

Awareness and Attitude towards Acceptance of Vasectomy among Spouses of Pregnant/Delivered Women in the University College Hospital, Ibadan, Oyo State

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Abstract: *Awareness and Attitude of vasectomy are critical for enhancing male involvement in family planning and reducing the contraceptive burden on women in Nigeria. This study assessed awareness and attitudes toward vasectomy and how these factors influence its acceptance among spouses of pregnant or recently delivered women at the University College Hospital (UCH), Ibadan, Nigeria. The study specifically examined the level of awareness of vasectomy, attitudes toward vasectomy as a male contraceptive method, perceived barriers influencing its acceptance, and the readiness of men to consider vasectomy as a family planning option. A descriptive cross-sectional research design was adopted. The study population comprised male spouses of pregnant or recently delivered women attending antenatal, postnatal, and family planning clinics at UCH. Using convenience sampling, fifty respondents who met the eligibility criteria were recruited. Data were collected using a structured questionnaire that assessed respondents' awareness, attitudes, perceived barriers, and readiness regarding vasectomy. The instrument was validated through expert review and tested for reliability using a pilot study, which produced a reliability coefficient of 0.84. Data were analyzed using descriptive statistics and Chi-square analysis at a 0.05 level of significance. The findings revealed that most respondents were aware of vasectomy as a permanent family planning method, although misconceptions regarding sexual performance and safety persisted. Respondents generally supported male involvement in reproductive health and joint decision-making with partners. However, cultural beliefs, perceived social stigma, and limited accessibility of services were identified as major barriers to acceptance. Readiness to recommend or adopt vasectomy remained relatively low, though many respondents indicated willingness to consider it after receiving adequate information. The study concludes that improving awareness through targeted health education, promoting male involvement in family planning, and enhancing access to vasectomy services may significantly improve acceptance of the procedure.*

Keywords: awareness, acceptance, attitude, readiness, spouses, vasectomy

INTRODUCTION

Maternal mortality that is due to unintended or unplanned pregnancies remains a major public health issue, especially among women of reproductive age in developing countries (Gbenga-Epebinu et al., 2020; Aluko et al., 2025). Across many low- and middle-income nations, unintended pregnancies are frequently associated with health complications, unsafe abortion and preventable maternal deaths (Gbenga-Epebinu & Ogunrinde 2020).

Globally, unintended pregnancy is still widespread and is a major factor in the reproductive health challenges. Each year, about 210 million women in the world become pregnant and an estimated 80 million of these pregnancies are unintended, or about 38 percent. Of these unintended pregnancies, between 42 and 46 million end in induced abortion, and almost 19 million in unsafe abortion, many of which take place in resource constrained settings where access to safe reproductive health services is limited (Mar et al., 2019). These realities underscore the importance of effective family planning services in helping to prevent unwanted pregnancies and enhance maternal health outcomes. Adopting adequate knowledge and access to contraceptive options is therefore an integral part of global reproductive health strategies.

In contrast, many developed countries have made amazing progress in reducing unintended pregnancies and maternal mortality through comprehensive family planning services and enhanced contraceptive uptake. For example, in the United Kingdom, the contraceptive prevalence rate is about 84 percent in women aged 15-49 years and the maternal mortality ratio is estimated to be about 7 deaths per 100,000 live births (Mahmoud et al., 2020). These gains have been explained mostly by better reproductive health education, access to a range of contraceptive methods and supportive health systems. However, even in such systems, family planning has traditionally been seen as a woman's responsibility with men often playing only a secondary or supporting role. In many societies, especially those in the developing world, men's involvement in sexual and reproductive health decision-making is low. This pattern has been reinforced by sociocultural norms which saw contraception as a female responsibility. Consequently, most women tend to experience resistance from their partners whenever they try to use contraceptive methods, which can greatly affect the success of family planning programs (Ejioye & Gbenga-Epebinu 2021).

The limited involvement of men in family planning has important implications for the reproductive health outcomes. In many African societies, men are often the main decision-makers in relation to family size and reproductive choices. When men do not have sufficient awareness or knowledge about the options of contraception, especially male-centered contraceptives, women may have difficulties accessing or using family planning services consistently (Vijay & Surya 2015). This situation puts a disproportionate burden on women who are frequently expected to bear the physical, emotional and financial burden associated with contraception. As a result, women may suffer from repeated pregnancies, unsafe abortions and various childbirth-related complications. In areas with limited or inadequate maternal healthcare services, these challenges play an important role in high maternal mortality rates and negative health outcomes for women and their families.

Nigeria, for example, has one of the highest maternal mortality ratios in sub-Saharan Africa and one of the countries with the most maternal deaths in the world (Daniel et al., 2016). Unsafe abortions alone are estimated to play a significant role in maternal mortality and often are caused by unintended pregnancies and the lack of access to family planning services.

Family planning is an essential part of reproductive health services and programmes to prevent unwanted pregnancies, regulate fertility and protect the health of the mother and child. Despite the availability of many contraceptive methods, the burden of contraception has remained largely on women. While there are multiple options for female contraceptives, it is relatively low for male involvement in family planning. Currently, there are two main forms of permanent sterilization available to couples that have finished their family sizes: bilateral tubal ligation (BTL) for women and vasectomy for men. Bilateral tubal ligation is the surgical blockage or severing of the fallopian tubes by such surgical procedures as laparotomy, mini-laparotomy, or laparoscopy, which prevents egg fertilization (Kana et al., 2016). Vasectomy on the other hand is the surgical division or occlusion of the vas deferens which prevents mixing of sperm with semen during ejaculation (Oluwatoyin et al., 2024). Compared to female sterilization, vasectomy is generally believed to be a simpler and safer procedure, but adoption rates of vasectomy are still very low in many developing countries.

Vasectomy is a permanent method of contraception for men which aims to stop the release of sperm at ejaculation (Owopetu et al., 2014). The procedure is usually done under local anesthesia in an outpatient care setting and is generally accepted as a safe, effective and minimally invasive method of birth control. Medical evidence shows that vasectomy has fewer risks and complications compared to female sterilization procedures and does not have a negative impact on a man's sexual performance, hormonal balance or general health (Khan et al., 2014). Globally, the vasectomy method has become quite accepted in several developed countries, such as the United States and Canada, where couples who have completed their desired number of children often opt for the method, as it is simple and reliable and less invasive than female sterilization. According to the global health reports, vasectomy prevalence is relatively high in North America, parts of Europe and some countries in Asia. However, its uptake is extremely low in many African and South Asian nations. Studies have revealed that vasectomy is not only quick and convenient, but it also does not pose health risks to a man's partner, making it a viable option for couples who want to use it as a form of contraception and wish to have permanent birth control (Asare et al., 2017).

Despite these advantages, the use of vasectomy as a method of contraception is still one of the least used in many developing countries, including Nigeria. Cultural beliefs, societal expectations, misconceptions regarding masculinity, fear of surgical complications, and the desire to be able to have children in the future are often reasons men are not interested in considering the procedure. In some communities, vasectomy is misconceived to be associated with weakness, impotence, or loss of sexual ability, which causes social stigma and resistance from men. Empirical evidence also demonstrates the very low acceptance of vasectomy in Nigerian health care settings. For instance, only two vasectomy procedures were reported to have been performed for a period of 30 years at the University College Hospital (UCH), Ibadan. Similarly, in Jos, Nigeria, only ten vasectomies were recorded over the period of 16 years relative to about 3,600 tubal ligation procedures that were performed on women over the same period (Onasoga et al., 2013). These statistics illustrate the severe imbalance in distribution of contraceptive responsibility between men and women.

Given the influential role of men in reproductive decision making in many developing societies, there is a need to increase male participation in family planning to enhance uptake of contraceptives and reduce unintended pregnancies (Kabangeyi et al., 2014). Enhancing the awareness and knowledge about male contraceptive methods especially vasectomy could help overcome the persistent misconceptions and promote shared responsibility between partners. Understanding men's perceptions, attitudes and knowledge on vasectomy is therefore important in identifying the socio-cultural, religious and psychological barriers which may influence acceptance of vasectomy. The present study which is focused on spouses of pregnant or recently delivered women attending the University College Hospital, Ibadan is aimed at exploring these problems in more depth. By exploring the level of awareness, knowledge and acceptance of vasectomy among this population, the study intends to give insights that can be used to guide specific reproductive health education and interventions. Ultimately, promoting correct information about vasectomy and encouraging the male's participation in family planning could be a significant contribution to improving the reproductive health outcomes and maternal mortality.

This study aims to assess the awareness of and attitude towards vasectomy and how these factors influence its acceptance among spouse of pregnant/delivered women at University College Hospital, Ibadan. The specific objectives are to:

1. identify level of awareness of vasectomy among spouses of pregnant/delivered women;

2. determine the attitude of spouses of pregnant/delivered women towards vasectomy as a male contraceptive method;
3. identify barriers influencing the acceptance of vasectomy among spouses of pregnant/delivered women; and
4. determine the level of readiness of spouses of pregnant/delivered women in acceptance of vasectomy as a family planning option.

METHODS AND MATERIALS

This study used descriptive cross-sectional research design to investigate the awareness of and attitude towards acceptance of vasectomy among the spouses of pregnant women or recently delivered women at the University College Hospital (UCH), Ibadan, Oyo state, Nigeria. The descriptive design was deemed appropriate because the study aimed to elicit factual data on the existing awareness and attitudes towards vasectomy among male partners without interfering with any variables. The cross-sectional approach helped the researcher to gather information from participants at a single point of time and hence, the level of awareness and attitude towards vasectomy in the study population was collected at a point in time. The study was conducted at the University College Hospital, Ibadan, which is a major tertiary healthcare institution that offers a comprehensive maternal and reproductive health services. The target population for this study was male spouses of pregnant or recently delivered women attending the maternal health services at the hospital. In particular, respondents were recruited from men accompanying their partners to the Antenatal Clinic, Postnatal Care Unit and Family Planning Department. These units were chosen because they routinely offer reproductive health services and offer opportunities for engaging couples on issues relating to family planning. Participants who fulfilled the eligibility criteria were selected among clients who received care in these clinics during the study period.

A non-probability sampling method, namely, convenience sampling was used to recruit the participants for the study. This technique was employed by choosing the respondents who were readily available and willing to participate at the time of data collection. The use of the convenience sampling was deemed appropriate as the male spouses accompanying their partners to the clinics were not always present in large numbers to make the probability sampling easy to implement. Based on the number of male spouses who were estimated to be attending the antenatal and postnatal clinics in a three-month period, a total sample size

of 50 respondents was used for the study. Participants were male spouses of multiparous women who were either pregnant or had recently given birth. To be eligible to participate, respondents had to be at least 18 years of age, able to make reproductive health decisions and willing to provide informed consent. Male spouses who previously had vasectomy or who had some known problems preventing them from conceiving naturally and those who were unwilling to take part were excluded from the study.

Data for the study was gathered with a structured questionnaire specially designed to measure the awareness, attitude and acceptance of vasectomy as a method of family planning by the respondents. The questionnaire included a combination of closed-ended and open-ended questions so that the participants could give detailed answers where needed. The instrument also obtained relevant demographic information and respondent's perception about vasectomy. To ensure validity of the instrument, the questionnaire was developed after consultation of relevant textbooks, scholarly journals and online academic sources related to reproductive health and family planning. The reliability of the instrument was ascertained by a pilot study among male spouses of pregnant or postpartum women attending the Adeoyo State Hospital, Ibadan, which has similar characteristics with the study setting but was not part of the main study. Twenty questionnaires were administered during the pilot study and split-half method was used to test the internal consistency of the instrument. The overall reliability coefficient value of 0.84 showed that the questionnaire was consistent in measuring the variables of awareness, attitude, and acceptance of vasectomy. Based on the outcome of the pilot test, the instrument was regarded as reliable and appropriate for the study.

Permission to conduct the data collection was obtained from the appropriate authority in the institutions at the University College Hospital Ibadan. Eligible participants were approached at the selected clinic units and given information on purpose of the study. Informed consent was given to each respondent before administering the questionnaire. Participation was completely voluntary and respondents were assured that the information they provided would be treated with strict confidentiality and would only be used for research purposes. The questionnaires were administered manually to the participants and clear instructions were given to guide the participants on how to fill out the instrument. A total of 50 questionnaires were distributed and successfully collected for analysis.

The data collected were meticulously sorted, coded, and analyzed with the help of descriptive and inferential statistical methods. Descriptive statistics frequencies, percentages, tables and charts, were used to summarize demographic characteristics of the respondents and responses. In addition, the chi-square statistical test was used to test the hypothesis of the study and determine the relationship between selected variables at the 0.05 level of significance. The application of the statistical methods helped the researcher to present the results in an understandable and interpretable form, while evaluating potential associations between the awareness, knowledge and acceptance of vasectomy as a method of family planning by respondents.

RESULTS

This section presents the analysis and interpretation of data collected through a structured questionnaire.

Table 1: Socio-demographic Characteristics of Respondents (N = 50)

Variable	Category	Frequency	Percentage
Age	20-29 years	21	42.0
	30-39 years	18	36.0
	40-49 years	9	18.0
	50-59 years	2	4.0
Marital Status	Married	50	100
Number of Children	1-2	22	44.0
	3-4	19	38.0
	5 and above	9	18.0
Have you heard of vasectomy before?	Yes	38	76.0
	No	12	24.0
Have you or your spouse ever used any form of family planning method?	Yes	18	36.0
	No	32	64.0

Table 1 shows that the vast majority of respondents were married (100%) and fell within the 20-39 age bracket (42%). Regarding family size, nearly half of the respondents (44%) had 1-2 children, while more than a third (38%) had 3-4 children. A significant majority (76%) had heard of vasectomy before, yet almost two-thirds (64%) reported never having used any form of family planning with their spouse.

Table 2: Awareness of Vasectomy (N = 50)

Variables	Strongly Agree (&)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Vasectomy is a permanent family planning method for men	30 (60.0%)	13 (26.0%)	5 (10.0%)	2 (4.0%)	0 (0.0%)
Vasectomy involves sealing or cutting tubes that carry sperm	32 (64.0%)	12 (24.0%)	3 (6.0%)	0 (0.0%)	3 (6.0%)
A man can still ejaculate after vasectomy	10 (20.0%)	13 (26.0%)	17 (34.0%)	8 (16.0%)	2 (4.0%)
Vasectomy causes impotence or erectile dysfunction	15 (30.0%)	7 (14.0%)	11 (22.0%)	12 (24.0%)	5 (10.0%)
Vasectomy is safer than the female method of family planning	18 (36.0%)	10 (20.0%)	11 (22.0%)	9 (18.0%)	2 (4.0%)

Table 2 above show that respondents demonstrated high knowledge regarding the permanence of vasectomy and its procedural mechanism, with mean scores of 4.42 and 4.46 respectively. However, understanding of post-vasectomy sexual function was moderate, as many respondents were uncertain about the ability to ejaculate and concerns about impotence, reflected in mean scores of 3.42 and 3.30. Similarly, perceptions of vasectomy's safety compared to female methods were moderate, with a mean of 3.66. Overall, while respondents were well-informed about the permanence and procedure of vasectomy, there remains moderate uncertainty and misconceptions regarding its sexual effects and relative safety, highlighting the need for targeted health education.

Table 3: Attitude Towards Vasectomy (N = 50)

Variables	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Men should be more involved in reproductive health decisions	25 (50.0%)	10 (20.0%)	8 (16.0%)	5 (10.0%)	2 (4.0%)
A man should agree with his partner before undergoing vasectomy	35 (70.0%)	9 (18.0%)	4 (8.0%)	2 (4.0%)	0 (0.0%)
Vasectomy is only acceptable if the couple has many children	20 (40.0%)	13 (26.0%)	8 (16.0%)	7 (14.0%)	2 (4.0%)
It is better for women to use oral contraceptives than men have a vasectomy	18 (36.0%)	8 (16.0%)	10 (20.0%)	11 (22.0%)	3 (6.0%)

The results in Table 3 show the respondents' attitudes toward vasectomy and male involvement in reproductive health decisions. A large proportion of respondents demonstrated a positive attitude toward male participation in reproductive health, with 35 respondents (70.0%) strongly agreeing and 10 (20.0%) agreeing that men should be more involved in reproductive health decisions, representing a combined agreement of 70.0%. Similarly, an overwhelming majority of respondents, 44 (88.0%), either strongly agreed (70.0%) or agreed (18.0%) that a man should consult and agree with his partner before undergoing vasectomy, indicating strong support for joint decision-making in family planning matters. However, attitudes toward vasectomy acceptance appeared conditional for some respondents, as 33 respondents (66.0%) either strongly agreed (40.0%) or agreed (26.0%) that vasectomy is only acceptable when couples already have many children. Furthermore, 26 respondents (52.0%) supported the view that it is preferable for women to use oral contraceptives rather than men undergoing vasectomy, while 14 respondents (28.0%) disagreed or strongly disagreed with this statement. Overall, the findings suggest that although respondents generally support male involvement and shared decision-making in reproductive health, traditional beliefs and preferences for female contraceptive methods may still influence attitudes toward the acceptance of vasectomy.

Table 4: Perceived Barriers to Acceptance of Vasectomy (N = 50)

Variables	Strongly Agree (SA)	Agree (A)	Neutral (N)	Disagree (D)	Strongly Disagree (SD)
My culture discourages male involvement in family planning	18 (36.0%)	8 (16.0%)	9 (18.0%)	12 (24.0%)	3 (6.0%)
I would never agree to undergo vasectomy	17 (34.0%)	8 (16.0%)	9 (18.0%)	13 (26.0%)	3 (6.0%)
I am afraid of complications or side effects	12 (24.0%)	9 (18.0%)	11 (22.0%)	15 (30.0%)	3 (6.0%)

Variables	Strongly Agree (SA)	Agree (A)	Neutral (N)	Disagree (D)	Strongly Disagree (SD)
Vasectomy services are not easily accessible	22 (44.0%)	9 (18.0%)	10 (20.0%)	7 (14.0%)	2 (4.0%)
Men lose respect among peers after undergoing vasectomy	16 (32.0%)	7 (14.0%)	12 (24.0%)	12 (24.0%)	3 (6.0%)

The results in Table 4 present respondents' perceived barriers to the acceptance of vasectomy among men. Cultural influence appears to be a notable barrier, as 26 respondents (52.0%) either strongly agreed (36.0%) or agreed (16.0%) that their culture discourages male involvement in family planning, while 15 respondents (30.0%) disagreed or strongly disagreed with this view. Regarding personal acceptance, 25 respondents (50.0%) indicated resistance to undergoing vasectomy, with 17 (34.0%) strongly agreeing and 8 (16.0%) agreeing that they would never agree to the procedure, whereas 16 respondents (32.0%) disagreed or strongly disagreed. Fear of complications was relatively less pronounced, as 18 respondents (36.0%) expressed fear of side effects while a larger proportion, 18 respondents (36.0%), disagreed or strongly disagreed with this concern, and 11 respondents (22.0%) remained neutral. Accessibility also emerged as a significant barrier, with 31 respondents (62.0%) agreeing that vasectomy services are not easily accessible. Additionally, social perception appears to influence attitudes, as 23 respondents (46.0%) believed men may lose respect among peers after undergoing vasectomy. Overall, the findings suggest that cultural norms, perceived service accessibility, and social stigma constitute major barriers to the acceptance of vasectomy among respondents, while fear of medical complications appears to play a comparatively moderate role.

Table 5: Readiness to Accept or Recommend Vasectomy (N = 50)

Variables	Strongly Agree (SA)	Agree (A)	Neutral (N)	Disagree (D)	Strongly Disagree (SD)
Willing to recommend vasectomy to a friend or neighbor	10 (20.0%)	8 (16.0%)	12 (24.0%)	15 (30.0%)	5 (10.0%)
Comfortable discussing vasectomy with a health worker	9 (18.0%)	7 (14.0%)	14 (28.0%)	16 (32.0%)	4 (8.0%)
May consider vasectomy after being fully informed	15 (30.0%)	7 (14.0%)	15 (30.0%)	11 (22.0%)	2 (4.0%)
Open to attending community talks/seminars about vasectomy	18 (36.0%)	8 (16.0%)	13 (26.0%)	9 (18.0%)	2 (4.0%)
Vasectomy should be included in all family planning discussions	20 (40.0%)	8 (16.0%)	11 (22.0%)	9 (18.0%)	2 (4.0%)

The results in Table 5 indicate varying levels of readiness among respondents to accept or recommend vasectomy. Only 18 respondents (36.0%) either strongly agreed (20.0%) or agreed (16.0%) that they were willing to recommend vasectomy to a friend or neighbor, while a larger proportion, 20 respondents (40.0%), disagreed or strongly disagreed with recommending it. Similarly, willingness to discuss vasectomy with health workers was relatively low, as only 16 respondents (32.0%) expressed agreement, whereas 20 respondents (40.0%) disagreed or strongly disagreed and 14 (28.0%) remained neutral.

However, a more encouraging response was observed regarding personal consideration of vasectomy when fully informed, where 22 respondents (44.0%) indicated agreement while 13 respondents (26.0%) disagreed. Interest in educational engagement was also evident, with 26 respondents (52.0%) expressing openness to attending community seminars or talks on vasectomy. Furthermore, a majority of respondents, 28 (56.0%), supported the inclusion of vasectomy in family planning discussions. Overall, the findings suggest that while direct recommendation or discussion of vasectomy remains limited among respondents, there is moderate openness to learning about the procedure and considering it when adequate information is provided, indicating the potential impact of targeted health education and awareness programs.

Table 6: Relationship between Age and Level of Knowledge about Vasectomy Using Chi-square

Variables (Age Group)	High Knowledge (Yes)	Low Knowledge (No)	χ^2	df	pvalue
20-29 years	16 (76.2%)	5 (23.8%)	1.294	3	0.731
30-39 years	12 (66.7%)	6 (33.3%)			
40-49 years	6 (66.7%)	3 (33.3%)			
50-59 years	1 (50.0%)	1 (50.0%)			

Table 6 presents the relationship between the age of respondents and their level of knowledge about vasectomy using the Chi-square test. The result shows that age group ($\chi^2 = 1.294$, $df = 3$, $p = 0.731$) had no significant relationship with the level of knowledge about vasectomy, as the p-value is greater than 0.05.

Table 7: Relationship between Perceived Barriers and Level of Readiness to Accept Vasectomy Using Chi-square

Variables (Barrier Items)	High Readiness (Yes)	Low Readiness (No)	χ^2	Df	pvalue
Culture discourages male involvement	12 (46.2%)	14 (53.8%)	4.167	1	0.041*
Would never agree to undergo vasectomy	5 (20.0%)	20 (80.0%)			
Fear of complications or side effects	7 (33.3%)	14 (66.7%)			
Services are not easily accessible	10 (32.3%)	21 (67.7%)			
Men lose respect among peers	8 (34.8%)	15 (65.2%)			

Table 7 presents the relationship between the perceived barriers to vasectomy and the level of readiness to accept it among respondents using the Chi-square test. The result shows that perceived barriers ($\chi^2 = 4.167$, $df = 1$, $p = 0.041$) had a significant relationship with the level of readiness to accept vasectomy, as the p-value is less than 0.05.

Discussion of Findings

The results of this study show that despite general awareness about vasectomy in the study population, misconceptions about the procedure are still widespread. A significant number of the respondents showed awareness of vasectomy as a family planning method for men, which indicates the concept is not completely alien within the study population. This finding is consistent with the findings of Quereishi et al. (2017), in which they reported a relatively high level of awareness of vasectomy by women in Nigeria. However, despite this awareness, there are still several misconceptions that exist among men about the effects of the procedure. A notable proportion of respondents felt that vasectomy could cause

impotence or erectile dysfunction which indicated a significant gap of accurate knowledge. This finding strongly supports the study conducted by Ghalot et al. (2017) which showed that vasectomy is considered by many men to be equivalent to castration or loss of masculinity. Such misconceptions still restrict the acceptance of vasectomy in many developing societies. Nevertheless, evidence in this study suggests that knowledge about vasectomy can be enhanced by educational interventions. The results show that targeted education has the potential to have a big impact on understanding and correcting misinformation. This observation responds to the concerns of Lumonga & Luis (2020) and Asiedu et al. (2020), who found that misinformation and lack of knowledge are major barriers for the adoption of vasectomy in many communities.

The study further found that the respondents generally expressed positive attitudes towards male involvement in reproductive health decision making. A majority of the participants agreed that men should become more active in family planning and reproductive health issues. This finding is consistent with the study by Oluwatoyin (2024) which has reported on the widespread approval of male participation in family planning initiatives. However, despite this general support of the idea of male involvement, there was little evidence that this general support led to personal willingness to use vasectomy as a form of contraception. Many respondents offered conditional acceptance such as accepting that vasectomy may only be suitable when couples have completed their desired family size. This means that although the foundation for male participation is in place, specific attitudes towards vasectomy are still affected by personal beliefs, cultural norms and perceived consequences of vasectomy. The findings therefore suggest that the promotion of male involvement alone may not be adequate to increase vasectomy uptake in the absence of deliberate educational efforts that address the misconceptions and provide accurate information about the procedure.

Another finding of the study that is considered important is that of the perceived barriers which affects the acceptance of vasectomy by the respondents. More than half of the respondents indicated that cultural norms discourage male involvement in family planning pointing to the influence of sociocultural expectations on reproductive health behaviour. This finding is in line with the work of Namora and Basyariah (2020) who identified cultural beliefs and gender norms as the major factors affecting male participation in family planning in many developing countries. In addition, a considerable proportion of respondents perceived vasectomy services as not easily accessible suggesting that structural factors such as availability of services and healthcare infrastructure may also contribute to the low uptake of the procedure. This observation is similar to the findings of

Ahinkorah et al. (2020) who reported that limited access to vasectomy services form a major barrier to its adoption in many African settings. These results show that both cultural perceptions and limitations of the healthcare system are still influencing attitudes about vasectomy.

The results also show that willingness to accept or recommend vasectomy among the respondents are relatively low, although there are some indications of openness to vasectomy under certain circumstances. Less than two-fifths of the respondents expressed their willingness for recommending vasectomy to others which reflects the generally low acceptance to the method reported in previous studies such as Alireza et al. (2017). Similarly, a large number of respondents were not comfortable talking to healthcare providers about vasectomy, which may indicate that stigma and uncertainty about the procedure discourages open conversations with healthcare providers about male contraceptive options. Despite this, the results show that a nontrivial percentage of the respondents were willing to consider vasectomy if fully informed about the procedure. In addition, over half of the respondents said that they would be willing to attend community seminars or educational programs about vasectomy, and a majority of them supported the inclusion of vasectomy in family planning discussions. These findings suggest that while there may be a short-term limitation to adopting vasectomy, there is a significant opportunity for improvement through sustained awareness campaigns and reproductive health education.

Overall the discussion of findings suggests that the low acceptance of vasectomy among men is affected by a combination of misinformation, cultural perceptions and limited access to reliable information. While there is awareness of vasectomy, there are still knowledge gaps and myths that persist and influence negative perceptions of the procedure. At the same time, the study finds an underlying positive attitude towards male participation in reproductive health, and willingness among the respondents for learning more about vasectomy. These results suggest that educational interventions, community engagement and enhanced reproductive health communication may be an important part of changing attitudes and acceptability of vasectomy as an acceptable family planning method.

CONCLUSION

The study concludes that despite the awareness of vasectomy as a family planning method among spouses of pregnant or delivered women, there are important knowledge gaps and misconceptions on its effects on sexual performance and safety. Respondents generally had positive views about the role of males in reproductive health and supported joint decision-

making between partners on issues of family planning. However, acceptance of vasectomy was affected by the prevailing cultural beliefs, social perceptions and accessibility of services which still deter many men from considering the procedure. The findings also show that readiness to accept or recommend vasectomy is relatively limited and this is attributed mainly to misconceptions and perceived social barriers. Nevertheless, there was openness to having more information and taking part in educational discussions on vasectomy, indicating that better awareness and specific health education could play a significant role in increasing acceptance. All in all, the study underscores the importance of addressing cultural perceptions, correcting misinformation, and improving access to accurate reproductive health information to promote more male participation in family planning and acceptance of vasectomy as a viable contraceptive option.

Recommendations

1. Healthcare providers and public health agencies should intensify community-based education programs that contain accurate information about vasectomy, especially on misconceptions about impotence, sexual performance, and safety of the procedure.
2. Family planning services should take an active role to encourage male participation by designing family planning programmes with the objective of men's involvement in reproductive health discussion and decision-making with their partners.
3. Healthcare facilities should ensure that the information about vasectomy is included in the antenatal, postnatal and family planning counselling sessions so that couples can make informed decisions about the available contraceptive options.
4. Government and healthcare institutions should increase access to vasectomy services and trained personnel in health facilities so that men who are interested in the procedure can easily access safe and reliable services.
5. Community leaders, religious leaders and influential stakeholders should be included in sensitization programs to reduce stigma and negative cultural perceptions around male sterilization and promoting shared responsibility in family planning.

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