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Knowledge and Attitudes Towards Vasectomy Among Married Men and Women in Kampi Ya Moto, Kenya: A Cross-Sectional Study

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ABSTRACT

Vasectomy remains one of the least utilized family planning methods in sub-Saharan Africa, despite being a safe, effective, and cost-efficient permanent contraceptive option. Limited knowledge, negative attitudes, and deep-rooted sociocultural barriers have contributed to its low uptake, particularly in rural settings. This study assessed the level of knowledge and attitudes toward vasectomy among married men and women in Kampi Ya Moto, Nakuru County, Kenya. A descriptive cross-sectional study design was employed among 196 married men and women aged 18 years and above with two or more children. Data were collected using a structured questionnaire and analyzed using descriptive statistics. Participants' knowledge was categorized as good, fair, or poor, and attitudes were assessed using Likert-scale responses across cultural, religious, and behavioral domains. While 77.04% of participants recognized vasectomy as a method of family planning, and 92.05% correctly identified it as a permanent procedure, only 32.45% knew it was appropriate for any man desiring it. Acceptance of vasectomy was low (19.39%), with higher willingness among participants with good knowledge (50.88%) compared to those with fair (7.29%) and poor knowledge (4.65%). Attitudinal findings revealed strong cultural resistance, misconceptions about masculinity, and perceived religious prohibitions. Although basic awareness of vasectomy exists, widespread misinformation and negative attitudes persist. To improve uptake, targeted community education, male-inclusive counseling, and culturally sensitive engagement strategies are essential. Empowering men with accurate information may foster shared contraceptive responsibility and support national family planning goals.

Keywords: Vasectomy; Family Planning; Male Contraception; Knowledge and Attitudes; Kenya

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INTRODUCTION

Family planning has long been recognized as a critical pillar of public health and sustainable development, enabling individuals and couples to achieve their reproductive goals, reduce unintended pregnancies, and improve maternal and child health outcomes (Planning, 2020). Globally, the uptake of modern contraceptive methods has continued to rise, with female-oriented options such as injectables, oral contraceptives, implants, intrauterine devices (IUDs), and female sterilization dominating usage patterns. According to the Slaymaker et al. (2020), female sterilization accounted for approximately 18% of global contraceptive use, while oral contraceptives and injectables represented 9% and 5%, respectively. In contrast, vasectomy, despite being medically safe, highly effective, and cost-efficient, remains significantly underutilized, contributing to only 2.4% of global contraceptive use.

In many African countries, the uptake of male contraceptive methods, particularly vasectomy remains exceptionally low, despite ongoing efforts to promote gender equity and reproductive health (Kabagenyi et al., 2014). Vasectomy prevalence in sub-Saharan Africa is consistently below 1%, with some countries recording negligible or undocumented usage (Jacobstein et al., 2023). Cultural norms that emphasize male dominance, fertility as a symbol of masculinity, and widespread misinformation about vasectomy's effects on sexual performance contribute to this poor uptake (Nicholas et al., 2021). Health systems in many African contexts also lack the infrastructure, trained personnel, and community outreach mechanisms necessary to support widespread vasectomy services (Shattuck et al., 2016). In contrast, developed countries have demonstrated significantly higher acceptance of vasectomy (Jacobstein et al., 2023; Ross and Huber, 1983). For instance, in the United States, approximately 10% of married couples rely on vasectomy as their primary method of contraception, while in Canada and New Zealand, the rate exceeds 20% (Jacobstein, 2015; Pile and Barone, 2009). This disparity can be attributed to greater public awareness, higher education levels, more comprehensive health systems, and cultural attitudes that support shared reproductive responsibility. Moreover, men in developed countries are more likely to be included in family planning counseling, and vasectomy is often framed as a rational, responsible, and permanent contraceptive solution for men who have completed their families (Wilson, 2022). In contrast, African contexts continue to associate family planning primarily with women, reinforcing gendered assumptions and discouraging male engagement. Even where knowledge of vasectomy exists, it is often superficial and clouded by myths (Bashir, 2022). The resulting gap in male contraceptive participation not only places a disproportionate burden on women but also limits the effectiveness of national family planning programs.

In the Kenyan context, data from the 2022 Kenya Demographic and Health Survey (KDHS) indicated that 57% of currently married women were using a modern contraceptive method. Among the most commonly used were injectables (30%), implants (18%), and pills (6%) (Monari et al., 2022). Male involvement remained minimal, with male condoms accounting for 1.3% and vasectomy less than 0.1% of total contraceptive use (Nesro et al., 2020). This lopsided distribution reflects a systemic imbalance in contraceptive responsibility, where the burden of family planning largely falls on women. Additionally, deep-rooted myths, misconceptions, and sociocultural beliefs surrounding vasectomy continue to hinder its acceptance (Wono, 2024). These include unfounded associations with impotence, loss of sexual performance, or diminished masculinity, which discourages both men and their partners from considering vasectomy as a viable contraceptive option.

This study explored these critical gaps in contraceptive responsibility by focusing on vasectomy, a method that is both under-researched and underutilized in Kenya. While short-acting and reversible methods have remained popular, the need for reliable and permanent solutions, particularly among couples who have attained their desired family size, has become increasingly evident. Despite the documented advantages of vasectomy over female sterilization in terms of safety, simplicity, and cost-effectiveness, limited knowledge and widespread attitudinal resistance have constrained its uptake. Notably, research and public health campaigns have historically prioritized women, resulting in a lack of emphasis on male contraceptive literacy and shared decision-making within couples (Kapadia-Kundu et al., 2022; Meier et al., 2021). Furthermore, most available literature has concentrated on urban and peri-urban populations, leaving rural and underserved communities largely unexamined.

Kampi Ya Moto, a rural area in Nakuru County, Kenya, was selected as the study site due to its limited health infrastructure, relatively low access to reproductive health education, and prevailing adherence to traditional gender norms. Preliminary community insights indicate that awareness of male contraceptive methods remains minimal, with vasectomy rarely discussed as a practical or acceptable option. Moreover, family planning decisions are often dominated by female choices, with minimal male engagement or shared responsibility. Against this backdrop, we assessed the level of knowledge and examined the attitudes of married men and women in Kampi Ya Moto toward vasectomy as a contraceptive method.

MATERIALS AND METHODS

Study Design

This study adopted a cross-sectional descriptive

design (Kesmodel, 2018) to explore the knowledge and attitudes of married men and women toward vasectomy in Kampi Ya Moto, Nakuru County. The cross-sectional approach allowed the collection of data at a single point in time without manipulating variables, enabling the researchers to observe prevailing characteristics in the target population. This design was well-suited for the study objectives, which focused on understanding community-level perceptions, awareness, and socio-cultural influences related to vasectomy.

Study Area

The research was conducted in Kampi Ya Moto, a locality situated within Rongai Constituency in Nakuru County, Kenya. The area is located in the Rift Valley region and is characterized by semi-arid climatic conditions, rural settlement patterns, and limited access to healthcare services. According to the 2019 Kenya Population and Housing Census, Nakuru County had a population of 2,162,202 people, comprising approximately 4.54% of Kenya's total population. Within the county, Rongai Constituency had an estimated population of 2,778. These demographic characteristics provided a suitable context for examining underexplored perspectives on male contraceptive methods in a low-resource rural setting.

Study Population

The target population comprised married men and women aged 18 years and above residing in Kampi Ya Moto who had at least two children. The selection of individuals with two or more children was informed by medical guidelines that recommend vasectomy as a permanent contraceptive method for individuals who have completed their desired family size. Individuals who did not meet these criteria or had resided in the area for less than six months were excluded. The study thus focused on informed adult couples capable of making reproductive health decisions.

Sample Size Determination

The sample size was determined using Noordzij et al. (2011) for population surveys. Given the finite number of family planning clients recorded at the Kampi Ya Moto dispensary in 2022, a correction for small populations was applied using Cochran's adjustment. The final calculated sample size was 196 participants, which was deemed sufficient to ensure representativeness and allow for meaningful statistical analysis.

Sampling Procedure

A combination of convenience and systematic sampling techniques (Golzar et al., 2022; Mostafa and Ahmad, 2018) was employed. Initially, all households in the study area were numbered. Using systematic sampling, every third household was selected after a random starting point was determined. Within selected households, individuals who met the eligibility criteria and consented to participate were included in the study. Convenience sampling complemented this by ensuring inclusion of willing and accessible participants within each selected household.

Inclusion and Exclusion Criteria

Eligible participants included all married men and women aged 18 years and above, residing in Kampi Ya Moto for six months or longer, and with two or more biological children. Individuals who refused to give informed consent or had not met the residency or reproductive criteria were excluded from participation. These criteria ensured the focus remained on participants most likely to be considering permanent family planning methods like vasectomy.

Data Collection Tools and Procedures

Data were collected using a structured, self-administered questionnaire developed in alignment with the study objectives. The questionnaire comprised both closed- and open-ended questions covering sociodemographic characteristics, knowledge of vasectomy, and attitudinal dimensions. A Likert scale was used to assess participants' attitudes toward vasectomy. Respondents completed the questionnaires independently after receiving appropriate instructions and consenting to the study. Assistance was offered where necessary to clarify questions without influencing responses, thereby minimizing interviewer bias.

Validity and Reliability

To ensure content validity, the questionnaire items were developed based on a thorough review of existing literature and aligned with the study objectives. Reliability of the tool was established through a pre-test conducted in Morop, a neighboring locality with comparable demographic characteristics. Ten percent of the sample size (20 participants) was used in the pre-test. The tool was revised for clarity, language, and logical flow based on feedback obtained during this preliminary assessment.

Data Management and Analysis

Completed questionnaires were reviewed for completeness, coded, and entered into Microsoft Excel for analysis. Data cleaning involved identifying and resolving inconsistencies or missing values. Descriptive statistics, frequencies, means, and percentages, were used to summarize sociodemographic data and response patterns. Findings were presented in tabular and graphical formats, including bar charts and pie charts. Hard copy questionnaires were securely stored and disposed of through incineration three months after data collection to uphold confidentiality and ethical standards.

Ethical Considerations

Ethical approval for the study was obtained from the Kabarak University Research Ethics Committee (KUREC), under reference number KABU01/KUREC/001/VOL.1. A research permit was also secured from the National Commission for Science, Technology and Innovation (NACOSTI), reference number NACOSTI/P/23/28348, and clearance was sought from local administrative authorities, including the area chief. Written informed consent was obtained from all participants. The principles of respect for autonomy, privacy, and confidentiality were strictly observed throughout the study, and no participant was coerced or exposed to harm in any form.

RESULTS

Socio-Demographic Characteristics of Study Participants

A total of 196 participants were included in the study. The majority were aged below 50 years (62.24%), while those aged above 50 years constituted 37.76%. By gender, 59.69% were male and 40.31% were female. Regarding religious affiliation, 63.27% were Protestants, 33.67% were Catholics, 2.04% were Muslims, and 1.02% reported no religion. In terms of educational attainment, most participants had attained secondary education (54.59%), followed by tertiary education (24.49%), primary education (19.90%), and a small proportion with no formal education (1.02%). Concerning duration of marriage, 44.39% had been married for 11–15 years, 40.31% for 6–10 years, 14.29% for more than 15 years, and 1.02% for 1–5 years. The number of current children per household showed that 64.80% had 2–3 children, 25.00% had 3–5 children, and 10.20% had more than 5 children. In terms of desired family size, 48.98% of participants preferred having 3–5 children, 40.31% preferred 2–3 children, and 10.71% desired more than 5 children.

Table 1:

Socio-Demographic Characteristics of Study Participants

Variable		N	%
Age (in years)	Below 50	122	62.24
	Above 50	74	37.76
Gender	Male	117	59.69
	Female	79	40.31
Religion	Catholics	66	33.67
	Protestants	124	63.27
	Muslims	4	2.04
	None	2	1.02
Level of Education	No education	2	1.02
	Primary	39	19.90
	Secondary	107	54.59
	Tertiary	48	24.49
Years in Marriage	1 to 5	2	1.02
	6 to 10	79	40.31
	11 to 15	87	44.39
	More than 15	28	14.29

Current Children	2 to 3	127	64.80
	3 to 5	49	25.00
	More than 5	20	10.20
Desired Children	2 to 3	79	40.31
	3 to 5	96	48.98
	More than 5	21	10.71

Level of Knowledge on Vasectomy

The results of the knowledge assessment on vasectomy among married men and women revealed varying levels of awareness across different domains. A majority of the participants (77.04%) correctly identified vasectomy as a method of family planning, and an even higher proportion (92.05%) accurately classified it as a permanent method. Additionally, 75.50% of the respondents understood that a man cannot impregnate his partner after undergoing vasectomy, while 95.36% correctly indicated that vasectomy is performed through surgery. Notably, 98.01% of participants were aware that vasectomy does not protect against sexually transmitted infections (STIs), reflecting a strong understanding of its limitations. Furthermore, 67.55% correctly rejected the misconception that vasectomy results in loss of sexual drive. However, notable knowledge gaps were observed. Only 59.69% of participants were aware that vasectomy is not an expensive procedure, suggesting lingering financial misconceptions. Most significantly, only 32.45% of respondents knew that vasectomy can be chosen by any man desiring it, with 67.55% incorrectly believing it is limited to men with many children.

Table 2:

Socio-Demographic Characteristics of Study Participants

Question	Expected Answer	Number Correct	Number Wrong	Percentage Correct	Percentage Wrong
Is vasectomy expensive?	False	117	79	59.69	40.31
Is vasectomy a family planning method?	True	151	45	77.04	22.96
If so, what kind of family planning method is it?	Permanent	139	12	92.05	7.95
What kind of men should get a vasectomy?	Any man desiring it	49	102	32.45	67.55
Does vasectomy prevent sexually transmitted diseases?	No	148	03	98.01	1.99
Does a man lose his sexual drive after a vasectomy?	False	102	49	67.55	32.45
How is vasectomy performed?	Surgery	144	07	95.36	4.64
Can a man impregnate his partner after vasectomy?	No	114	37	75.50	24.50

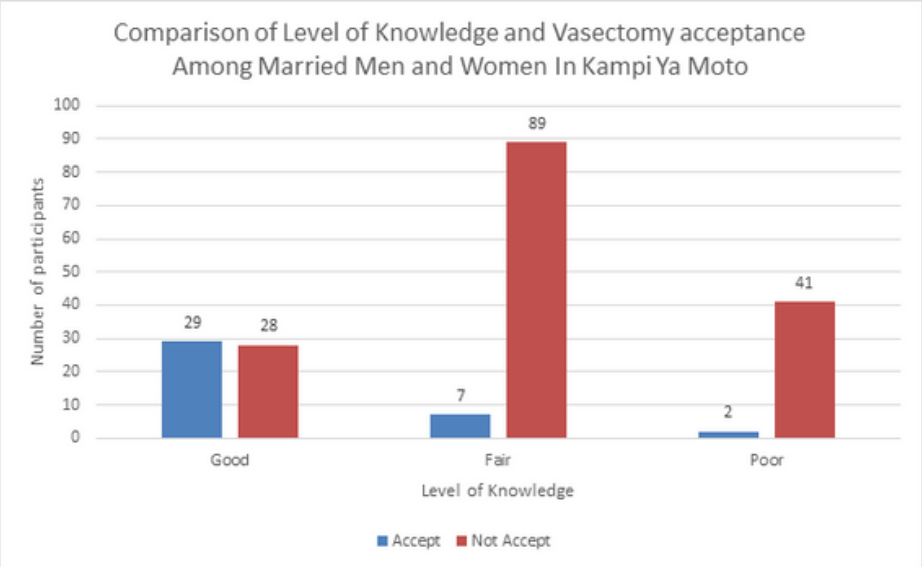
Comparison of Level of Knowledge and Willingness to Accept Vasectomy

The study revealed a generally low willingness to adopt vasectomy among participants, with only 19.39% indicating acceptance, while a significant 80.61% expressed unwillingness to use the method. When willingness was analyzed in relation to participants' level of knowledge, a clear association emerged. Among the 57 participants classified as having good knowledge, 50.88% expressed willingness to undergo vasectomy, suggesting that accurate information may positively influence acceptance. Conversely, 49.12% of participants with good knowledge still remained reluctant, indicating that knowledge alone may not be sufficient to change attitudes or overcome underlying cultural and personal reservations.

In the group with fair knowledge (n = 96), only 7.29% were willing to accept vasectomy, while the vast majority (92.71%) were unwilling to consider it. This demonstrates a significant drop in acceptance as knowledge quality declines. Among those with poor knowledge (n = 43), only 4.65% indicated willingness to accept vasectomy, while an overwhelming 95.35% were not open to its uptake.

Figure 1:

Participants' Knowledge Levels Versus Willingness to Accept Vasectomy



Distribution of Participants' Attitudes Toward Vasectomy Based on Likert-Scale Responses

A total of 196 participants responded to a series of attitude statements regarding vasectomy using a 5-point Likert scale. Regarding cultural perceptions, 83 (42.35%) strongly disagreed that vasectomy is not acceptable in their culture, while 31 (15.82%) agreed and 4 (2.04%) strongly agreed. When asked if vasectomy results in loss of manhood status, 85 (43.37%) agreed and 37 (18.88%) strongly agreed, while 53 (27.04%) disagreed or strongly disagreed. Concerning responsibility in family planning, 58 (29.59%) disagreed and 31 (15.82%) strongly disagreed with the idea that men should undergo vasectomy, while only 14 (7.14%) strongly agreed with the statement. On safety perceptions, 62 (31.63%) disagreed and 44 (22.45%) strongly disagreed that vasectomy is a safe method, whereas 27 (13.78%) agreed and an equal number 27 (13.78%) strongly agreed.

With respect to the belief that vasectomy promotes promiscuity, 62 (31.63%) disagreed, 44 (22.45%) agreed, and 32 (16.33%) strongly agreed. On religious grounds, 67 (34.18%) strongly disagreed and 58 (29.59%) strongly agreed that vasectomy conflicts with their faith. Regarding the misconception that vasectomy is synonymous with castration, 40 (20.40%) agreed and 49 (25.00%) strongly agreed, while 33 (16.84%) strongly disagreed. When asked whether vasectomy contradicts divine control over childbearing, 40 (20.40%) strongly agreed, 22 (11.22%) agreed, and 67 (34.18%) were neutral. 53 (27.04%) participants strongly agreed and 36 (18.37%) agreed that vasectomy can lead to female infidelity, while 85 (43.37%) disagreed or strongly disagreed. Regarding the adequacy of information, 71 (36.22%) strongly agreed and 49 (25.00%) agreed that information on vasectomy was insufficient for informed decision-making. 49 (25.00%) participants strongly agreed that vasectomy should be reserved for men with more than five children, and 44 (22.45%) were neutral. On the belief that men should have many children and thus avoid vasectomy, 40 (20.40%) strongly agreed, and 67 (34.18%) were neutral.

Regarding preference for female sterilization over vasectomy, 80 (40.82%) remained neutral,

while 27 (13.78%) strongly agreed or disagreed. Finally, 36 (18.37%) strongly agreed and 31 (15.82%) agreed that the permanency of vasectomy makes adoption a viable consideration, while 53 (27.04%) strongly disagreed.

Table 3:

Distribution of Participants' Attitudes Toward Vasectomy Based on Likert-Scale Responses (N = 196)

QUESTION	STRONGLY DISAGREE (1)	DIASAGRE (2)	NEUTRAL (3)	AGREE (4)	STRONGLY AGREE (5)
Vasectomy is not acceptable in our culture	83(42.35%)	37(18.88%)	41(20.92%)	31(15.82%)	4(2.04%)
Vasectomy results in loss of manhood status in the society?	9(4.59%)	44(22.45%)	21(10.71%)	85(43.37%)	37(18.88%)
Men should be responsible for family planning and get a vasectomy	31(15.82%)	58(29.59%)	62(31.63%)	31(15.82%)	14(7.14%)
Vasectomy is a safe method of contraception.	44(22.45%)	62(31.63%)	36(18.37%)	27(13.78%)	27(13.78%)
Vasectomy makes men more promiscuous since they cannot impregnate their partners.	22(11.22%)	62(31.63%)	36(18.37%)	44(22.45%)	32(16.33%)
It's against my religious belief for a man to practice vasectomy.	67(34.18%)	40(20.40%)	22(11.22%)	9(4.59%)	58(29.59%)
Vasectomy is synonymous to castration and hence should not be practised.	33(16.84%)	26(13.27%)	48(24.49%)	40(20.40%)	49(25.00%)
Vasectomy should not be practised because it is God who decides the number of children one should have.	22(11.22%)	45(22.96%)	67(34.18%)	22(11.22%)	40(20.40%)
Having a vasectomy make women unfaithful to their husbands	32(16.33%)	53(27.04%)	22(11.22%)	36(18.37%)	53(27.04%)
Information on vasectomy is not adequate to allow adequate decision making.	18(9.18%)	27(13.78%)	31(15.82%)	49(25.00%)	71(36.22%)

QUESTION	STRONGLY DISAGREE (1)	DIASAGRE (2)	NEUTRAL (3)	AGREE (4)	STRONGLY AGREE (5)
Vasectomy should only be done if someone has more than five children.	36(18.37%)	36(18.37%)	44(22.45%)	31(15.82%)	49(25.00%)
A man should have many children and hence vasectomy is prohibited.	18(9.18%)	44(22.45%)	67(34.18%)	27(13.78%)	40(20.40%)
Female sterilization (tubal ligation) is what should be done and not vasectomy.	27(13.78%)	40(20.40%)	80(40.82%)	22(11.22%)	27(13.78%)
Because vasectomy is permanent, it constitutes a factor of consideration for adoption	53(27.04%)	44(22.45%)	32(16.33%)	31(15.82%)	36(18.37%)

DISCUSSION

This study set out to assess the knowledge and attitudes of married men and women in Kampi Ya Moto toward vasectomy as a method of family planning. The results provide important insights into the socio-demographic context of respondents, the prevailing understanding of vasectomy, and the complex attitudinal and sociocultural dynamics that shape its acceptability in a rural Kenyan setting. The demographic distribution of participants presents a relevant foundation for interpreting the knowledge and attitudes assessed. A majority of respondents were below the age of 50 (62.24%), and most had attained at least secondary education (54.59%). This educational background, coupled with the fact that a considerable proportion of respondents had been married between 6 to 15 years and had two or more children, positions the study population as an ideal target for long-term or permanent contraceptive solutions such as vasectomy. However, despite this seemingly favorable demographic profile, vasectomy acceptance remained remarkably low at just 19.39%.

Knowledge levels regarding vasectomy were mixed. While 77.04% of respondents correctly identified vasectomy as a method of family planning, and 92.05% recognized it as a permanent procedure, substantial gaps persisted in key domains. For instance, only 59.69% of participants correctly indicated that vasectomy is not expensive, and just 32.45% knew that any man who desires it regardless of family size, can undergo the procedure. This finding suggests that misinformation and assumptions about eligibility criteria and cost are still prevalent, even among relatively well-educated individuals. These results mirror findings from previous studies in sub-Saharan Africa, where knowledge about vasectomy is often partial or skewed, especially when compared to the more commonly promoted female-oriented contraceptive methods (Daniele, 2017; Kidzuga, 2012).

A significant correlation emerged between knowledge and willingness to accept vasectomy. Among participants with good knowledge, 50.88% expressed willingness to consider vasectomy. This sharply contrasts with the 7.29% and 4.65% acceptance rates among those with fair and poor knowledge, respectively. These findings underscore the vital role of accurate and comprehensive knowledge in shaping health-seeking behavior (Mandlik et al., 2024; Onuoha et al., 2024). However, it is notable that even among those with good knowledge, nearly half were still reluctant to accept vasectomy. This implies that while knowledge is an enabling factor, it does not override entrenched beliefs and cultural attitudes.

The attitudinal findings from the Likert scale responses further explain this hesitancy. Deep-seated negative perceptions about vasectomy were evident across various cultural, religious, and psychological dimensions. A significant majority of respondents either agreed or strongly agreed that vasectomy results in the loss of manhood (62.25%), can make men promiscuous (38.78%), and is comparable to castration (45.40%). Similarly, a large proportion (54.08%) disagreed with the statement that vasectomy is a safe method of

contraception. These views illustrate the persistent myths, misconceptions, and sociocultural fears surrounding the procedure, despite global evidence confirming vasectomy as a simple, safe, and effective method for long-term contraception (Onyango, 2015; Perry et al., 2016).

Religious opposition also played a significant role in shaping attitudes. Approximately 63.77% of respondents agreed that vasectomy goes against their religious beliefs. These findings align with previous studies that have identified religious conservatism as a major barrier to the uptake of vasectomy, particularly in patriarchal and theologically conservative communities (Baird, 2011; Montufar, 2019). Furthermore, a large portion of respondents expressed support for traditional notions of masculinity and procreation, with 34.18% agreeing that men should have many children and 25.00% suggesting that vasectomy should only be performed after siring more than five children.

Another barrier identified was the perceived inadequacy of information, with 61.22% of participants agreeing that there is not enough information on vasectomy to support informed decision-making. This finding reflects gaps in Kenya's public health messaging, where vasectomy receives far less attention compared to female-oriented methods such as injectable contraceptives, implants, and tubal ligation. It also reflects the absence of male-focused reproductive health education and counseling services in rural health facilities. The reliance on women as the primary targets of family planning further entrenches the notion that contraception is a female responsibility (Herbert, 2015; Lévesque et al., 2024).

Finally, the study revealed a skewed preference for female sterilization. A significant proportion of respondents (40.82%) remained neutral, while 25% favored female sterilization over vasectomy. This underscores the systemic gender imbalance in family planning, where men often abdicate responsibility, and women are expected to bear the physical, emotional, and social costs of contraception (James-Hawkins et al., 2019; Lévesque et al., 2024).

Conclusion

This study reveals that knowledge and attitudes toward vasectomy among married men and women in Kampi Ya Moto are shaped by a combination of partial awareness, cultural misconceptions, religious beliefs, and entrenched gender norms. While a fair proportion of the population demonstrates foundational knowledge about vasectomy's function and permanence, acceptance remains low due to fears of compromised masculinity, inadequate information, and a persistent preference for female-centered contraceptive methods. The findings affirm that knowledge is a critical but insufficient condition for vasectomy acceptance —attitudinal and sociocultural barriers must also be addressed.

Recommendation

To enhance knowledge and promote positive attitudes toward vasectomy in Kampi Ya Moto and similar settings, the following interventions are recommended:

1. Implement community-based education programs that dispel myths about vasectomy's safety, cost, and impact on sexual function. These programs should leverage male champions and peer educators to normalize vasectomy among men.
2. Health facilities should offer inclusive counseling sessions for couples, ensuring that men are actively engaged and informed about all available contraceptive options, including vasectomy.
3. Collaborate with religious leaders and local elders to foster dialogue and dismantle culturally entrenched resistance to male contraception, particularly around masculinity and fertility.
4. The Ministry of Health should integrate vasectomy awareness into national family planning campaigns and utilize radio, TV, and social media to reach wider rural audiences with accurate information.
5. Train healthcare providers in male reproductive health counseling and communication, equipping them with culturally sensitive tools to address community concerns without reinforcing gender biases.

Confit of Interest

Authors declare no conflict of interest.

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