

Experiences and Attitudes Towards Vasectomy in Family Planning Decision-Making: A Qualitative Study

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Abstract

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Received on 20 March, 2026

Accepted on 22 April, 2026

Published on 24 April, 2026

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In Pakistan vasectomy has not been the most popular form of contraception amongst men but remains as a safe, effective and relatively simple permanent form of contraception. It was this qualitative research that attempted to discover the experiences, meaning, and the attitude of a married man who underwent vasectomy and

how they negotiated the decision process about family planning in the mind of considering the social, marital, economic and religious life of Pakistan. A family planning center at the Jinnah postgraduate medical centre, Karachi was used using a descriptive phenomenological design. The sampling method used was purposive and five married males of age above 30 with one or more kids and who were interviewed in-depth until a thematic saturation was reached. The data was collected by using a demographic form and an interview guide with questions, which are open-ended questions, about family size, prior experience with the use of contraceptives, religious knowledge, socially

related attitudes and a discussion on marital and expectation of vasectomy. Interviews were transcribed to audio then coded and analyzed through the thematic analysis. Seven themes were developed and they included: definition of the complete family, sources of information on vasectomy, vasectomy as the procedure, possible outcomes of vasectomy, religious attitudes, the reason of vasectomy and the use of other contraceptives. The respondents were biased towards a small family as a desirable one, the family restriction was connected to the welfare of children, and vasectomy was considered to be less of a burden in comparison to female sterilization. The majority thought that the process was not going to lead to decreased sexual prowess and lives and marriages were not going to be disrupted. The social opinion played a crucial role as well although the majority respondents were not interested in the opinion being voiced in the street but concerned with what was going on at home. Religious interpretation was the ambiguously area, with some men finding nothing wrong in the area as long as it was the care of children, and with others being assured that permanent contraception could not be something a man could be bound to. The findings are that ignorance alone can bring the acceptance of vasectomy to the men only partially and the overall effect of gender norms, economic pressure, peer pressure, spousal bargain and moral convictions are the reason. Programs that allow normalization of male participation, strengthen the counseling process and the reaction to the religious myths can increase the acceptance of vasectomy as a family responsibility in planning as a family affair.

Keywords: vasectomy, family planning, men, qualitative research, Pakistan, reproductive decision-making

Introduction

The previous high level of population growth has remained to haunt Pakistan as it has adversely affected health, household economy and social development of Pakistan. The historical statistics they employ in the source thesis pale on an explanation of such a huge and growing number of population, of so low a prevalence of contraceptive use against the other countries of the region and of such an inexpressible alarm at the possibility of the family and the state in the future burdening the people with education, food, housing, and medical treatment in abundancy (Khan, 2010) Sathar and Zaidi

The management by an individual and couples of the number of children desired and the time and years between births is a phenomenon that has been dubbed family planning (WHO, 2010). But in practice contraceptive decision is not technical. It is mediated by the use of gender power relations, social expectations, availability and cultural perceptions of fertility, masculinity as well as religion. In Pakistan, where men have always been put at the centre of the home as the key decision makers, the role of males should play a centre stage in explaining why certain modes of contraception are adopted and others are abandoned.

Although both can be done both temporarily and permanently, contraceptives are often the responsibility of women. Female approaches prevail, are more visible in the service delivery and are written about in the community more often. In comparison, vasectomy is highly peripheral since it has been proved as equally effective, simple and not so cumbersome to perform compared to female sterilization (Dhar and Jones, 2007; Schwingl and Guess, 2000; Norton, 2004). Majority of the studies discussed in the thesis also imply that the awareness on vasectomy in Pakistan has been low and that it had been absolutely low in its acceptance compared to that of tubal ligation in the past (Bibi et al., 2008; Bhutta, Zaeem, and Korejo, 2004).

Clinical aspects are unable to clarify disregard of vasectomy. Through Pakistani and other literature myths cite it as the lead to weakness, impotency, loss of masculinity, the inability to work or can even be mocked by people. It is not a female one because males might fear that they lose their role with picking the female (rather than the male) variant of the responsibility, and females may envisage that they are doomed to take contraception (Nishtar et al., 2013; Char, Saavala, and Kulmala, 2009; Rajesh et al., 2003). The uncertainties in religion also make it hard to make decision (when a permanent contraception is thought to interfere with the will of God).

Meanwhile, it has new indications that the mindset of male does not entirely bode ill. It has been established by the Muslim and non-Muslim studies that men will be able to support contraception when they are put in the context of child welfare, maternal health, cost of household and shared responsibility (Nasir, Tahir, and Ghazali, 2012; Grady et al., 1996; Abraham, Adamu, and Deresse, 2010). This would mean that a more qualitative study of how men themselves construct meaning regarding vasectomy

in context and not a perceived rejection following misinformation would have to be done.

That gap has been filled by the current study, as it talks about the experiences of married men who have already experienced what already married men whose experiences and attitudes were already at the stage of contemplation / seeking vasectomy at a state run family planning facility in Karachi. The study was not just a measure of prevalence or awareness as it was an inquiry on how men were building a complete family, how men were being educated about vasectomy, the expectations they held on the process, and how they discussed the decision with their wives, and how they reconstructed the meaning of the decision in relation to social and religious ones. The sort of investigation is important in the sense that not only the challenges are made evident, but also the frontiers where the male involvement in family planning may potentially be.

Study Aim

The research was not only concerned with the identification of the life experiences and attitudes of men, who are married, towards vasectomy as family planning strategy, but also how the researcher would find out the way these men arrived at their decisions under the intersecting intellectual facets of family welfare, masculinity, social norms and religion.

Methods

The qualitative descriptive phenomenological design was applied due to a qualitative research question which focused on subjective meaning and previous experience. Phenomenology is pleasant as long as scientists want to learn how individuals engage or perceive a phenomenon in their social world and not test a priori variables.

The research was conducted at the Family Planning Center of Jinnah Postgraduate Medical Centre (JPMC), Karachi, Sindh, Pakistan, over a study duration of six months, from September 2012 to February 2013. The target population consisted of males listed for vasectomy as a contraceptive method. Purposive sampling was used to select information-rich respondents who could provide meaningful insights into the research question. The inclusion criteria were males aged over 30 years with one or

more children undergoing vasectomy. Men who had undergone the procedure for reasons other than contraception were excluded.

The last sample had five participants. Lines with the qualitative phenomenological work with depth as the main aspect are small, but the size of the sample. According to the source thesis, since four interviews were carried out, along with an additional interview to provide saturation, it was guaranteed that saturation was achieved to provide description further.

The data gathering technique involved a survey and interview schedule, with an illustration of an interview-demographic survey questionnaire, and an interview guide with open ended questions. Interviews were used to give the meaning of family planning, the desired family size, an understanding of vasectomy, effect to a family life and their sexuality, religious influences and their previous use of contraception. Two pilot interviews were carried out on the refinements to style of questioning and gaps in the guide. Any last interviews that followed were therefore done with permission and were audio-taped by the principal investigator approximately 20-30 minutes in Urdu.

Data analysis was done by thematic content analysis. On other occasions, the transcripts were read and acquainted with the reading, line by line (coded), in groups, including the themes and subthemes. Comparison of the readings of the two transcripts enabled the researcher to discover patterns, convergences and divergences. The Urdu was translated to the English language which was confirmed by another bilingual person who comprehended both the languages. Protections against ethics included departmental approval, informed consent, privacy when interviewing, recording and transcript privacy, and pseudonymization by code of participant.

Participant Profile

Participant	Age (years)	Education	Marriage duration
P1	32	Primary	8 years
P2	38	Graduate	12 years
P3	38	Intermediate	24 years
P4	45	Matriculation	24 years
P5	45	Primary	24 years

Table 1: *Demographic profile of participants.*

Participant	Total children	Male children	Female children
P1	9	7	2
P2	3	2	1
P3	4	3	1
P4	4	2	2
P5	9	7	2

Table 2: *Family size and sex composition of children.*

Results

The seven themes and various subthemes when the five interviews were conducted were analyzed. Altogether, the results demonstrate that the readiness to have a vasectomy done was not rarely spontaneous. Instead it was a consequence of past reproductive experience, economic constraint, observations of female contraceptive loads as well as so-called discussions with wives, peers or health workers. The interviewees did not passively receive medical guidance but they could be moral agents, responsible and efficient in making decisions, taking family obligations, social salience and religious interpretation into consideration.

Theme	Key subthemes	Interpretive summary
Concept of complete family	Two children; three children; four children	A "complete" family was defined less by fertility alone than by the ability to provide proper care, education, and gender balance.
Sources of knowledge	Relatives; friends/colleagues; family planning personnel	Knowledge often came through trusted social networks rather than mass media.
Vasectomy as a procedure	Permanent contraception; complications than ligation	Participants generally understood vasectomy as a minor operation and viewed it as easier than

Possible effects of vasectomy	Sexuality; personal/family life; social life	female sterilization. Most expected no negative effect on sexual or marital life, though a few feared criticism or physical change. Religion was the most contested meaning domain, with both permissive and prohibitive interpretations.
Religious perspectives	No restriction; inappropriate/haram	Economic strain and children's welfare were central drivers of decision-making.
Purpose of vasectomy	No need for further children; betterment of children	Prior dissatisfaction with temporary methods and female side effects increased openness to vasectomy.
Use of other contraceptives	Male methods; female methods	

Table 3: *Major themes and interpretive summaries.*

Concept of a Complete Family

The individuals or family members should always maintain their families bearing in mind the element of responsibility and not biological capacity. Other men thought there would be nothing like having two kids; a boy and a girl because they could be brought up, taught and fed. Others preferred three or four children but even these respondents indicated that the family size should not go on past the income and the ability to offer children care. Whether parents will be in a position to fulfill the rights of children was a recurring fear not only numeric. This is a utilitarianism of planning family rationally based on good will and not merely on a mere rhetoric of population control.

Sources of Knowledge Regarding Vasectomy

The members normally heard the story of vasectomy through someone that they have confidence in: a brother, relative, wife, friend, or a health worker. The specified result is

striking as it implies that interpersonal credibility can be even more successful than generic awareness campaigns. The group of men that had worked with a familiar individual that had undergone a vasectomy were more assured about sexual functioning and recovery. Such peer normalization may become vital in the settings that still have myths.

Vasectomy as a Procedure

Most of the interviewees described vasectomy as a basic surgery, which involves cutting/tying an opening, where the sperms passed. Despite the presentation of the anatomy still being wanting in points, the overall concept was operationally viable: the surgery introduces an indefinitely lasting obstruction of the birth. In essence, men likened vasectomy with tubal ligation and often ascertained that the feminine procedure was far more critical, debilitating and perilous. Such a parallel made vasectomy an ethically responsible choice as it saved wives the extra burden on the physical part.

Possible Effects of Vasectomy

Most men did not anticipate losing on sexual performance and marital sexuality after having vasectomy. Others of them claimed that they were going to continue with life but only change was that they would avoid subsequent births. Women were normally reported to be supportive especially when they had been counseled. It also helped participants to dismiss their belief that vasectomy would interfere with normal levels of social participation; one man was afraid of being negatively judged by the community. The trend implies that there was manifest anticipated stigma that were not always so great as to offset perceived family profits.

Religious Perspectives

The theme that was ambivalent was religious interpretation. Other participants justified their fewer births when they could afford them by saying that Islam encouraged people to be responsible, educated, and just to their kids hence it was morally right to have fewer births. The other people thought that enduring contraception was a breach to the will of God and it should be religiously wrong or even haram. It is this paradox, which shows how a single and identical ethical language, the duty to God and to children and family, can, in the context of interpretive authority and experience, yield two diametrically opposite responses.

Purpose of Vasectomy

The purpose expressed by participants was not their hatred towards children, on the contrary, they wanted to save the children that they had at home. Men talked of inflation, low income, over populated households, and their educational deficiency. Vasectomy was a decision where the family was felt to be complete and when further births were going to ruin the family life. It turns vasectomy to a renunciation of fatherhood, yet a means to good fatherhood.

Other Contraceptives

Most of the couples tried other temporary solutions before adopting vasectomy. Men had also stated that they use condoms and in some instances, they were not satisfied because of the reduced pleasure. Women had injected, swallowed pills and used copper-T generally with some sort of unpleasant effects or discomfort. These past experiences played a vital role since they gave the men a relative standpoint of evaluating vasectomy. Acceptance of vasectomy therefore appeared to augment areas where temporary treatments were experienced in order to become hostage, unreliable and/or physically demanding on ladies.

Theme area	Illustrative quotation	Interpretive meaning
Complete family	"Two children are better for complete family... family should have a boy and a girl."	The ideal family was tied to manageability, balance, and child welfare.
Procedure meaning	"It is little type of surgery... it has fewer complications than other procedures."	Men viewed vasectomy as technically minor and comparatively safer than female sterilization.
Sexuality	"No effect. It remain as routine as it was before it."	The dominant expectation was preserved masculinity and unchanged sexual life.
Spousal support	"She herself gave me permission. She said you do otherwise I will do."	Decision-making was relational and often framed as protecting wives from

Religion	“If there is small family, then he do easy... in religion, I think, there are no restrictions.”	contraceptive burden. Some men reconciled in family limitation with Islamic responsibility toward children.
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Table 4: *Selected participant quotations and meanings.*

Discussion

Other than the awareness about technical aspects in this qualitative study it can be demonstrated that far beyond the awareness on technical issues is what makes the decision to be made when deciding on who to have vasectomy is the much more. The decision-making process was nourished by having a set of lived-events, a set of children with temporary or permanent means pushing towards economic, observing the suffering of women, discussing and witnessing failure of their peers in marriage. Vasectomy definition thus incinerated itself in the day-to-day existence, rather than knowledge like contraceptives, in the abstract.

Among the most important outcomes, one can single out a standardized definition of a complete family that is implemented by the participants and, in its turn, a family where the latter had an opportunity to bring up its children in a proper way. This view replicates the previous literature which was interested in establishing the link between family size and perception of household affordability, education and social mobility and need not necessarily preference to bear more children (Donahoe, 1996; Scott, Alam, and Raman, 2011; Testa, 2011). Whereas some men still complained that they desired a son and a daughter; the general thread of argument was utilitarian and caring. To this extent, sterilization has been considered a parental love action.

Interpersonal influence is as well important supported by the results. Men that were informed about vasectomy by other individuals (family members, friends or health care workers) did not appear as terrified. This is in tandem with ones that postulate that social example and peer-credibility can be used to reduce the fear and acclimatize the male sterilization (Scott et al., 2011). It also proposes clinical explanation should not be the only approach to counseling interventions; they also need to develop community

narratives that debunk myths and demonstrate vasectomy as not at odds with dignity and manhood.

The fact that the participants believe vasectomy is not as grave and as an easy procedure when compared to tubal ligation is especially crucial in an area where the feminization of contraceptives has become a norm. Other men claim that, as long as one of the couple has to go under a permanent procedure it should be the husband who does it, because it is more ethical to do it to one who is male because sterilization is more difficult, and because they already bore the physical burden of having multiple pregnancies, as well as having temporary forms of birth control. This foils the innocent depictions whereby Pakistani men are also never at home to distribute the load to procreate. The current results however indicate that it is true that particular men can be vasectomized since the separation of sacrifice seems more justified.

Unlike the myths, a majority of the participants were not convinced that they could no longer have sex after undergoing the surgery (vasectomy). This is indicative of clinical guidance that vasectomy does not correlate with lowered testosterone, sexual drive, and healthy sexual performance (American Academy of Family Physicians, 2015; Sharlip et al., 2012). Even the fact that one of the participants is left only with what seems a minuscule amount of doubt is indicative of how even here the myths cannot be completely made to vanish even in the face of men who are even willing to undergo the procedure. The interventions, related to health education, should, therefore, not just around getting men say whether they are hearing about vasectomy, but whether they believe the information to such a degree that they will act upon it.

The most complicated theme could be considered to be religious ambivalence. The respondents were also interested in using Islam to justify and refute vasectomy. Parental responsibility, right of children, and financial lacks: the stresses of sovereignty of Divine over prolepsis too, the unsufferability of utter loss of reproduction process. This finding is coupled with the presence of literature that demonstrates that religious beliefs can be a barrier or easier to the process of acceptance to contraceptives depending on their interpretations and the instructions of the scholars (Underwood, 2000; Adongo et al., 2014; Anwar and Shahzad, 2014). This means that religious considerations cannot be taken care of as a rigid fence in terms of policy and practice.

They are more appropriately viewed as a domain of interpretation which could be approached with respectful attitudes by giving counseling and being able to engage religious leaders involved into a conversation.

The role of centrality given to spousal communication is also emphasized in the study. Men tended to speak with their wives about the procedure and women tended to support them particularly when it was the only other option, as opposed to them remaining ill at the hands of temporary procedures. This is in contrast to the larger studies of the literature on family planning that indicate a relationship between couple communication, and the subsequent upsurge of contraceptive use and shared-decision making (Abraham et al., 2010; Tuloro et al., 2006). As opposed to making vasectomy appear as a male act, services should promote it as a couple leveled reproductive decision with adequate counseling to the couple.

And last but not least is that the findings help in making an even more subtle depiction of masculinity. The respondents had foreseen that they would have people laugh at the phenomenon of vasectomy or that it is a sign of weakness but the majority of them were not considering manhood as something that has no limit to procreation. Rather, they associated masculinity with provision, caring and judgment. In such framing the good man is the man with the highest number of children and the man who can take the children that he already has. This reinterpretation may turn into one of the most intuitive conceptual points of departure of male oriented family planning interventions in Pakistan.

Implications for Practice and Policy

Area	Implication
Counseling	Give clear advice about sexual performance, length of recovery, and permanence, in words male and couples comprehend.
Couple-centered care	Encourage each other to counsel each other: wives and husbands would discuss relative burdens of male and female ways.
Community engagement	To overcome stigmas and misinformation, recruit men that have undergone vasectomy as excellent sources of

	information.
Religious dialogue	Develop evidence-based and culturally competent conversations with honored religious leaders on child welfare and family responsibility.
Program design	Share responsibility and responsible fathering, not loss of masculinity, make frame vasectomy.

Table 5: *Practice and policy implications derived from the findings.*

Limitations

There are a few limitations on the study. The sample size was limited and only one public-sector was sampled in Karachi, which means that the results cannot be statistically generalized. The entire sample consisted of Muslims only and this limits generalisation of those males belonging to other religious groups. Moreover, the respondents had already been on the journey towards vasectomy which implies that their perceptions could be more positive than that of men in the general population who have never thought about the process. However, the article is worth reading as it brings out a meaning-making at a place that men are triggered to take part in the decision-making.

Conclusion

Moral and social flavors of everyday life in decision making of vasectomy are demonstrated in the life experiences of the male respondents in this paper. Participants did not just view the process as a biomedical treatment, they viewed the process through the prism of the vocabulary such family completion, child rights, family affordability, wives, man roles and religion. A majority of the respondents looked at vasectomy as an option that was effective and relatively human as opposed to the cost-involving the women in cases of recurrent pregnancies and the other contraceptives. Simultaneously, acceptance was susceptible to religious ambiguousness, myths in the community, and masculine fears. The family planning programs aimed at propelling the number of men practicing family planning should, thus, go further than the provision of information. They should also seek out the couples, peer and religious interpreters whom they trust and bring vasectomy into the limelight as a responsible fatherly courtesy. Throughstrengthening the notion about family planning as the issue of care,

rather than mark of loss of identity, vasectomy can be introduced as a more acceptable and more legitimate choice in the reproductive life of men.

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