

**VOLUNTARY VASECTOMY:
RETHINKING *PAGKALALAKI*
AMONG
MARRIED CEBUANO**

June 2005

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This is to acknowledge the support provided by the
**Academy for Educational Development (AED) and the
United States Agency for International Development (USAID)**



CHAPTER I

INTRODUCTION

RATIONALE

In Central Visayas, the City of Cebu is the hub in terms of political and economic activities. Several pull factors draw people to it, such as employment opportunities, institutions of higher education, hospitals, and a relatively peaceful environment. People choose to live in Cebu to better their lives. According to a National Statistics Office report (July 2001), the population growth rate of Metro Cebu almost doubled from 1.87 percent in 1995 to 3.02 in 2000. The Cebu City Health Department reported in 2001 that the city population increased from 718,821 in 2000 to 731,544 in 2001. Its Total Fertility Rate in 2001 was 1.7. Because of its attractiveness to many, its population growth is already placing a strain on its limited resources such the delivery of basic social services.

Family Planning is an option that the Philippine government is looking at to curb current and future problems related to population growth. Its approaches are still essentially traditional such as heavily targeting women and placing the responsibility for the number and spacing of children on them. Men's responsibilities in this regard are left unattended. This is despite the Programme of Action of the United Nations International Conference on Population and Development in Cairo (1994), which highlighted the increased participation and sharing of responsibility of men in the actual practice of family planning.

Among the top family planning methods that the Cebu City Health Department reported in 2001, vasectomy was not on the list. Condom use was the third most common method. The top two are pills and DMPA both of which are for women. Vasectomy remains unpopular because in a male-dominant, "macho" society, men are not supposed to take an active part in fertility regulation. Women have always been perceived as responsible for family health in general and fertility regulation in particular. This has become a "domain" of women where men play passive roles. The lack of male involvement with contraception is due to the fact that it is considered "a woman's affair" (Diaz and Diaz, 1999: 229 in Manhoso and Hoga, 2005: 102). Moreover, vasectomy is highly disliked because of misconceptions that surround it, wherein vasectomy is confused with castration, it is said that it decreases sexual abilities, and that it leads to loss of vitality or changes in a man's physical characteristics such as hair loss and change of voice, and even to changes in his personality (Atkins and Jezowski, 1983: 91).

There are now efforts from both government and non-government agencies that seriously include men in their family planning programs and one such effort is to promote vasectomy as a contraceptive method. There is a sense that men are now beginning to open themselves up and accept vasectomy as an option. However, the materials are limited that specifically explain the reasons for the choices that some men are now making and that reveal whether and how these decisions may have created a difference to the people that are involved,

such as the family, health care personnel and the community. It is the intent of this study to present the contextual circumstances and the impact of the choices that some men are now making on *pagkalalaki* (Ceb. "maleness"), a cultural concept.

REVIEW OF RELATED LITERATURE: MASCULINITY IN CULTURE AND SOCIETY

Understanding Masculinity and Male Dominance

Most societies value men over women and there are three theoretical explanations for this stratification suggested by Nielsen (1990:197-225). First, the *functionalist theory* suggests that it is necessary for the survival of society. Marvin Harris's anthropological studies on male dominance in horticultural societies suggest that males are valued because they are important during warfare in order to expand territories to increase productivity. In such societies, females have value only in that sex with women is a reward for male bravery in war.

In modern societies, the sexual power of men over women can also be extended to the analysis of the sexual division of labor, sexual politics in workplaces, and the interplay of gender relations with class dynamics (Carrigan, Connell and Lee, 1987). Men have occupied higher positions in the workplace thereby according them more pay over women and better work conditions and more certain job security. Men, according to Talcott Parsons in his *sex-role theory* (Parsons and Bales, 1953:101), are able to assert their dominance

because of their “instrumental” interests, needs and functions making them occupy technical, executive and judicial roles while women, due to their “expressive” interests, needs and functions, are relegated to supportive, integrative and “tension-managing” roles. This was further supported by a study in Mexico done by Melhuus (1998) where the sexual division of labor expects a man to work to maintain his family while the wife is not expected to work outside of the home although she can generate some income while staying at home. Women in this case are not absolutely denied work but their capacity to provide is severely limited. But even if men are willing to take part in child rearing, financial concerns hinder them from doing so and since economic discrimination which favors men provide them with an advantage in terms of earning capacity, it further reinforces the traditional pattern of men as breadwinners and women as child rearers (Polatnick, 57: 1973). Melhuss (1998) adds that a wife who works outside the home is perceived as challenging her husband’s honor by making obvious his inability to provide for the family all on his own. These role divisions also reflect how men and women treat themselves at home in domestic life. In matters of decision-making, even in reproduction, men have a greater say than women.

Second, *ideological theories* emphasize factors pertaining to values. Sex stratification is brought about by beliefs, especially of dominant groups, about the basic natures of women and men. De Beauvoir’s classic work entitled *The Second Sex* explained that women have always been defined by men as the

Other, while men define themselves as the Self. Thus, "the Self becomes the subject and the Other becomes the object." An example was given by Levi-Strauss' "exchange-of-women" notion. He said that men in some cultures perceive women as valuables, thus, fitting as gifts. Women are "traded and exchanged" by and for the benefit of men, in marriage. This resulted in women being "commodified, reified, and objectified."

Lastly, *materialist theories* look at economic relations in society as the core determinant in status differences. For example, the Marxist feminists view subordination of females as beneficial to men and to capitalism, in capitalist societies. Women are relegated to doing the least profitable tasks such as food preparation, cleaning tasks and child care. These domestic responsibilities of women free men to increase their surplus value to the advantage of capitalists. Because men have become dependent on capitalists for the economic needs of the family, they stay on their jobs even if they are subjected to harsh conditions. But some women work outside their homes, too. The domestication and dependence of women led to a decrease in their labor value, spelling profit for capitalists. Moreover, the commodification of women's bodies helped boost profits when women were used as sex objects in advertisements that bordered on pornography.

In relation to the domestication of women, childrearing which has been relegated to them is perceived as a limiting factor in terms of income capacity. Thus, rather than taking on this role, men prefer to be the breadwinners which

has given them more economic power. With this comes occupational achievement, which is the gauge in terms of looking at the family's status measured through the occupational success of the husband (Parsons in Polatnick, 61: 1973).

Asserting Masculinity

The preceding explanations elucidate the status that men occupy and how they perceive themselves. In most societies, men strive hard to assert their status. They pass through several challenges to prove their masculinity. *Masculinity* refers to a culture's ideal definition of maleness or male behavior. It also refers to the reality of male lives as revealed in concrete male activities and behaviors (Watson-Franke, 1992:475). Masculinity is linked with "dominance, and notions of power are part of male discourse, so much so that power is assumed to be a male prerogative, representing a contested space for the articulation of male identity" (Melhuus, 1998:359). Moreover, Gutmann (1997:386) stressed that, foremost, masculinity is anything men think and do to be men, and some men are intrinsically considered more manly than other men. This is further supported by issues on *masculine gender role* or what men are, *stereotype of masculinity* or what people *think men are*, and *gender ideal* or what people *think men should be* (Clatterbaugh, 1990, cited in Watson-Franke, 1992:475).

Studies among Trukese men in Micronesia revealed that men are so obsessed with their masculinity that they have to prove that they are strong and

manly by participating in deep-sea fishing expeditions in shark-infested areas. They also engage in “weekend brawls, drinking sprees and sexual conquests” (Marshall, 1979, cited in Gilmore, 2001:209). Everywhere men are believed to rightfully dominate social, economic, and sexual spheres. These involvements also give them the right to control women’s sexual and reproductive capacities (Chodorow, 1978:9).

Another example of men’s pursuits in relation to masculinity is seen among the Amhara of Ethiopia. Men have a belief in masculinity called *wand-nat*. This involves “aggressiveness, stamina, and bold ‘courageous action’ in the face of danger; it means never backing down when threatened.” Amhara youths are forced to participate in whipping contests called *buhe*. This often leads to lacerated faces, ears torn open and bloodied faces (Levine, 1966; Reminick, 1982, cited in Gilmore, 2001:209). With physical strength comes the expectation that men should be “strong and tough” characteristics that are valued among northern Mexican men. This means that a man never avoids a fight, and he must always win thus, courage is important. No wonder that Mexico has the highest known homicide rate in the entire world (Gilmore and Gilmore, 1979: 282).

Aside from physical prowess that men must possess to 1997 prove their maleness, another aspect is in the domestic sphere where modeling contributes to men’s concept of being masculine. This was revealed in the critique of Millman (1971) on the work done along the lines of the sociology of gender where she said that in the learning process that American boys experience about

parenthood, they came to realize that “they don’t have to take care of children” because in the homes, fatherhood has not been central. Nurturance is something not in line with masculinity or maleness. Engaging in motherly activities such as taking care of babies is “negatively sanctioned” thus, handling babies is something they are not good upon and besides, females are around to take care of the job. Even in the area of health promotion for the family, it is still basically gendered. Men’s attention had been focused on earning money for the family that leaves almost everything in the home up to the wife. The “most traditional wife is responsible for managing the health and social-emotional condition of the family members including that of her husband and herself (Stolzenberg, 2001:66).

In the work done by Whitehead (1997:423) among Americans, found that masculinity in America has two major themes: “respectability and reputation”. Respectability includes notions such as: having economic power to provide for one’s family; being law abiding; winning through competing successfully; and exhibiting a strong Judeo-Christian sense of morality and fair play. Masculine reputation included sexual prowess; defiance of authority and general rowdiness.” This is supported by a study among men in the circum-Mediterranean region where maleness is defined by “three moral imperatives: first, impregnating one’s wife; second, provisioning dependents; third, protecting the family” (Gilmore, 1990, cited in Gutmann, 1997:389). An expression of masculinity in Mexico is being *macho* and this means, for a man, a display of his

being on top of the situation. However, it can have an adverse effect, and men and women both admit that it may result in unnecessary drunkenness and fits of violence including the abuse of women. Women however, do not want a soft husband but rather someone “hardworking, responsible and respected-- a true man” (Melhuus, 1998: 360).

Growing Up Male in Philippine Society

Concepts of masculinity start from childhood. Socialization plays a vital role in shaping ourselves, how we see ourselves and how others see us. Being masculine is apparently upholding male values by following norms set for male behavior. Socialization into gender roles from childhood to adulthood shape men’s liking for certain things like “guns, forms of behavior like womanizing, and forms of leisure like long range shooting, gambling, and drinking”. These are even reflected in movies and television shows that deify wrong concepts of maleness including certain forms of violence against women (Angeles, 2001:19). The paper of Connell (1997:9) further supports this by saying that sports on television, thriller movies in Hollywood, video games and super-hero comics, highlight the physical supremacy of men and their being “masters of technology and violence”. These create a great impact on men’s lives that they cannot entirely be faulted for their transgressions.

In the Philippines, “male norms stress values such as courage, inner direction, certain forms of aggression, autonomy, mastery, technological skill,

group solidarity, adventure, and a considerable amount of toughness in mind and body" (Sexton, 1969:209). As a result, there are traits that men should possess and masculinity is comprised of being *malakas* (strong), *matipuno* (brawny), *malaki ang katawan* (big bodied), *maskulado* (muscular), and *malusog* (healthy) (Jimenez in Liwag, de la Cruz and Macapagal, 1998:2). Emphasis is placed on physical characteristics because a man is expected to do heavy work, and in Maranao culture, a set of brothers are considered as their fathers' "army" (Macalandong, Masangkay, Consolacion, and Guthrie, 1978, cited in Liwag, de la Cruz and Macapagal, 1998:7).

Correlated with this requirement of physical strength are the kinds of games that boys play. They are allowed to engage in "rougher, more daring, and more action-filled activities" (Jocano, 1988). They play at hitting bottle caps, gambling, and gun-fighting (Estrada,1983; Lagmay,1983). Older boys, according to Jocano (1988), swim, box and kick imitating those they see in the movies, although these boys also play gender-neutral activities such as street football, hide-and-seek and an indigenous variation of tag. This indicates that boys are able to play certain games comfortably with girls. Additionally, boys are given more time to play outside of the home because they are not expected to do a lot of household chores (Mendez and Jocano, 1979). This signifies that boys have more time for leisure compared to girls who are expected to stay in the home and help their mothers in domestic work. In the long run, children are socialized in such a way that girls are raised as "dutiful daughters."

Chores assigned to boys are characterized by physical vigor, distance from home and minimal socio-emotional skills. Tasks include fetching water, gathering and chopping firewood, scrubbing the floor, lifting furniture and carrying heavy objects, to cite a few. Most of the time, they work closely with their fathers. However, they also provide relief to their mothers by assisting in child care when girls are not available (Liwag, de la Cruz, and Macapagal, 1998). These behavioral patterns are prevalent among adolescent boys. Boys grow up assuming that a husband's role is to decide on family investment and securing the family, while they see that a wife's role is to take care of family planning and household management (Macrohom, 1978). The training of sons prepare them for their traditional role of head of family.

Filipino Models of Masculinity

The above concepts of masculinity are strongly influenced by Western culture dating back to the Spanish Era. For instance, when the Philippine government started to build a national army in the 1930s, it emulated the European standard of military masculinity and its biases. Women were barred from conscription and from entering the Philippine Military Academy. It was only thirty years later, in 1963, that women soldiers were recruited by the army and another thirty years after that, in 1993, that women were admitted to the Philippine Military Academy (McCoy, 2000:316). Within the Academy, male initiation has taken the form of hazing which is central to armies everywhere as a

way of expressing one's masculinity. This is so because manhood in many societies must be earned and so rituals such as hazing are invented.

To garner support for the army, the Philippine government used gendered propaganda with "men strong, women weak; men defenders, women the defended." So, young men were recruited to defend "her" and her defenseless womankind. But what tasks were given to women in relation to building the Philippine army? Then Senate President Quezon, who spoke before the Federation of Women's Clubs in 1935, urged the women to mould a citizenry of virile manhood capable of carrying the burdens of the country's independent existence (McCoy, 2000:325-6).

U.S. media has reinforced the concept of going to war in order to affirm one's masculinity. This was shown in films such as *Judge Dredd* and *Born on the Fourth of July* where men were depicted as violent, brutal and domineering, and devoid of any emotional baggage. In the latter film, however, the issue of losing one's virility as a result of war was also reflected. The main character became paralyzed and asked the doctor if he was still capable of reproduction. He was answered in the negative and was shattered by the revelation (Hatty, 2000). Virility is a central issue among men because failure to produce children is seen as a reflection of one's masculinity. In Philippine society, the siring of children is considered such an important achievement that children are often assumed to have a lifelong indebtedness to their parents for giving them life (Tan, 1989). In the same study by Tan (1989), he described the "procreator father" as someone

who womanizes and impregnates other women and popular actors such as Joseph Estrada (who incidentally was a former President of the Philippines), Lou Salvador, Jr and Dolphy embody such characteristics.

Childbearing is key not just for reproduction but for other related reasons as well. For instance, among Ilokans, where kinship is considered bilaterally, fathering children and having a family is a way of asserting not just masculinity but political claims as well. Ilokano overseas migrant workers often see their work as limiting the number of children that they could have produced (Margold, 2002:187)

Aside from going to war and fathering children, Filipino men have also taken on the conspicuous role of being sole providers of their families, a much-valued characteristic found among men in many cultures. A study conducted by Pingol (2001) among Ilocanos revealed that masculinity is primarily associated with men's ability to provide for the family which is related to success in the workplace. Modern-day Ilokans revealed that the ideal husband is someone who can attend to his household and familial duties, most significantly to securing his family's economic stability (Margold, 2002:185) Other attributes cited by Pingol included: "being a good leader, with intelligence and expertise, being principled, helpful, decent, law-abiding, trustworthy, and understanding". Additionally, attributes such as virility, physical strength, good looks, a capacity to take risks such as in gambling and having illicit affairs without being irresponsible to one's family were likewise cited by men.

Understanding the Filipino Father

Philippine society does not differ much from Western cultures when it comes to fathering. Western fathering, like Filipino fathering, is an expression of men's sexual and reproductive control. A father is not expected to play a significant role as a participative and nurturing parent, rather he is there as a progenitor who keeps everything under control (Watson-Franke,1992). Allen Tan (1989) found Filipino fathers to fall into four types:

- 1) *The Procreator*. His idea of fatherhood is centered on siring children and he often does not go beyond his biological duties aside from providing for his offspring. Fatherhood is basically seen as a sign of virility and procreating is an end itself. A majority of Filipino fathers are in this category. Related to being a procreator is the role of being a *PROVIDER*. He must ensure that the children mature and continue his lineage. This means that he must be able to meet their basic needs including education. On the downside, because of the strong effect of masculinity, some in this group are just basically concerned with siring many children to prove their virility and insure genetic continuity without much thought given to how to care for them. For the procreator, his primary satisfaction is a sense of having achieved a genetic immortality. He becomes frustrated whenever a child, especially a son, fails to continue his family.

- 2) *The Dilettante*. This person is not a very active father, but his emotional involvement seems to be positive. This is the case of the overseas worker, who must be absent in order to provide economically for the family. He may visit his family only for a month or so in a year but is able to form an affectionate relationship with his children (Dulagrosa, 1986). The dilettante father's role is that of a *FRIEND*. He takes on a supporting role while the mother is the main caretaker of the children. He is not bothered with the daily challenges related to child rearing but he is around to provide emotional support when needed. As a friend, his satisfaction lies in his being a companion to his children especially during happy moments of fun and play. He is frustrated when the children confide or ask advice from someone else.
- 3) *The Determined Father*. This is a father who sees fatherhood as a mission, an obligation and a task. He sets goals, to control the children's destiny towards what he wants them to be. At times, the children become extensions of himself and his ambitions in life. His role is that of a *MOLDER*. He sees the children as incompetent, incapable of making sound decisions. His satisfaction comes from their accomplishments of the goals he has set. He is frustrated when the goal of a child is different from his own goal for them.

In the Filipino household, the father figures conspicuously in terms of instilling discipline in a child. A mother may also take on this role,

but when she faces problems, the father is the one to whom she, ultimately turns (Lagmay, 1983). This kind of father is perceived as having *authority* over the children (Espina, 1996).

- 4) *The Generative Father*. This father's involvement is high and he reacts positively to fatherhood. He sees his experience as a maturing and fulfilling one for himself. His role is that of a *GUARDIAN*, nurturing and guiding his children. He does not dictate to his children; rather he allows them to develop. This is similar to the Hopi father who highly values fatherhood and therefore strives to be a good father (Schlegel, 1989). The same is evident among Navaho fathers who publicly take care of their babies, nurse and nurture them even if they are busy with other chores (Malinowski, 1927).

The generative father's satisfaction is derived from the personal fulfillment of being able to oversee the development of the children to achieve *his* goals for them, but by allowing them to pursue their personal goals within limits.

Masculinity, Fatherhood and Contraception

In patriarchal societies, men are seen as the superior sex (Wood, 2001: 179)) and this shapes how men assert their masculinity in their behavior. Men rate their masculinity based on the extent of their machismo. Machismo encompasses "virility, strength, ability to stand up against difficulty and maintain

their stance as true 'men among men' " (Velez, n.d.:1). In a study in Brazil, the main fears of men on vasectomy can be summarized under the "macho" concept. They thought that it would reduce their self-esteem due to their belief that vasectomy would affect their sexual performance (Manhoso and Hoga, 2005:104). For a man to be macho or masculine, he should be sexual and be able to impregnate a woman or even a few of them within or outside the confines of marriage. Machismo is not just a personal thing, it has also become political and structural. Society tolerates and perpetuates it (Sternberg, n.d.). Having extramarital affairs is something prevalent in Philippine society and there is a double standard of morality where men can easily get away with it and women sometimes turn a blind eye on their husbands' infidelity like cohabiting with mistresses and engaging in paid sex with prostitutes (Angeles, 2001: 10).

Part of showing a man's strength is his ability to control his emotions even to the extent of not showing fear, pain, and remorse when it might be expected. The danger of a man's strength is also his ability to physically express it through violence on women and children. Despite many challenges, a man should be able to face other men on his own and without the help of anyone, especially a woman (Doyle, 1995 cited in Wood, 2001: 182). Watson-Franke (1992) adds that men's roles are perceived as structurally at the epicenter of society from where women are always controlled by men. This is evident in the seeming tolerance of women when it comes to men's activities in a study conducted by Angeles (10:2001) where women in an urban poor community in Leveriza were

going about their usual duties while men were “chatting, smoking, and playing a game of pool.” As Sternberg (n.d.) puts it, “machismo gives rise to powerful images which legitimize women’s subordination, and establish a value system which is concerned with regulating not so much relationships between (sic) men, and women, but relationships between men, where women are conceived of as a form of currency.”

Doyle (1995), outlined five themes of masculinity which shape the role of men in society:

- 1) *Don't be female.* This means do not embody feminine characteristics. Anything that is considered womanly is strongly discouraged because women are considered inferior. Thus, men are discouraged from crying, showing pain, acting ladylike and showing emotional sensitivity. This was also highlighted in a study of boys in Philippine society where men should “endure physical pain or at least suffer in silence” (Flores, 1969 cited in Liwag, de la Cruz and Macapagal, 1998: 8).
- 2) *Be successful.* Men are expected to achieve in their chosen careers. This is the reason why in Philippine society males are prioritized in terms of their educational needs over females since they are expected to be the future providers of their families (Lamug, 1989). Whatever men take up, they should perform well and outdoing others is acceptable. Part of the measurement of success is a man’s ability to provide for the economic needs of his family. Being the breadwinner is the primary responsibility of

- men (Lee and Dodson, 1999:40). Staying home to take care of the children and do house chores is shunned.
- 3) *Be aggressive.* Boys are taught to play rough games which encourage violence, force and dominance. This early encouragement of aggression may later be translated into physical violence against women because women are seen as inferior and subordinate to men. Physical violence is perceived as a sign of mastery.
 - 4) *Be sexual.* Men are expected to be sexually experienced, thus, their having had many partners is not frowned upon (Gaylin, 1992 cited in Wood 2001: 182). Men may be expected to be sexually active prior to marriage, quite the contrary and in contradiction to society's expectation of women that they must remain chaste before marriage. A man is supposed to conquer women and everything centers on his wants and desires (Velez:n.d). It is no wonder that even if a man is married and has sexual liaisons outside of marriage, society does not strongly condemn him because it is part and parcel of masculinity.
 - 5) *Be self-reliant.* A man should be able to stand his ground no matter how difficult the situation may be (Velez:n.d.). He should assert his independence and toughness. When family problems arise, he is expected to solve them, especially with regard to financial matters. Little or nothing is expected from the wife. A man must "depend on himself, take care of himself and rely on nobody."

The above themes are ideas which, rightly or wrongly, still exist today. Because of them, men fail to fully harness their potentials. For instance, it has been pointed out that norms and expectations regarding men have hindered their ability to communicate with their wives on matters regarding sex and sexuality (Stycos, 1996: 2). This is even reflected in the form of jokes in a research done by Angeles (11: 2001) where men say they are "*macho, machunurin sa asawa*" (macho here means being obedient to one's wife), then there's "*Yakuza, yuko sa asawa*" (means bowing to one's wife) and finally, "*Pedrong Taga, taga-luto, taga-laba*" (means tough men who does the cooking and laundry). So, even if there is a changing climate on the male image, there is still some sense of uneasiness thus, joking about it provides some relief. Additionally, the macho image has prevented men from sharing domestic responsibilities with women, such as the decision to try contraception. Because young men live up to strong male stereotypes such as having many sexual partners and, showing a lower level of emotional intimacy, they hesitate to share in sexual responsibility (UNFPA, 2000). Men are, often with good reason, stereotyped as lazy, disinterested or unconcerned in relation to reproductive health issues. Even program planners have this stereotype of men as simply not being interested in reproductive health issues: they still need to be forced to attend social activities related to them, they are way too old to be taught, they do not see anything

advantageous in them, they do not want to share their personal lives, they fear their masculinity will be challenged, they believe that women should be the ones to participate, they know little about health, or they do not perceive certain health issues as problems (Lee and Dodson, 1999: xvi).

Male self-stereotyping limits the options available to men and, therefore, of women also. However, machismo as the excuse to perpetuate the status quo, in which men dominate and women are subordinated, can be challenged. For instance, women's rights advocates have questioned the pitfalls of family planning programs in the Philippines since it still heavily targets women and to some extent excluding men and thereby abandoning their responsibilities on contraception (Angeles, 15: 2001). Giving up to machismo has been committed by programs in many cultures where it is pervasive. In Latin America for instance, machismo was thought to be the factor limiting the use of vasectomy, but research revealed that other factors, such as inadequate information, education and accessibility, should be given more importance (Vernon, 1991; Foreit, *et al.* 1989). In the Philippines, a study by Lee and Dodson (1999) revealed that there are programs on reproductive health that encourage male participation, but male participation is minimal (as in attending women's or mother's classes or seminars or as receivers of educational materials). A more considerable participation of men has occurred in the decision to use condoms and in trying vasectomy.

The pervasive problem of machismo as a limiting factor is one that health care providers must challenge. It is not just about male participation and responsibility, but more about raising the issue of gender equality and family welfare to another level (UNFPA, 2000). Gender equality is a complex challenge since success in this area requires far-reaching changes in social, economic, and ideological factors related to gender relationships (Mundigo, 1995 in Manroso and Hoga, 2005:107). There is now a growing interest among young men to accept principles of gender equality and some have supported women's efforts to end male violence such as the case of Men Against Sexual Assault in Australia. This has not been easy at all since men are "likely to be met with antagonism and derision from other men" (Connell, 7:1997). The case in Australia is not isolated, in so many countries, efforts have been made to involve men, young and old alike. Now, it is about rethinking and reshaping old and oppressive concepts and practices that impinge on the development of both men and women.

REVIEW OF RELATED LITERATURE: VASECTOMY

Antecedents to Acceptance

It is important to understand what we know about the decision-making process that men undergo before submitting themselves for vasectomy because this may vary from one culture to another. In the design of programs, therefore, culturally appropriate strategies need to be put in place that seriously consider the felt needs of the target population. In a study

conducted by Mumford (1983: 83) in the United States, the length of the decision-making process may take from two to more than ten years. This is unlike the findings from a study conducted in Brazil, Colombia and Mexico (Vernon, 1996: 28) that it only took men four months to a little over a year to decide. In the Philippines, it has been found to take men about three years to finally undergo vasectomy after giving it a first thought. However, it only took them about three months to undergo vasectomy after making the decision to be sterilized (de Guzman, 1990).

Reasons for Vasectomy

1) *Concern for women's health.* Pregnancy is a major event in a woman's life that may place her in a difficult situation. Pregnancy can pose great risks to a woman's life and that of her child. A case in point is the experience of a medical doctor in the Philippines (Flavier, 2002: 1) who said that he and his wife always enjoyed her pregnancies but she never had an easy time. Both of their children were born through Caesarean section. The first pregnancy was difficult because the baby went into distress a few hours into labor. The second baby was also delivered by Caesarean section because his wife experienced abnormal uterine bleeding. Such difficult situations that women experience often make men decide to share, even take on sexual responsibility. They lead to the realization that as "economic providers" and "men of the household", men must now take greater responsibility unto

themselves because the women have previously carried the great burden of contraceptive use and childbearing (Landry and Ward, 1995: 61). The incorporation of vasectomy as part of reproductive health services is sound because it challenges the traditional masculinity concept. Submitting one's self for vasectomy can be "macho"; men can be responsible and this time around they take up the cudgel in terms of contraception (Berkowitz 2002: 4).

2) *Decision not to have more children.* Children in most cases have always been a welcome treat but when times get hard and basic needs sometimes cannot even be met, this situation changes. Couples are then compelled to decide to stop having children even if they would have wanted more. This has been supported by the study of De Guzman (1990) where men decided not to have more children because they already had all the children they wanted. One benefit of successful vasectomy is its relative permanency. Couples no longer have to worry about having more babies and can concentrate on providing for their current children (McEachran, 2002: 8). In other forms of family planning, the economic benefits of having no further children are coupled with the fear of having unwanted pregnancies (Mumford, 1983: 84; de Castro *et al.* 1984:127). Unwanted pregnancies may lead to greater risks such as resorting to unsafe abortion services especially where abortion is illegal.

3) *Dissatisfaction with other methods.* The contraceptives tried before resorting to vasectomy are usually the pill, the condom and the IUD. The fear of the medical side effects of the pill and IUD have prompted couples to stop using them. Condoms, on the other hand, lessen sexual satisfaction and a condom's breakage has caused unwanted pregnancies. (Mumford, 1983: 85; Vernon, 1996: 27; Flavier, 2002: 2). The option to go for vasectomy was borne-out of discussions between the husband and the wife and a result of many troubles related to contraceptive methods they experienced. The first option was mainly female methods. Thus, vasectomy was the last option after the negative effects as a result of other contraceptive methods (Manhoso and Hora, 2005:105). The continued use of these "temporary" or impermanent methods is inconvenient, inaccessible, ineffective, and costly. They have adverse effects on sexual satisfaction because couples lose their spontaneity and there is always that fear of unwanted pregnancy (de Castro *et al.*, 1984: 128; Landry and Ward, 1995: 62).

4) *Advantages of vasectomy.* Vasectomy is preferred over tubal ligation and other temporary methods because it leads to a pregnancy rate of zero to 2.2 percent. It is "simpler, easier, safer, quicker and most comfortable" (Vernon, 1996: 28). Landry and Ward (1995) said that their respondents found vasectomy a better choice compared to ligation because recovery time is shorter and there are fewer risks involved. For instance,

there is now an increasing interest in no scalpel vasectomy which was developed in China in 1974 . It only takes eight minutes, requires a puncture rather than an incision, and men can immediately go home after the procedure with only a Band-Aid on the puncture site (Flavier 2002). This procedure carries still fewer risks, requires an even shorter recovery period and is cheaper compared to the traditional method (malehealth.co.uk 2002).

Although in the Philippines ligation is still more popular than vasectomy, the no-scalpel vasectomy is also popular because it is safe, inexpensive and simple. Vasectomy is inexpensive because it can be paid for through Philhealth. FriendlyCare, a non-government organization, also offers it at a discounted rate of PhP 200 (\$4) in some places. Another NGO is Management Sciences for Health which works with local government units and its rates are subsidized (Flavier, 2002: 2).

Events Leading to Vasectomy

In addition to the above considerations, Mumford (1983) discussed the seven events common to men seeking vasectomy:

- 1) *New awareness of vasectomy.* Most men who decide to undertake vasectomy have known about it for two years or more. This does not mean, however, that they gain full knowledge about the method and its implications in that period.

2) *Interaction with a vasectomized man.* A majority of men have already talked to a vasectomized man. In a study by de Castro *et al.* (1984: 128) in Brazil, most referrals to the study clinic were from previous vasectomy patients. This was also the reason that prompted the personnel of Profamilia in Colombia to hire a promoter to give talks in the clinics and communities (Vernon 1996: 28). In a more recent study in Brazil, men decided to have a vasectomy after understanding the positive experiences of other men and this was significant in terms of demystifying fears related to vasectomy (Manhoso and Hoga, 2005: 105). Other popular sources of information that are cited for Latin American countries are friends and relatives, radio, and clinic staff (Vernon 1996: 29). Manhoso and Hoga (2005: 105) also cited that the involvement of professionals in the educational process and health care received from them facilitated the clarification of doubts and encouraged a better understanding of the surgical procedure. In the Philippines, 400 men who underwent vasectomy were interviewed and they opted for vasectomy after they "first consulted another sterilized person or their friends, relatives or neighbors" (de Guzman, 1990:109).

3) *Decision not to have more children.* De Guzman (1990) found that this decision usually stems from reasons that include "financial consideration, population problem, difficulty during pregnancy or child delivery, age and emotionally could not handle more." In the same study of de Guzman (1990),

aside from economic reasons, a majority of the men already had achieved their desired number of children aside from the failure of other methods.

4) *Started seriously considering vasectomy.* Almost half of the respondents interviewed by Mumford said that they seriously considered vasectomy for two years or more; in Latin American countries, the length of decision-making is shorter (Vernon 1996: 28). In the Philippines, among the male vasectomy acceptors, the interval between the birth of the youngest living child and the date of the vasectomy is five years on the average. However, "more than seven out of 10 males went under the knife for their vasectomy one month or less after making the decision to accept vasectomy" (de Guzman, 1990:111).

5) *Realization that temporary contraceptives are no longer acceptable.* Mumford found that couples only decide that temporary contraceptives are no longer acceptable after the birth of the child that is seen as completing the family. Temporary methods are then no longer attractive and their disadvantages become heightened. For instance, Berkowitz (2002: 2) decided to have a vasectomy after his second child. The side effects of the pill made him and his wife eliminate it among their options. They tried condoms and the calendar method but found that they were like playing Russian roulette. Though still experiencing sexual excitement, they simultaneously feared having another child. They decided to use a permanent and safe method. Men in Cebu who had vasectomy said that their fear of

bearing additional children during intercourse had been eliminated (*SunStar*, 2005: A12).

6) *Decision that vasectomy is the best contraceptive method.* Mumford found that among the reasons for deciding that vasectomy is the best option were that, because of its "effectiveness, [it] does not interfere with sexual satisfaction and lacks side effects." The Philippine study of de Guzman (1990: 112) also cited the positive characteristics of sterilization such as its effectiveness, goodness for health, convenience, simplicity, and cheaper cost. The low cost of vasectomy compared to the pills and other family planning methods was also cited by men in Cebu who underwent vasectomy (*SunStar*, 2005: A12).

7) *Experienced a "scare".* A "scare" is usually associated with a missed period and with severe side effects of the pill. Fears also escalate with the respondents' dissatisfaction with the temporary methods.

Given the above stated "flash" events that men undergo, Mumford (1984) developed five distinct phases that men experience before undergoing vasectomy.

1) *Phase I.* This is the time before the number of children is seen as complete. The man is relatively content with temporary methods because their "temporariness" serves a purpose. This lasts for several years.

2) *Phase II*. The desired number of children is already complete. The man begins to be discontent with temporary methods of contraception. This usually lasts for several months to years.

3) *Phase III*. The husband begins to seriously consider vasectomy. Discontentment with temporary methods heightens. This usually lasts for one month to three years.

4) *Phase IV and V*. The man finally decides that vasectomy is the best method. There is usually a period of delay for one month to three years. Ultimately, the man has a vasectomy.

Involvement of Women in Decision-making

As men go through the process of deciding to submit themselves to vasectomy, women also participate in the decision-making process. In the successful program in São Paulo, Brazil, 68 percent of the clients of PRO-PATER who were interviewed stated that their wives had influenced their decision to get a vasectomy (de Castro *et al.* 1984). However, the extent of the wife's influence was not discussed by de Castro *et al.* The same was true in a study commissioned by the New Zealand Family Planning Association which revealed that husbands needed "a little push" from their wives or partners. Once the joint decision was made, they were no longer influenced by misperceptions or adverse attitudes echoed by their male friends (malehealth.co.uk.feature 2002). On the contrary, the study of de Guzman

(1990) revealed that a majority of the Filipino males never consulted their wives about their plan to be vasectomized. However, the spouse was the influential person affecting the decision among a minority.

It is understandable that women are more knowledgeable about family planning methods because almost all family planning programs target women. Thus, the lead role that they can take in informing and influencing their partners must be capitalized upon. In Colombia, studies of vasectomy acceptors show that their initial source of information on the procedure is the wife and she is also the main person who influences the decision. Communication between partners about the possibility of sterilization is very important because they discuss when and how to terminate their reproductive capacity. It is unfortunate that many physicians see only one partner and are unaware of the benefits of having couples jointly discuss their decision-making regarding contraception (Ringheim, 1993: 92). Of course, we also have to take into consideration that not in all countries do women have a major role in deciding the number of children. This is especially true in countries where women do not know and assert their reproductive rights. For instance, in Bangladesh and Sri Lanka, both men and women feel that the husband should be the one to decide the family size and so wives do not take an active role in the decision-making regarding vasectomy (Landry and Ward, 1995: 64; McEachran, 2002:10).

In countries where women take an active role, we must learn from their experiences and apply those that are acceptable in certain settings. In Kenya, Rwanda, Mexico and the USA, women are participants in the vasectomy decision. In these countries, couples discuss vasectomy before the operation. In several cases, women are the first to suggest the operation to their partners. Men and women also report that the women have been more supportive of having a vasectomy than friends and relatives (Landry and Ward 1995: 64).

Given that the decision of husbands for vasectomy is influenced by both external factors (services in health care settings, the influence of family and friends) and internal (values, beliefs, aspirations and ambitions), descriptive decision theory will be used in relation to the phases that men undergo before getting a vasectomy as presented by Mumford (1983). Descriptive decision theory is "concerned with how and why people think and behave the way they do. It is an empirical and clinical activity that investigates decision making contextually" (Bell *et al.* 1988 in Kayser-Jones, 1995).

In this work, I explore the important role the social support system plays in helping a male to make the decision to undergo vasectomy. The focus, however, will be on the role of wives in the decision making process from the time husbands receive their first information on vasectomy until the time they accept the need to undergo sterilization.

THE PROBLEM

Statement of the Problem

Within the problem area of what constitutes gender norms and gender self-perceptions in Cebuano culture, the study intends to determine the ways in which concepts of masculinity have shaped the contraceptive choice of men for vasectomy and how this choice, in turn, has changed the meaning of masculinity for an urban sample of married Cebuano men.

Sub-problems:

The study will specifically determine:

- 1) How masculinity is defined in Cebuano culture as reflected in the sample interviews;
- 2) The social and cultural conditions in Cebu that have encouraged males in the sample to choose vasectomy as a family planning method;
- 3) The influences that family members, peers, and health care providers have had on the men's decisions to undergo vasectomy in a Cebuano culture;
- 4) The stereotypical roles (seen to be characteristic of or associated with men) and local cultural concepts of masculinity that hinder and/or promote the provision and utilization of vasectomy as a family planning option, from the viewpoints of both vasectomy providers and acceptors;
and

- 5) If and how self-concepts of masculinity have been affected by the process of making a decision to undergo vasectomy, and thus how cultural change in concepts of masculinity might be taking place among Cebuano vasectomized males.

Statement of Hypotheses

- 1) Certain specific cultural concepts of masculinity are associated with the decision to undergo vasectomy.
- 2) Men who choose vasectomy are likely to have had not reference groups not strongly critical of vasectomy.
- 3) Stereotypes of men held by service providers hinder the provision and utilization of vasectomy services.
- 4) The decision-making process of men who choose vasectomy are negatively affected by society's views on whether men should be involved in family planning.

Significance of the Study

This study is significant for the following reasons:

There has been no study to the knowledge of the researcher that focuses on understanding Cebuano male gender norms, let alone on the effects of vasectomy on Cebuano male self-perceptions. These will be investigated among

a sample of married couples in Cebu City, Philippines, the male partner of whom has undergone vasectomy.

This will guide program planners in designing culturally-specific programs that will meet the felt needs of their clients by learning from the results of this study and those in other countries. This study will be carried out in the context of a society that places the burden of contraception on women as men are traditionally valued for their virility (this refers to sexual potency with emphasis in the capacity to bear children), and vasectomy would mean the end of this valued status.

As part of the holistic approach in designing programs that are culturally sensitive, research findings can facilitate the inclusion of vasectomy among other reproductive health services, and will strengthen male participation in promoting reproductive health. This study also hopes to contribute to the growing literature veering away from the position where men have been treated as the “problem” in terms of family planning services (Angeles, 2000). It envisions a positive treatment of men as real partners in the area of reproductive health by highlighting contributions they can make to relieve women of being overburdened in the bearing of reproductive responsibility.

It will also test the similarities and differences in the vasectomy decision-making process of Cebuano urban males as compared to other cultures. A model has been developed by Stephen Mumford (1983) based on his study in the United States and a similar study was also done by Landry and Ward (1995) in

six countries, namely Bangladesh, Kenya, Mexico, Rwanda, Sri Lanka and the USA. In the latter study, insights were revealed that can aid program planners in their approaches. Another significant study of comparable nature was also done in Brazil, Mexico and Colombia by Vernon (1996). All of these studies revealed that there are cultural differences that must be taken into account in addition to the many lessons that were learned from prior studies. The present research aims to add to these insights.

Limitations of the Study

This study does not include men who opted against vasectomy. Thus, no comparison can be made in terms of differences on men's views regarding acceptance and non-acceptance of vasectomy. Only men who opted for vasectomy were included because the researcher only wanted to capture the change of behavior towards vasectomy as a family planning method.

The study was only done in partnership with one hospital that has been known to have pioneered No-Scalpel Vasectomy. There are now a few more health facilities offering the said service but they were not included since it was only recently that the study leader came in contact with them. Besides, in terms of long experience in dealing with vasectomy as a family planning option, Sacred Heart Hospital has the edge through its long experience and available human resource to perform the procedure.

RESEARCH METHODOLOGY

Research Environment

Sacred Heart Hospital, a private health facility that is known to promote no-scalpel vasectomy as a family planning option, was visited several times to become familiar with the services they offer, identify the candidate respondents, and consider how they will be contacted. Sacred Heart Hospital has a reproductive health center that caters to the needs of both men and women. It has a steady pool of medical trainees from the College of Medicine of Southwestern University and a staff nurse has been assigned to focus on the facilitation of the delivery of its reproductive health services. Medical graduates of the university who are now working in the United States have been known to conduct free no-scalpel vasectomies for willing men on visits back to the Philippines. Moreover, they have been training doctors to do no-scalpel vasectomies when these graduates return.



The main entrance of Sacred Heart Hospital.

Features of the promotion of no-scalpel vasectomy are aggressive mass media campaigns, production and distribution of information materials, barangay level education campaigns, and networking in government and non-government agencies conduct orientation seminars and eventually obtain referrals of clients.

Study Participants

In my visits to the Reproductive Health Center of Sacred Heart Hospital, that for the past three years, 106 no-scalpel vasectomy clients had come from Cebu City, Mandaue City, Lapu-lapu City and Talisay City. But of the 106 men, only 63 had complete names, addresses, and telephone numbers. I was only able to interview an opportunity sample of 44 out of 63 clients because the others had already transferred residence, gone to work abroad, or declined because they were too busy with their work schedule and responsibilities at home to find time for an interview. This is 41.5 percent of the clients. The wives of men who underwent vasectomy were also interviewed; but we were not able to interview all the wives since some were living outside Metro Cebu, or were too busy with their household chores.

Personnel from Sacred Heart Hospital assisted in locating and giving a brief background on the study participants. Moreover, community residents also assisted in locating the study participants for those whose addresses were difficult to track down.

Selected personnel of Sacred Heart Hospital who are directly involved in delivering vasectomy services were interviewed as key informants. The pioneers of no-scalpel vasectomy who introduced it to Sacred Heart Hospital were interviewed through electronic mail because they are based in the United States. In January, 2005, a chance was taken to meet with them

during their visit to Sacred Heart Hospital for their yearly No-Scalpel Vasectomy free clinic.

Profile of Participants

Table 1 The personal characteristics of vasectomized Cebuano

Characteristics	N (44)	%
Marital Status		
Legally married	44	100
Living together	0	0
Number of children		
02	6	14
03	18	41
04	8	18
5 or more	12	27
Average number of children	4	
Age range		
26-31	10	23
32-37	23	52
38-43	8	18
44-49	3	7
Average age	35	
Age range at the time of marriage		
15-20	7	16
21-26	29	66
27-32	7	16
33-38	1	2
Average age at the time of marriage	25	
Income range		
1,000-6,000	21	48
7,000-12,000	19	43
13,000-18,000	0	0
19,000-24,000	1	2
24,000 and above	1	2
Confidential	2	5
Average income	8,346.00	

Table 1 shows that the average age of men who underwent vasectomy at the time of the interview was 35 years old . The oldest client was 44 years old while the youngest was 27 years old. At the time that they underwent the procedure, the mean number of children they already had was four. The most number of children was eight while the least number was two. The average monthly income was a little over PhP 8,000.00 and the lowest income recorded every month was at PhP 2,000.00. The daily wage in 2004 is pegged at PhP

208.00 per day or a monthly income of PhP 6,240.00. Half of the study participants do not receive the required minimum wage. The mean age that the study participants got married was 25 years old. The youngest age recorded at the time that a study participant got married was 18 years old.

The mean age of the wives when they got married was 21 years old (**Table 2**). The youngest age at marriage was 16 years old while the oldest was 30 years old. Majority of the wives are not employed and the mean income is a little over PhP 4,000.00.

Table 2 Personal characteristics of wives of vasectomized men

Characteristics	n(34)	%
Marital Status		
Legally married	34	100
Living together	0	0
Number of children		
02	6	18
03	12	35
04	5	15
5 or more	11	32
Average number of children	4	
Age range		
20-25	4	12
26-31	11	32
32-37	12	35
38-43	7	21
Average age	33	
Age range at the time of marriage		
15-20	17	50
21-26	12	35
27-32	5	15
Average age at the time of marriage	21	
Income range		
1,000-6,000	9	26
7,000-12,000	4	12
13,000-18,000	2	6
19,000-24,000	0	0
24,000 and above	1	3
Confidential	4	12
None	14	41
Average income	4,516.00	

Research Procedure

The Preparatory Stage. A male, married interviewer was hired to assist in-depth interviewing of men who had undergone vasectomy. A female interviewer was hired to interview the wives. The study leader held key informant interviews of the personnel of Sacred Heart Hospital directly involved in the delivery of no-scalpel vasectomy and facilitated focus group discussion of the men after the in-depth interviews were conducted by the research assistant.

The research assistants were oriented regarding the study, research instruments, ethics, mechanics of data gathering and reporting.

All the instruments except those for the service providers were translated from the local language, Cebuano. Interviews were also done in Cebuano.

Interviews. One-on-one in-depth interviews with vasectomized married men were conducted using an interview guide designed for this purpose. Topics included responsibilities assigned to them when they were still young and how these had affected their participation in rearing their children; characteristics of a "real man" and if any of these characteristics facilitated or hindered their decision to undergo vasectomy; participation of men in family planning; social and cultural reasons for their decision to undergo vasectomy; involvement of their partners, in-laws, friends and health provider in the decision making process; effects of vasectomy on their concepts of masculinity; changes in the perceptions of their wives, in-laws and friends on

their masculinity after undergoing vasectomy; and their recommendations to improve the delivery of vasectomy services in a macho culture.

The wives of the men who underwent vasectomy were interviewed to capture their views on masculinity; male involvement in family planning; reasons for the unpopularity of vasectomy among men; participation in the decision making process; changes in their own views, as well as those of their in-laws and friends of their husbands, after the vasectomy; and recommendations on how to encourage men to undergo vasectomy.

Interviews were conducted with health care professionals who were directly involved in the promotion and delivery of services related to vasectomy. The topics included the background to offering no-scalpel vasectomy; the training program; activities related to information, education and communication campaigns to popularize vasectomy as form of family planning method; efforts made to challenge the traditional concepts of *pagkalalaki* to enhance the delivery of vasectomy services in a "macho society"; and the challenges they faced in the promotion and delivery of vasectomy services.

Focus Group Discussions. After the in-depth interviews, there were still gaps in the data. Thus, the study leader and male research assistant did two focus group discussions covering the topics: concepts of machismo; effects of vasectomy on their concepts of machismo; involvement of wife, in-laws and friends on decisions to undergo vasectomy; changes in their lives especially

as a husband and father after undergoing vasectomy; and three important reasons for their decision to become directly involved in family planning by undergoing vasectomy.

Focus group discussions provide some form of check and balance in the answers of study participants because they reject wrong and extreme views. They also collectively clarify certain points raised. Participants tend to enjoy themselves by sharing their experiences. On the other hand, because time is of the utmost consideration and several people give their ideas, the number of questions may be limited and the facilitator must be able to manage the interviews, especially if there are those who tend to dominate the discussions (Patton, 1990).

Secondary Data Gathering. Performance records of health care facilities were utilized to acquire information on the number of vasectomized men over a period of two years (as to whether it has increased or decreased), the problems encountered, and interventions made in relation to problems faced.

Conduct of Data Gathering.

- 1) The study leader held several meetings with the personnel of Sacred Heart Hospital to orient herself on their delivery of no-scalpel services. These meetings helped in the formulation of research instruments and establishment of a plan to undertake with the data gathering stage. A

list of clients for the past two years was found and the study leader was given an orientation on their backgrounds. The two research assistants were introduced to these personnel.

- 2) Before the interviews were conducted, several phone calls and home visits either in the home or office of the possible respondents for appointments were made to arrange appointments and instructions on the time and place where the interviews would be conducted were discussed.
- 3) Interview transcripts were submitted on a weekly basis. Together with the interviewers, the transcripts were immediately checked for gaps in the data and clarifications that needed to be made, so that call backs were done immediately as well. Challenges encountered by the research assistants were discussed in order to properly strategize the data gathering process. No major problems were encountered.
- 4) All data were first processed by entering all answers belonging to the same question. At the onset, data were encoded thematically and then common patterns of knowledge, attitude, behavior and experiences were identified by going over the transcripts several times. Different and conspicuous answers belonging to the same questions were also grouped together. They were then content analyzed through the set of themes or categories made. Salient words were given

greater weight by taking note of the number of times they were mentioned by the study participants (Ryan and Weisner, 1998:59)

Organization of the Study

The study is organized under the following topics: Chapter One: Introduction; Chapter Two: a discussion on the background of Sacred Heart Hospital and the beginnings of its involvement in no-scalpel vasectomy, vasectomy campaign drive, and networking activities to garner support for no-scalpel vasectomy; Chapter Three: views of participants on masculinity in Cebuano culture; Chapter Four: socioeconomic and cultural conditions encourage participants to choose vasectomy as a family planning method; Chapter Five: the influences that family members, peers, and health care providers had on men's decisions to undergo vasectomy; Chapter Six: stereotypes that hinder or promote the provision and utilization of vasectomy from the viewpoints of vasectomy providers, acceptors and wives; Chapter Seven: the decision-making process undertaken by men to undergo vasectomy; Chapter Eight: post-operative effects on perceptions of masculinity; Chapter Nine: summary, hypothesis testing, conclusions regarding the research problem, and recommendations.

Definition of Terms

- 1) ***Pagkalalaki***. Concepts of maleness in Cebuano language and culture.

- 2) *No-Scalpel Vasectomy*. A permanent family planning method which involves accessing the vas deferens through a small puncture by using a forcep.
- 3) *Voluntary*. Involves the choice of freely submitting one's self after knowing about the entire procedure and its consequences.
- 4) *Cebuano Married Men*. Men who are residing in Metro Cebu, speak Cebuano (Cebuano Bisayan) and are in a legally intimate relationship who have reached their desired number of children and chosen to undergo no-scalpel vasectomy.

CHAPTER TWO

BACKGROUND OF SACRED HEART HOSPITAL AND THE BEGINNINGS OF ITS INVOLVEMENT IN NO-SCALPEL VASECTOMY

Sacred Heart Hospital of Southwestern University, Urgello Street, Cebu City, started to offer no-scalpel vasectomy in 2002. This was mainly through the efforts of their alumni in the College of Medicine of Southwestern University who are the founders of No-Scalpel Vasectomy International, Incorporated. These founders included Dr. Ramon Suarez, Dr. Nenita Suarez and Dr. Benita Kiamco who are all based in the United States. These founders had been inspired by the work done by the current



Medical Director of Sacred Heart Hospital, Dr. Lydia [The main entrance to the Reproductive Health Clinic.](#) 1970's on population management. From its onset, Dr. Aznar-Alfonso was already supportive of their program when they came to the Philippines to discuss their intent to partner with Sacred Heart Hospital.

The Beginnings of No-Scalpel Vasectomy International, Incorporated

The founders of No-Scalpel Vasectomy International, Incorporated were previously involved in "traditional" surgical or medical missions in the Philippines as their way of giving back to the country their expertise and resources. They were also involved in other activities such as helping family members and

relatives to start their own businesses and sponsoring scholarships. Such efforts were at times fruitless because many of those they helped, especially the scholars some of whom were their own siblings, were not able to find gainful employment after graduating from college. These in turn might not be able to fully educate their own children, as a multiplier effect. All these efforts although rewarding, yielded less than satisfactory results because they came to realize that they were unable to address one of the "root" causes of the problems of the country, which according to them, is "too many people going after limited resources."

It was in 2000 that the founders decided to take another route, to help manage the population growth. Thus, they formed the foundation with a mission to "provide free voluntary vasectomy to manage population growth in the Philippines and other Third World countries." As retirees, they can now both enjoy life and give something in return to those who need it most. Their yearly funding amounts to \$10,000.00. Of this amount, the founders contribute 25 percent, friends, neighbors and colleagues, contribute 65 percent, and other Filipino-American Organizations contribute 10 percent. All American volunteers pay their own travel and lodging expenses when on mission trips.

A Training Program of No-scalpel Vasectomy Providers

Among the founders, Dr. Ramon Suarez is the prime mover of No-Scalpel vasectomy. He is a Diplomate of the American Board of Urology, a Fellow of the

American College of Surgeons, and a Professor of Urology, College of Medicine of Pennsylvania State University. He was previously trained in the traditional type of vasectomy which required two scrotal incisions and a sutured closure. In 1998, he learned about No-Scalpel Vasectomy developed by Dr. Li in China, that is a quicker and simpler procedure with less risk of bleeding and discomfort to the patient. He started to modify the traditional techniques based on his readings until he went to China to undergo training with Dr. Li. He was one of the first American physicians trained and certified by Dr. Li on No-Scalpel Vasectomy. He teaches No-Scalpel Vasectomy in the United States of America and other countries abroad such as China when in 2002, he became a visiting Professor in Chengdu. Together with Dr. Colin Kerr, they developed a video tape on No-Scalpel Vasectomy, intended for teaching would be trainees and as material for their advocacy work.

Dr. Ramon Suarez has taught doctors in the Philippines on No-Scalpel Vasectomy. One such doctor is Joseph Al Alesna, Training Officer at Vicente Sotto Memorial Medical Center and a consultant of Sacred Heart Hospital. He had been trained in the traditional type of vasectomy as a medical intern and as a medical practitioner, and was providing services with his involvement in a non-government organization called MASS ADS headed by Dr. Alberca from the 1970s until the early part of the 1990s. Its services focused on family planning and vasectomy was one of the methods provided by the agency. He came to know Dr. Suarez, Dr. Li and Dr. Liu when he was invited by the Reproductive Health

Center of Sacred Heart Hospital to undergo training on No-Scalpel Vasectomy in February 2004. Since then, he has been providing his services during outreach activities and at Sacred Heart Hospital, Vicente Sotto Memorial Medical Center, and Minglanilla District Hospital.

Aside from the training conducted by Dr. Suarez, the foundation have also linked up with EngenderHealth, a non-government organization based in Manila that provides family planning services. Dr. Ramon Suarez and Dr. Nenita Suarez have co-authored a training manual on No-Scalpel Vasectomy through EngenderHealth, distributed by the Department of Health.

The Promotion of No-Scalpel Vasectomy

Initially, the founders only campaigned in their hometowns in Leyte and Cebu. The campaign focused on their own testimonials since they have also been vasectomized. They enlisted the help of a younger relative in the United States who works in the Armed Forces to write about his experience of vasectomy. They do couple-to-couple educational and testimonial sessions and, in one of these sessions, were able to convince a Barangay Captain to undergo the procedure. The barangay official and his wife eventually became one of their active educators and advocates.

In 2002, the founders were introduced to Ms. Frohnie Cagalitan, Medical Social Worker of the College of Medicine of Southwestern University who had been detailed with the Sacred Heart Hospital. Ms. Cagalitan is an active

reproductive health advocate whom the founders had trained through its linkage with EngenderHealth. That training had included an orientation on No-Scalpel Vasectomy and observations of the actual procedure. She also enriched her knowledge by searching for relevant materials through the internet. These have been of value for her to thoroughly explain the procedure to clients including its advantages and disadvantages. Ms. Cagalitan has been their point person in terms of promoting no-scalpel vasectomy.

Flyers in English and *Cebuano* are now being produced through the help of Ms. Cagalitan. These materials explain that the procedure is simple, safe, does not require surgery, and takes only ten minutes (Annexes C.1-C.5). The reading materials highlight that the sex life of those who have been vasectomized actually improve and no problems related to their sexuality have been experienced. The founders of no-scalpel vasectomy are also mentioned as having undergone the procedure for some time already and now enjoy life even more and they would like others to enjoy their lives as well.



The counseling area inside the Reproductive Health Clinic.

These materials are distributed during orientation activities in different work establishments and during barangay meetings. They are also being distributed through different agencies such as the Philippine Information Agency, Barangay Health Centers, Government Offices, Non-government Organizations,

and hospitals. Previous client-advocates are also asked to distribute these materials to potential clients.

Letters containing information regarding no-scalpel vasectomy and its related schedule of activities are also distributed to different government agencies such as the Population Commission, Department of Labor and Employment and Department of Social Work and Development. The group has also enlisted the help of the Cebu Chamber of Commerce to get private companies to participate. The Cebu City Medical Center has also been instrumental in disseminating information regarding their activities. Another partner non-government organization whose help in dissemination has been enlisted by Sacred Heart Hospital are the Marie Stoppes Clinics, because helped in they are strategically located in three areas of Metro Cebu. They are present during free clinics assisting in the registration, counseling, and giving grocery coupons worth PhP 300.00 per client in exchange for the clients' income loss by being present. The coupon is used to avail of grocery items at grocery store near Sacred Heart Hospital. This was aside from the free lunch, t-shirt, medicines and condoms given by Sacred Heart Hospital through funding support by No-Scalpel Vasectomy International, Incorporated.

The group visits radio stations to promote its activities in the different programs of stations such as DYLA, DYSS, DYHP, Aksyon Radyo, and Bombo Radyo. During radio visits, phone calls are entertained to accommodate questions regarding the procedure and correct misconceptions about vasectomy.

Posters and streamers are placed in strategic areas where there is heavy human traffic. These areas include Barangay Health Centers, bus and *jeepney* terminals, Carbon Market and other business establishments.

Another person whose help has been enlisted is the nurse stationed at the Reproductive Health Center of Sacred Heart Hospital. Ms. Myrna Danuco helps distribute information materials, accommodates potential clients who visit the center, and answers telephone inquiries. Her training included actual observation of the procedure. She now assists in the actual procedure which is being performed in the Emergency Room of Sacred heart Hospital. As a staff regularly assigned to the reproductive health clinic, she entertains inquiries on no-scalpel



The minor operating room located at the emergency room where no-scalpel vasectomies are done.

vasectomy and schedules acceptors for the free procedure every Friday. At times, rescheduling of appointments is done when the doctor who performs the procedure is not available.

Aside from the staff of Sacred Heart Hospital, former clients have been instrumental in the campaign to increase male involvement in family planning by opting for no-scalpel vasectomy. These clients offer testimonies regarding their experience, facilitate the introduction of no-scalpel vasectomy in their workplaces, bring clients to the clinic, and assist in the distribution of information materials.

CHAPTER III

VIEWS OF PARTICIPANTS ON MASCULINITY IN CEBUANO CULTURE

Growing-up Male and its Effects on Childrearing

A majority of the study participants shared in doing household chores while they were growing up. Most of them were given responsibilities by their parents while a few took the initiative to help in domestic work even if they were not encouraged by their parents to take part in doing household chores. As one participant said:

I was not really given any responsibilities in the home. It was self-imposed. I helped clean the house and did the laundry.

Another participant revealed that:

I was not given any responsibility in particular by my parents. There were instances though that I helped in doing simple household chores such as cleaning the house.

Aside from household chores, there were those who at a young age, were already trained to help in their family's means of livelihood such as farming, fishing, and small business. A few participants shared their experiences:

I fed the pigs and helped my father till our land (Security guard, thirty-eight years old with three children).

In our house, I was tasked to fetch water from a nearby deep well. Outside of the home, it was more of a self-imposed initiative on my

part. I sold goods in the market and ice candy to my classmates. So as early as ten years old, I already started making money (Pastor, forty-four years old with three children).

A few claim that since they were the eldest or there was no female child, they were compelled to take on most of the household chores even those that are normally considered tasks for female children, such as taking care of the younger siblings, cooking, and doing the laundry. A participant said:

I cooked food and washed our clothes since I do not have female siblings.

On the other hand, there are also those who were only assigned tasks fit for male children such as feeding the animals, chopping firewood, and fetching water. Most of the domestic responsibilities as shown in **Table 3** are cleaning the house, cooking, and fetching water.

Table 3. Domestic Chores Done During Childhood

Domestic chores (N=44)	Number of Mentions
Cleaning the house	17
Cooking	13
Washing the dishes	8
Doing the laundry	8
Fetching water	10
Feeding animals	1
Chop firewood	1
Take care of younger sibling	1

Multiple response

Table 4. Taught domestic chores to their children

Responses	N=44	%
Yes	31	70
No	0	-
NA (children are very young)	13	30
Total	44	100

Table 5. Domestic chores assigned to children

Domestic Chores (N=44)	Number of mentions
Doing the laundry	5
Cleaning the house	4
Buying from the nearby <i>sari-sari</i> store	4
Cooking	3
Washing the dishes	5
Fetching water	2

Multiple response

For those with grown children, a majority admit that the way they had been reared by their parents influenced how they rear their own children. As in their past training, they also consciously teach their children to do household chores and even divide the tasks among them with older children taking more responsibilities (**Table 4**). The common tasks assigned included washing the dishes, doing the laundry, and cleaning the house (**Table 5**). It is deemed important that children, even at a young age, should be taught domestic responsibilities so that if anything adverse might happen, such as running into financial distress, they will not find it hard to adjust in terms of helping in

domestic responsibilities. This response also held true for those with household help around. A participant shared that:

In a way, I think it has affected the way I have been dealing with my children. Now, my wife and I have been teaching them basic responsibilities in the home like cleaning up their own mess especially after playing with their toys even if we have a household help.

One parent admits that even if it is important to teach children to participate in domestic work, it should not be to the detriment of their studies. Studying for the next day's lessons remains the top priority for their children.

For those who were trained to help in their family's source of income, they also imparted it on their children such as helping them sell goods in their stall in the market when there are no classes. Additionally, there were those who assigned tasks based on the gender of their children. For instance, females did the laundry and cooking while males fetched water.

Study participants with very young children cannot yet say if their upbringing affected the way they reared their children because they have not yet assigned tasks to them.

The Measure of a "Real Man": Views of Husbands and Wives

Predominantly, a "real man" is viewed as responsible for meeting the basic needs of his family such as food, clothing, and education (**Table 6**). This means that a husband must be able to answer the financial needs of his family,

thus he should be earning on his own. However, he should still be able to make time for his family and be caring and sweet towards his wife. His family should be his priority and he must have a keen sense of foresight in terms of establishing a good future for them especially in terms of handling the family's finances. A wife said:

He should be responsible for his family and can provide for their needs. He should also be able to find means to ensure the future of his children. He must also have his own stand on certain matters and must have a plan in life. All these must be good because it is for the future of his family.

Engaging in vices such as drinking and having extramarital affairs would prove to be detrimental to the future of his family. If the husband does resort to drinking, it should only be in limited amounts and must not become habitual. In connection, honesty towards his wife is important. It does help that the husband is God fearing and morally upright.

As head of the family, the husband is not only expected to take care of the financial needs of the family, when needed he should help in the household chores rather than spend his time hanging around the neighborhood. Additionally, he is obliged to be involved in taking care of the children and instilling discipline in them. As a partner, he is expected to understand his wife, her work schedule, and her interest in helping to meet the financial needs of the family by being gainfully employed or engaging in small business endeavors. A husband also needs to support his wife emotionally. For instance, during heated arguments, the husband is expected to listen rather than angrily engage his wife

and shout at her. As a result, he should not harm or ridicule her; instead, he must respect her.

Table 6. Characteristics of a “real man”

Characteristics	Number of Mentions	
	Husbands (N=44)	Wives (N=34)
Responsible	41	29
Not effeminate	1	3
Respects women	2	8
Attracted to women	1	1
Shares in domestic work	1	4
Does not have vices	1	4
Affectionate towards wife	0	3
Capable of siring children	0	2
God-fearing	0	2
Physically strong	0	6
Honest	0	3
Disciplines children	0	4
Participates in Family Planning	0	1

Multiple response

The physical characteristics of a “real man” include his ability to sire children thus, he should be attracted to the opposite sex. But even if he is expected to sire children, he should also be responsible to take measures to participate in family planning to be able to meet the needs of his family in the future. Other physical attributes include his strength and ability to do simple

household repairs such as plumbing, electrical work, and other minor mechanical problems. This requires him to be energetic, not frail.

It was conspicuously cited that a real man is not gay or possesses characteristics attributed to gays. As a wife cited:

You would not see him engage in small talks with women like gays do. Gays almost always mind their neighbors' business and backbites them. He should only mind his own business and must be able to discipline his family.

A man who is *macho* is physically fit, robust, strong, and mentally competent. Because he is physically healthy, he is predictably hardworking and can be relied upon by his family to meet their needs. The downside of being *macho* occurs when a man succumbs to wrong notions such as refusing to participate in domestic work like doing the laundry and taking care of the children, leaving the wife burdened with domestic work.

Beyond the physical characteristics, a majority of the respondents equate being responsible with being *macho*. This means that a husband takes care of his wife and children and works to ensure their future. Even if family members heavily rely on the husband, he does not have a monopoly in terms of deciding what is best for the family. Decisions must be reached together with the wife or if not, the wife should at least be consulted and her views taken into consideration.

One respondent mentioned that being *macho* is positive because he believes that men should be strong especially since women are weak physically. But generally, a *macho* man is seen positively because he only seeks what is good for the family and this comes with great responsibility.

CHAPTER IV

SOCIOECONOMIC AND CULTURAL CONDITIONS ENCOURAGE

PARTICIPANTS TO CHOOSE VASECTOMY AS A

FAMILY PLANNING METHOD

Financial Situations, Wives' Health, and Quality Fatherhood

The difficult financial situation of most families prompted the men to undergo vasectomy (**Table 7**). They realized that due to spiraling prices of basic commodities and the increasing cost of meeting the basic needs of their families such as food, clothing, shelter and education, they should take matters in their own hands. Being the family heads had never been easy especially when their incomes could barely meet family needs especially for those having more than three children. One father admits, that as a responsible partner he should be able to match his income with the number of children he has whose needs he must be able to provide.

Table 7. Reasons for choosing vasectomy

Reasons (N=44)	Number of Mentions
Economic	27
Health of wife	8
Contraceptive failure	2
Limit number of children	15
Spend quality time with children	1

Multiple response

Men are also concerned with the health of their wives. For instance, frequent pregnancies had caused reproductive health problems for their wives.

As one husband narrated:

I was very afraid of the idea that my wife would get pregnant again because she almost died during her last delivery.

For those whose wives were also using artificial contraceptive methods such as pills, the husbands were concerned with its adverse effects, which included perceived mood swings.

For couples who were already using family planning methods, they experienced failures both in the natural and artificial contraceptive methods. Moreover, men had realized that the burden of reproduction and raising children had always been with them the wives' concern, which brought about health problems for their wives. One husband said that:

I really thought that we would only have four children but my wife got pregnant a fifth time. We were using the rhythm method which failed. My wife was going to have a ligation but we found out that her blood pressure is elevated. I was told that ligation would not be good for her.

Men had chose vasectomy because they had already reached their desired number of children. More importantly, spending quality time with the children is important, for according to one father:

First of all, I think having only three children is wise enough. The reason for not having more children is not primarily due to my financial capability to meet their needs, it is more on raising them well by spending "quality time" with them. Having only three kids, I still sometimes feel guilty because I am not able to give equal attention to all of them.

When the men were asked during the focus group discussions to enumerate the three reasons for opting to undergo vasectomy, they cited that the prevailing economic crisis, coupled with threats to their financial stability, the future of their family especially their children, and their wives' health most often. Where their children were concerned, their education remains a priority. One respondent, however, adds that there are also men who go for vasectomy so that they can play around without the fear of impregnating someone, especially if it's a mistress.

Male Involvement in Family Planning

Many of the men say that family planning is something that couples should agree about and decide upon together. They realize though, that being the head of the family, with the responsibility to plan and chart its future, is a big challenge placed upon them. Thus, they are now taking the full responsibility to stop having children by choosing vasectomy. For those men who see the initiative to undergo vasectomy as solely their own, they claim that as men, they have the exclusive responsibility to look for a job to earn for the family and this also means looking after its future.

Men view family planning not only in the context of limiting the number or spacing of their children. They cite that they got involved also because of their desire to meet the needs of their family especially their children. The needs ranged from giving them food, shelter, education, and guiding them by participating in their care and nurturance. Husbands recognized the fact that the methods available are woman-centered such as pills, ligation, and intrauterine devices. However, no-scalpel vasectomy is also an available option that couples can choose to safely plan the number of their children.

One respondent confesses that it is better if husbands and wives are able to agree on family planning, although in his case he decided against the view of his wife. She was against vasectomy because she views it as a sin.

In **Table 8**, wives emphasize that male involvement in family planning not only means limiting the number of children but is more importantly about sharing the responsibility of nurturing them and ensuring their future, especially their education. Nurturance of children means taking an active part in instilling in them discipline and good manners. Additionally, husbands ought to share in the domestic responsibilities like doing household chores and helping in the marketing. Since women are burdened with risks associated with pregnancy and giving birth, thus, having a vasectomy is a husband's contribution.

Table 8. Reasons cited by wives on the importance of male involvement in family planning

Reasons for male involvement in FP (N=34)	Number of Mentions
Ensure future of family	16
Limit number of children	8
Shared responsibility	23

Multiple response

In discussing with the husband which family planning method to adopt, wives emphasize that factors such as spacing and number of children should be considered. For instance, if couples choose the natural family planning methods, the husbands are expected to be cooperative and understand that there are times that their need for sex must be forgone to avoid pregnancy.

CHAPTER V

THE INFLUENCES THAT FAMILY MEMBERS, PEERS, AND HEALTH CARE PROVIDERS HAD ON MEN'S DECISIONS TO UNDERGO VASECTOMY

The study participants claim that their wives and health providers were the most instrumental in their decision to undergo vasectomy (**Table 9**). According to most of the men, after they discussed their plans to undergo vasectomy with their wives, and obtained their support, the health providers were then largely significant in their final decisions. However, their in-laws and friends did not greatly affect their decision to have a vasectomy.

Table 9. Involvement of wives, in-laws, friends and health providers in men's decision to have a vasectomy

Persons Involved in the decision	Responses (N=44)	
	Yes	No
Wife	31 (70%)	11 (30%)
In-laws	3 (7%)	41 (93%)
Peers	7 (16%)	37 (84%)
Health providers	43 (98%)	1 (98%)

Multiple response

The "Significant Others", In-Laws, and Friends

A majority of the men involved their wives in their decision to have a vasectomy. **Table 10** shows that there were those who first learned about no-scalpel vasectomy from their wives who had either attended an orientation, got hold of a flyer containing information about vasectomy, or had found a health

provider who explained the procedure to them. Both men and women seriously took into account their adverse experiences of contraceptive use, most notably contraceptive failure and the high cost of artificial methods. Other considerations included unpleasant experiences during pregnancy and childbirth, having already had more children than desired, the status of wife's health, and current financial standing. A wife said that:

We both decided that he should undergo vasectomy. I supported him because I also wanted to stop getting pregnant so that we would not have additional children. I cannot use the IUD because I have hypertension. That is why vasectomy is a better option.

The negative experiences of women with contraceptive use included palpitations, headaches, moodiness, loss of weight and the appearance of varicose veins for the pill users. An IUD user mentioned experiencing severe abdominal cramps. They also mentioned contraceptive failure for those who were using the rhythm method, withdrawal, and pills. Many spouses, especially the women had contemplated on having a ligation but decided against it because it was expensive, their health would not allow it because they had hypertension, one found out that there was something wrong with her fallopian tubes which would not qualify her for ligation, and post-operative recovery would be cumbersome because they have a lot of domestic work to attend to that would be contraindicated.

Table 10. Wives' participation in husbands' decision to have a vasectomy

Extent of participation (N=34)	Number of Mentions
Husbands initiated discussion and wives gave support	16
Wives initiated discussion on vasectomy	11
Wives cited reproductive health problems experienced	22

Multiple response

Some couples decided to choose vasectomy because of risks to health they had experienced during pregnancy and delivery. One woman had had a difficult pregnancy and ultimately a cesarian section during delivery, only to learn that the fetus had died before delivery. Some women's hypertension led to pre-eclampsia which may result in death during delivery. Miscarriage or spontaneous abortion is another reason cited. Difficult pregnancy and delivery lead to additional medical cost when a newborn needs incubation and a longer stay in the hospital after delivery.

A majority of those who have opt for vasectomy have three or more children. This is already very difficult for them in a period of increasing prices of basic commodities, when at the same time they either do not have a steady source of income or they are earning less than what their family needs.

Table 11. Wives supported husbands' decision to have a vasectomy

Answers	N=34	%
Yes	32	94
No	2	6
Total	34	100

Table 11 above shows that only two women did not agree to let their husbands go through vasectomy because they considered it sinful or because and their live-in union was not stable. Were they to separate later, the man would no longer be able to sire children to the woman he will eventually marry. A husband explained his decision to have a vasectomy without his wife's consent:

My wife was not part of the decision-making process because she is against vasectomy since she considers it a sin. I thought of having a vasectomy when we already had eight children. But that time, I asked my wife to have a ligation but she did not like the idea because it is still a sin. When we already had ten children, I solely decided to have vasectomy. We had fights because she was concerned that it might adversely affect my health. She even went to the Security Agency that I work for and demanded why she was not informed (*the security agency asked the personnel of Sacred Heart Hospital for an orientation on No-Scalpel Vasectomy for their workers*).

The wife said:

It was solely his decision. I did not support him because it is a mortal sin. We fought because I could not understand the reason why he had a vasectomy and he never answered. I really cried when I knew that he had had a vasectomy. My mother advised me to just accept it and our priest told me to just pray for my husband because anyway, he is looking after the future of our family.

There were husbands who did not include their wives in their decision because they had to take matters in their own hands, especially given difficult times when the future of the family was at stake. One husband decided to surprise his wife because at the onset, it was supposed to have been the wife who would go for ligation but they had decided against it when they learned that it has a number of side effects. Because of these possible undesirable effects of ligation on his wife, he decided to have a vasectomy. His wife was very supportive upon learning that her husband had gotten a vasectomy.

The Health Providers

A majority of the study participants were greatly encouraged by the health providers who they considered to be experts knowledgeable about the procedure. The manner in which it was explained to them provided an assurance that it is safe, thereby easing their apprehensions. There examined visual aids used to facilitate a clear understanding of what should be expected during and after vasectomy. They felt confident that nothing adverse would happen because they read or heard testimonies given by previously vasectomized clients

regarding their experiences. It helped a lot that during counseling, instructions given to them were clear in terms of what to do and what to expect after the procedure to ensure that nothing unfavorable would happen. One client was even accompanied by a health provider to Sacred Heart Hospital prior to the scheduled date of the procedure to ensure that he knew where the venue would be.

Only a very few of the men involved their in-laws and friends in their decision to undergo vasectomy. Those who were influenced by their in-laws bared that they were encouraged to undergo vasectomy because they brought up the facts of the economic crunch, that religion did not prohibit the practice of vasectomy, and that their in-law also had had a vasectomy. Friends positively influenced their decision to have a vasectomy when they decided to undergo the procedure together, thereby allaying fears and anxiety. Friends also assured its safety because of their own previous experiences, and they also said there was nothing wrong with it because it is not against their religion.

CHAPTER SIX

STEREOTYPES THAT HINDERED AND /OR PROMOTED THE PROVISION OF VASECTOMY FROM THE VIEWPOINTS OF VASECTOMY PROVIDERS, ACCEPTORS, AND WIVES

The Downside of Vasectomy

Vasectomy is unpopular as a contraceptive choice because of erroneous beliefs associated with it. A common is the notion that vasectomized men can no longer attain erection. This is a threat to their *pagkalalaki*. They think that they will no longer enjoy having sex or be able to have sex with their wives. That this might result in their wives' philandering because they will no longer be sexually satisfied by their mates. Eventually, this will lead to their break-up. Some wives think that because vasectomized men can no longer impregnate, they will no longer have second thoughts about having extramarital affairs. One male study participant pointed out his wife's worry that he would become a "sex maniac" because he would be free from the fear of getting his wife pregnant, and would also have extramarital affairs to satisfy his lusts. One wife mentioned that men might worry about absolutely not being able to sire children even if, for example, the wife dies, he wants to have children in a second legitimate relationship.

Another misconception of vasectomy is that it is equivalent to castration. This leads to the opposite conclusion from one stated above, that vasectomized

men will no longer be interested in sex. Moreover, it is believed that men will no longer release semen. Failure to release semen was interpreted by a friend of a study participant as a factor that would eventually result in prostate cancer. Thirdly, castration also means to some being inutile; a vsectomized male will be unable to attain erection.

Table 12. Reasons cited by wives on vasectomy's unpopularity among men

Reasons for refusal to have a vasectomy (N= 34)	Number of Mentions
Failure to have an erection	11
Vasectomy equated with castration	3
Will become gay	2
Lessened sexual drive	13
Affects physical strength	10
Will become a sex maniac	3
Against the teachings of the church	2

Multiple response

Another erroneous and common belief is that, physically, vasectomy lessens a man's strength (**Table 12**). He will no longer be able to do heavy work because it is thought to be risky for his health. Health risks erroneously mentioned included enlargement of the testes and death if there are complications. In the long run, men will become lazy because they are selective of the kind of work they do even to the extent of no longer participating in domestic work. They will end up unemployed, which would mean financial loss and a bleak future for the family.

Other than these physical aspects, there are also erroneous beliefs about psychological consequences such as moodiness and the tendency to get angry

easily. These are attributed to the lack of sex drive, leading to an adverse effect on a couple's sex life. The husbands would also have to contend with being teased by neighbors and friends who think they are not able to attain erections anymore and their sex lives have ended (because of the fear of being teased, a few men and their wives never mention that the husbands underwent vasectomy). Men might become gay in the end since sex with a woman is no longer enjoyable.

Religious beliefs play another major factor in the unpopularity of vasectomy because religious Filipinos, believe in what the Bible says which is "go out into the world and multiply." Vasectomy is equated with sin because it runs counter to what God wants couples to do.

Two men experienced failure in vasectomy. One admitted that he failed to have a sperm count before engaging in unprotected sex with his wife. One opted to have another while the second did not opt to have another procedure. The one who had a repeat vasectomy is not fully convinced of the effectiveness of vasectomy and is still using condoms especially since he did not have a sperm count yet after the second procedure. Their wives got pregnant less than a year after the procedure. Both failures led to domestic conflicts, because the wives were hoping that they would not get pregnant again and experience the hardships of another pregnancy. Moreover, the pregnancies caused the wives to feel ashamed for relatives and friends knew that the husbands had vasectomies.

These people could not help but think that the pregnancies were a result of the wives' having extramarital affairs. One of the wives expressed her frustration:

I regret that I suggested the procedure to my husband. They said that it is 98% effective. Perhaps we belong to the 2% ineffective. By August, he was supposed to have been vasectomized for one year but I got pregnant in June. My menstruation stopped. Had we not tried this method, I believe I would not have gotten pregnant since he was pretty good at using the calendar method. We were using it for two years and I did not get pregnant. Just when we decided to make it sure with vasectomy, I got pregnant. My experience was really frustrating and especially I felt ashamed in the presence of the doctor who performed it. I hid every time I saw him from a distance and if I could not avoid meeting him, I covered my belly. My husband did not have a sperm count after the procedure. People probably think that I had an extramarital affair although I know the truth. I definitely would not recommend it to men.

Their husbands said that the possibility of failure sometimes affects their initiatives to encourage others to undergo vasectomy.

The Upside of Vasectomy

The best way to counter the misconceptions of vasectomy is to launch massive information drives using media and going to the barangays to ensure that many communities are covered by the campaign. During the information drive, reading materials describing the procedure and how to ensure its effectiveness are necessary. Facts should be presented to correct the usual misconceptions. Testimonials of the experiences of men who underwent

vasectomy would encourage men. Wives also say that having couples share their experiences would go a long way to encourage men to have a vasectomy.

Majority of the study participants emphasize that discussion of the exacerbation of economic hardships faced by families with many children is an eye opener. The future of those having many children will be bleak because times are hard, especially for those receiving low wages and facing job loss. Having more than three children is already a financial burden. As one husband says:

These are hard times. It would be not be good if we just keep on having children. One must be able to match his income with the needs of his family. Just look at our population growth and how the economy is ailing. There is no balance.

The same husband echoes the concern of others regarding the harmful effects of continuous pregnancies on the women's health:

Another thing, men must also be aware that family planning is not an exclusive responsibility of women. Men also have a role to play. If we talk about family planning, women are the ones hardest hit. Just look at the methods--pills, IUD, ligation. For us men, there is vasectomy which is easy, free, and safe. It is better if we choose vasectomy.

The men who participated in the focus group discussions agrees that their sex life has become better because they no longer worry about unwanted pregnancy. They are able to clearly chart the futures of their families because they are no longer worried of another person whose needs they must meet.

Men mention that no-scalpel vasectomy is a better option compared to ligation because it is not a surgery, it is safe, and recovery is fast as long as one religiously follows the instructions given during post-counselling.

Another concern is the religious aspect. A husband said that vasectomy should not be seen as against the law of God, rather it is being responsible to wife and family as a whole. A husband discloses:

Well, for those who have not planned their future, they better start it now before it is too late. Men can be encouraged by explaining to them that it is not a sin. I am an avid student of the Bible and I could not find why the Catholic Church says that it is a sin.

A wife who refused to have a ligation for religious reasons, felt bad when her husband had a vasectomy but she was later enlightened after talking to a trusted priest who said that she should not worry because her husband is after all, looking at the future of their family.

CHAPTER VII

THE DECISION-MAKING PROCESS UNDERTAKEN BY MEN TO UNDERGO VASECTOMY

The decision to undergo no-scalpel vasectomy did not take long for majority of participants. In fact, it did not take more than one month for them to decide after knowing about the procedure (**Table 13**). There were a few who only took a day to decide to have the procedure. The urgency to have the decision was brought about by the number of children they already had at that time. Some had already reached their desired number while others had already exceeded the number of children they desired. They explain that having more children would mean additional financial difficulties in terms of raising them and meeting their needs. In fact, some were already facing problems in terms of answering the basic needs of their family. The concern for their wives' health also compelled them to have the procedure done immediately. They pointed out that too many pregnancies took a toll on their wives physical health. Some wives had already experienced high-risk pregnancies and difficult deliveries.

Table 13. Length of time on deciding to have a vasectomy after knowing about the procedure

Length of time to decide	N= 44	%
Less than one month	39	89
One month	3	7
More than one month to six months	1	2
More than one year	1	2
Total	44	100

The decision to undergo vasectomy did not come about without first seeking information about the procedure. Their sources of information included television (ABS-CBN's *TV Patrol*), radio (DYHP's radio program entitled, *Kini ang Akong Suliran* [*This is My Problem*] anchored by Dr. Lourdes Libres-Rosaroso, a newspaper (*SunStar Daily*), flyers, streamers, health providers, neighbors, in-laws and wives. A study participant narrates how he came to his decision:

After I read in the newspaper about no-scalpel vasectomy, I immediately called up Sacred Heart Hospital. The person who answered the phone explained the procedure and family planning also. My wife and I first discussed it and I then decided to have the procedure. It did not take one week for me to decide.

Table 14 shows that majority mention health providers as source of information and these include barangay health workers, medical interns and doctors from Sacred Heart Hospital who thoroughly explained the procedure, which made them understand that unlike, in the past, it is not a procedure that

takes a long time, and it is safe. Its safety was very important to one of the study participants because a neighbor had an infection after he had the traditional vasectomy procedure. A person from Sacred Heart Hospital also gave an orientation in the workplace of a few of those who decided to undergo vasectomy which convinced them of its effectivity, safety, and practicability. He said:

At the time when I still had four children, I already planned to have a vasectomy but it was going to be the traditional type, which required an operation. I had a neighbor who suffered an infection after the procedure. I got scared then. Now, when the number of my children reached eight, there was somebody from the barangay health center who explained the new procedure. She also said that it is free, safe, and not painful. So, I then went to Sacred Heart Hospital to have a vasectomy.

Neighbors were one source of information when they either heard or read about vasectomy and talked about it with a participant. These neighbors also encouraged them to attend an orientation on vasectomy in their barangay or in Sacred Heart Hospital. Five of the study participants underwent the procedure together with their neighbors, which was an advantage to them because they gave each other moral support.

Table 14. Sources of information on vasectomy

Sources of information (N=44)	Number of Mentions
Wife	5
Health provider	18
Television	3
Newspaper	8
Radio	5
Streamer and flyers	6
Friend or neighbor	5

Multiple response

Another source of information were wives, some of whom knew about vasectomy through various sources such as a doctor when they had their regular pre-natal check-ups, and health personnel who conducted orientations regarding the procedure. The wives discussed the information they got with their husbands and this encouraged the latter to have the procedure. A few husbands still sought other sources of information about the procedure such as attending an orientation, which they also knew about through their wives.

CHAPTER VIII

POST-OPERATIVE EFFECTS ON PERCEPTIONS OF MASCULINITY

Study participants' perception of *pagkalalaki* has not changed after undergoing the procedure. Husbands equated it with being responsible in terms of putting the needs of the family first. Such needs include providing food on the table and sending their children to school. Education of their children figures prominently in their priorities since this is one way to give them a chance in life.

This concern of husbands is also held by their wives. Beyond the issue of reproduction, women should be respected, not be subject to physical abuse, such as the physical abuse of continuous childbearing. In the same way, women must not be burdened with problems stemming from the vices of their men such as drinking and womanizing.

A number mention that their sex life has been significantly enhanced because they are no longer anxious and even fearful of another pregnancy. Their sex drives have improved. Now, they also have "peace of mind" and their domestic life has become better, whereas in the past, they had fights due to frequent unplanned pregnancies and failure to immediately respond to the basic needs of family members such as food and education expenses and other expenses related to the upkeep of the home. Fewer domestic spats have led to couples becoming closer. A husband shared his experience:

It (vasectomy) makes me feel better now about myself. My sex life is good because there are no more apprehensions before the contact. No more worries of bearing another child.

A wife shares how their sex life improved after the procedure:

There were hurdles like we were advised not to have sex before completing 20 ejaculations but after that, there were really positive changes. No more worries of getting pregnant. In terms of stimulation, there were no changes. The operation in fact, made our sex life better--no worries, guilt feelings and apprehensions. You only need to sleep soundly after.

Wives see their husbands' choices to have a vasectomy in a positive way because they have been spared from undergoing ligation which is perceived as more expensive and riskier compared to vasectomy. One wife is happy because her life is no longer endangered by difficult pregnancies. In the past, she experienced a complicated pregnancy, which eventually resulted in a stillbirth.

In-laws see the move to go through vasectomy optimistically because they no longer have to help to meet the food and schooling needs of the grandchildren, should more of them have come along. Their present grandchildren would have a better future when expenses would not have to go to the unborn siblings. They see the move as something to be proud of.

The friends of the participants were concerned about any adverse physical effects of vasectomy, such as no longer being able to attain an erection. This, many misconceived, would have an impact on their *pagkalalaki* because impotence would mean the end of a man's sex life. Failure to have erections was coupled with fears of doctors committing errors during the procedure. Eventually,

some said, not being able to have an erection was also interpreted as a man becoming gay.

Table 15. Post-operative perceptions of wives', friends' and in-laws' on men's masculinity (N=44)

Perceptions	Wives	In-laws	Friends
Positive	43	43	40
Negative	0	0	3
NA (did not inform anyone)	1	1	1
Total	44	44	44

In brief, the perception of the vasectomized man's *pagkalalaki* remained positive and the same after as before vasectomy (**Table 15**). Vasectomy is seen as one of the acts of responsibility a male should take to ensure the well-being of his family of procreation.

CHAPTER IX

SUMMARY OF FINDINGS, HYPOTHESIS-TESTING, FURTHER CONSIDERATION OF THE PROBLEM AND RECOMMENDATIONS

Summary of Findings

The study intended to determine the ways in which concepts of masculinity have shaped the contraceptive choice of men for vasectomy and how this choice, in turn, has changed the meaning of masculinity for some sample of married Cebuano men. Specifically, it aimed to determine: (1) how masculinity is defined in Cebuano culture as reflected in the interviews; (2) the social and cultural conditions in Cebu that encouraged males to choose vasectomy as a family planning method; (3) the influences that family members, peers, and health care providers have on men's decisions to undergo vasectomy in a Cebuano culture; (4) the stereotypical roles (seen to be characteristic of or associated with men) and local cultural concepts of masculinity that hinder and/or promote the provision and utilization of vasectomy as a family planning option, from the viewpoints of both vasectomy providers and acceptors; and (5) If and how self-concepts of masculinity are affected by the process of making a decision to undergo vasectomy, and thus how cultural change in concepts of masculinity might be taking place among Cebuano vasectomized males.

Guide questions were formulated in Cebuano. Data gathering methods included one-on-one in-depth interviews with vasectomized men and their wives,

focus group discussions among vasectomized men, key informant interviews among health service providers and secondary data on vasectomized men were gathered.

A total of 44 No-Scalpel Vasectomy clients were interviewed. While only 34 wives of vasectomized men were interviewed. A total of five service providers were interviewed regarding their involvement in the delivery of No-Scalpel Vasectomy. Selected men who were previously interviewed on a one-on-one basis formed part of the two focus group discussions that were conducted.

All data gathered were encoded and were organized based on set themes or categories. They were then content analyzed and similar, different, and “salient” answers were taken into account. Direct quotes from respondents were presented to provide “meat” to the data gathered.

The study was organized into nine chapters, namely: (1) Introduction; (2) A discussion on the background of Sacred Heart Hospital and the beginnings of its involvement in no-scalpel vasectomy, vasectomy campaign drive, and networking activities to garner support for no-scalpel vasectomy; (3) Views of participants on masculinity in Cebuano culture; (4) Socioeconomic and cultural conditions encourage participants to choose vasectomy as a family planning method; (5) The influences that family members, peers, and health care providers had on men’s decisions to undergo vasectomy; (6) Stereotypes that hindered and /or promoted the provision and utilization of vasectomy from the viewpoints of vasectomy providers, acceptors and their wives; (7) The decision-

making process undertaken by men to undergo vasectomy; (8) Post-operative effects on perceptions of masculinity; and (9) Summary of findings, Hypothesis-testing, Conclusions of the Summary Problem, and Recommendations.

Chapter 1 presented the rationale behind the study to support its relevance in terms of contributing to the available knowledge and social significance of vasectomy. It also delved into studies already conducted on the topic that gave guidance on the organization of the topics dealt into by the study. Moreover, it contextualized the study based on the researches done in and out of the country. The study's significance on Cebuano culture was outlined and how it could contribute to the body of knowledge and society in general. Chapter one likewise discussed the research methodology which included the research environment, study participants, research procedure, conduct of data gathering, organization of the study and definition of terms.

Chapter 2 discussed the background of Sacred Heart Hospital as a service delivery point including how it started its involvement in the delivery of No-Scalpel Vasectomy (NSV) through its ties with NSV International, Incorporated. It also covered the training background of the service providers and the hospital's activities related to the promotion of NSV.

Chapter 3 outlined how men had been socialized by their families and consequently, its impact on the way they reared their children. It also encompassed the views of men and their wives on the characteristics of a "real" and "macho" man.

Chapter 4 presented the socioeconomic and cultural conditions that encouraged men to choose vasectomy as a family planning method. It also discussed factors that made significant impact on their decision to directly participate in family planning and how they viewed the latter beyond the traditional way of looking at it as a way to limit the number of children.

Chapter 5 examined the influences that family members, peers, and health service providers had on men's decision to undergo or not to undergo vasectomy. The wives and health care providers had a great effect on their decision to have the procedure.

Chapter 6 discussed the downside of vasectomy such as the myths and misconceptions that prevented men from undergoing vasectomy. The study participants enumerated physical, psychological, and religious reasons that previously hindered their acceptance of the procedure. The upsides of vasectomy were also tackled and significant of these were the presentation of facts that countered myths and misconceptions they once held. Noteworthy also was the mention of an improved sex life after the procedure.

Chapter 7 dealt with the decision-making process that men underwent prior to having a vasectomy. Majority did not take a lot of time to decide to have the procedure since they already reached or exceeded their desired number of children. It helped that timely and accurate information were given by various sources known to the study participants.

Chapter 8 talked about the study participants' concept of *pagkalalaki* after having vasectomy. Generally, their concept of *pagkalalaki* did not change although having had the procedure was seen more positively by men and their wives.

Findings

1) Masculinity is defined as being a responsible husband and father. This means that a man should be able to meet the basic needs of his family--food, clothing, and education. He should be able to take part in raising the children and sharing in domestic work. Should devote time for his wife and support her not just financially but also emotionally. In terms of decision-making, the husband as well as the wife must jointly decide; if not, the wife should at least be consulted.

A man is expected to sire children but with this expectation comes the responsibility to take care of them. Part of this responsibility towards the children is his direct participation in family planning. Aside from siring children, physical strength is likewise attributed to being a man. Thus, he is expected to be hardworking not just in terms of having a steady source of income but also participating in domestic work.

2) Men were encouraged to undergo vasectomy most importantly due to economic reasons. They had been feeling the crunch of ensuring the future of

their family members, especially their children. This would prove to be more difficult were another child to come along. In fact, a had majority already reached or even exceeded their desired number of children.

The husbands' concern for the health of their wives, who in the past experienced various reproductive health problems during pregnancy and childbirth, made them take charge of choosing vasectomy. Added to this was the constant pressure placed on women to regulate fertility by way of contraceptive methods.

3) Wives made a significant contribution to the decision of men to undergo vasectomy. Aside from providing husbands with information regarding the procedure, the extent of support given by the wives as expressed through their agreement on the decision of their husbands to have a vasectomy made a marked impact to go through with the procedure.

The encouragement given by health providers by thoroughly explaining the procedure and correcting myths and misconceptions and assuring them of its safety and reliability provided an extra push on the acceptance of husbands to have vasectomy.

In-laws and friends did not have a noteworthy influence on the decision of men to submit themselves for vasectomy.

4) In the past, men were not keen on undergoing vasectomy because of various misconceptions regarding the procedure. Foremost, there was the notion

that they could no longer attain erection and even the confusion of it with castration which would greatly affect men's virility. This in turn, would affect their *pagkalalaki*, their sexuality, strength, maleness and ability to provide. Psychological and religious factors also figured prominently in their decision to forego vasectomy in the past. All these were corrected through accurate information given by various reliable sources such as health care providers and vasectomized men.

Aside from the accurate information given, men as *padre de pamilya* (head of family), seriously took into account their responsibility as fathers of their children and husbands of their wives. They took matters into their own hands by making the decision to actually submit themselves for vasectomy.

5) As cited previously, men equated masculinity with responsibility towards the family. This is the very reason that prompted men to have a vasectomy without much delay from the time they received accurate information regarding the procedure. Thus, after having the procedure, men felt that nothing actually changed with the way they perceived their masculinity. In fact, having vasectomy affirmed their concept of being a responsible man, husband, and father. Their wives also saw this in the same light.

HYPOTHESIS-TESTING

Hypothesis No. 1) Certain specific concepts of masculinity are associated with the decision to undergo vasectomy.

The study participants revealed that masculinity is associated with being responsible for the needs of the family. This is focused more on meeting the *financial* needs of the family especially in relation to food and education. Being responsible also includes a sense of foresight for the future of the family by planning ahead of time and prioritizing the family's needs. To be able to do this means not engaging in vices such as drinking and "womanizing."

A real man is attracted to the opposite sex and is able to sire children. Coupled with the ability to sire children, is the responsibility to raise them. Attaining the desired number of children and even exceeding that number, one way of asserting one's responsibility is to take active part in limiting the number of children and going for a vasectomy. Additional children would mean added expense and a more difficult life given current incomes.

Although the financial aspect figures prominently in the study participants' view of being a responsible man, they also mention that participating in the nurturance of their children is also important. Moreover, being able to participate in domestic chores even if they are already the ones earning for the family is seen positively.

In their families of orientation, a majority of the men grew up helping in domestic chores that included cleaning the house, cooking, washing the dishes, and doing the laundry. In fact, there were those who took it upon themselves to help in household chores even without the parents telling them to do so. Early on, responsibility was taught and internalized, and training at home was also being passed on to their children.

Certain misconceptions of vasectomy include failure to attain erection and equating it to castration that adversely affect the sexual activity of a man. Then, the procedure is believed to result in reducing a man's physical strength valued for his means of living to meet the needs of his family and his contribution in the domestic work. Psychologically, a man will turn-out to be moody and easily gets angry which is related to a man's decreased sex drive leading to problems in a couple's sex life. Religion plays a role in a man's choice to have a vasectomy because it is believed to be sin. After having a vasectomy, the above-mentioned notions were proven to be wrong and the decision to proceed with the procedure proved to be right.

Hypothesis 1 is accepted.

Hypothesis No. 2: Men who choose vasectomy are likely to have had reference groups not strongly critical of vasectomy.

The male reference groups are much less significant to male decision-makers than their wives.

When men decide to undergo vasectomy, they usually consult or decide together with their wives. However, even without consulting or getting the consent of their wives, there are husbands who still go through the procedure. The wives have a critical role in the decision to undergo vasectomy, foremost because the men learn about no-scalpel vasectomy through their wives. The health status of the wives is also seriously taken into consideration when the men decide to undergo vasectomy. Adverse experiences with contraceptive use, pregnancy, and delivery, which have placed their wives in uncomfortable or dangerous situations, prompt men to have the procedure. These are also discussed when the wives are consulted or their consent is sought by the husbands.

Aside from husbands' concern for the health of their wives, the number of children whose immediate and future needs they must respond to figure conspicuously in the discussion to undergo vasectomy. The family's income vis-à-vis the number of family members must be matched especially now that times are difficult due to continuous economic crunch.

A majority of wives support the decision of the husbands to undergo vasectomy given the difficult circumstances they have been facing. The support of wives make a difference in the acceptance to undergo vasectomy.

After the wives, the health providers are influential in the decision to undergo vasectomy especially since they are considered as experts knowledgeable in the procedure. The efforts of health providers to inform men on the procedure that they would undergo, including its safety, have made men more resolute to have vasectomy. The strategy to include testimonies of previously vasectomized clients helps facilitate and even hasten the decision-making process.

The negative comments of friends and in-laws did not have significant weight. A majority of the acceptors did not bother to consult them also. When there are apprehensions voiced by these groups regarding the possible harmful effects of vasectomy, the men still push through with having the procedure because what matters most is the information and support given by the wives and health providers.

The reference groups whose views affect men in their decision to undergo vasectomy are those of the wives and health providers. Noteworthy is the opposition of two wives on their husbands' decision to have a vasectomy because of religious reasons. The men proceeded with the procedure because they believe otherwise and what matter most is the future of the family. Majority of the wives and all health providers favored vasectomy as a family planning

method appropriate for men given the circumstances they are in. The influence of friends and in-laws is not significant compared to the two previously mentioned.

Hypothesis 2 is thereby accepted.

Hypothesis No. 3: Stereotypes of men held by service providers hinder the provision and utilization of vasectomy services.

The key informant interviews reveal that the founders of no-scalpel vasectomy had also undergone vasectomy and are convinced of its effectiveness. In fact, they directly participate in its promotion by having couple-to-couple dialogues, turning vasectomized men into active advocates, and doing radio guestings a few days prior to the scheduled date for vasectomy services. They are instrumental in persuading men to directly participate in family planning by undergoing vasectomy to terminate the burden women face in terms of their reproductive health.

Those providers who are based in the Philippines have been active in promoting vasectomy by producing information materials, doing the rounds on the different radio programs, conducting barangay information activities, visiting government and private agencies to conduct orientations, and making no-scalpel vasectomy available throughout the year at Sacred Heart Hospital through the doctors which they train. The staff person of Sacred Heart Hospital directly who handles information campaigns on no-scalpel vasectomy is a reproductive health advocate who had undergone trainings on gender sensitivity, sexual and reproductive health and rights, and male participation in reproductive health, to name a few.

In so far as providers are concerned, they are directly involved in correcting misconceptions about vasectomy taking into account the existing stereotypes that society has of men. These stereotypes include the prevailing notion that men are not keen on directly participating in family planning thereby leaving the responsibility on women. Men are believed not to take control in terms of family planning because their *pagkatalaki* is at stake if they lose their virility. Service providers themselves do not hold these stereotypes of men that could have hindered the provision of their services.

Hypothesis 3 is rejected.

Hypothesis No. 4: Men's decision-making process concerning their own vasectomy is negatively affected by society's views on whether men should be involved in family planning.

Men's decision to undergo vasectomy has been greatly influenced by their wives and health providers. Many of them have talked or consulted with other people especially that family planning is seen as something that only couples should talk about and decide on.

Topping the list of important reasons for men to undergo vasectomy is the economic aspect. Men emphasize that their utmost responsibility is being able to meet the needs of the family especially that of their children. Having many children means greater expenses which is very challenging especially that their earnings might not be able to sufficiently answer the needs of the family. Besides, when one has already reached his desired number of children, then it is time to take control. As head of the family, the challenge is greater on the father. This is compounded by the fact that women, have been weighed down with reproductive problems related to fertility regulation, pregnancy, and childbirth. Men see the need to directly participate by having vasectomy since many of the methods available are woman-centered. However, vasectomy is a choice that men can make. This is even amidst the opposition of a very few wives who see vasectomy as against the teachings of the church. What matters

most to men, as head of the family, is ensuring the future of their family especially that of their children.

The comments and views of other people are not seen as significant in their decision to undergo vasectomy. Views of others are not sought by men since their concepts of family planning do not only revolve around the traditional ways like limiting or spacing the number of children. Men assert that family planning is also about taking an active part in raising and nurturing children. It also means spending quality time with them.

Hypothesis 4 is rejected.

CONCLUSIONS AND FURTHER DISCUSSION

This study outlines the reproductive choices of Cebuano men to undergo vasectomy and explains the concepts of *pagkalalaki* that Cebuano men hold which created an impact on their choice. Cebuano married men understand the concept of *pagkalalaki* as being responsible in terms of meeting the basic needs of the family such as food and education. A related finding on masculinity by Whitehead (1997) in a study conducted in America is that masculinity involves two themes, namely, respectability and reputation. The former includes having economic power to provide for one's family. Men see that it is their primary duty to financially meet the needs of the family and this is also supported in the Philippines by studies done among Ilokanos by Pingol (2001) and Margold (2002).

Beyond being able to meet the economic needs of the family (Whitehead, 1997), men likewise see their role as actively to participate in the nurturance of their children by spending "quality time" with them. Moreover, they should also be able to spend time with their wives despite the many responsibilities they have, which includes participation in domestic work. Doing household chores is not an issue among Cebuano men also, and this can be related to the way they were socialized in their childhood years when they were trained to do simple household chores. Also in the Philippines, Mendez and Jocano (1979) revealed in their research that Tagalog boys were assigned chores which require physical strength, traveling some distance from the home, and minimal socio-emotional

skills. Liwag, de la Cruz, and Macapagal (1998) found that boys assisted in child care when girls were not available.

Masculinity as perceived by both men and women include physical characteristics although they are not considered significant in the decision to choose vasectomy. These physical characteristics include physical strength and the ability to sire children. An emphasis on physical strength was found in the present study and also by Liwag, de la Cruz and Macapagal (1998) because they found out where men are expected to do heavy work. There is another important expectation which is the ability of men to impregnate women which, in fact, Gilmore (1990) and Gutmann (1997) report in their studies among men in the circum-Mediterranean region. There part of the "moral imperatives" of maleness involved impregnating one's wife aside from meeting the needs of dependents and protecting the family. In the Philippines, Tan (1989) believes that the siring of children is considered an essential achievement.

Men choose vasectomy despite the prevailing myths that surround it, for instance, its leading to an inability to attain erection, lack of interest in having sex, and being equal to castration. These are discussed by Atkins and Jezowski (1983). First, our men are concerned for the future of the family especially now that times are now economically difficult. In Margold (2002), an ideal husband is seen as someone who can secure his family's economic stability. Second, the health status of their wives is threatened by risky pregnancies and deliveries. The threat of pregnancy to women's health is also a concern raised by Flavier

(2002) who was himself prompted to have a vasectomy. For so long in these men's partnerships, women have been carrying the burden of reproduction, family planning, and using women-centered family planning methods. But the males have come to realize that, indeed, there is another choice centered on *them*. Landry and Ward (1995) learned in their research that men have come to realize that it is now their turn. In relation to women's health, couples have had adverse experiences with certain artificial and natural family planning methods. These have also been alluded to by Mumford (1983), Vernon (1996) and Flavier (2002).

Thirdly, decided to stop having children because the couple had either reached or surpassed their desired number. This was likewise found by De Guzman (1990) in his study on vasectomy.

The decision of men to have vasectomy can be facilitated through the support extended by the wives and health care providers. Wives play a crucial role in the decision of many men because, foremost, they provide information about the procedure and reinforce men's resolve to have a vasectomy. Similarly, Ringheim (1993) divulges that vasectomy acceptors in Colombia point to their wives as initial sources of information and as the key persons to influence the decision. Additionally, in a successful program in Brazil initiated by PRO-PATER, which was studied by de Castro *et al* (1984), wives indeed influenced men's decisions. However, a study by de Guzman (1990) in the Philippines, found that

the men in its sample never consulted their wives about their plan to be vasectomized.

The key role that health care providers play in the decision-making of men is in the area of educating them regarding the procedure and explaining the prevailing misconceptions on vasectomy. The advantages of vasectomy over other methods enable men decide that it is the better choice especially compared to ligation which Landry and Ward (1995) also discovered this. Vernon (1996) says that vasectomy is preferred because it is "simpler, easier, safer, quicker and most comfortable". Friends and in-laws do not have a significant impact because once men get the support of their wives through a joint decision, nothing else matters not even the misconceptions or adverse attitudes reverberated by their male friends.

Finally, men still hold the same positive concepts of *pagkalalaki* after vasectomy as they had before, and it does make a big difference that men are now taking an active and direct participation in terms of family planning. This is indeed a huge departure from the study done by UNFPA (2000) where strong male stereotype prevented men from sharing in sexual responsibility.

Recommendations

Based on the findings, the following recommendations are forwarded:

The physical characteristics of a "real man" include his ability to sire children thus, he should be attracted to the opposite sex. But even if he is expected to sire children, he should also be responsible to take measures to participate in family planning to be able to meet the needs of his family in the future. Other physical attributes include his strength and ability to do simple household repairs such as plumbing, electrical work, and other minor mechanical problems. This requires him to be energetic, not frail.

1) In the information campaigns that will be launched to garner the participation of men in family planning, especially vasectomy, it is not enough that myths will be corrected and facts presented. Another convincing manner to get the support of men, based on this research and other, is stressing their responsibility towards their children and wives. The concept of responsibility hinges on securing the future of the family by being able to sire the number of children whose basic needs like food and education can be met under their current circumstances, and stopping there.

2) It is noteworthy that men are concerned to secure the economic welfare of the family. This means that they are tied to their jobs and may not have the opportunity to spare time for discussions on other matters or in other places. Efforts should be made to reach out to men in their workplaces through of

information, education, and communication campaigns. They would be a captive audience with an opportunity to closely interact with men who may have previously held concepts and misconceptions on vasectomy similar to their own.

3) In relation to the above recommendation, community gatherings of men and women need to be embedded in any such campaign plan since men who are at work for most of their day will prefer to stay at home during time off due to their participation in domestic chores. Community-based gatherings will not only enhance couple-centered decision making but will also improve male involvement in family planning through interaction with other men in the community. Worth mentioning that these discussions must be kept time-bound so that men can still have time for their families.

4) There is a need to involve men who have been previously vasectomized in the massive education campaigns in support of vasectomy. Their testimonies as to the nature of the procedure, its success, and the joys they are currently experiencing can help other men realize that it is alright to submit one's self for vasectomy. This is also an effective way to dispel erroneous beliefs about vasectomy in relation to cultural conceptions of masculinity based on the actual experiences of previously vasectomized men.

5) Couple-centered information activities including pre and post counseling is key in terms of helping males to make a firm decision on family planning. Veering away from women-centered or male-centered only campaigns helps enhance greater participation in family planning. This is also a departure from the usual frame-of-mind of program planners and implementors that “men are the problem” when it comes to family planning. Additionally, there is a need to veer away from stereotyping men in terms of their participation in family planning simply because age-old concepts about their masculinity may be a hindrance in any program designed for them. For as we have seen, this was not a problem for our Cebuano vasectomy acceptors. Eventually, this will ease the burden of responsibility placed on women in terms of reproduction and fertility regulation because men will then take a proactive stance not only in family planning but the more politically correct and encompassing concept of responsible parenthood.

6) Health service providers need to graduate from the usual information dissemination approaches like focusing only on how the procedure will take place and clients’ responsibilities after undergoing vasectomy. Instead, program planners must raise the discussion to a higher level that will include issues on gender, women’s health, male participation, and family welfare.

7) A study on men who undergo vasectomy must be pursued in comparison with those who do not undergo vasectomy but are using other family planning

methods. This will highlight differences in terms of methods used, client satisfaction, and even the state of a couple's relationship.

8) A study on male rejectors of vasectomy to get a full picture of what is happening to Cebuano concept of pagkalalaki.

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