

Perspectives from Couples on the Vasectomy Decision: A Six-Country Study

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This paper contains data from a qualitative study from 218 in-depth interviews with men and women and their partners who decided to have a vasectomy in six countries: Bangladesh, Kenya, Mexico, Rwanda, Sri Lanka and the USA. It examined the key factors that led men to choose vasectomy and what role their partners played in this decision. The reasons for choosing vasectomy were similar in all of the countries despite many cultural, economic and racial differences; importantly, both men and women cited concern for the woman's health as a principal reason. However, the way in which problems were framed and, to some extent, the degree to which some reasons outweighed others differed. Women's role in the decision tended to be limited in Bangladesh and Sri Lanka, but more active in the other countries. Encouraging men to have vasectomy for their partners' sake and stressing that it is the man's 'turn' to take responsibility for family planning may be effective promotional strategies. Women's ability to support men's decision to a greater degree could be strengthened and vasectomy introduced in a light-hearted or joking way. Issues raised about multiple partners and the need for protection against sexually transmitted infection for those who are not in mutually monogamous relationships are also explored.

RECENT research in developing countries has revealed that men can play an important role in deciding whether or not women use a family planning method.¹⁻³ National contraceptive prevalence surveys for many developing countries now include interviews with male respondents and include questions related to communication between partners about family planning.⁴ Existing studies show that men's role varies greatly according to cultural and social context.⁵ In the USA, among couples who choose both tubal occlusion and vasectomy,⁶⁻¹⁰ the woman plays a key role in the decision to have a vasectomy. Among couples who have chosen vasectomy, women are more likely to have discussed the procedure with their partners and to have known a satisfied vasectomy user before the choice was made.^{6,9}

Although vasectomy is an important alternative to female sterilisation for couples who want a permanent method of contraception, barriers to its wider use exist in many places. Service providers who believe men are not interested and who consequently limit information and access are a principal constraint; other barriers

are negative attitudes and misinformation. Yet even in Latin America and Africa, where few family planning policymakers believed vasectomy would ever be used, experience has shown that when information and services are provided, men will seek out and use vasectomy.^{11,12}

Between 1992 and 1995, a qualitative, exploratory study on the vasectomy decision was conducted in four countries where vasectomy prevalence was relatively low - Bangladesh, Kenya, Mexico and Rwanda - and two where vasectomy prevalence was relatively high - Sri Lanka and the USA. This was part of a larger initiative by AVSC International aimed at increasing awareness and use of condoms, vasectomy and other methods which involve the direct participation of men (withdrawal, abstinence, rhythm and other fertility awareness methods; increasing men's awareness of and support for the family planning choices of their partners and safeguarding the reproductive health of their partners and themselves. The results were used to assist programme managers from the reproductive health organisations where the research was conducted to improve

service delivery approaches to reach men. Based on the findings in the six country reports¹³⁻¹⁸ this paper describes the key factors related to the decision to choose vasectomy and the role both partners played in the decision to control family size, use contraception and choose vasectomy.

Vasectomy use in the six countries

Current levels of modern contraceptive use among married women of reproductive age vary widely across the six countries in this study, from 13 per cent in Rwanda to more than 60 per cent in Sri Lanka and the USA. (Table 1) Awareness of vasectomy as a contraceptive option also varies across countries. Women in Bangladesh, Mexico and Sri Lanka were more likely to have ever heard about vasectomy than women in Kenya and Rwanda (data not available for USA).

Vasectomy services have been established longer in Bangladesh, Sri Lanka and the USA (dating from the 1960s and 1970s) and more recently in Kenya and Rwanda (late 1980s and early 1990s). Access to and availability of vasectomy services differ substantially. In Kenya, the public sector does not provide services; in the other five countries both private and public sector institutions provide vasectomy services. In Mexico, two of the largest public sector health institutions, the Ministries of Health and Social Security, provide vasectomy services in more than 200 sites around the country.²⁵ Access was limited to about 20 sites in Kenya and two sites in Rwanda at the time of the study.^{17,18} In the USA vasectomy is provided, for the most part, by private practitioners – mainly urologists; access to vasectomy through the public sector is limited,

though efforts are underway in a few states to make public financial support for vasectomy more readily available.

Methodology

In each country, between 10 and 31 couples were interviewed, with each partner in the couple interviewed separately. In all six countries respondents who had a vasectomy in the previous six to twelve months before data collection began, were randomly selected from the clinic registers of at least two service sites. Except in Mexico and the USA, where all respondents came from urban locations, all respondents were recruited from both urban and rural locations. In all but two of the countries most couples were interviewed within one to six months following the vasectomy procedure. One man in Kenya and two men in the USA were interviewed more than one year after the procedure.

In all six studies, an open-ended, semi-structured interview guide was used. A core interview guide was developed which included questions on previous use of family planning, reasons for not having more children, reasons for choosing vasectomy over other contraceptive methods, the roles of each partner in the decision to use a method, and women's role in the vasectomy decision. The interview guide was modified based on specific programmatic differences for each country.

Local, trained interviewers, both men and women, did the interviews.²⁶ In Mexico, only women did the interviews. Each research team (interviewers and study supervisors) was trained for approximately 3-5 days in in-depth inter-

Table 1. Selected Contraceptive Prevalence and Awareness Data: Study Countries

%	Bangladesh ¹⁹	Kenya ²⁰	Mexico ²¹	Rwanda ²²	Sri Lanka ²³	USA ²⁴
Using a modern method*	36.2	27.3	52.7	12.9	65.8	59.0
Using female sterilisation*	8.1	5.5	36.2	0.7	24.9	29.5
Using vasectomy*	1.1	<1.0	1.5	<1.0	4.9	12.6
Women aware of vasectomy*	82.9	45.4	67.1	37.6	90.8	nk
Men aware of vasectomy	89.4	56.2	nk	nk	nk	nk

* = married women of reproductive age

nk = not known

Table 2: Number of Respondents and Selected Characteristics by Country²⁷

Country	Male Respondents			Female Respondents			Total
	Number	Mean age	Mean no living children	Number	Mean age	Mean no living children	
Bangladesh	20	35	3.3	17	26		37
Kenya	20	40	6.0	10	34	4.6	30
Mexico	15	31	2.7	15	28	2.8	30
Rwanda	15	40	6.0	15	35	5.3	30
Sri Lanka	15	34	3.3	15	27	3.4	30
USA	31	27	3.0		33	3.0	61
Total	116			102			218

viewing techniques. In all countries, interviews took place in the respondents' language. They lasted between 60 and 90 minutes each and were all tape recorded. They were later transcribed by the interviewers, reviewed for accuracy by the study supervisors, and translated into English for analysis.

In the USA, interviews were conducted in English. The transcripts from Mexico were analysed in Spanish, so translation was also not necessary. In the other four countries translation had to be done twice. For example, in Rwanda interviews were conducted in Kinyarwanda, translated first into French and then into English. In an attempt to control for possible distortions due to two translations, each country research team reviewed the translations from the local languages. Nevertheless, given the limitations of such a procedure, little weight has been placed on the specific wording or phrasing of responses.

Profile of respondents

The mean age of male respondents ranged from 27 to 40 years. Female respondents were generally younger than the men (see Table 2). Couples in Kenya and Rwanda had an average of five to six living children, compared with an average of three in the other countries. The vast majority of respondents from each country had children of both sexes (one couple in Mexico, four in Sri Lanka, and six women and two men from the USA had no sons; one couple in the USA had no children). Couples had been married

or living in union for 7-17 years (*data not shown*).

Over half the male respondents in Bangladesh, Kenya, Mexico and the USA had completed at least some secondary education (in the USA all but two men had completed secondary school). Male respondents in Sri Lanka and Rwanda had the lowest levels of education: the majority had completed some level of primary school. The level of education of the women was lower than that of the men in each country except the USA. These data are similar to data found in other larger country specific studies with profiles of vasectomy users (except Rwanda because no national level data exist).^{19,28-30}

In Sri Lanka and Rwanda the majority and in Bangladesh about a third of the men were farmers. In the other countries the men's jobs ranged from teaching school to owning a business. Type of occupation of the US respondents was not recorded but all but two of them were employed. Most of the women respondents were not employed; many worked in their homes.

Previous use of family planning was common among all couples. Fewer than six respondents from each country reported never having used any method to space births, modern or traditional, prior to vasectomy. Respondents from all countries except Mexico and the USA reported they had previously used on average one modern method.

Reasons for not having more children

Virtually all of the respondents in all six countries cited economic issues as a reason for not having more children. For some couples, extreme financial need was clearly the most compelling factor in the decision to seek vasectomy. In Rwanda, couples spoke about hunger and the near starvation of their children, and similar stories of extreme hardship were given by respondents in Sri Lanka and Bangladesh.

In Bangladesh and Sri Lanka, the role of compensation payments to poor men and women seeking sterilisation services and their influence on the decision-making process have been studied.^{31,32} In Sri Lanka low income men did not differ in their desired number of children from higher income men,³² but they were more likely to decide that vasectomy was the best option available for improving their family's economic situation and providing better opportunities for their existing children in terms of education. In Bangladesh the situation was similar,³¹ but it was also found that men and women of higher economic status had greater access to other contraceptive options than those with lower income.

Our data from Sri Lanka confirm those from the earlier study. Couples from other countries in the study (especially Kenya, Mexico and the USA) cited financial reasons as well, but these were not as severe. In Mexico and Kenya, respondents wanted to provide better for the children they currently had. While both men and women described family finances as a principal motivation for not having more children, the women were more likely than the men to mention the specific needs of children for food, clothing and education.

For many, the birth of a child (or in several cases, twins) and the resulting strain on the family economy prompted the decision to end childbearing. Many couples had made the decision to have a vasectomy during or immediately following the birth of their last child. One man in Sri Lanka had the vasectomy while his partner was pregnant with their third child.

Another reason for halting childbearing cited by both men and women in every country was concern for the woman's health, including the toll of multiple pregnancies. Men described how their partners had been weakened by pregnancies and childbirth. One man from the

USA summed it up this way: '...I'd seen the way she suffered carrying the last one and I didn't want her to go through it again.'¹³ Some respondents in each of the countries felt that contraceptives, especially the pill, had contributed to the poor health status of the woman.

Gender preference (usually for boys) has often been cited as a factor associated with fertility decisions.⁵ Although virtually all of the couples in this study had had children of both sexes, a few men mentioned that they would have decided to halt childbearing earlier, but wanted to have a boy (or in one case, a girl). In Sri Lanka, four couples had had only daughters. One of these men explained that he could not afford any more daughters because of the cost of dowry.

Reasons for choosing vasectomy

One of the most striking findings of this six-country study was that the reasons for choosing vasectomy were similar in all of the countries, despite the many cultural, economic and racial differences between them. What varied was the way in which people framed the problems and, to some extent, the degree to which one reason outweighed others as a primary rationale.

Much of the literature on vasectomy reports that men and women around the world are misinformed about vasectomy, eg. that it causes impotence or makes men weak. In this study virtually all respondents reported hearing negative comments about vasectomy, mostly from friends, but their concerns were dispelled when they obtained information from providers or other vasectomised men.

Women's health

As with the desire to end childbearing, concern for the woman's health was a factor in choosing vasectomy over other methods, including the effects of pregnancy or contraception, 'poor health' in general or specific health problems. Some said that men were stronger and thus should take responsibility for the operation, while the African and Asian men in the sample (though not the Mexican or US respondents) often felt that as the economic provider or head of household they had to take responsibility. Some men and women in all the countries simply said that it was now the man's turn, since the woman had been responsible for previous

contraceptive use and childbearing. As a woman from the USA said: 'To me it was being done to him instead of to me, so that was the best. I wasn't having any more medical intrusions into my body.'¹³

Many couples in all the countries saw vasectomy as a better choice compared to tubal ligation in that the recovery time for tubal ligation was longer than for vasectomy and tubal ligation was more risky than vasectomy.

These findings suggest that at least some men are more concerned about the well-being and health of their partners than has been commonly believed by service providers. While these data do not indicate what proportion of men feel this way, they do suggest that a subset of men in each country find such concerns important enough to motivate the vasectomy decision. Messages which encourage men to have a vasectomy for the sake of their partner's health and which stress that it is the man's 'turn' to take responsibility for family planning may thus be effective promotional strategies. This conclusion has been corroborated by recent research in Latin America.³³ The fact that problems with pregnancy and delivery and that many couples made the decision to have a vasectomy during a pregnancy or at the time of the birth of their last child suggests that information and, where requested, counselling about vasectomy would be an appropriate component of antenatal and post-partum care.

Dissatisfaction with other methods

Lack of satisfaction with other methods was a reason some couples in each of the countries gave for choosing vasectomy. It is interesting that this was an important issue for couples who had previously used contraception, as had most of the Mexican and US couples. In countries where previous contraceptive use was less common among those in the sample, eg. Bangladesh and Kenya, fear of the side effects of other methods was a reason for choosing vasectomy. Many of the Mexican couples had discontinued use of other methods due to side effects, and dissatisfaction with other family planning methods was an important factor in their decision to obtain vasectomy. Fear of the side effects of female sterilisation was another factor for a few of the couples in each of the countries.

Male respondents in Mexico expressed con-

cerns about other methods that were typical of those expressed in the other countries as well, for example: 'Pills bothered her body', 'I don't like condoms', 'The methods for women have more complications'.¹⁴ They also mentioned the general dislike of chemical or other interference with the body: 'My wife no longer has to go to the doctor. She can live a normal life without alterations to her body, and I can also live normal life without worries.'¹⁴

In the USA, in addition to citing the side effects of other methods (especially the pill), men and women also mentioned the inconvenience of other methods, which was less commonly discussed by respondents from other countries, eg. the messiness and discomfort associated with barrier methods.

Discontinuation or method change due to side effects or other causes of dissatisfaction is relatively common^{1,34} and points to the need for counselling on all methods, including for clients who have opted for a temporary method. Those who are familiar with a variety of methods may be able to switch more easily from one method to another, rather than discontinue use altogether.

Vasectomy services and related practicalities

In Bangladesh, Kenya, Rwanda and Sri Lanka, health and family planning workers were among the most common and important sources of information on vasectomy and were considered a safe, non-threatening source of reliable information. The data suggest that supportive service providers have an important role in making sure that men and women are aware of vasectomy and have adequate information and encouragement to make the decision to obtain the procedure. In addition, despite the barriers that exist in terms of information and access to services, providers gave these men and women information about vasectomy as a possible option for contraception which would help them achieve their reproductive intentions. These men and women chose vasectomy as the best option after deciding they were sure they wanted no more children and considering the undesirability of other contraceptive methods.

Not surprisingly, economic advantages of vasectomy over other methods were mentioned more frequently among the poorer respondents

in Rwanda, Bangladesh and Sri Lanka. Lack of accessibility to other methods and cost were also cited. As one man in Sri Lanka said: 'Those [other methods] might or might not be available when we got to the shop. If we did not have money we could not buy them and use them. But if we had the operation we would not have to think about anything so there is no problem.'¹⁶

Men and women in all countries excluding the USA reported that vasectomy was a more practical option compared to female sterilisation because the woman could not be spared for the few days that her recovery would take – there would be no one to watch the children. This was especially an issue in families with small children. One Mexican man said: 'If she had [tubal occlusion] I would have to take time off my job to take care of her.'¹⁴ Another from Sri Lanka said:

*'[Vasectomy] is the cheapest and easiest method. I am strong, there were no after-effects and no problems for our sex life; on the other hand, the female operation is time consuming, there are some after-effects and they [women] get ill afterwards for some time. So I think this is best and I like to tell the others too.'*¹⁶

In the USA convenience was more of a concern. Many USA couples considered the length of recovery from a tubal ligation inconvenient: 'It is major surgery. It's supposed to be a lot less invasive for a man than a woman. Men recover very quickly, the woman has a couple of days of very bad discomfort.'¹³

These findings suggest that for clients who are interested in permanent contraception, family planning counsellors should encourage couples to discuss which partner can best be spared from their responsibilities for the recovery periods needed for sterilisation and to explain the minimal time needed for recovery from vasectomy. This type of information would enhance clients' abilities to make choices based on their individual and family needs.

Sexual roles and relationships

In Kenya, Mexico and Rwanda, some men talked about the advantage that vasectomy protects against pregnancy with more than one sexual partner. In Kenya and Rwanda, women also mentioned this as a factor. In one case, a man had

suggested female sterilisation to his partner, but she told him to have a vasectomy because she said she suspected that he had other partners. Some men explained that since they were in polygamous marriages, vasectomy was very practical. Others were more concerned about preventing pregnancy with a casual partner. One Rwandan man said: 'I can go out and have fun and not have to worry'¹⁸ while a Mexican man stated, 'I did it as security for myself, in order not to have more children here, there, children everywhere.'¹⁴ In Kenya, some men said fear of pregnancy with someone other than their current partner had been a concern. This concern had led two of the couples in the sample to have both a vasectomy and tubal occlusion.

Men who have multiple partners (and their partners) would benefit from STI/HIV counselling. Yet none of the men or women in any of the countries cited the lack of protection against STIs as an issue or disadvantage related to vasectomy. This strongly suggests that in many countries counselling on dual protection (using one or more methods that protect against both pregnancy and infection) should become an integral component of all vasectomy programmes.

The importance placed by society on women's capacity to bear children may also make vasectomy more acceptable than tubal occlusion in some cultures. One respondent from Kenya said, for example:

*'It is wise for the man to be vasectomised...if the woman has been sterilised, she will worry about her husband chasing her away from their matrimonial home and marrying another woman who will give him more children.'*¹⁷

A woman's ability to have children is also an important factor in her status and marriageability in Asia. In Sri Lanka, two men described postponing their vasectomy until a new partner had borne a child. One Bangladeshi man hinted about the hardship that not having another child could bring on a woman in his concern for his much younger partner:

*'She is still young. Almighty Allah knows that at any time I might have an accident, but she may survive; she may even be bound for another marriage. Considering all of this, we decided for vasectomy. Also, she was pregnant when we finally decided on a permanent method.'*¹⁵

Although infrequently, a few respondents mentioned that they could enjoy sex more if they did not have to worry about contraception. One woman from the USA said: 'One of the nice things about being married with a permanent [method] is the freedom to have sex whenever you like and it's not a lot of fun to have to concern yourself with birth control.'¹³

Gender-related issues

Respondents were asked whether they thought decisions concerning the number of children to have should ideally be made by the woman, the man or both partners, and what their actual practice had been regarding these decisions. While most respondents felt that decisions about family size should be taken jointly, in many situations this apparently did not actually happen. In Kenya, Sri Lanka and Rwanda, the majority of couples reported that the man had decided when they had had enough children. In all countries but the USA, some of the couples reported that the man had been the one to decide on family size.

The opinion that the decision should be a joint one was not universal, however. The idea that men should make these decisions was also expressed by a few men in each country, most commonly in Rwanda. In Bangladesh and Sri Lanka, there were some men and women who felt that the man should be the one to make the decisions concerning family size. One Rwandan man commented: 'I made up my mind, I informed my wife and she accepted. Why should she have refused? I am the head of the household.'¹⁸ Only infrequently was the opposite view represented. Two of the Kenyan women said they felt that decisions about family size should be made by the woman, both because the woman customarily makes such decisions and because it is the woman's health that suffers from childbirth.

The extent to which women take an active role in discussing and supporting their partners in the decision to have a vasectomy also varied considerably both within and between countries, as with other reproductive decisions. Not surprisingly, where women felt they had little say in reproductive decisions in general (eg. Bangladesh and Sri Lanka) they were also not very active participants in the vasectomy decision. In Kenya, Rwanda, Mexico and the USA, the women were participants in the vasectomy decision. In

these four countries, most couples had discussed the vasectomy decision before the operation and in several cases, it was the women who first suggested the operation to their partners. Similarly, in these four countries, men and women both reported that the woman had been more supportive of having a vasectomy than family and friends.

The women respondents in most of the countries indicated that suggesting vasectomy to a man was a delicate matter and had to be handled with diplomacy. One Rwandan woman commented: 'He is the one who [first suggested it], because I would not have dared to. I used to think that he would not want to do it, but when I heard him talk about it, I was very glad, because he would not be able to give me another child.'¹⁸ However, the men frequently reported that once they made the initial suggestion their wives were very enthusiastic. In Mexico, the men thought that their wives were more influential in the decision than the wives themselves thought.

Nevertheless, a few women in Kenya and Mexico reported that they had no problems suggesting vasectomy to their partners. For example, one Mexican woman said: 'We started thinking "Should you have the operation or me?" I asked him, "From what I hear your operation is easier and quicker. With good rest, you can recover quickly without any danger."¹⁴ About half of the couples in the USA reported that the woman was the first to suggest vasectomy, a greater proportion than in the other countries. Discussions had taken place over a relatively long period of time, and several couples mentioned that initially it had been brought up jokingly: 'Before it was more or less a little tease. You know, "Well, you get the vasectomy", and then he was the one who really brought it up.'¹³

Within the movement to encourage constructive male involvement in sexual and reproductive health, women are being encouraged to talk to their partners about reproductive health and services. Given that in some places men have higher fertility than women³⁵ and that in some countries and cultures women can suggest vasectomy to their partners, women could potentially serve as a link between their partners and services.

In Bangladesh, many of the women were not consulted by their partners prior to the operation

and they had very little information about it; two of them were not at all happy that their partners had had the operation when they found out. In fact, in Bangladesh the men frequently did not even tell their partners about the vasectomy: less than half the men said they had spoken with their partners about vasectomy prior to obtaining the operation. Most of the women did not know when their partners had sought information about vasectomy, and many were not told about the vasectomy itself until some time afterwards.

Several women in Sri Lanka also reported that their partners had not discussed the vasectomy with them, although their partners claimed to have done so. When asked who had been most supportive of the decision to have a vasectomy, few Sri Lankan and no Bangladeshi men mentioned their partners. In Sri Lanka, women saw their role as less important; only one woman mentioned herself as a source of support to her partner in the decision.

The women's attitudes towards vasectomy were also a factor in how active they were in the decision-making process. Women were more often worried about potential side effects of vasectomy than were their partners. Not surprisingly, women who had not discussed vasectomy with their partner before the operation and had not been exposed to vasectomy information were more likely to be worried than women who had more information. The majority of men and women in all of the countries reported that women were in favour of their partners obtaining vasectomy the first time they discussed the issue. After the vasectomy, almost every woman respondent reported she was pleased that her partner had obtained a vasectomy, in that it lessened the burden on them.

Service providers could strengthen women's ability to support men's decision to a greater degree by giving women more information and suggesting how to raise the issue in a non-threatening manner, eg. in a light-hearted or joking way. In more difficult situations, women could be given information to give their partners and could suggest they meet with a service provider, as some of the Bangladeshi women had done.

Future considerations

Although this was a small, non-representative sample and the results are not generalisable, it is striking that there were so many similarities across countries. There is a strong need for additional research on attitudes towards male contraception and couple communication on all reproductive health issues. While cross-cultural studies such as this one highlight similarities and interesting contrasts, it is important that programme planners and others obtain the opinions of more of their clients and potential clients in order to plan appropriate programmes. It would also be useful to obtain quantitative information from larger surveys to ascertain whether the opinions and behaviour found here are present more widely.

Discussions with other researchers suggest that with cross-national analysis of qualitative data such as ours, problems related to the accuracy of the translations (especially where two translations are necessary) are common, even though the literature has not reflected this very often. For example, the use of translations which cannot be verified by the analysts limits any sense of comfort with using quotes. In one study this difficulty was circumvented, in part, by having all of the local researchers meet together to work on the analysis;³ where feasible, we highly recommend this.

Among the respondents in all of the countries in this study, the women spoke less than men in these open-ended interviews. They were less knowledgeable about vasectomy and possibly less comfortable expressing their opinions. However, the women corroborated findings which might have been less believable coming solely from the men, eg. men's concern for their wives' health, and greatly enriched the analysis. It was important to learn that there was a high degree of concordance between partners, and the cases in which women's reports did not agree with those of their partners were also telling and useful. Future research into methods of contraception should consider both men's and women's perspectives whenever possible.

It would be useful to know how couples communicate about these issues and how they make other reproductive health-related decisions. Operations research could be used to assess the effectiveness of couple-focused counselling. In addition, as has been shown

elsewhere, men and women seem to have limited awareness of the potential risk of STIs following either a tubal ligation or vasectomy,³⁶ and service providers may have a limited view of the needs men and women have in terms of other reproductive health services once childbearing has been ended by sterilisation.

This study clarifies some of the issues which affect the vasectomy decision and the dynamics surrounding the decision. Further, the results illustrate the existence of differing roles and levels of participation of women and men in the countries included in this study. Health care providers in reproductive health programmes need to acknowledge the existing power relationships within partnerships, as well as within society, in the provision of information and counselling services about contraceptive options.

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