraceptive methods were available at regional hospitals, the 1996 GSA noted that no family planning clients received information about vasectomy and only 29% received information on female sterilization, even though two-fifths indicated that they wanted to use contraceptives to limit further births (GSS, 1998).

Awareness of contraception in general is almost universal in Ghana, with 98% of women and 99% of men knowing at least one method of contraception. However, fewer than half of women and only three in five men have heard of vasectomy (GSS, NMIMR, and ORC Macro, 2004). Ten years ago, fewer than one in three men had heard of vasectomy. Awareness of vasectomy as an option has risen in the past five years as a result of efforts by the Ghana Health Service and EngenderHealth to expand access to and awareness of services through the training of service providers and recruitment of satisfied vasectomy clients to talk about vasectomy at the community level. This effort coincided with the launch of the national 2001 “Life Choices” behavior change campaign, which promoted family planning in general and included all modern methods (although it only briefly addressed vasectomy).

Even when men and women are aware of vasectomy, their information is frequently incomplete or incorrect. In 2001, EngenderHealth conducted a qualitative study in Ghana to assess knowledge about and attitudes toward vasectomy among both users and nonusers of the method. The research found that while users of vasectomy were very satisfied with the method, nonusers had very negative attitudes toward it. Among men who “knew about” vasectomy, their information was frequently incomplete or incorrect, with the primary misconception being that vasectomy is equivalent to castration. (In some dialects in Ghana, the term for vasectomy in fact translates to “castration.”) Other false fears identified were that vasectomy would result in a lack of sex drive, poor sexual performance, decreased strength, or a loss of manliness.

Overall, research found that the underutilization of vasectomy in Ghana and elsewhere can be attributed to four key factors—a lack of awareness of vasectomy as a contraceptive option, myths and rumors about vasectomy, a lack of access to services, and indifference and bias on the part of providers (The ACQUIRE Project, 2005).

In 2003, EngenderHealth, with funding from the U.S. Agency for International Development (USAID),<sup>1</sup> worked with the Ghana Health Service<sup>2</sup> to design a vasectomy program for implementation in two large metropolitan areas of Ghana. The project was intended to introduce and expand vasectomy services in a range of public- and private-sector health facilities. The project was designed to address both the supply-side and demand-side issues that have contributed to the underutilization of vasectomy by couples interested in a permanent family planning option. The structure of the project evolved from recommendations of a workshop convened by the Ghana Health Service, the National Population Council, and EngenderHealth in the late 1990s that discussed how to increase the involvement of men in family planning (see box).

### **Ghana Health Service: Giving More than Lip Service to Male Involvement**

While many talk about the importance of addressing men's concerns, the family planning program in Ghana has taken some very concrete steps in addressing this issue. Both the private and the public sectors in Ghana have made progress in implementing education and services for men's reproductive health needs, with several important milestones on the journey to date. Planned Parenthood Association of Ghana (PPAG) pioneered services for men with its Daddies' Clubs and community-based distribution programs in the 1980s.

In 1994, the Ghana Health Service (GHS) developed a five-year action plan that included a strategy to address male involvement in family planning. Since that time, the GHS has turned the action plan into reality by training doctors in no-scalpel vasectomy (NSV), developing community education programs that can reach men and women outside of the traditional clinic setting, and ensuring that clinical services are available to male clients.

EngenderHealth began training in NSV in 1994, and services were available at six sites. In 1998, the GHS, the National Population Council, and EngenderHealth convened a national workshop to look at how to improve the involvement of men in family planning. Recommendations from this workshop served as a practical means for the GHS to realize the goals of its five-year plan and set the stage for EngenderHealth's vasectomy initiative.

From 2001 to 2003, health partners in Ghana worked to reposition family planning via the "Life Choices—It's your life, it's your choice" campaign. Upon further reflection and analysis, the Ghana Health Service and health partners realized that a more concerted effort for male involvement was needed, thus leading to the "Get a Permanent Smile" campaign.

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<sup>1</sup> Operational funding for this project came from USAID's 1998–2003 cooperative agreement with EngenderHealth (HRN-A-00-98-00042-00) and from the USAID bilateral agreement for Ghana (641-A-00-00-00080). Evaluation efforts were funded by USAID through the ACQUIRE Project cooperative agreement (GPO-A-00-03-00006-00).

<sup>2</sup> Entitled the Ghana Ministry of Health at that time.

# The Vasectomy Intervention

The project sought to provide a comprehensive approach to closing the gaps in the current environment, by addressing both supply-side issues and demand-side concerns (Table 1). Supply-side issues consisted of provider biases and the lack of availability of services; on the demand side, the primary issues were low levels of knowledge about vasectomy and the prevalence of myths and misinformation.

The project consisted of five key interventions. To address problems on the supply side, the project trained physicians in no-scalpel vasectomy (NSV) and created “male-friendly” service-delivery points. To address issues affecting demand, the project initiated a community outreach program, designed a media campaign to reach potential clients, and established a telephone information hotline.

These interventions were focused on two major metropolitan areas—Accra and Kumasi—and specifically were geared toward improving services at seven public, nongovernmental, and private-sector health care sites. These sites were four public-sector facilities (La General Hospital and Ashaiman Health Center in Accra and Komfo Anokye Teaching Hospital [KATH] and Kumasi South Hospital in Kumasi), one nongovernmental facility (the Planned Parenthood Association of Ghana [PPAG] Link Road Clinic in Accra),<sup>3</sup> and two private-sector facilities (Okanta Memorial Clinic and Nyaho Clinic in Accra).

**Table 1. Gaps in the Supply and Demand of Vasectomy Services and Interventions for Closing the Gaps**

<b>Gaps</b>	<b>Interventions</b>
<i>Supply</i> <ul style="list-style-type: none"><li>♦ Low availability</li><li>♦ Provider bias</li></ul>	<i>Supply</i> <ul style="list-style-type: none"><li>♦ Clinical training in no-scalpel vasectomy</li><li>♦ Creation of “male-friendly” services</li></ul>
<i>Demand</i> <ul style="list-style-type: none"><li>♦ Low knowledge</li><li>♦ Misinformation</li></ul>	<i>Demand</i> <ul style="list-style-type: none"><li>♦ Community outreach</li><li>♦ Media campaign</li><li>♦ Telephone hotline</li></ul>

## Addressing Barriers to Vasectomy “Supply”

Site-level preparation included two main components: clinical training of providers in NSV and whole-site training of clinic staff to prepare them to better provide services to male clients.

<sup>3</sup> Direct support to the PPAG clinic ended in September 2003, but their activities and services continued to be monitored or reported during the time in which the project described here was being implemented.



## Clinical Training in NSV

Seven service providers received training or retraining in NSV.<sup>4</sup> The training was conducted at an international NSV training center located in New Delhi, India was selected as the training site so that trainees would have a sufficient caseload to ensure they could develop competence in the procedure. Training lasted five days and included didactic and practicum sessions. In the practicum, trainees observed procedures, practiced on scrotal models, and performed procedures on their own. All trainees performed a minimum of 15 procedures. Additional detail about the training is included in Appendix 1.

At three of the project's participating sites (La General Hospital, KATH, and Kumasi South), the NSV providers were on staff; at the remaining sites, a trained provider was on call to provide services.

**Each site developed a detailed action plan for the provision of vasectomy services, one that included community outreach work to be conducted by staff.**

## Site Staff Training in “Male-Friendly” Services

The second key component of the supply-side strategy was to implement a whole-site training approach<sup>5</sup> to involve personnel at all levels at each project site in the provision of quality information, counseling, and NSV services.

During January and March 2003, four four-day workshops were conducted in Accra and Kumasi.<sup>6</sup> Workshop participants represented all levels of clinic staff who, as people who can either facilitate or hinder client access to services, are “gatekeepers” for vasectomy services. These included doctors, nurses, midwives, health educators, receptionists, cleaning staff, and guards. The overall goal of these workshops was to ensure health workers' active participation in and sustained commitment to serving existing clients and conducting outreach to new clients.

The objectives of the training were to improve providers' knowledge of men's reproductive health issues in general (and of NSV, specifically) and to raise their awareness of how their attitudes toward men's reproductive health and family planning could affect facility staff. Each site developed a detailed action plan for the provision of vasectomy services, one that included community outreach work to be conducted by staff.

Nurses and family planning counselors at all project sites were also oriented to data collection forms for the project; these were used to compile basic data about clients (age, marital status, and number of children), information on the services clients sought, and data on how long since they had first heard about vasectomy and where they had heard about the site. (The data collection forms are shown in Appendix 2.)

<sup>4</sup> Four of the providers had been previously trained in NSV but attended refresher training to improve their skills in ligation with fascial interposition. (Fascial interposition involves pulling the sheath covering the vas deferens over one severed end of the vas and then sewing it shut to create a natural tissue barrier.)

<sup>5</sup> Whole-site training treats the local service-delivery site as a system and the personnel as members of a team who make the system function. The goal of whole-site training is not simply to transfer knowledge and develop critical skills, but also to forge an effective, smoothly functioning service-delivery system and promote effective local teamwork within the family planning unit. Whole-site training includes training in inreach (staff orientations, referrals, linkages between departments, and adequate signage) to ensure that clients do not miss opportunities to access information and services for male clients.

<sup>6</sup> Workshops were conducted at La General Hospital and Ashaiman Health Center/Okanta Clinic in Accra and at Komfo Anokye Teaching Hospital (KATH) and Kumasi South in Kumasi. Staff at Nyaho Clinic in Accra did not attend the training, but EngenderHealth staff provided an on-site orientation for the nurse and surgeon there.

## **Training Follow-Up and Supervision**

Because of delays in other project components, staff at participating sites received refresher orientations around the timing of the campaign launch (February 2004). Following the orientations and training, EngenderHealth/Ghana staff periodically visited the sites to assess the quality of service provision, record keeping, sufficiency of information, education, and communications (IEC) materials, and other aspects of the project.

## **Addressing Barriers to Vasectomy “Demand”**

To support the introduction and expansion of vasectomy services in Accra and Kumasi, a communications initiative was designed both to serve as a catalyst for men considering vasectomy to take the final step and access services and to raise awareness of vasectomy as a contraceptive option and dispel rumors. These demand-side activities included a media campaign, community outreach by clinic staff, use of satisfied clients as spokespersons in the community, and a telephone hotline. Meridian Group International, Inc., provided technical assistance in the design of the communications campaign, media planning, and integration of messages into the overall project. The ACQUIRE Project conducted the evaluation activities described in this report.

## **Media Campaign Development and Strategy: “Get a Permanent Smile”**

The results from qualitative research conducted by EngenderHealth in 2001 on clients’ perceptions of vasectomy were used as a basis for designing a communications strategy. Among the key findings from the 2001 assessment were:

- ◆ Users of vasectomy were very satisfied with the method
- ◆ Nonusers had very negative attitudes toward vasectomy
- ◆ Men who were aware of vasectomy frequently had incomplete or incorrect information about the procedure
- ◆ The primary misconception was that vasectomy is “castration”

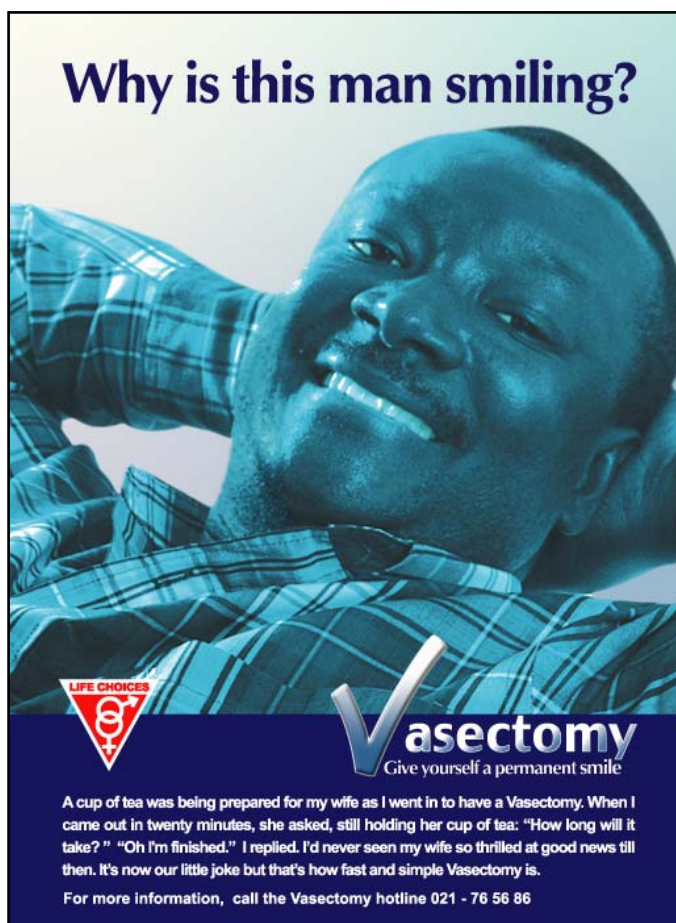
Based on these research findings, the following communications objectives were set for the campaign:

- ◆ To create awareness of and a positive image for vasectomy
- ◆ To provide correct information on vasectomy (and on NSV) and to educate both men and women about its benefits
- ◆ To increase awareness of the names and locations of sites where NSV services are available
- ◆ To encourage acceptance of vasectomy by using testimonials from satisfied clients

In addition, the tone of the campaign needed to be positive and upbeat to help change the method’s image. A decision was made not to translate or change the term “vasectomy,” but rather to change the image and dispel the myths surrounding the method.

The campaign was targeted to the profile of current users: married men who are 35 years of age or older, have three or more children, and do not want any more children.

For the vasectomy promotion and mass media component, a professional advertising agency (Lintas-Ghana Ltd.) was competitively selected to create and develop appropriate communication plans and materials. Among the several campaign concepts that the agency developed for evaluation by the target audience, the “Permanent Smile” campaign was the strongest. It was



well-understood and well-liked by members of the target audience. The campaign slogan “Vasectomy...Give yourself a permanent smile” anchored the campaign as its theme and was included in all advertising materials. A satisfied user of vasectomy from Kumasi (left) was identified to be the “face” of the campaign; his smiling image was featured in all campaign materials.

### Campaign Elements

The “Permanent Smile” campaign included a wide range of communications materials, including television, radio, a documentary, printed IEC and promotional materials, and public relations efforts. Throughout the campaign, vasectomy was positioned as a family planning method that can enhance men’s lives and their ability to care for their partner and children. This campaign linked conceptually with the national “Life Choices” campaign for repositioning family planning.

The lead medium in the vasectomy campaign was television. Two television advertisements were produced, one with a local orientation and one with an international focus: Both positioned vasectomy as a viable family planning option for men in stable relationships—a choice that can help them thrive at home and in their careers. The “international ad,” however, also portrayed vasectomy as a method widely accepted internationally and featured men and families of all races, while the “local ad” featured a Ghanaian family and the man’s success in the local context. Television and print materials were produced in English, and the campaign’s two radio spots were produced both in English and in two local dialects. A summary of the campaign components (including photoboards of the television spots) is provided in Appendix 3, and a message analysis is provided in Table 2.

### Media Plan and Materials Dissemination

Both television and radio advertising were scheduled to air in four-week intervals separated by two-week periods of no advertising. This “flighted” strategy was selected to maximize the impact of the campaign, given the program time frame and budget. Both television and radio spots were aired on the leading national television and radio stations during prime-time hours (evening for television and morning and evening for radio).

Although the campaign was originally to air exclusively from March to June, the two main television stations in Ghana overbooked advertising during the first three quarters of 2004 and missed a significant number of scheduled advertisements.

**Table 2. Key Message Analysis of Campaign Components**

	Knowledge	Attitudes	Behavior/Call to Action
<b>Television</b>			
International ad (“Join the Brotherhood”)	<ul style="list-style-type: none"> <li>♦ Vasectomy is a simple procedure.</li> <li>♦ Vasectomy takes 20 minutes or less.</li> <li>♦ Forty-two million men around the world have used vasectomy.</li> </ul>	<ul style="list-style-type: none"> <li>♦ Vasectomy allows a man to provide for the wife and children that he already has.</li> <li>♦ Vasectomy is an important asset.</li> <li>♦ Join the brotherhood of men who are satisfied with their vasectomy.</li> </ul>	<ul style="list-style-type: none"> <li>♦ The ad tells men they can get more information by calling the vasectomy hotline at 774-854 or by visiting one of the following sites in Accra and Kumasi.</li> <li>♦ The ad encourages them to join the brotherhood of men who are satisfied with their vasectomy.</li> </ul>
Local ad (“Episodes of Life”)	<ul style="list-style-type: none"> <li>♦ Vasectomy is a viable family planning choice for men.</li> </ul>	<ul style="list-style-type: none"> <li>♦ Vasectomy allows a man to focus on his career and his family.</li> <li>♦ The decision to have a vasectomy is a personal one.</li> <li>♦ The ad encourages men with the slogan “Wo ye barima” (“You’re a real man…”).</li> </ul>	<ul style="list-style-type: none"> <li>♦ The ad tells men they can get more information by calling the vasectomy hotline at 774-854 or by visiting one of the following sites in Accra and Kumasi.</li> </ul>
<b>Radio</b>			
Radio spot (Love Note)	<ul style="list-style-type: none"> <li>♦ Vasectomy is a family planning method.</li> </ul>	<ul style="list-style-type: none"> <li>♦ Vasectomy allows men to enjoy their relationship with their partner.</li> <li>♦ Vasectomy gives men the freedom to focus on their success and their family.</li> <li>♦ Vasectomy is for men who are happy and stable in their relationship.</li> </ul>	<ul style="list-style-type: none"> <li>♦ The ad tells men to call 774-854 for more information on vasectomy.</li> </ul>
Radio spot (Answering Machine)	<ul style="list-style-type: none"> <li>♦ Vasectomy is a family planning method.</li> </ul>	<ul style="list-style-type: none"> <li>♦ Vasectomy gives men the freedom to focus on their success and their family.</li> <li>♦ Vasectomy is for men who are happy and stable in their relationship.</li> </ul>	<ul style="list-style-type: none"> <li>♦ The ad tells men to call 774-854 for more information on vasectomy.</li> </ul>
<b>IEC Materials</b>			
Poster	<ul style="list-style-type: none"> <li>♦ Vasectomy takes less than 20 minutes.</li> <li>♦ Vasectomy is fast and simple.</li> </ul>	<ul style="list-style-type: none"> <li>♦ Couple are satisfied with their decision.</li> </ul>	<ul style="list-style-type: none"> <li>♦ The poster tells men they can get more information by calling the vasectomy hotline at 774-854.</li> </ul>

(cont.)

**Table 2. Key Message Analysis of Campaign Components** (*cont.*)

	<b>Knowledge</b>	<b>Attitudes</b>	<b>Behavior/Call to Action</b>
Brochure	<ul style="list-style-type: none"> <li>◆ Vasectomy is for men who are satisfied with the number of children they have.</li> <li>◆ Vasectomy is a minor procedure.</li> <li>◆ Vasectomy is one of the safest ways to prevent pregnancy.</li> <li>◆ Vasectomy does not protect against HIV and other sexually transmitted infections.</li> <li>◆ Vasectomy will not affect your manhood.</li> <li>◆ Vasectomy is safe.</li> <li>◆ Vasectomy is permanent; there's no turning back.</li> </ul>	<ul style="list-style-type: none"> <li>◆ Vasectomy allows you to enjoy sexual intercourse without worry of pregnancy.</li> <li>◆ Vasectomy allows men to express their commitment to and love and respect for their partner.</li> </ul>	<ul style="list-style-type: none"> <li>◆ The brochure encourages men to do a vasectomy “self-assessment.”</li> <li>◆ It encourages men to talk to a doctor, nurse, or counselor.</li> <li>◆ It informs men that vasectomy is offered in the following centers in Accra and Kumasi.</li> </ul>
Flyer	<ul style="list-style-type: none"> <li>◆ Vasectomy is for men who are comfortable with the number of children they have.</li> <li>◆ Vasectomy is one of the safest and most reliable methods.</li> <li>◆ Vasectomy is quick and easy.</li> <li>◆ Vasectomy does not protect against HIV and other sexually transmitted infections.</li> <li>◆ Vasectomy is permanent.</li> </ul>	<ul style="list-style-type: none"> <li>◆ Vasectomy is a personal decision.</li> <li>◆ Vasectomy allows a man to focus on his family and career.</li> <li>◆ Vasectomy allows men to enjoy their love life.</li> </ul>	<ul style="list-style-type: none"> <li>◆ The flyer encourages men to talk to a doctor, nurse, or counselor.</li> <li>◆ It informs men that vasectomy is offered in the following centers in Accra and Kumasi.</li> <li>◆ The flyer tells men they can get more information by calling the vasectomy hotline at 774-4854.</li> </ul>

As a result, 160 television spots ran from March to June and 53 television spots (33% of the campaign's total 213 spots) ran from September 20–October 20, 2004. A small number of missed radio spots were also aired in October during the final week of this period of supplemental advertising. The media flow chart in Appendix 4 depicts the number and timing of the campaign advertisements, by week.

The majority of the IEC print materials were provided to site-level staff, who then distributed the materials at their facilities, within their communities, and during their launch events. In addition, the advertising agency distributed some IEC materials in public places where men were easily reached (e.g., bars and garages).

## Community Outreach

Staff at each facility designed and implemented programs for reaching out to their local communities to increase awareness of the availability of vasectomy services. One key component of this outreach at all sites was a campaign “minilaunch.” Conducted by the nurses from the family planning department of each of the project clinics in the community surrounding each site, these

events featured speeches by providers, by public health officials, and by satisfied clients, as well as other activities designed by the site. Most of the minilaunches were attended by approximately 300 people. However, due to scheduling difficulties among other Ghana Health Service events, some of the minilaunches only took place late in the campaign (with dates ranging from April 15 to June 9).

Volunteer *satisfied clients* were identified to speak to communities about their personal experiences using vasectomy. In preparation for this role, the volunteers were trained in public speaking and communication. Other activities included printing vasectomy T-shirts for community health nurses to wear, dedicating several monthly “health walks” in Accra by La General Hospital nursing staff to vasectomy (in which health information was projected by megaphone during a walk through communities), and a quarterly Daddy’s Forum. Several clinics’ community health nurses made visits to places where men can be reached, such as truck stops (lorry parks), transport unions, and the like, to disseminate IEC materials. In addition, some nurses who became vasectomy champions placed the project bumper stickers on their purses and carried IEC materials with them to disseminate during their off hours at the market and elsewhere, as well as designating certain days for staff to wear vasectomy T-shirts at the clinics.

#### **“Daddy’s Forum”**

The Kumasi South Hospital organized an event for husbands of pregnant women in the care of the maternity unit. The event’s goal was to sensitize men on the need for male involvement in reproductive health. It covered family planning, protection from sexually transmitted infections, caring for their wife’s pregnancy, and treatment of infertility. During the campaign, these events were used as a forum for distributing campaign materials and educating men about vasectomy.

### **Hotline**

The project established a hotline service to provide men and women interested in seeking more information about vasectomy with a convenient, anonymous, and reliable mechanism for addressing their initial questions about the method. Virtually all of the communication materials encouraged men and women to call the hotline if they were interested in more information about vasectomy. Male and female operators were trained to answer questions, provide information about vasectomy, and refer callers to vasectomy service sites.

The hotline operated six days a week, from 8:00 am to 10:00 pm, during the first four months of the campaign and was set up again during the second period of advertising that aired from September 20–October 20. In both periods, the hotline operated for two weeks after the campaign stopped airing. During all other times, an answering machine featuring a key-controlled menu enabled callers to select prerecorded answers to frequently asked questions about vasectomy, including the contact information for sites offering vasectomy services.

Hotline attendants filled out forms on each call. (See Appendix 5 for the hotline questionnaire form.) These forms recorded basic data about callers (their age, marital status, and number of children), about the nature of the callers’ questions, and from where they had heard about the hotline. However, no such information could be collected on the numbers and characteristics of men and women who reached the answering machine only.



# Project Results

The project used several monitoring and evaluation tools to assess the effectiveness of its various interventions. These included tracking service statistics, evaluating the impact of whole-site training on staff knowledge and attitudes toward vasectomy, using a mystery client study to evaluate service quality, having project staff complete survey questionnaires when men called the hotline or visited clinics for information or services, and conducting a panel study of men in the greater Accra area prior to and after the promotional campaign to measure its impact. Results measured and the related data collection tools are summarized in Table 3.

**Table 3. Results Reported from Project Monitoring and Measurement Tools and Data Sources Used**

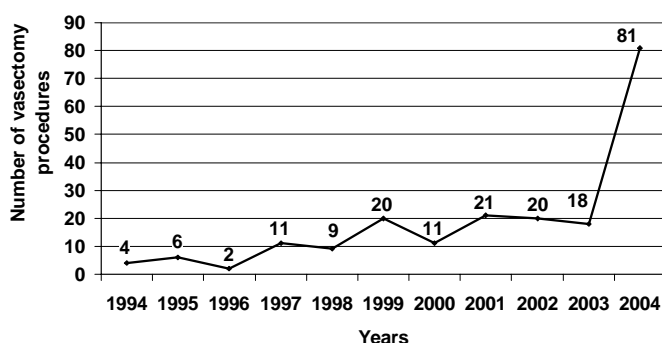
Result Measured	Measurement Tool/Data Source
Changes in the number of vasectomies requested and provided	Service data from clinics
Profile of information-seekers (at hotline and clinics) and source of information about hotline	Data from clinic and hotline record forms
Quality of services provided to information seekers	Mystery client study
Changes in providers' knowledge and attitudes and in their ability to provide services.	Whole-site training pretest and posttest (and mystery client study)
Quality of clinical NSV service provision	Monitoring visit by NSV specialist/trainer
Profile of vasectomy seekers and source of information about hotline	Clinic record forms
Reach of communications campaign, and its impact on awareness, knowledge, and attitudes.	Panel study in metropolitan Accra

## Service-Delivery Statistics

During 2004, the number of vasectomies performed in the communities in Ghana served by the project increased over the number provided in the previous year by a factor of four and a half:

Eighty-one men requested and received vasectomies at the seven service sites in 2004, compared with just 18 at the same sites in the prior year (Figure 1).

**Figure 1. Number of Vasectomy Procedures Performed at EngenderHealth-Supported Sites**



**During the project year, vasectomies increased by 350% over the number provided in the previous year.**



This service volume was 6.6 times higher than the average number of procedures provided in the 10 years prior to the project (1994–2003). Figure 2 shows the key project milestones and the trend in the rate of vasectomy services by quarter over the last three years.

## Quality of Services

### Impact of Whole-Site Training on Providers' Knowledge and Attitudes

Written questionnaires were used to assess facility staff attitudes toward providing services to men and knowledge of vasectomy before and after on-site training in male-friendly services. In addition, the quality of services was later assessed through mystery client visits.

Following the orientation to male-friendly services, facility staff:

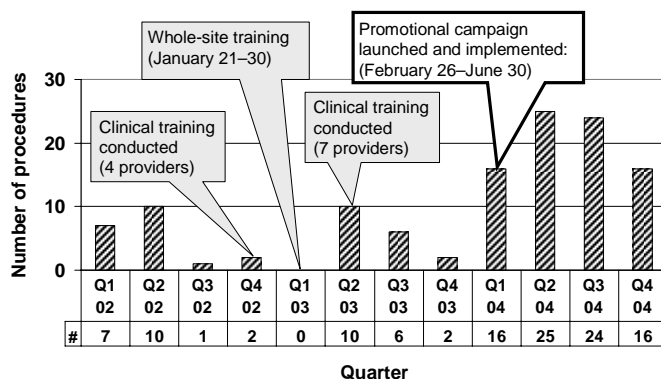
- ◆ Were more receptive to offering men's health services
- ◆ Had a better understanding of male anatomy
- ◆ Had fewer misconceptions about vasectomy
- ◆ Expressed more comfort in talking to men about vasectomy

Following the intervention (orientation), facility staff were less likely to agree with the statement that “Providing male reproductive health services will take away needed resources for women.” While prior to training nearly one in three participants agreed or strongly agreed with that statement, following training only one in five agreed or strongly agreed with that statement, and more than half reported that they strongly disagreed with this statement (Figure 3).

Facility staff were also more likely to disagree with the statement “Few men will use sexual and reproductive health care services even with services specifically designed for and marketed to them.” Two in five facility staff initially agreed or strongly agreed with this statement, but following the on-site training, nearly all either disagreed or strongly disagreed with it (Figure 3).

### Impact on Understanding of Male Anatomy and on Misconceptions about Vasectomy

**Figure 2. Number of Vasectomies Performed and Program Interventions, by Quarter, 2002–2004**



Providers had significant gaps in their knowledge of male anatomy. Before the intervention, only physicians (all of whom were male) could correctly identify various male reproductive structures (e.g., the vas deferens, epididymis, or the seminal vesicles). Following the training, nine out of 10 participants correctly identified the various structures.

Following the training, participants had a more positive attitude toward vasectomy and had a clearer understanding of the procedure and its outcomes (Figure 4). After the training, staff were much more likely to *strongly disagree* with the following statements:

- ◆ “Contraceptive methods for men, such as vasectomy, diminish the ability of a man to feel sexual pleasure.”
- ◆ “Vasectomy is like castration.”
- ◆ “A man cannot have sex or ejaculate after vasectomy.”
- ◆ “A man becomes fat after a vasectomy.”

## Comfort Talking with Clients about Men’s Reproductive Health

The percentage of providers who reported that they were very comfortable explaining the different parts of the anatomy and their functions rose from 76% before the intervention to 92% afterwards, and the percentage of providers who felt they were very capable of answering “any questions a male client may have about his anatomy and physiology” rose from 72% to 92%.

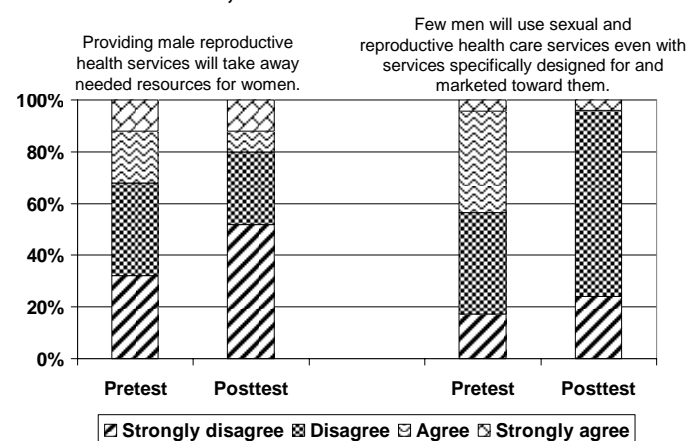
## Quality of Services Provided

To assess the quality of services being provided at the participating facilities and the impact of the whole-site training approach, EngenderHealth-Ghana staff conducted periodic visits to the sites and the ACQUIRE Project implemented a mystery client study at six facilities<sup>7</sup> in August 2004.

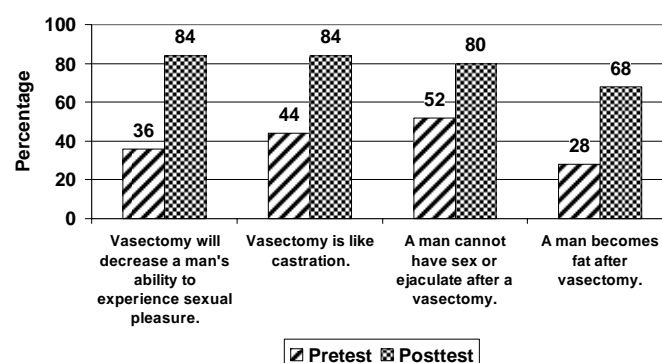
Each of the facilities was visited by one of two trained mystery clients who inquired about vasectomy services. Mystery clients were interviewed after they exited the service sites to:

- ◆ Determine how receptive the service providers were to someone interested in receiving information on vasectomy
- ◆ Determine if IEC materials were available and were being used by the service site
- ◆ Assess the overall quality of services from the client’s perspective, including waiting times

**Figure 3. Percentage Distribution of Respondents, by Level of Agreement with Statements on Services for Men, Pretest and Posttest**



**Figure 4. Percentage of Providers Strongly Disagreeing with Statements Presenting Misconceptions About Vasectomy, Pretest and Posttest**



<sup>7</sup> The mystery client survey was done at five of the seven sites participating in the intervention—Komfo Anokye Teaching Hospital, Kumasi South Hospital, La General Hospital, Ashiaman Health Center, and the PPAG Link Road Clinic—and at one site (Korle Bu Hospital Accra) that did not participate in the whole-site training but that had a trained NSV provider.

### ***Reception by facility staff***

All of the participating sites had clearly visible signs directing potential clients where to go. When mystery clients asked for directions, facility staff were able to provide them with information. At one facility, one of the cleaning staff was able to direct the client to the family planning clinic. Once inside the clinic, the mystery clients had to wait to speak to someone knowledgeable about vasectomy at three of the sites. (The waiting time averaged 34 minutes and ranged from 12 to 55 minutes.)

At none of the facilities visited did the mystery client feel that staff were judgmental about or opposed to the idea of his having a vasectomy; however, at three of the sites, the mystery clients noted that staff did not give them any special attention. At no sites did the mystery clients feel pressured to have a vasectomy. Both mystery clients noted that they felt odd being the only male client in the family planning clinic.

### ***Counseling techniques***

At the five participating sites, the mystery clients reported that nurses provided counseling in a space ensuring auditory and visual privacy; however, at the nonintervention site, there was visual but not auditory privacy.

The amount of time staff spent talking to the client ranged from 10 minutes to 60 minutes. Staff at all sites stressed the permanence of the procedure. At three sites, the mystery clients were told that the procedure would not be very painful. At two facilities, without prompting, staff stressed that the vasectomy procedure was not castration, while at a third site, staff reassured the client that it was not castration when the client asked. At half of the sites, the mystery clients were instructed to discuss their decision with their partner. At three, staff probed the mystery clients regarding their age and their number of children. At only two facilities did staff discuss other family planning options with the client. At two sites, the mystery clients were informed that they would have to come back to speak to someone about vasectomy or were referred to another clinic for information.

### ***Accuracy of information provided***

Overall, the description of the procedure staff provided was correct, although at two facilities the mystery clients felt that more details should have been provided. Information regarding follow-up was incorrect at two sites. At the sites not participating in the on-site orientation, the mystery client was incorrectly told to use condoms for 20 ejaculations after the procedure rather than to use condoms (or another method of family planning) for three months. At one facility, the mystery client was told that he needed to use condoms for only one month.

### ***Availability of IEC materials***

At four of the six sites, flipcharts were used to describe the vasectomy procedure. At the remaining two sites, the client was referred to a general wall chart on family planning methods. At four of the six sites visited, the mystery client was provided with written materials on vasectomy.

## **Evaluating the Impact of the Communications Campaign**

### **Methodology**

To evaluate the effect of the communications campaign, the ACQUIRE Project implemented a panel study among more than 200 men in metropolitan Accra. The study was designed to measure the effect of the campaign among a group of men representative of the project's overall target audience. The baseline survey was conducted among a panel of 221 men during the two weeks prior to the launch of the communications campaign, and the follow-up survey was conducted among

216 of these same men during the two weeks following the campaign's conclusion. Given the limited project budget and short time frame, a panel study design was selected, because it was likely to elicit more reliable measures of knowledge, attitudes, and behavioral changes at the individual level with a relatively small sample. The disadvantage of this type of study is that some of the apparent increase in men's awareness of vasectomy at follow-up could result from its having been introduced in the baseline survey.

Men were eligible for the study if they were married, had at least three children, and were between the ages of 30 and 55. In addition, they either had to want no more children or had to be undecided about wanting additional children. The panel study used a stratified random sample of households throughout metropolitan Accra. The objectives of the study were the following:

- ◆ To determine the effect of the campaign on the target market's awareness of, knowledge about, and attitudes toward vasectomy
- ◆ To determine the effectiveness of the campaign in providing information about vasectomy services
- ◆ To determine which aspects of the campaign were best recalled and most effective

#### **Panel Study Participant Profile**

Median age: 43  
 Median no. of living children: 3  
 (range, 3–13)  
 Median no. of years married: 14.5  
 (range, 4–32)  
 % working full-time: 61%  
 Education:  
 Some education: 98%  
 Junior secondary or middle school: 44%  
 Senior secondary or technical: 37%  
 Language spoken/understood:  
 Ga: 41%  
 Akan: 38%  
 English (understood): 91%

## **Key Findings**

### **Changes in awareness**

Overall awareness of vasectomy essentially doubled from the baseline to the follow-up. At baseline, 31% of respondents (67 out of 216 men) were aware of vasectomy, while at follow-up, 59% (127 out of 216 men) were aware of the method. For the purposes of this study, respondents were defined as aware of vasectomy if they reported that they had heard of vasectomy as a family planning method (either unprompted or after prompting<sup>8</sup>).

**Awareness of vasectomy almost doubled among men interviewed.**

### **Changes in knowledge**

To assess the impact of the campaign on men's knowledge, respondents were asked an open-ended question regarding what they knew about vasectomy. Qualitative aspects of vasectomy knowledge were coded at baseline and follow-up. Three main codes were created:

1. Vasectomy is an operation or surgery.
2. Vasectomy is a family planning method for men/prevents pregnancy.
3. Vasectomy is permanent.

<sup>8</sup> This question was asked both unprompted ("What family planning methods do you know?") and prompted ("Of the following methods, which have you heard of?"); a list was then read that included "vasectomy." It should be noted that "awareness" of vasectomy in this study thus entails the respondent's knowing the term "vasectomy." Awareness among currently married men, as measured by the Demographic and Health Survey in Ghana is 59.6% (GSS, NMIMR, & ORC Macro, 2004), but that measure differs from what was used in our study, in that the prompted question asked if they had heard of "male sterilization," *not* the term "vasectomy."

**Figure 5. Percentage of Men in Panel Study with Knowledge of Selected Vasectomy Characteristics, Baseline and Follow-Up**

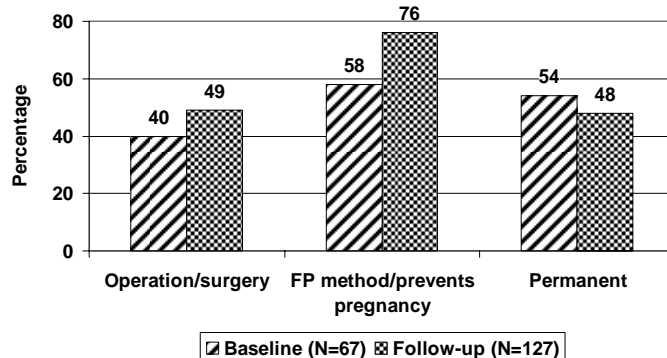


Figure 5 shows that men's knowledge that vasectomy is a family planning method or a method to prevent pregnancy (as expressed by the proportion of men spontaneously describing vasectomy as such) increased most significantly, from 58% of respondents to 76%. Put in terms of the numbers of men reporting this information, at baseline 39 men (out of a total of 67 who were asked) described vasectomy as a method of family planning or a means to prevent pregnancy, while at follow-up 97 (out of 127 men asked) did so. The change in responses among men who were aware of vasectomy both prior to and after the

campaign (a total of 61) was analyzed to attempt to isolate the impact of the campaign. At baseline, 34 of these men mentioned that vasectomy prevents pregnancy, while at follow-up, 46 of the men did so, a 35% increase.

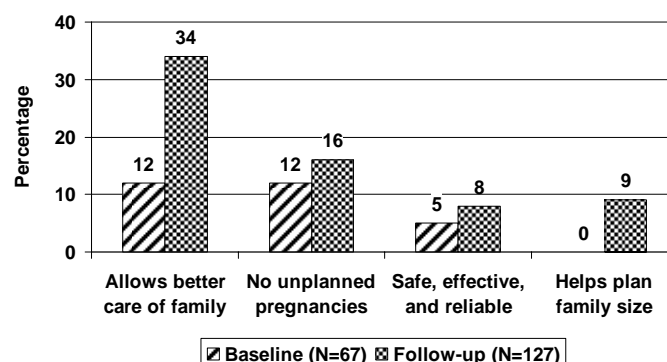
### **Changes in attitudes**

Changes in men's attitudes toward vasectomy were estimated using three measures: changes in the positive attributes men described about the method, changes in the negative attributes that men cited, and changes in their intention to consider the method for themselves. Here again, the men were asked only the open-ended questions "What are the advantages of vasectomy?" and "What are the disadvantages of vasectomy?" at both baseline and follow-up. Analysis examined how the responses had changed by follow-up.

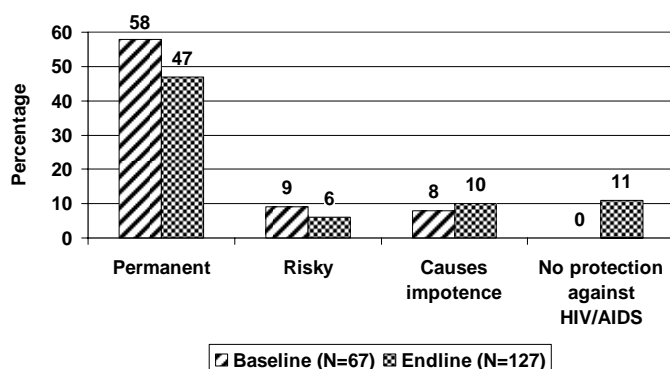
As shown in Figure 6, the significant improvement was a threefold increase in the proportion of men who spontaneously described vasectomy as "allowing a man to take better care of his family." The other attitudinal characteristics (that vasectomy eliminates unplanned pregnancies, that it is safe, effective, and reliable, and that it allows a man to plan his family size) improved less dramatically. The proportion of men who said vasectomy would allow them to enjoy intercourse without worry of pregnancy remained the same from baseline to follow-up (14%). Overall, men cited 10 different advantages of vasectomy at baseline and 14 at follow-up. New advantages included "helps to plan family size" (n=14), "helps to space children" (n=2), and "helps to assure a woman's health" (n=2). The percentage who cited no advantages for vasectomy fell by more than one-third, from 9% at baseline to 5.5% at follow-up.

In terms of disadvantages, two features cited were technically correct: that vasectomy is permanent (which is seen as a disadvantage is not allowing them to

**Figure 6. Percentage of Men Agreeing about Positive Aspects of Vasectomy, at Baseline and Follow-Up**



**Figure 7. Percentage of Men Agreeing about Potential Disadvantages of Vasectomy, at Baseline and Follow-Up**



have children in the future in case of separation, divorce, or death of their existing children) and that it does not protect against HIV/AIDS (Figure 7). In terms of myths and misinformation, at both baseline and follow-up, only a small proportion of the men (10% or fewer) stated that vasectomy causes impotence or that it is a risky procedure.

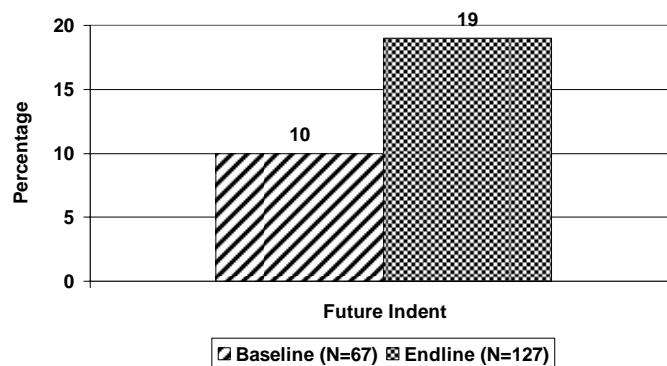
### **Number of men considering vasectomy**

The study also sought to evaluate the impact of the campaign on whether men would consider using vasectomy in the future. Among men who were aware of vasectomy, the proportion who said

they would consider vasectomy in the future nearly doubled from baseline to follow-up (Figure 8). Before the campaign, one in 10 men who were aware of vasectomy indicated that they would consider having the procedure in the future. Following the campaign, nearly one in five men who were aware of vasectomy said that they would consider a vasectomy in the future.

**The number of men reporting they would consider vasectomy in the future almost doubled.**

**Figure 8. Percentage of Men Who Would Consider Having a Vasectomy in the Future, at Baseline and Follow-Up**

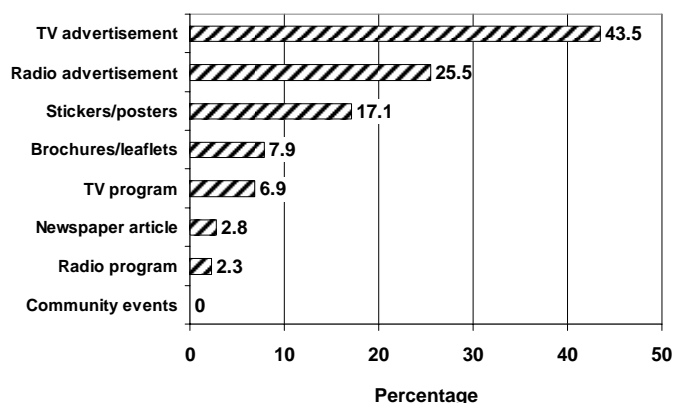


### **Campaign recall and relative effectiveness of components**

Among the 216 men interviewed in the follow-up survey, 56% reported having seen or heard one or more of the vasectomy campaign components. Of these, three out of five reported having been exposed to two or more campaign elements. As is seen in Figure 9 (page 18), the television advertisements had the highest recall (44%)—this is consistent with the strength of television in reaching an urban population. The radio advertisements had the second highest recall rate (26%), followed by bumper stickers and posters (17%). Recall in this case depended upon

**Television achieved the highest levels of campaign recall.**

**Figure 9. Percentage of Respondents Who Could Recall Selected Components of the Vasectomy Campaign (N=216)**



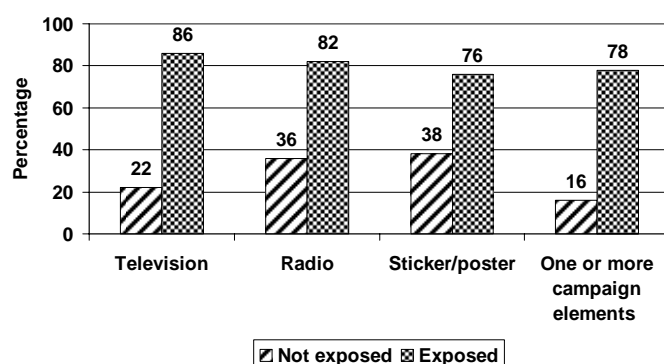
being able to tie the ad seen with the term vasectomy, as the questions asked about recall of advertising about “vasectomy.” Only those responses in which the ads were described accurately were retained as valid.

In general, the campaign was well-liked by respondents. Among men who recalled the television ads, 68% stated that they liked the campaign overall. The “local ad” had higher recall, although this may have been because the local ad was aired more frequently during the February-June campaign period.<sup>9</sup> In response to the question of whether respondents liked

or did not like the advertisement they saw, of those who spontaneously recalled the international ad, 84% (16 of 19) said that they liked it; of respondents who recalled the local ad, 65% (34 of 52) said they liked it.

The main reason given for not liking the TV and radio ads was that the ad did not provide enough information (47% and 67% for TV and radio, respectively); also, 23% noted that they did not like the TV ad because the campaign was targeted at too high of an income group.

**Figure 10. Percentage of Men Who Were Aware of Vasectomy, According to Whether They Recalled/Were Exposed to Selected Campaign Components (N=149)**



Men who said they had seen a television advertisement were asked to describe the ad. Among the characteristics of the campaign that they spontaneously recalled, 44% described people smiling and 36% described the ads as depicting happy people (responses not mutually exclusive). Of the other visual media, 49% of men who saw the poster described a man smiling or laughing, and 65% described this feature of the leaflet or brochure.

Other top features recalled about the television advertising included 26% saying that vasectomy enhanced the

quality of life, 32% recalling the phrase “Wo ye barima” (“You’re a real man”), 22% saying that the ads conveyed the idea that vasectomy does not affect virility or sexual performance, and 21%

<sup>9</sup> The campaign was launched with the local advertisement (43 confirmed spots) and was completed with only the international advertisement (35 confirmed spots). Documentation from the television stations was insufficient to tabulate the frequency of each ad in the intervening weeks (a total of 70 spots); however, instructions to the media buyers were to air the ads equally during this time.

reporting that vasectomy is a family planning method. All of these were key campaign messages. Findings from an analysis of the radio messages were similar.

Study results suggest that exposure to the different campaign elements indeed impacted this increased awareness. Awareness of vasectomy among those who reported having seen one or more campaign elements was 78%, as compared with 16% among those who did not report having seen any campaign component (Figure 10). Awareness among those who had seen the television advertising was 86%, compared with only 22% among those who did not recall seeing the television advertising. This suggests that the television campaign significantly increased awareness in those who remembered the advertising.

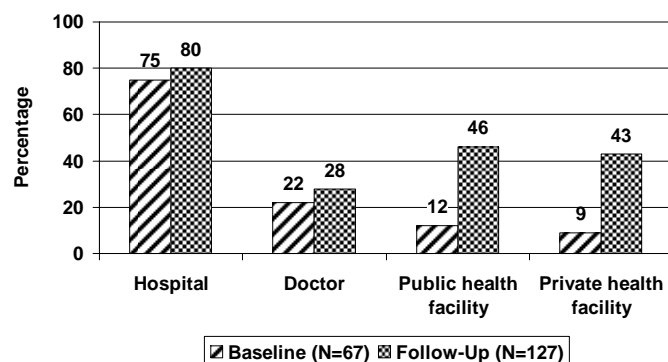
Awareness was also significantly higher among respondents who reported having seen or heard other elements of the campaign (e.g., radio ads, stickers, and posters) than among those who did not.

### ***Campaign effectiveness at providing information about vasectomy services***

The television advertisement, brochure, and flyer specifically mentioned service-delivery sites that offered vasectomy. Among those who reported exposure to the campaign, 63% (50 of 79) recalled, unprompted, the name of a facility that was advertised in the campaign materials. Results also indicate that following the campaign, more men were aware of the range of facilities where they could obtain services. While the proportion of men who knew that one could go to a hospital for vasectomy services was nearly equivalent from baseline to follow-up, the proportion of men who cited public and private facilities as a place to go increased fourfold, from approximately one in 10 men at baseline to nearly half at follow-up (Figure 11).

**Television succeeded in generating discussion on vasectomy with colleagues, friends, and partners.**

**Figure 11. Percentage of Men Who Knew of a Source of Vasectomy Services, Baseline and Follow-Up**

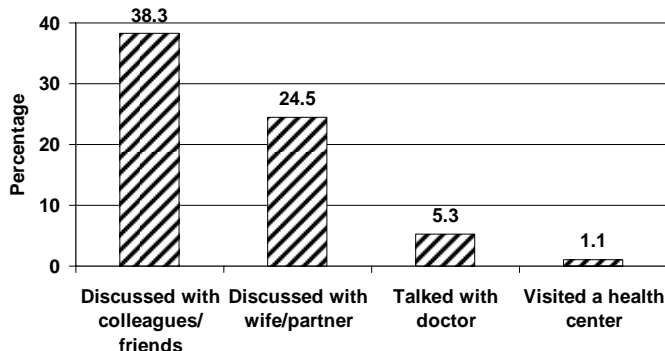


### ***Actions taken as a result of the communications campaign***

Overall, a high percentage of respondents who reported being exposed to different elements of the campaign were motivated to take action by discussing the method with their colleagues, friends, and partners. More than half of all respondents (54%) who reported seeing a television advertisement took at least one action related to vasectomy.



**Figure 12. Percentage of Men Who Reported Taking an Action as a Result of Exposure to TV Advertisement (N=94)**



As seen in Figure 12, 38% of the men discussed vasectomy with colleagues or friends, and 25% discussed the procedure with their wife or partner. Those men who recalled the television ads took the highest levels of action based on the campaign.

Anecdotal data from conversations with program managers, clinic nurses, and donors indicates that the campaign was successful in generating a “buzz” about vasectomy. The most common comment when asked whether anything has changed since the project began was “everyone is now talking about it.” One nurse said: “Before, people were afraid

to ask about it, but now, people have some idea what vasectomy is and want to know more about it.” One hotline attendant said: “People call and can’t pronounce the word, but they want to know more about it.”

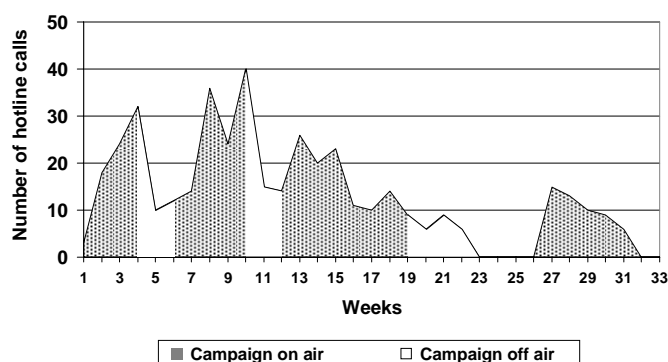
## Hotline Call Volume and Information Requests

A total of 425 calls were answered by attendants during the six months in which the hotline was in operation during the program period (including the periods February 28–July 13 and September 21–October 30). In fact, many more than 425 calls came in to the hotline; attendants reported that after advertisements ran on radio or television, anywhere from several to all 10 lines sometimes were flashing at once. However, because of technical limitations, only one call could be answered at a time; the others went into the prerecorded information line or were dropped.

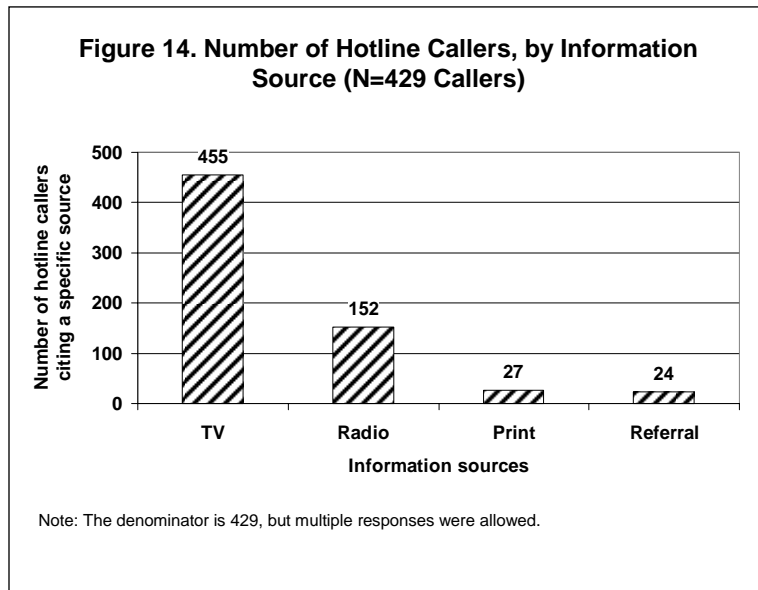
As is typical for hotline advertising, the volume of calls increased when the campaign was on the air and decreased during breaks in advertising and after the campaign finished (Figure 13).

As part of the survey that hotline attendants completed, callers were asked where they learned about the hotline. Multiple responses were allowed. Nearly all callers said that they learned about the hotline from television advertising. Two hundred callers (47.1%) cited Ghana Television (GTV) and 231 (54.5%) cited TV3. The two Accra-based radio stations were the sources next most often cited: Joy FM and Peace FM were mentioned 66 (15.4%) and 74 times (17.4%), respectively.

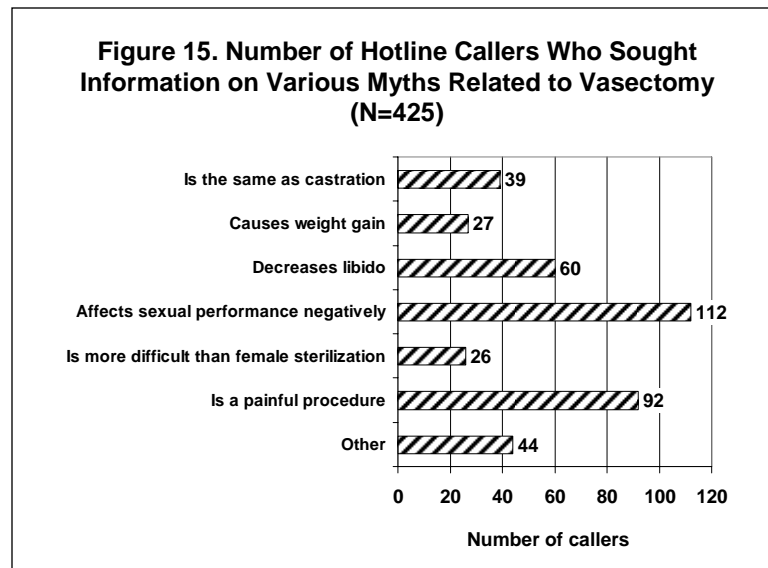
**Figure 13. Number of Hotline Calls Received per Week, Relative to Timing of TV and Radio Advertising**



Print and referrals were the source cited least often. Figure 14 shows the numbers of hotline callers citing the different campaign elements as their sources of information about the hotline. Hotline attendants recorded on a standardized checklist the questions and concerns that callers asked about. Eighty percent of callers (n=339) asked for basic information about vasectomy (e.g., what it is or what the procedure entails), and 69% asked for information about clinics where the service is provided or where they could speak with a provider. Forty-one percent of callers asked about side effects.



Information was also collected on specific myths that callers asked about. Figure 15 shows that the primary myths or misinformation that callers asked about were whether vasectomy affects sexual performance (26%), whether it is a painful procedure (21%), and whether it decreases libido (14%).



## Profiles of Vasectomy Acceptors, Hotline Callers, and Information Seekers

To determine who was responding to the project, data were collected on the men (and women) who sought vasectomy services and/or information at project sites and the project hotline.

## Vasectomy Acceptors

Data on the 81 vasectomy acceptors in 2004 yielded the following profile:

### ***Profiles of 81 NSV users***

Average age of clients: 43.7 years

Age range: 26–65 years

Number of living children: 2 to 7 (average, 4)

Reason for wanting no more children: Majority had desired number of children

#### *Source of information*

TV advertisements: 90%

Radio advertisements: 8%

Health care worker: 2%

#### *Decision making process*

Made decision themselves: 80%

Made decision with spouse: 20%

Average length of time to decide: 1 month

## Hotline Callers

Callers to the hotline were asked for information on their demographic characteristics. They ranged in age from 16 to 78, with the majority being between ages 35 and 44. The majority of callers who answered the question about their number of children (n=403) reported having between two and four children (63%), with responses ranging from none to nine children. Only 296 of the 425 callers answered the question about their occupation; of those, the majority were professionals (businessmen, bankers, civil servants, etc.).

Regarding current family planning method used, 43 of the 425 callers did not respond and 143 (34%) reported using no method of family planning. Of those who said they were currently using a method, the condom was the most prevalent (31.3%), followed by the pill (10%) and injectables (6%).<sup>10</sup>

### ***Information requests on vasectomy***

Data are available on 55 men and women who sought information on vasectomy (through telephone or in person) from the clinics participating in the pilot. The majority of these clients were male (86%). (Three women came to the clinic to ask questions on their husbands' behalf.) More than half of the clients reported that they had heard about vasectomy through a television advertisement (52%).

Just over one-third (38%) of the information seekers were not using a method of family planning; 15% were using injectables and 9% condoms.

One-third (35%) of the information seekers asked about the side effects of vasectomy—specifically whether vasectomy decreases libido (58%), is the same as castration (53%), negatively affects sexual performance (49%), or is a painful procedure (47%). Among interviewees who were asked why they decided to seek information about vasectomy at that time, most responded that they did not want any more children (32%), that they wanted more information (28%), or that they had decided to have the procedure done (18%).

<sup>10</sup> Note that in some cases, men reported using more than one method; only the first method that they mentioned is included in these data.

# Discussion and Lessons Learned

The results of the “Get a Permanent Smile” campaign demonstrate that NSV is a viable contraceptive choice for Ghanaian men when a targeted media campaign is coupled with interventions to provide quality client-centered vasectomy services. It further demonstrates that family planning services that traditionally serve women can provide quality care to vasectomy clients, and it verifies that men are interested in learning more about vasectomy. Some specific findings and lessons learned are discussed below, by project component.

## Factors for Success at the Site Level

Rates of vasectomy provision varied significantly across the individual sites. Ninety percent of vasectomy procedures were provided at three sites. At one site, no procedures were performed. The two sites that were most active before the initiative accounted for the greatest increase after the project was launched; these two sites (both in Accra) provided 42% and 30% of vasectomies, respectively.

The sites with the highest caseloads shared three characteristics:

- ◆ A champion—The highest-performing sites all had an NSV provider or counselor or nurse who talked about vasectomy in the media and/or at the community level.
- ◆ A team effort—As important as a “champion” is, without a supporting cast that includes nursing staff and gatekeepers, clients may still have difficulty in accessing services.
- ◆ Active community outreach/mobilization—Although very few vasectomy acceptors cited community outreach or health workers as their source of information, it is striking that the two highest-performing sites had the most active outreach and community mobilization activities.

The site that provided the majority of services, and that also saw the largest increase during the project year (a fivefold increase, from seven procedures to 35) was a public-sector site in Accra that had an especially enthusiastic and motivated provider and nursing staff. The doctor was invited onto radio and television talk shows as a vasectomy expert throughout the project. He made himself especially available; his staff would call his mobile phone when vasectomy clients arrived so that services could be arranged as soon as possible and at the client’s convenience. Staff wore T-shirts that read “Get a Permanent Smile” and displayed the bumper sticker on their purses and bags. The nursing staff at this site had one of the most active community outreach programs.

## The Whole-Site Training Approach

Programs initiating vasectomy services often conduct short-term centralized surgical training, usually for doctors only. The trainees then frequently face serious obstacles when trying to introduce the technology at their home sites, because they somehow need to change the knowledge, attitudes, and behavior of their fellow workers. As an alternative to this approach, the Ghana Vasectomy Initiative used a whole-site training approach that focused on changing attitudes, not just on imparting information. The goal was not only to transfer knowledge and develop critical skills, but also to forge an effective, smoothly functioning service-delivery system and promote effective local teamwork within the family planning unit.

The interventions were successful in improving staff knowledge of vasectomy, as well as in creating a positive or impartial attitude toward the method. In none of the mystery-client interactions did staff try to persuade the client either to have or not to have a vasectomy. In all instances, the mystery clients were told that the procedure is permanent and that they should discuss it with their spouse. The vasectomy clients appeared to be treated no differently than any other family planning clients, and the waits encountered by the mystery clients were typical of what any family planning client experiences.

While providers' comfort in talking with men is laudable, one of the mystery clients noted that staff take things very casually: "I felt that because vasectomy is not an ordinary thing that is done normally, one would have thought that they would have made me a lot more comfortable than ... they did." The weaknesses in the quality of services the mystery clients identified are not unique to the provision of vasectomy services. Male clients basically want the same quality of services as female clients—short waiting times, confidentiality and privacy, and knowledgeable and attentive staff.

Maintaining quality client-centered services is an ongoing process. Observations from the mystery clients were shared with staff at the six sites. EngenderHealth staff met with the staff at the service-delivery sites to discuss the results and to help streamline some of the problem areas. These included providing privacy by using screens, supplying additional IEC materials, and providing more on-the-job training in counseling and interpersonal communication skills.

## **Role of the Communications Campaign**

The vasectomy communications campaign achieved high levels of recall and was well-received by the target audience. The campaign was successful in increasing awareness, as well as in increasing knowledge of key characteristics of vasectomy, indicating that more men now know that vasectomy is a family planning method for men and that it prevents pregnancy. The campaign also influenced attitudes toward vasectomy, increasing positive attitudes and improving awareness of key advantages (although these changes occurred to a lesser degree, as measured by the panel study). More than 50% of respondents who recalled some component of the campaign were motivated to take action by discussing the method with their colleagues, friends, and partners. Men reported increased intent to use vasectomy in the future, and the campaign motivated men to discuss vasectomy with their colleagues, friends, and partners. Last, the campaign has served as a catalyst for men considering vasectomy to take that final step and access services.

## **Implications for Future Communications Investments**

*Myths and rumors must continue to be addressed.* The panel study found only a small proportion of men (fewer than one in 10) stated that vasectomy causes impotence or is a risky procedure, each of which formative research had indicated as a key fear surrounding the method. However, data collected on the questions that men asked of service providers and hotline attendants showed that these were the most frequently mentioned concerns expressed in their questions. This suggests that these issues remain important concerns for men and may factor into their decision making when choosing a method and therefore must be addressed in both communications campaigns and in counseling.

*Many men perceive vasectomy's permanence to be a disadvantage.* That nearly half (47%) of the men in the panel study with knowledge of vasectomy said that vasectomy's permanence is a disadvantage was an unexpected finding. This finding led the project team to hypothesize that men with this perception were probably younger or had not yet completed their family size. However,

further investigation found that men who perceived permanence as a disadvantage did not differ in age or number of children from men who did not mention it as a disadvantage, suggesting that psychographic features, rather than age and parity, likely affect how men perceive the permanence of vasectomy.

This result was also surprising given the prominence of the concept of permanence in the campaign slogan: “Vasectomy...Give yourself a permanent smile.” The concept of “smiling” and happiness was one of the most salient campaign features, as indicated by panel study participants’ recall. However, the concept of permanence was not mentioned by study participants (or respondents) as a campaign feature. Future campaign adaptations may want to explore this concept further in research to assess its role in vasectomy decision making, how it can best be addressed in communications messages.

*Television is an important medium for reaching men.* The results of the campaign support the well-established importance of television in reaching urban audiences. Men who recalled the television spots demonstrated the highest changes in awareness, knowledge, and attitudes toward vasectomy, as well as follow-up action taken (as measured by the panel study). Further, television was cited significantly more than other sources by men who sought information via the hotline and by men who sought vasectomy services at the project sites.

*A telephone hotline is helpful as an additional, anonymous source of information about vasectomy where men can get further information and services.* A hotline increases access to information about vasectomy. It provides an easier “interim” action step that interested men (and women) can take, enabling them to call in and ask questions privately and conveniently, without having to go to a clinic. Our data show that in many cases the hotline served to clarify doubts and bridged the stages of moving the client from getting information to actually getting the service. Advertising the hotline number also facilitated client referrals to service sites. Further periods of hotline availability need to be supported with advertising and need to operate for a longer periods in order to have sustained impact over time.

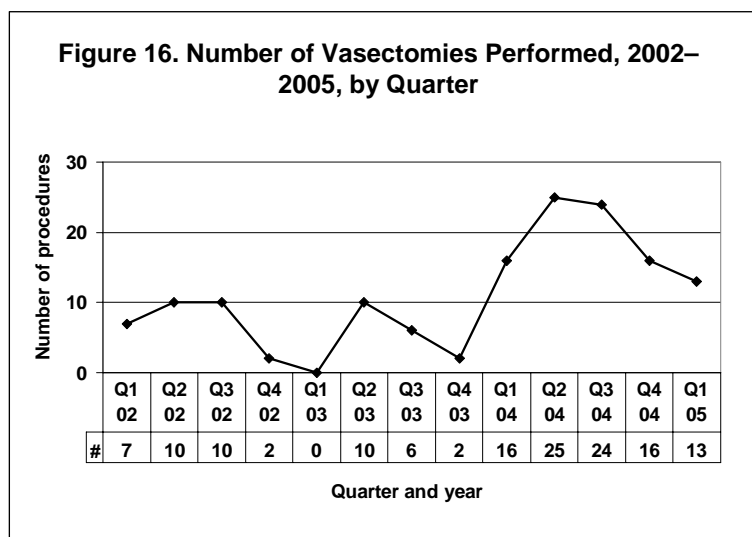
## Coordinating the Timing of Project Components

The media and community outreach activities were launched more than a year after the training had been conducted, necessitating “refresher” training of staff at project sites at the start of the project. Providers’ comfort level with performing the procedure may also have declined during this period. Ideally, the demand campaign should have been launched shortly after training was completed, allowing enough time to verify the quality of services but not so much time that technical competence or enthusiasm diminishes.

**“Vasectomy is as much an IEC operation as a surgical operation.”**

## Where Are We Now?

In terms of achieving longer-term impact, there is evidence that more potential demand for vasectomy is being captured since the campaign’s conclusion. Data available from the first quarter of 2005 indicate that demand for vasectomy is higher than baseline levels prior to the campaign. Thirteen vasectomies were performed at program sites in the first quarter of the year, compared with none and seven during the same quarter of 2003 and 2002, respectively (Figure 16, page 26). However, if this positive momentum is to be sustained, follow-up activity on both the supply and demand side should be undertaken.



The EngenderHealth office in Ghana reports that although no attendants currently man the hotline, men continue to call for information (albeit less frequently than during the campaign).

Clinic staff and the hotline attendants have recommended several ideas for expanding the reach of the campaign and for utilizing the materials produced. The main ideas included distributing the documentary to clinics to show on video monitors in clinic waiting

rooms, holding road shows (taking the “minilaunches” on the road) through which community outreach nurses and satisfied clients can address people living in communities in other parts of the clinic catchment areas, and providing physicians with a Powerpoint slide show on the program that they can use to inform their colleagues at professional medical meetings.

## Recommended Next Steps

### Site-Level Support

- ◆ Continue periodic whole-site training, to combat misconceptions about vasectomy and keep the entire staff’s knowledge base concerning vasectomy up to date.
- ◆ Expand referral systems and possibilities for inreach among men and women in other health care services, referring interested clients to sites where services are offered.
- ◆ As mystery clients were instrumental to identifying the level of service being provided at the site level, periodically utilize mystery clients to assess the quality of both clinical services and counseling services and review the results with providers to identify any problem areas on which they need to focus their attention.
- ◆ Champions have proven to be a key component in promoting vasectomy services at the site level. Each site needs to identify champions who will promote sustained effort and energy to the vasectomy initiative. However, as important as a champion is, without a supporting cast that includes nursing staff and gatekeepers, clients may still have difficulty in accessing services.
- ◆ Efforts to expand vasectomy services should focus on a small number of skilled providers and support expansion through those providers who perform well. While having an NSV provider on staff is ideal, three of the participating sites relied on doctors who were on call to provide services.
- ◆ Scale up services offered at the sites to include other men’s health services and consider devoting specific days or times of day to services for men.
- ◆ Train male community outreach workers to address men’s concerns. (Most project staff were women, and research has shown that men prefer to speak with male providers about men’s issues.)

## **Demand and Client Communications**

- ◆ Concentrating the media campaign into short, concentrated time periods has proven effective and should be repeated at least twice a year to continue to improve awareness, knowledge and use and catalyze men considering vasectomy to take that final step and seek services. The media timing should be coordinated with the project's interpersonal components, including mobilizing site staff for community outreach and reinstating the hotline.
- ◆ Run a hotline during and for at least three months after the campaign bursts, to serve as an intermediate action that interested men can take to get further information.
- ◆ Mass media constitutes an effective channel for creating awareness and providing information about vasectomy. Analysis of the type of information sought by callers to the vasectomy hotline and by men visiting sites for additional information indicated that opportunities for men to seek answers to their personal questions about the method are an important factor in the decision-making process. Thus, the program's interpersonal communications channels (hotline, counseling opportunities, community outreach) should also be maintained and timed to be available in conjunction with the media campaign bursts.
- ◆ Conduct a follow-up workshop with participating clinic staff to pool their ideas and add them to a scaled-up project.





# Conclusions

This project demonstrates that with a relatively small investment and a six-month intervention period of time, a strategically designed program that addresses both supply and demand barriers to vasectomy can have significant impact. Viable, quality vasectomy services are now available in Ghana's two largest metropolitan areas. More men have become interested in the method and know where to seek further information and services. Providers' attitudes have also been improved; doctors and nurses themselves conduct outreach to potential clients. And most importantly, services increased to a meaningful degree for the first time in 10 years.

Service statistics data from the first quarter of 2005 show that while the number of vasectomies performed has declined since the campaign concluded, rates remain higher than they were prior to the start of the campaign. The Ghana Health Service and the ACQUIRE Project will continue to monitor trends in services. However, as studies of projects in other countries have concluded, if this positive momentum is to be sustained, follow-up activities on both the supply and demand side should be undertaken.

Based on the lessons learned from this project, we recommend that the Ghana Health Service and other donors consider how to sustain this momentum, and in particular, to derive continued benefit from the investment in the design of training curricula and promotional materials that has been made by USAID and the project managers in the project reported here.

Ultimately, a need for greater access to long-term and permanent methods remains strong in Ghana. One in four married women in Ghana say they do not want any more children, yet less than half of their need to limit future births is being met. This translates to more than 350,000 couples with an unmet need for family planning services. Vasectomy is simpler, safer, and less expensive than female sterilization and can be performed in more types of medical facilities. Continuation of this project has the capacity to increase the share of reliable contraception that vasectomy can provide in Ghana, resulting in a potentially more balanced method mix and with families using reliable contraception that better meets their needs.



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## Appendixes

1. Training Overview .....	35
2. Clinic Intake Form .....	37
3. Summary of Campaign Components, Television Advertisement Photo Boards, and Radio Advertisement Scripts .....	39
4. Media Flow Chart .....	49
5. Hotline Questionnaire .....	51



# Appendix I

## Training Overview

The no-scalpel vasectomy (NSV) training for this project was conducted at Maulana Azad Medical College in New Delhi, India. India was selected as the training site so that trainees would have a sufficient caseload to ensure they could develop competence in the procedure. Training lasted five days and included didactic and practicum sessions. The didactic training covered an overview of vasectomy, anatomy and physiology, counseling and informed consent for NSV, prevasectomy evaluation of the client, infection prevention, a slide presentation of the NSV technique, postvasectomy care, and management of complications. The EngenderHealth publications *No-Scalpel Vasectomy: An Illustrated Guide for Surgeons* and *No-Scalpel Vasectomy: A Training Course for Vasectomy Providers and Assistants* were used as training resources. Before moving on to the supervised clinical and surgical practicum, the trainees practiced on a scrotal model. In the practicum, trainees first observed one or two procedures, assisted in one or two procedures, and then performed on their own. All trainees performed a minimum of 15 procedures.





## Appendix 2

### Clinic Intake Form

**Ghana Vasectomy Promotion Initiative  
NSV Client Profile  
Clinic Questionnaire for Information Seekers**

Questionnaire ID# \_\_\_\_\_

**Instructions:** Please complete this form for each person who either calls or walks in to ask about the vasectomy services in your hospital; **kindly complete this form regardless of whether or not vasectomy was actually performed on the person inquiring.** Results of this checklist will help determine the next steps of the program. You may use the back of the form if more space is needed. Thank you.

1. Date: \_\_\_\_\_  
(dd/mo/yr)

2. Time: \_\_\_\_\_ AM/PM

3. Name of provider: \_\_\_\_\_

4. Sex of information seeker (check one):

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

5. Information sought by clients (check all that apply)

Basic information about vasectomy (NSV) (example: length of procedure, sex of vasectomy surgeon, is the procedure painful, etc.)	<input type="checkbox"/>
Clinics that provide vasectomy service	<input type="checkbox"/>
Side effects of vasectomy	<input type="checkbox"/>
Myths about vasectomy	<input type="checkbox"/>
• It is the same as castration.	<input type="checkbox"/>
• The procedure causes a man to gain weight.	<input type="checkbox"/>
• It decreases sex drive/libido.	<input type="checkbox"/>
• It affects sexual performance negatively.	<input type="checkbox"/>
• It is a more difficult procedure than female sterilization.	<input type="checkbox"/>
• It is a painful procedure.	<input type="checkbox"/>
• Other myths (list: _____)	<input type="checkbox"/>
STIs/HIV	<input type="checkbox"/>
Other (list: _____)	<input type="checkbox"/>

## 6. Additional information

**Ask:** “Would you mind if I took a minute of your time to ask you a few questions about yourself?”

What area do you live in?	
How old are you?	
Do you have children? (circle one y/n)	YES NO
If yes, indicate number of children	

## 7. Are you currently using family planning (check one):

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which method (e.g., Norplant, condoms, abstinence etc.)?

## 8. Feedback on vasectomy

a. When was the first time you heard about vasectomy?

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b. How did you first hear about this clinic (check ALL that apply)?

- Newspaper (write newspaper) \_\_\_\_\_
- Radio (write radio station) \_\_\_\_\_
- Television (write television station) \_\_\_\_\_
- Other (referral from facility, friend, family member, provider, community outreach) \_\_\_\_\_

c. What has made you decide to seek more information now?

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**Notes:**

## Appendix 3

### Summary of Campaign Components, Television Advertisement Photo Boards, and Radio Advertisement Scripts

#### Summary of Campaign Components

##### **Television**

The lead medium for the campaign was television. The “Permanent Smile” campaign included two different television advertisements, both tied to the campaign concept. One television advertisement, named the “International Ad,” positioned vasectomy as a method that is widely accepted internationally—as such, it features a mix of smiling men of different ages and races from around the world, together with their spouses and children. The other television advertisement, referred to in this report as the “Local Ad,” focused on the Ghanaian context, showing the benefits of choosing vasectomy. This ad featured a successful Ghanaian man and his wife in their everyday life. In addition to the slogan “Vasectomy...Give yourself a permanent smile,” the ad featured a phrase in the local language “Wo ye berima,” a congratulatory phrase that means, “You are a real man...” Both television advertisements concluded with the telephone hotline number, as well as with the names of project clinics. (See pages 43–47 in this appendix for photoboards of these advertisements.)

##### **Radio**

The “Permanent Smile” campaign also consisted of two different radio advertisements. Both radio spots featured vasectomy users who were satisfied with their family life and enjoying the freedom and security provided by their decision to have a vasectomy. The radio spots encouraged men to call the vasectomy hotline for more information. The radio spots were aired in English and two local dialects from March to June 2004. (See pages 49–50 in this appendix for scripts of these advertisements.)

##### **Poster and IEC Print Materials**

The “Permanent Smile” poster featured the same vasectomy user from the “local” television advertisement, in which he commented on how quick and simple the vasectomy procedure was. The poster encouraged men to call the vasectomy hotline.

The campaign also included a variety of other IEC materials that were designed to provide more detailed information about the advantages and disadvantages of vasectomy. These included a Q&A brochure, a flyer, and bumper stickers (known as “car stickers” in Ghana). These materials (not including the stickers) also encouraged men to speak with a service provider or to call the hotline to get more information about vasectomy.

Within clinics, posters were displayed in clinic entrance areas and in the waiting areas of various service-delivery units, including family planning counseling services. In some areas, posters were also hung in local pharmacies, chemist shops, private clinics, maternity homes, barbershops, and truck stops.

##### **Documentary**

The campaign also included a 14-minute documentary that aired once on Ghanaian television during prime time. The documentary featured several doctors explaining the vasectomy technique, as well as several different vasectomy acceptors talking about their experiences. The documentary openly discussed

the fears and concerns that these men had about vasectomy and how positive their real-life experiences with the method were .



### **Site “Branding”**

To increase awareness of the availability of vasectomy services at participating facilities, a large plastic sign was mounted outside each of the sites. The signs used the vasectomy logo and colors of the other campaign materials. Due to delays in production and logistics, the signs were added at the facilities during the seventh week of the campaign.

### **Public Relations**

The campaign, launched with a press conference on February 26, 2004, featured high-profile speakers from the Ghana health community and a satisfied client from each project region—including the man featured in the campaign—who spoke about his choice of vasectomy as a family planning method. The initial press launch and launch of the media campaign generated interest in the media and led to additional radio and TV talk-show appearances, including interviews with project medical providers, “man on the street” surveys by television stations, and television and radio call-in programs. This publicity continued intermittently throughout the campaign.



Vasectomy client (and man featured in TV spot and all IEC materials) speaking at project launch, Feb. 26, 2004

## Television Advertisement Photo Boards

Local ad, 45 seconds—page 43

International ad, 45 seconds (clinics' names scrolling)—page 45

International ad, 60 seconds (clinics' names in separate frames)—page 47





# Vasectomy "Get a Permanent Smile" Campaign

Ghana/Local Version :45



KWAME VO: Many people wonder



why I smile.



I smile for a very personal reason.



My decision to have a Vasectomy.



FRIEND: Kwame wo ye.



Wo ye berimah.



KWAME VO: The right family planning choices



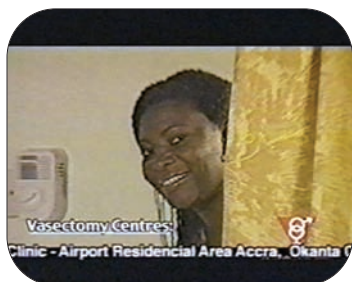
gives you the ability



to focus on your career...



DAUGHTER: Hey dad.



KWAME VO: ...and the family



you already have.



WIFE: Wo ye berimah.



MVO: Vasectomy is a viable family planning choice for men.



MVO2: Give yourself a permanent smile. Vasectomy: wo ye berimah!





# Vasectomy "Get a Permanent Smile" Campaign

International Version :45



MVO: Why is this man smiling?



For the same reasons over 42 million other men are.



Thanks to a simple procedure,



a vasectomy, he's chosen



not to have more children



and to do more for a family he already has.



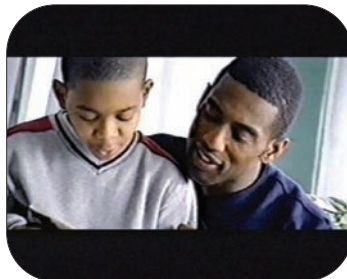
A vasectomy



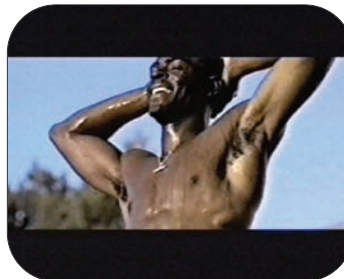
takes 20 minutes or less.



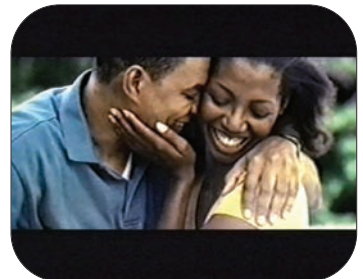
Minutes that



give a man



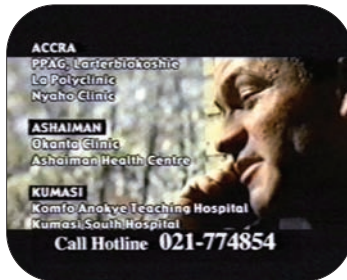
an important asset.



The power of



a permanent smile.



For more information, call the Vasectomy Hotline



or visit these centers



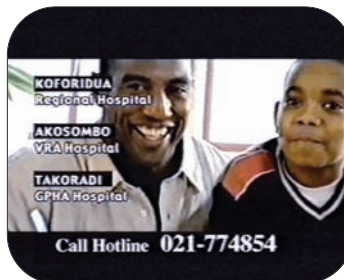
and join the brotherhood of men



whose smiles



go on and on.



Vasectomy.



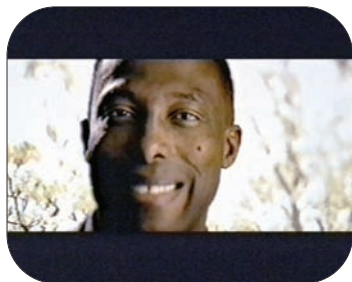
Give Yourself a Permanent Smile.



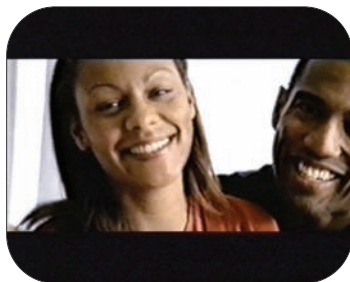


# Vasectomy "Get a Permanent Smile" Campaign

International Version :60



MVO: Why is this man smiling?



For the same reasons over 42 million other men are.



Thanks to a simple procedure,



a vasectomy, he's chosen



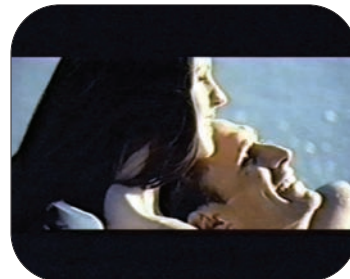
not to have more children



and to do more for a family he already has.



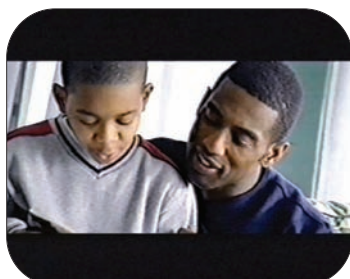
A vasectomy



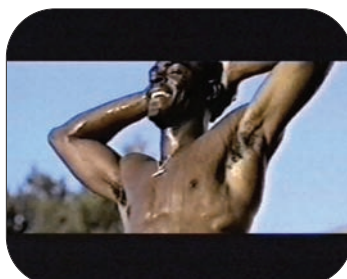
takes 20 minutes or less.



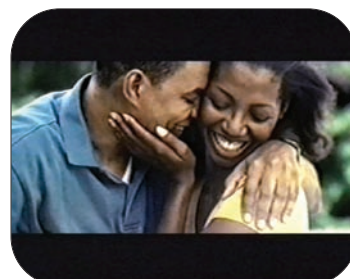
Minutes that



give a man



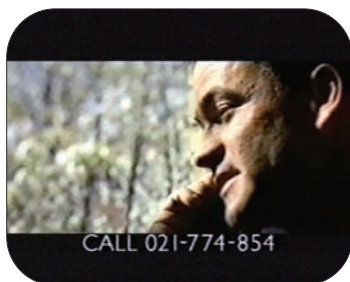
an important asset.



The power of



a permanent smile.



CALL 021-774-854

Call 021-774-854 for the facts.



CALL 021-774-854

Then join the brotherhood of men



CALL 021-774-854

whose smiles



CALL 021-774-854

go on and on.



Vasectomy. Give Yourself a Permanent Smile.



Vasectomy services and information are available at the following clinics and hospitals in Accra,



Ashaiman, Kumasi, Koforidua, Akosombo and Takoradi.



## Radio Advertisement Scripts

# Lintas Ghana

**Client:** EngenderHealth

**Campaign:** Vasectomy

**Medium:** Radio

**Time:** 45 seconds

**Title:** Love Note

**Preamble:** Man tells friend about a funny love note his wife planted in his pocket.

MVO1	(amused) Kojo. I say, my wife made me laugh this morning. Look what she put in my pocket.
MVO2	(loud laughter) I can't believe this... (laughs) Ehheh? Ei she loves you paa oh! ... (laughter) She still writes you love notes.
MVO1	'Cos I make her happy.
SFX	(laughter)
MVO2	Kwame. It is great how your marriage is blossoming after 13 years.
SFX	(laughter)
VO	<b>Why is this man smiling? [pause] Like many men, he's discovered vasectomy as the family planning choice that's best for him...Because it gives him the freedom to focus on success and the family he already has. Your life is always your choice...Give yourself a permanent smile.</b>
VO2	<b>For further information on vasectomy, call 021-77 48 54. Vasectomy...wo ye berima.</b>

# Lintas Ghana

**Client: EngenderHealth**

**Campaign: Vasectomy**

**Medium: Radio**

**Time: 45 seconds**

**Title: Answering Machine**

**Preamble:** Man listens to his answering machine on which we hear the voices of his daughter, friend and wife.

MVOI	OK...let's see what's on the answering machine...
SFX	Taps Answering Machine
Female Tel sfx	Hi Dad. It's Agna. Now don't forget my graduation is 2pm this Saturday. Can't wait to see you. Byeeeeeeee.
MVOI	<i>(chuckles)</i> OK bye.
Male Tel sfx	Hi Kwame! This is Kweku. I heard about your promotion...congrats congrats. Let's celebrate after tennis tomorrow.
MVOI	<i>(chuckles)</i>
Female2 Tel sfx	Kwams, come home early tonight please...I want to show you something.
MVOI	<i>(laughs)</i> Okay Darling, I'm on my way... <i>(chuckles)</i>
<b>MVOI</b>	<b>Why is this man smiling? [pause] Like many men, he's discovered vasectomy as the family planning choice that's best for him...Because it gives him the freedom to focus on success and the family he already has. Your life is always your choice...Give yourself a permanent smile.</b>
<b>MVO2</b>	<b>For further information on vasectomy, call 021-77 48 54. Vasectomy...wo ye berima.</b>

## Media Flow Chart

### Communications Chart

	February				March				April				May				June				Total Spots	September				October				Total Spots	Grand Total		
Week commencing	2	9	16	23	1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21	28	(Feb–Aug)	6	13	20	27	4	11	18	25	(Sep–Oct)	Spots
Television																																	
TV3	0	0	0	0	6	4	10	5	1	4	6	6	6	0	0	6	7	7	4	4	11	0	87	0	6	6	4	3	3	0	22	109	
GTV	0	0	0	0	4	9	3	0	0	0	0	9	9	0	0	7	3	1	0	6	10	0	61		9	7	6	6	3	0	31	92	
Metro TV	0	0	0	0	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12									12	
Total Spots Weekly	0	0	0	0	14	17	17	5	1	4	6	15	15	0	0	13	10	8	4	10	21	0	160	0	15	13	10	9	6	0		213	
Radio																																	
Peace FM	0	0	0	0	11	11	11	0	0	4	6	6	6	0		7	6	2	5	0	0	0	75									75	
Fox FM	0	0	0	0	11	11	11	0	0	4	7	7	8	6	2	0	0	4	6	0	0	0	77									77	
Joy FM	0	0	0	4	11	11	11	0	0	4	6	7	8	0	0	5	8	7	6	0	0	0	88					3	6		9	97	
Luv FM	0	0	0	0	10	10	11	2	0	4	6	6	5	0	0	5	5	3	6	0	0	0	73									73	
Total Spots Weekly	0	0	0	4	43	43	44	2	0	16	25	26	27	6	2	17	19	16	23	0	0	0	313								9	322	
Documentary																																	
GTV															5/19								1										
Print materials																						Total Pieces											
Posters	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	5,000											
Simple Facts	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	20,000											
Car stickers	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	2,000											
Q&A booklet	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	20,200											
Site branding (outside signage)	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	>	6											
Public Relations																																	
Press articles, radio/TV discussions, documentary, etc.					>	>	>	>	>		>				>																		
Briefing session for media				X																													





## Hotline Questionnaire

### Ghana Vasectomy Promotion Initiative Hotline Information Seekers

**Instructions:** Please complete this form for each person who calls to ask about the vasectomy services.

**1. Date:** \_\_\_\_\_  
(dd/mo/yr)

**2. Time:** \_\_\_\_\_ AM/PM

**3. Name of Attendant:** \_\_\_\_\_

**4. Sex of Information Seeker (check one):**

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

**5. Information sought by clients (check all that apply)**

Basic information about vasectomy (NSV) (Example: length of procedure, sex of vasectomy surgeon, is the procedure painful, etc.)	<input type="checkbox"/>
Clinics that provide vasectomy service	<input type="checkbox"/>
Side effects of vasectomy	<input type="checkbox"/>
Myths about vasectomy	<input type="checkbox"/>
• It is the same as castration.	<input type="checkbox"/>
• The procedure causes a man to gain weight.	<input type="checkbox"/>
• It decreases sex drive/libido.	<input type="checkbox"/>
• It affects sexual performance negatively.	<input type="checkbox"/>
• It is a more difficult procedure than female sterilization.	<input type="checkbox"/>
• It is a painful procedure.	<input type="checkbox"/>
• Other myths (list: _____)	<input type="checkbox"/>
STI/HIV	<input type="checkbox"/>
Other (list: _____)	<input type="checkbox"/>

**Ask: “Would you mind if I took a minute of your time to ask you a few questions about yourself?”**

**Additional Information**

**6. Source of information: “Where did they hear about the hotline?”**

(Please mark first response they give with a “1.” Then probe: “Did you hear about us from anywhere else?” and check “√” all their responses.)

Print Material		Radio		TV		Other	
Brochure/leaflet		Joy FM		GTV		Referral from facility	
Poster		Peace FM		TV3		Friend	
Newspaper article		Fox FM		Metro		Family member	
Other _____		LUV FM				Provider	
Other print (describe)		Other radio		Other TV		Community outreach (describe)	

**7. What method of family planning are you or your partner currently using? (Check one)**

None		Injectables	
Condoms		Implants	
Pills		Female sterilization	
IUD		Withdrawal	
Periodic Abstinence		Other	

**8. How old are you?** \_\_\_\_\_

**9. How many children do you have?** \_\_\_\_\_

**10. What is your occupation?** \_\_\_\_\_

**Notes:**