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Cultural and Social Influences on Vasectomy Acceptance Among Married Men and Women in Rural Kenya

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ABSTRACT

Despite vasectomy being one of the most effective and permanent methods of contraception, its uptake remains extremely low in many African settings. In Kenya, cultural, religious, and gender-based perceptions continue to hinder male involvement in family planning. This study explored the cultural and social factors that influence vasectomy acceptance among married men and women in Kampi Ya Moto, a rural community in Nakuru County, Kenya. The study employed a qualitative exploratory design grounded in phenomenological inquiry. A purposive sample of 18 married men and women aged 18 years and above, with at least two children, was selected. Data were collected through in-depth semi-structured interviews and analyzed thematically using Braun and Clarke's six-step approach. Trustworthiness was ensured through credibility, transferability, dependability, and confirmability strategies. Three major themes emerged: (1) Perceptions of masculinity and gender roles, vasectomy was widely seen as a threat to male identity, with fertility equated to manhood and social dominance; (2) Religious and spiritual beliefs, participants believed that permanent contraception contradicted divine will, often reinforced by limited exposure to formal family planning education; and (3) Community norms and misinformation, widespread myths linked vasectomy to impotence, weakness, or castration, discouraging interest and uptake. Nonetheless, a subset of participants, especially women, showed conditional acceptance, expressing willingness if accurate information and spousal consensus were available. Vasectomy acceptance is constrained by deeply rooted sociocultural narratives, gender norms, and religious doctrines. However, emerging openness suggests potential for change. Community-based education, male-inclusive counseling, and strategic engagement with religious and cultural leaders are recommended to promote informed decision-making and enhance male participation in family planning in rural Kenyan contexts.

Keywords: Vasectomy, Male Contraception, Cultural Beliefs, Gender Roles, Kenya

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INTRODUCTION

Globally, family planning is recognized as a critical public health intervention that contributes to improved maternal and child health outcomes, gender equity, and socio-economic development (Shah et al., 2025). Modern contraceptive use enables individuals and couples to determine the timing, number, and spacing of children, thereby reducing unintended pregnancies and associated health risks (Festin, 2020). While global contraceptive use has increased steadily over the past decades, disparities remain in method preference and gender participation. Most notably, the burden of contraception continues to fall disproportionately on women, with male-centered methods like vasectomy significantly underutilized particularly in sub-Saharan Africa (Kidula et al., 2025).

According to (Sharlip et al., 2012; Yang et al., 2020), vasectomy remains one of the most effective and safest permanent methods of contraception, with a failure rate of less than 1%. Despite its advantages, simplicity, affordability, reversibility in some cases, and minimal complications, vasectomy accounts for less than 3% of global contraceptive use and less than 1% in most African countries (Mukansoro and 2014). In stark contrast, female sterilization accounts for nearly 18% globally, reinforcing gender imbalances in contraceptive responsibility. Developed countries such as Canada and New Zealand have vasectomy uptake rates exceeding 20%, while uptake in sub-Saharan Africa is extremely limited due to a combination of misinformation, social stigma, and deeply rooted cultural beliefs about masculinity, fertility, and male roles in reproductive health (Pallangyo et al., 2020).

In Kenya, modern contraceptive use among women of reproductive age has increased over time, with the Kenya Demographic and Health Survey Mucha (2023) reporting a modern contraceptive prevalence rate of 57%. However, the contribution of male contraceptive methods remains minimal. Condom use accounts for approximately 1.3%, and vasectomy remains at less than 0.1% (Nieschlag, 2023; Ross and Hardee, 2017). Although policy frameworks such as Kenya's National Family Planning Costed Implementation Plan (2021–2024) acknowledge the need to involve men in family planning, implementation continues to lag, especially in rural and low-resource settings (Kachale et al., 2022). The limited inclusion of men in reproductive health programs and the persistent framing of family planning as a woman's responsibility continue to undermine efforts to promote male contraceptive methods (Hardee et al., 2017; Mukherjee and Kumar, 2024).

Several factors contribute to the low uptake of vasectomy in Kenya, including cultural constructions of masculinity, fears of sexual dysfunction, religious objections, misinformation about the procedure, and lack of targeted health education for men (Msoka et al., 2019; Ochieng, 2014). Many men equate vasectomy with emasculation or believe it will negatively affect their virility and social standing (Halcomb, 2018; Wibowo et al., 2016). Furthermore, the procedure is often viewed as appropriate only for men who have sired many children or are older in age. These perceptions are shaped by social norms, religious teachings, peer influence, and the absence of male role models or champions for vasectomy within communities.

Rural communities are particularly affected by these sociocultural constraints due to lower health literacy, limited access to reproductive health services, and strong adherence to traditional gender norms (Obaremi and Olatokun, 2022). In many rural Kenyan settings, male involvement in reproductive health remains superficial or symbolic, with limited efforts to challenge prevailing attitudes and normalize vasectomy as a responsible and voluntary choice (Lusambili et al., 2021). Health systems, meanwhile, often lack the infrastructure, training, and community engagement tools necessary to offer vasectomy services or promote them effectively (Rai and Sivakami, 2024; Shattuck et al., 2016). Consequently, family planning discussions in such settings are often limited to female methods, with men playing a passive or decision-making role without being directly engaged in contraceptive uptake.

Kampi Ya Moto, located in Rongai Constituency of Nakuru County, typifies these rural challenges. Characterized by semi-arid conditions, low socioeconomic indicators, and strong patriarchal social structures, the area has limited access to specialized reproductive health services. Anecdotal reports and health facility data suggest that male participation in family planning is minimal, and vasectomy is rarely discussed or promoted. Most men rely on traditional gender roles to inform their reproductive decisions, while women shoulder the responsibility for birth control, often through methods that carry greater side effects and risks.

Despite national and global advocacy for shared reproductive responsibility, little empirical research has explored the sociocultural dimensions influencing vasectomy uptake in such rural contexts. Understanding how beliefs, values, and social structures shape perceptions of vasectomy is essential for designing culturally appropriate interventions that address not just knowledge gaps, but also attitudinal and normative barriers. This study, therefore, sought to explore the cultural and social influences on vasectomy acceptance among married men and women in Kampi Ya Moto, a representative rural Kenyan community.

METHODS

Study Design

This study utilized a qualitative exploratory design (Stevens and Wrenn, 2013) grounded in

phenomenological inquiry (Qutoshi, 2018) to examine how cultural and social factors influence vasectomy acceptance among married men and women in rural Kenya. A qualitative approach was appropriate for this study as it enabled the collection of in-depth narratives, reflections, and experiences from participants within their real-world social and cultural settings. The phenomenological lens allowed for a deeper understanding of the subjective meanings individuals attach to vasectomy and its perceived impact on masculinity, family, and community norms.

Study Setting

The research was conducted in Kampi Ya Moto, a rural settlement located in Rongai Constituency, Nakuru County, Kenya. The area is predominantly inhabited by agrarian families, with traditional social structures and limited access to male-centered reproductive health services. This setting was selected due to its relevance in representing rural communities where male involvement in family planning is low and vasectomy is rarely practiced or discussed. The sociocultural environment of Kampi Ya Moto provided a suitable backdrop for exploring the beliefs and perceptions surrounding vasectomy.

Study Population

The target population consisted of married men and women aged 18 years and above residing in Kampi Ya Moto for at least six months and having two or more biological children. These criteria were intended to capture individuals who are actively engaged in family planning decisions and are socially embedded within the local cultural context. Participants were selected for their lived experiences and their ability to articulate cultural and social meanings attached to vasectomy.

Sampling Technique and Sample Size

The study employed purposive sampling informed by maximum variation sampling to ensure a diversity of perspectives (Campbell et al., 2020). Participants were selected based on their gender, age, religious affiliation, educational level, and previous exposure to family planning services. Sampling continued until data saturation was achieved, at which point no new themes or insights were emerging from interviews. A total of 18 participants (10 men and 8 women) were included in the final sample. This size was sufficient for thematic saturation in qualitative inquiry and allowed for detailed, nuanced analysis.

Data Collection Procedures

Data were collected through in-depth semi-structured interviews, conducted face-to-face in participants' homes or other private community spaces, depending on participant preference. An interview guide was used to explore participants' knowledge of vasectomy, personal beliefs, cultural expectations, and social influences. Interviews were conducted in Kiswahili or English, depending on participant fluency, and lasted between 45–60 minutes. All interviews were audio-recorded with participant consent and supplemented by observational notes and reflective memos by the research team. The interview guide was pre-tested in a nearby village to ensure clarity, cultural appropriateness, and alignment with the study objectives. Modifications were made to improve question flow and the depth of responses elicited.

Data Management and Analysis

All interviews were transcribed verbatim and translated into English where necessary. The transcripts were analyzed using thematic analysis, guided by Braun and Clarke's six-step framework. This process included familiarization with data, generation of initial codes, development and review of themes, theme definition, and reporting. An inductive coding approach was used to allow themes to emerge directly from the data without preconceived categories. Coding and analysis were conducted manually and validated using NVivo 12 software to ensure analytical rigor and data organization.

Three major themes emerged from the data: (1) constructions of masculinity and reproductive roles, (2) influence of religious and spiritual beliefs, and (3) social narratives and misinformation. Verbatim quotes from participants were used to illustrate key insights and preserve the authenticity of participant voices.

Trustworthiness

To ensure methodological rigor, the study adhered to Lincoln and Guba's criteria for trustworthiness:

- Credibility was established through prolonged engagement, triangulation of data sources, and member checking.
- Transferability was ensured by providing thick descriptions of the study setting and participants.
- Dependability was maintained through consistent documentation of the research process and use of audit trails.
- Confirmability was achieved through reflexive journaling and peer debriefing to minimize researcher bias.

Ethical Considerations

Ethical approval for this 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), with reference number NACOSTI/P/23/28348. Local permission was granted by the area chief of Kampi Ya Moto. All participants provided written informed consent prior to participation. Confidentiality was maintained through the use of pseudonyms and de-identification of transcripts. Participants were informed of their right to withdraw from the study at any point without penalty.

RESULTS

The qualitative findings from this study were derived from open-ended responses provided by participants during the questionnaire administration. Thematic analysis was used to identify recurring patterns and concepts. Three dominant themes emerged as key cultural and social influences on vasectomy acceptance: (1) perceptions of masculinity and gender roles, (2) religious and spiritual beliefs, and (3) community norms and misinformation.

Perceptions of Masculinity and Gender Roles

A prominent theme across participant responses was the perception that vasectomy undermines a man's identity and social status. Many male respondents associated their reproductive capacity with their masculinity, equating fertility with strength and social dominance.

"A man who has undergone vasectomy is no longer a full man. In our culture, a man must be able to sire children."

Several participants expressed concern that a man who agrees to a vasectomy may be viewed as weak or dominated by his wife. This aligns with traditional gender norms in the region, where family planning is often seen as a woman's responsibility, and men are expected to remain uninvolved in such decisions.

"It's a woman's job to plan the family. Men should not interfere with what women are supposed to do."

Religious and Spiritual Beliefs

Religious convictions play a significant role in shaping attitudes. Respondents from both Christian and Muslim backgrounds expressed the belief that vasectomy contradicts divine intent regarding procreation. Some participants referenced religious teachings that emphasize openness to the number of children God may provide.

"God decides how many children we should have. Blocking the process is interfering with God's will."

"Our church discourages any form of permanent family planning. We are taught to trust that God provides what we need, including children."

This belief was particularly strong among participants who had not previously engaged with family planning services, suggesting that religious-based opposition may stem from limited exposure to reproductive health education.

Community Norms and Misinformation

Widespread misconceptions were also evident. Many participants believed that vasectomy results in physical weakness, loss of libido, or impotence. Misinformation was commonly sourced from peers, local narratives, or older male relatives. In communities where few, if any, men have undergone vasectomy, these myths remained unchallenged.

"They say once you go for vasectomy, you will become useless in bed. I can't take that risk."

"People say it's like castration. Once you do it, you become like a eunuch."

In some cases, these community-held beliefs were reinforced by local leaders or even health workers who lacked accurate information. As a result, even when participants expressed interest in learning more, they lacked trusted sources to clarify doubts or correct false information.

Emerging Interest and Conditional Acceptance

While dominant views reflected resistance, a small subset of participants, particularly women, expressed tentative openness to vasectomy, conditional upon improved education and open discussion within couples.

"If it was explained well and we knew it does not harm a man, maybe we could consider it after getting the children we want."

This reflects a potential entry point for health promotion interventions focused on demystifying vasectomy and promoting joint decision-making among couples.

DISCUSSION

The findings of this study offer valuable insight into the complex sociocultural dynamics that shape perceptions and acceptance of vasectomy among married men and women in Kampi Ya Moto. Through thematic analysis, four interrelated themes emerged, perceptions of masculinity and gender roles, religious and spiritual beliefs, community norms and misinformation, and emerging interest with conditional acceptance, each of which reveals deeply embedded attitudes, values, and social constructs that influence contraceptive decision-making in rural Kenya.

The notion that vasectomy threatens a man's masculinity was a dominant barrier to acceptance. Participants' statements reflected a pervasive belief that reproductive ability is synonymous with manhood, social strength, and authority. The assertion that "a man who has undergone vasectomy is no longer a full man" highlights the cultural emphasis on fertility as a marker of male identity. Similar findings have been documented in previous studies across sub-Saharan Africa, where reproductive virility is valorized, and contraceptive responsibility is

disproportionately assigned to women (DiMartino, 2019; Lévesque et al., 2024). In this context, male participation in family planning is not only seen as emasculating but as a form of yielding control, particularly to one's spouse, which undermines traditional gender hierarchies.

This cultural construction relegates men to a peripheral role in reproductive health, further entrenching the idea that family planning is a "woman's job." Such views significantly inhibit dialogue around shared contraceptive decision-making and hinder public health efforts aimed at promoting equitable reproductive responsibility.
Religious ideologies also emerged as a powerful influence on perceptions of vasectomy. Both Christian and Muslim participants voiced strong opposition based on theological grounds, particularly the belief that human interference in procreation challenges divine will. The statement, "God decides how many children we should have," underscores the theological determinism that governs reproductive decision-making for many individuals in rural settings. These perspectives are consistent with findings from similar contexts, where religious doctrine has been shown to significantly shape fertility preferences and contraceptive behaviors (McQuillan, 2004).

Importantly, participants who expressed strong religious opposition were also those least engaged with formal family planning education or services. This suggests that religious resistance may be compounded by limited exposure to accurate reproductive health information (Arousell and Carlbom, 2016; Chandra-Mouli et al., 2018). Integrating faith-based dialogue into health promotion strategies, through partnerships with religious leaders, could be instrumental in shifting attitudes while maintaining respect for spiritual values.

The widespread misinformation surrounding vasectomy, such as associations with impotence, physical weakness, or castration, demonstrates the powerful role of community narratives in shaping health behavior. The belief that "you become useless in bed" or "like a eunuch" after the procedure reflects not only biological misconceptions but also a failure of public health communication in disseminating clear, culturally sensitive, and evidence-based information about male sterilization. These myths were often perpetuated by older male relatives or peers and, in some cases, reinforced by inadequately informed local health workers. This dynamic underscore the need for community-based education programs that target both men and women, utilize peer educators, and incorporate trusted voices to counter harmful narratives. In the absence of credible information sources, even those inclined to learn more about vasectomy find themselves trapped in a cycle of fear and misinformation (Agingu, 2010; Kissling, 2020).
Despite prevailing resistance, a notable minority, primarily women, expressed conditional openness to vasectomy. Their willingness was linked to the presence of accurate information and mutual consent within marriage. The quote, "If it was explained well and we knew it does not harm a man…" points to the potential for attitudinal shifts if knowledge gaps are addressed through participatory and respectful education. This emerging interest suggests a pathway for intervention, leveraging informed couples, community dialogue, and demonstrative success stories to normalize male participation in family planning (Habib, 2024; Mukherjee and Kumar, 2024).

This finding is particularly important, as it aligns with gender-inclusive models of reproductive health that advocate for joint responsibility and informed, consensual contraceptive choices (Greenfield et al., 2025; Taylor, 2021). It also highlights that some resistance to vasectomy is not ideological but informational, suggesting that knowledge-based interventions could yield significant impact if they are contextually adapted.

Conclusion

Overall, the qualitative findings underscore that vasectomy acceptance in rural Kenya is not merely a function of individual choice but a reflection of broader cultural, religious, and social systems. Masculinity, religious doctrine, peer influence, and misinformation form intersecting barriers that collectively hinder male contraceptive uptake. However, the presence of conditional acceptance offers a strategic opportunity for change. Efforts to promote vasectomy must therefore extend beyond clinical education to include culturally grounded, gender-sensitive, and community-driven strategies that redefine male roles in reproductive health without challenging the social identities that men value.

Recommendations

We recommend as follows:

1. Develop culturally sensitive education programs to dispel myths and misinformation about vasectomy, using trusted local influencers and male peer educators.
2. Partner with faith-based and traditional leaders to facilitate open dialogue that aligns family planning with religious and cultural values.
3. Integrate vasectomy counseling into routine reproductive health services, ensuring that men are actively involved in informed, couple-centered decision-making.

Conflict of Interest

Authors declare no conflict of interest

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