



Original research article

“We never thought of a vasectomy”: a qualitative study of men and women’s counseling around sterilization

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Abstract

Background: Sterilization is the most commonly used method of contraception in the United States; however, little is known about how providers counsel about these procedures or the information patients desire. In this study, we explore male and female experiences of sterilization counseling and their perspectives on ideal sterilization counseling.

Study design: In-depth individual and group interviews were conducted with 37 heterosexual couples between the ages of 25 and 55 years. Each couple had reached their desired family size. Interviews were recorded and transcribed using NVivo software and analyzed using modified grounded theory.

Results: Men and women differed in their experiences of sterilization counseling. Women commonly received counseling on female sterilization but not vasectomy, while men rarely discussed either form of sterilization with their providers. Both men and women desired more information about sterilization.

Conclusions: Contraceptive counseling of couples who have completed childbearing does not routinely include men or the option of vasectomy, despite the advantages of this method with respect to safety, efficacy and cost. Family planning and primary care providers have an important role in ensuring that couples are aware of all their options and can make an informed decision about their contraception.

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1. Introduction

Male and female sterilization, when combined, are the most commonly used contraceptive methods used in the United States [1]. Comparing male and female sterilization, vasectomy is safer and more cost effective. In 2003, the American Congress of Obstetricians and Gynecologists (ACOG) released a practice bulletin, which recommended that “physicians should advise patients that the morbidity and mortality of tubal ligation, although low, is higher than that of vasectomy, and the efficiency rates of the two procedures are similar” [2]. Despite these advantages, vasectomy has low utilization with 17% of women aged 15–44 years using female sterilization and only 6% of women relying on male sterilization for contraception [3]. In addition, men who select vasectomy are a largely homogenous group of non-Hispanic, white, well-educated men of high economic status [4].

Given the differences in use of male and female sterilization, it is important to understand how men and women receive counseling on these methods. Previous studies have demonstrated that provider counseling can influence patients’ contraceptive choices [5–10]. For example, a study in 11 countries showed that women who consulted health care providers had increased use of the patch from 5% to 8% and the contraceptive ring from 8% to 30% [5]. Another study reported that hearing a counselor or clinic staff member disclose a personal experience with intrauterine device (IUD) increased a patient’s likelihood of choosing IUD for post-abortion contraception [11].

Thus far, there are limited published materials regarding the content of sterilization counseling from both male and female perspectives. As such, qualitative methodology is a useful approach to begin exploring how sterilization counseling is currently provided and how couples wish to receive such counseling.

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2. Materials and methods

2.1. Study sample

Participants were recruited through flyers posted at San Francisco Department of Public Health (SFDPH) clinics and via SFDPH provider referrals. For both flyers and provider referrals, interested participants were given instructions to contact the research staff by telephone for eligibility screening. SFDPH clinics have a racially and ethnically diverse population, with many uninsured or Medi-Cal patients. In each couple, at least one partner received medical care at a SFDPH clinic. We focused on low-income populations since these groups utilize vasectomy the least.

We recruited heterosexual couples with both partners aged 25–55 years who self-identified as black, Latino or white and who reported reaching their desired family size. Couples had to self-report their partner as long term. We excluded those younger than 25 years because sterilization is not commonly performed before that age. We also excluded those older than 55 years since most US couples have completed childbearing and reproductive milestones at that age [12]. Couples could be using any form of contraception, including male or female sterilization. Both male and female partners were required to participate in order to include both partners' perspectives. Eligible participants were assigned to either group interviews or individual interviews. The study was approved by the UCSF Committee on Human Research.

Group interviews were used to understand the experience of and beliefs about counseling about sterilization within a group context. Groups had 3–5 participants and were stratified by gender and race/ethnicity and included a gender-concordant principal moderator and a notetaker. However, one male group interview had only two participants after two men chose not to participate at the beginning of the group interview. In total, we conducted 14 group interviews and each interview lasted between 1 and 2 h.

Individual interviews were used to verify results from the group interviews, assess external validity and triangulate findings. These interviews also addressed private issues around sterilization that may not have emerged in the group interviews. Participants were eligible to participate in either individual or group interviews but could not participate in both. A total of 9 couples were interviewed. Each interview session consisted of a one-on-one gender-matched interview of each member of the couple, followed by a joint interview (1 couple). Joint interviews were conducted by one member of the research staff. Each interview lasted approximately 1 h.

Both individual and group interviews were held in neutral, private environments. All participants received \$50 remuneration (\$100 per couple) at the end of the interview session. All interviews were audiotaped and transcribed. Informed consent and demographic surveys were completed from all participants before each interview.

2.2. Data analysis

Individual and group interviews were transcribed and then verified by written field notes taken during the sessions. All transcripts were independently coded by two members of the research team to identify themes around sterilization counseling. Transcripts were analyzed using modified grounded theory. Predefined themes included who received counseling, counseling content (risks, side effects, permanence and reversibility) and what information individuals desired from counseling. The coding and analysis were an iterative and collaborative process: as concepts emerged, the investigators created and added new codes and identified discrepancies in coding, which were then discussed and resolved by consensus. Preliminary themes and questions emerging from focus groups were used to inform and guide future individual interviews. Conversely, results from individual interviews also informed future focus groups. On reaching thematic saturation, transcripts were recorded to ensure congruence with the final coding scheme. The codes were then used to identify the central factors affecting sterilization counseling. QSR International's NVivo 8 software was used to facilitate the coding process and analysis.

3. Results

Characteristics of the 74 male and female participants are presented in Table 1. Six participants (3 couples) were using

Table 1
Characteristics of participants (n=74)

Characteristic	African American (N=24)	Latino (N=28)	White (N=22)
Female	11	15	11
Age, years			
25–34	2	8	4
35–44	10	13	5
>44	12	7	13
Education			
No high school diploma	2	3	0
High school diploma	8	9	3
At least some college	14	16	19
Number of children	4 (0–22)	2 (0–7)	1 (0–9)
Current birth control method ^a			
Vasectomy	1	3	2
Female sterilization	7	2	0
IUD/implant	1	3	2
Injection	4	0	0
Ring, patch, pills	3	3	7
Condoms	4	14	11
Other or none	7	10	3
Future birth control method			
Vasectomy	3	7	2
Female sterilization	8	10	2
IUD/implant	0	2	1
Injection	1	1	0
Ring, patch, pills	1	2	9
Condoms	7	7	10
Other or none	8	7	4

^a Respondents could select more than one method.

male sterilization. Nine participants (4 couples and 1 additional woman) were using female sterilization (in one, the male partner did not know that his female partner was using female sterilization). Ten couples planned to use female sterilization as their future birth control method, and six couples planned to use male sterilization. Themes that emerged from the interviews are presented below; no notable differences between racial/ethnic groups regarding content or receipt of sterilization were noted.

3.1. Actual counseling — women

Overall, we found that men and women had different experiences regarding sterilization counseling. The majority of women reported receiving counseling about female sterilization from their health care providers but reported receiving little information from their providers about vasectomy. Men reported a lack of counseling regarding family planning in general, including vasectomy.

The women who had received counseling on female sterilization had a range of experiences regarding the content of their counseling. Women reported having most of their questions answered about female sterilization including information on the risks, how much pain to expect and side effects. One woman explained her discussion about female sterilization as:

I ask him, what was the risk? I ask him, is it painful? And how long I got to stay no mobility or your got to walking or how my body changing the hormones?

Information regarding reversibility of female sterilization was varied, one woman stated:

My doctor, he broke it down, he was like... if I tie 'em, it's a possibility they can come back loose in so many years. If I tie 'em, tip 'em and burn 'em, then I ain't nothin' coming back.

In contrast, other women reported understanding that female sterilization was a permanent procedure.

[Female sterilization] is something that can't be turned back, it can't be changed. This is a permanent situation.

While the majority of women reported receiving adequate information during sterilization counseling, one woman described her experience as:

Back then in Florida, they didn't have classes. [You said] look, "This is what I want," you sign the paperwork, you sign the consent forms, and it's done.

Two women reported receiving information on intrauterine contraception during female sterilization counseling, with inclusion of this information being reported as helpful. One woman described her initial interest in female sterilization and learning about the IUD during counseling:

I keep saying I don't want to have any [kids] but I never want to give up my gift. So that's when my doctor talked about the IUD and I thought that was perfect, perfect.

Two women also reported receiving information about female sterilization when they were considering the IUD. One woman explained:

I wasn't thinking about [female] sterilization. I was thinking about the IUD. And [my doctor] brought up the sterilization and I brought it up to [my partner], you know, versus the IUD versus the sterilization and it's just more convenient to get the sterilization, especially if you just want to stay positive that you don't want anymore kids.

The majority of women reported no discussion about vasectomy during their counseling sessions. When asked directly if their providers discussed vasectomy with them, many female participants simply replied "no." One female participant elaborated on why vasectomy was not discussed and explained:

Well just [methods for] me 'cause, you know, they didn't really know him so it was just really me.

Furthermore, participants reported that because the health care provider did not mention vasectomy, it was not considered. As a female participant explained:

The doctor told me about getting my tubes tied. So I came home and talked to [my partner] about it. It was like we came to the decision. Vasectomy was not included as an option.

Only one woman reported receiving counseling on vasectomy from her health care provider. She explained:

[My doctor] actually talked to both [me and my male partner] because I had to take the IUD out. And so, you know, there were all these questions. And I was like... "I really don't want to get my tubes tied"... [The doctor was] like, "Well then go get a vasectomy."

Women also noted that health care providers did not routinely discuss birth control with men. When asked if their male partners discussed birth control with their health care providers, many simply stated "no." One woman expressed frustration with this experience, explaining:

Because [for] women they say, "Okay. After 21 and you have two kids, you can get your tubes tied." So why don't they do that to men? So [men] can say, "I have eight." And they're still not telling them, "Oh, you can have a vasectomy." You know?

3.2. Actual counseling — men

Men reported a lack of discussion, in general, on family planning with their health care providers. No male participants reported discussing female sterilization with their providers, and three of the four men who reported receiving vasectomy counseling had undergone the procedure and only received vasectomy counseling as a part of that process.

None of the men reported having general counseling on family planning methods. One male stated that his wife's doctor asks her if she uses birth control, but they "never ask me a direct question like that." He continued, saying that "[men] don't receive much [contraceptive] information." When asked directly if his provider discussed birth control options with him, another participant expressed feeling alone in that regard, stating "I guess she'd rather it was up to me to figure out what I want to do with that department." Other men reported feeling uneasy about discussing vasectomy

with their health care provider, with one man stating he would “never talk about [vasectomy] with a professional.”

All but one man who reported discussing vasectomy with their provider had also undergone the procedure. Men were unable to report the specifics of the counseling, stating that counseling covered “the basics.” Another man explained that he did have a discussion with his provider before the procedure, but it was not informative:

We did have an interview but, you know, I didn’t have a list of questions and it was just — it was kind of a meet and greet kind of thing.

One participant explained that, in retrospect, he wishes he had received more vasectomy information from his provider before his procedure, explaining:

I felt like I read some things [after my procedure] about the vasectomies, about the pain afterwards, and that as much as I like [the doctor], I felt like I didn’t quite hear [about] that.

3.3. *Ideal counseling*

Men and women had similar preferences for their ideal counseling on sterilization. Neither men nor women specifically stated a desire to receive counseling on other birth control methods such as IUD during sterilization counseling. Men and women desired information on side effects of the sterilization procedure including sexual function and mood changes, pain of procedure, reversibility and efficacy. One man outlined many of these concerns when he stated,

Is this going to affect my hormones? Am I still going to like girls? Is it going to hurt? Will I be able to get erect after this? Will I have to wait a year before I can have sex?

Men and women also had similar preferences for counseling to be done by their physician. A male participant explained,

I always ask my doctor, the doctor that I’ve been dealing with for the longest, which is my primary care physician. I’d ask her about [sterilization] and then I’d ask her if she’d be willing to sit down and talk with my girlfriend about it.

While speaking with their physician was important, men and women also described wanting to speak with a man and a woman who had received sterilization. A female participant explained,

Talking to somebody who’s been through it and asking them their experience... Like, “How long were you down for, like how was the surgery?”...“Did you gain weight?” Like, “Did you go crazy afterwards? Did you have emotional problems? What was your sex drive like afterwards?”

There was a range in preference among men and women about whether the counseling should be done individually, as a couple or in a group. With regard to individual counseling, one reported that benefit was the privacy of the conversation. One man explained:

I wouldn’t want to sit in a big group with a bunch of guys who want to be sterilized where everybody could see. I wouldn’t. No. I wouldn’t want a lot of people to know.

Of the participants who preferred individual counseling, many reported a desire to receive counseling with their partner. Some male participants reported that they would rather receive counseling alone, whereas all female participants reported a preference of couples counseling. One woman explained:

Having counseling with the two [partners], that’s a good idea because — and letting each person, the male and female, know exactly what they’re up against and what’s, you know, what the differences are in the operation part and, you know, just giving them information for them to sit down and talk together.

Three female participants specified that they would prefer to receive counseling “one-on-one and then with the partner.” In contrast, men had varied opinions with regard to couples counseling. One man stated:

My personal opinion, if we were both considering [sterilization], then I think the information should come to both of us.

However, some men reported desiring counseling about vasectomy without their female partners because they felt that their partners would monopolize the decision-making process. One man expanded upon his desire to receive counseling alone by stating:

If you’d get the information as a couple, she be the one that opens the mail. I don’t know how to put it. [She] may already make a decision...I don’t think getting it as a couple is fair. I don’t think it allows individual choice, personally.

Both men and women reported benefits to group counseling, but women reported interest in same-sex and co-ed group counseling while men only reported interest in same-sex group counseling. One man explained the benefits of group counseling when he stated:

I’d rather have it in a classroom setting, because everybody in the room is different races, different backgrounds so we all are going to have different questions...You know, he may ask something that I never even thought about asking or this person here may ask something that this person never thought about asking. You know, as long as we just get all the information that we can on it.

Regarding same-sex and co-ed groups, one male participant expressed,

I wouldn’t have nothing against women but [I would want to] split it up, you know, where guys could talk about [sterilization].

In contrast, one female participant explained a benefit of co-ed group counseling:

I would want men and women to be in there. I mean, like partners and stuff, so both of them can know what’s going on. I mean, on both ends.

Both men and women preferred face-to-face counseling in a health care setting. However, written information such as brochures was also reported to be beneficial so that they could be reviewed at home. One female participant stated that it would be helpful to receive “a pamphlet that shows

you what happens. That would be great. Like it's something more easy now for the people [to] understand."

4. Discussion

Our study found that men and women have different counseling experiences around sterilization. Most women had received counseling on female sterilization but not on male sterilization. In contrast, most men reported a lack of counseling around both female and male sterilization and contraception in general. Women and men reported similar desires for ideal counseling including preferred information sources (physician and a recipient of each sterilization method) and content of counseling (side effects, pain of procedure, reversal and efficacy). Women and men had a range of views on who should be present during counseling.

Our study suggests that there is an absence of routine counseling on vasectomy for men and women who have completed childbearing. This is in agreement with a previous study on sterilization counseling for men, which documented that only 2.5% of men who had completed family size reported counseling on vasectomy [13]. This lack of counseling may arise from the fact that, in our health care system, family planning services are generally directed toward women. In our current system, there is no provider or specialty that has accepted the responsibility to address male family planning needs or integrate vasectomy into contraceptive counseling. In a 2001 EngenderHealth survey of administrators and family planning providers randomly selected from professional organization lists in the United States, respondents reported the lack of male clients in their practice as a reason not to regularly discuss male sterilization as a contraceptive option [14]. This lack of vasectomy counseling occurs despite the recommendations from ACOG that this counseling should be routinely provided for men and women considering sterilization [2]. These studies highlight the lack of male clients involved in family planning services and also indicate that providers are not counseling women about vasectomy during family planning counseling, even when she is in a long-term heterosexual partnership and has completed childbearing. Family planning providers must remember that men are involved in contraception and vasectomy may be an appropriate contraceptive option for many women and men.

Routine inclusion of vasectomy as part of family planning counseling for eligible men and women depends on increasing awareness and knowledge of vasectomy among clinicians that provide contraceptive counseling. Currently, obstetrician-gynecologists carry most of the responsibility for contraceptive counseling followed by primary care providers [15,16]. The EngenderHealth survey cited above documented that health care professionals tend to counsel on methods they were personally able to provide [14]. Because obstetrician-gynecologists and primary care providers do not commonly perform vasectomies, they may be less likely to

discuss vasectomy with their patients. Increasing knowledge of vasectomy among obstetrician-gynecologists and primary care providers as well as increasing vasectomists in those specialties may improve vasectomy counseling. Vasectomy training may be particularly relevant for family medicine physicians since contraceptive counseling is included as a core competency by the Accreditation Council for Graduate Medical Education because family medicine physicians have experience with outpatient procedures and because family medicine physicians take care of both men and women [17]. One study examined the impact of vasectomy training at 43 clinics across the United States and found that, after the training, the number of clinics providing vasectomies rose by 40% and the number of vasectomies performed rose by 18% [18]. The majority of the physicians trained were family physicians, and nearly 40% had not received previous training in vasectomy [18]. In addition to increasing provider awareness and knowledge, international studies suggest that training and educating health care providers in vasectomy counseling and procedure can also increase client awareness and interest in vasectomy [19–21].

Finally, our study highlights areas in which health care professionals can improve sterilization counseling. Most of our participants desired more information about vasectomy from their providers, and they were specifically concerned with understanding if sterilization produced any changes in sexual function or mood, if the procedure was painful or reversible and if it was effective. Provision of accurate information is particularly important as there is evidence of substantial misconceptions about both female and male sterilization in the United States. One study found that 38% of black women and 13% of white women reported that a man could not ejaculate after vasectomy [22]. In addition, 60% of black women and 23% of white women reported that a woman's sterilization would reverse itself after 5 years [22]. As some participants in our study reported receiving erroneous information from their health care provider regarding the reversibility of female sterilization, health care providers may be contributing to these misconceptions or may be insufficiently emphasizing the permanence of female sterilization. This further emphasizes the importance of training of primary care and family planning providers to ensure the provision of accurate information about sterilization options. While none of our participants described ideal sterilization counseling to include counseling on highly effective, long-acting reversible contraception (LARC), such as the IUD and subdermal implant, some participants reported inclusion of these methods as helpful in making their contraceptive decision. Thus, inclusion of LARC counseling may be tailored to the needs of the individual patient. In clinical practice in which time is limited, decision aids containing information about the different types of sterilization, as well as LARC, may be helpful in providing contraceptive counseling. While there has been limited research with mixed results on the impact of decision aids on contraceptive use, one study focusing on vasectomy decision

aids helped reduce decisional conflict and increased patient knowledge with regard to vasectomy [23–27].

While qualitative studies can provide in-depth insight on sensitive subject areas, our study has several limitations. Our data are dependent on the interactions between participants and moderator/interviewer. We also studied women and men in the San Francisco area, and our findings may not be generalizable to other regions of the country. We focused on a low-income patient population because low-income populations have low use of vasectomy, but this may limit our generalizability. Finally, our questions focused on contraceptive counseling that may have occurred several years ago, making it difficult for participants to accurately recall their experiences.

5. Conclusion

Our study explores sterilization counseling from both male and female perspectives among a diverse population. Women and men reported limited counseling on vasectomy and men, in particular, lacked counseling on birth control in general. Women and men desired similar information regarding sterilization methods and preferred to receive counseling from a health care provider. Given the relative safety of vasectomy compared to female sterilization, vasectomy should be routinely included in contraceptive counseling for both women and men who have completed childbearing. Both family planning providers and men's primary care providers have important roles in increasing awareness and knowledge of this method and may benefit from dedicated training to increase knowledge and comfort level around the procedure.

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