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He's a Real Man: A Qualitative Study of the Social Context of Couples' Vasectomy Decisions Among a Racially Diverse Population

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Abstract

Vasectomy has advantages with respect to safety and cost when compared with female sterilization. The reasons underlying the overall low use of vasectomy, particularly among Black and Latinos, have not been adequately explored. The goals of this study were to (a) explore the social context of vasectomy decisions and (b) generate hypotheses about the social factors contributing to differences in vasectomy use by race/ethnicity. Fourteen group and nine couples interviews were conducted. Participants were 37 heterosexual couples aged 25 to 55 years who had reached their desired family size and self-identified as Black, Latino, or White. Participants discussed reasons that men and women would or would not select male sterilization. Reasons to select vasectomy included a desire to care for their current family, sharing contraceptive responsibility, and infidelity. Reasons not to select vasectomy included negative associations with the term *sterilization*, loss of manhood, and permanence. Misconceptions about vasectomy included misunderstandings about the vasectomy procedure and adverse postvasectomy sexual function. In addition, Black and Latino participants cited perceived ease of reversibility of female sterilization and lack of support around vasectomy as reasons not to choose it. Improving communication and social support for vasectomy, particularly among Black and Latino communities, may improve vasectomy utilization. Misconceptions regarding female and male sterilization should be targeted in counseling sessions to ensure men, women, and couples are making informed contraceptive decisions.

Keywords

male family planning, vasectomy, sexual health, male contraception, health inequality/disparity

Introduction

Vasectomy is safer and more cost-effective than female sterilization, yet it is rarely used in the United States (Smith, Taylor, & Smith, 1985; Trussell et al., 2009). In the 2006-2008 National Survey of Family Growth (NSFG), 17% of reproductive-age women reported using female sterilization, whereas only 6% reported relying on male sterilization for contraception (Mosher & Jones, 2010).

Race/ethnicity and socioeconomic variables are associated with use of both male and female sterilization. For example, Black women are significantly more likely than White women to use tubal ligation (Borrero et al., 2007). Regarding socioeconomic levels, vasectomy is used less frequently in populations with lower educational levels and public or no health insurance (Barone, Johnson, Luick, Teutonico, & Magnani, 2004). Conversely, men who choose vasectomy are most commonly non-Hispanic White men of higher socioeconomic status, who have private health insurance (Barone et al., 2004; Eisenberg, Henderson, Amory, Smith, & Walsh, 2009). The NSFG reports that in non-Hispanic Black populations, 22% of women use female sterilization, whereas only 1% rely on male sterilization. In Hispanic populations, 20% use female sterilization, whereas 3% rely on male sterilization. The gap between female and male sterilization is smallest in non-Hispanic White women, where 15% use

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female sterilization and 7% rely on male sterilization (Mosher & Jones, 2010).

Some studies have investigated potential reasons for high use of female sterilization among Black women such as knowledge about tubal sterilization and alternative methods, low use of vasectomy among their partners, and culturally based preferences (Borrero et al., 2011; Borrero, Nikolajski, et al., 2009; Borrero, Schwarz, et al., 2009). However, there has been limited research exploring reasons for low vasectomy use and observed racial/ethnic differences in vasectomy. In one study of vasectomy knowledge among men in San Francisco, only 54% of Latino men knew what a vasectomy was compared with 96% of White men (Arevalo, Wollitzer, & Arana, 1987). Another study examined whether differential receipt of vasectomy counseling may contribute to low vasectomy use among minorities and found no significant differences between racial/ethnic groups (Borrero, Moore, Creinin, & Ibrahim, 2010).

None of these studies have explored the social context of vasectomy decisions from both male and female perspectives in a racially diverse population. Understanding this social context may help providers tailor contraceptive counseling to ensure effective family planning decisions and increase acceptability of vasectomy, as well as inform community- and media-based interventions addressing vasectomy. This study used qualitative methodology to (a) explore the social context of vasectomy decisions and (b) generate hypotheses about the social and cultural factors contributing to differences in vasectomy by race/ethnicity.

Method

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. Eligible participants were heterosexual couples with both partners aged 25 to 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. Those younger than 25 years were excluded because sterilization is not commonly performed before that age. Those older than 55 years were also excluded since most U.S. couples have completed childbearing and reproductive milestones at that age (Alan Guttmacher Institute, 2003). 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.

In each couple, at least one partner received medical care at an SFDPH clinic. SFDPH clinics have a racially and ethnically diverse population, with many uninsured and Medi-Cal patients. After approval by the University of California San Francisco Committee on Human Research, participants were recruited through flyers posted at SFDPH clinics and via SFDPH provider referrals. Participants were screened on the telephone, and eligible and interested participants were assigned to either group or individual interviews. The recruitment strategy ensured that the study population was predominantly low income, because low-income men/couples are least likely to use vasectomy.

All group and individual interviews were held in private conference rooms. Each participant received a $50 gift card at the end of the interview. Participants gave informed consent and completed a demographic survey before interviews.

Group Interviews

Group interviews were used to explore attitudes and beliefs about male and female sterilization within a group context. To examine emerging themes by gender and racial background, groups were stratified by gender and race/ethnicity. Each group included a gender-concordant principal moderator and a note taker to help guide discussion.

Most groups had three to five participants. One male group interview had only two participants after two men chose not to participate at the beginning of the interview. In total, 14 group interviews were conducted: two group interviews for each gender and racial combination (e.g., Latino male, Latino female; Black male, Black female; White male, White female). In addition, one group interview was held with Spanish-speaking Latino males and one with Spanish-speaking Latina females. Each group interview lasted between 1 and 2 hours.

Individual Interviews

Individual interviews were used to capture private issues that may not have emerged in a group setting. Individual interviews were also used to verify and triangulate results from the group interviews. Participants assigned to the individual interviews did not participate in group interviews. A sampling matrix was used to ensure that the investigation captured a range of participants with respect to the male partner's race/ethnicity and the couple's sterilization status (i.e., one couple with a Latino male, not using any sterilization; one couple with a Latino male, using female sterilization; one couple with a Latino male, using male sterilization). A total of nine couples were interviewed to fulfill this sampling matrix. Interviews consisted of a one-on-one interview with a gender-matched

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	5
35-44	10	13	5
>44	12	7	13
Education			
No high school diploma	2	3	0
High school degree	8	9	3
At least some college	14	16	19
Number of kids	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, and 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.

facilitator for each member of the couple, followed by a couples' interview. Each interview lasted approximately 1 hour.

Data Analysis

All interviews were audiotaped, transcribed, and verified by written field notes. The two Spanish language interviews were translated and transcribed into English. Transcripts were independently coded by two members of the research team. Coding and analysis was an iterative and collaborative process where the coding structure evolved as concepts emerged and through discussion in group meetings. Transcripts were analyzed using modified grounded theory (Charmaz, 2006; Grbich, 2007). Predefined themes based on existing literature were used. These themes included reasons to choose vasectomy (care of family, permanence) and reasons not to choose vasectomy (contraceptive responsibility, loss of manhood). Themes arising from group interviews were used to inform future individual interviews, and similarly, codes from individual interviews informed future group interviews. Discrepancies in codes were discussed and resolved by consensus with three members of the research team. Once the coding scheme reached thematic saturation, transcripts were reviewed to adhere to the final coding scheme. NVivo software was used to assign codes to the themes.

Results

The characteristics of the 74 male and female participants are displayed in Table 1. Nine participants (four couples, one individual—the male partner did not report knowing that his female partner had undergone female sterilization) reported using female sterilization. Six participants (three couples) reported using male sterilization. Twenty participants (10 couples) planned to use female sterilization as their future birth control method, whereas 12 participants (six couples) planned to use male sterilization.

Reasons to Select Vasectomy

Men and women discussed a variety of reasons to undergo male sterilization including a desire to better care for

their current family and maintain financial responsibility, share contraceptive responsibility, avoid consequences of infidelity, and the presence of social support. These themes were present in both group and individual interviews.

Care of family. The majority of both male and female participants reported that a primary reason for selecting sterilization in general, including both female sterilization and vasectomy, would be their desire to care for their current family. Referring to vasectomy, one Latino man stated, "There are many advantages for me. To be able to raise one child better, give them better schooling, better attention." Participants also discussed both the financial strain and time commitment associated with having children. Concerning vasectomy, a White female stated, "In the long run that would be a lot cheaper than another two or three college educations." One Black man described the time burden of children when he stated, "You can have so many kids and sometimes you don't have time for you and your partner . . . you just have to say enough's enough."

Sharing contraceptive responsibility. While both men and women reported that contraception was ultimately the women's responsibility, men recognized vasectomy as a chance to take contraceptive responsibility. Men from each racial/ethnic group noted the burden of pregnancy and reported that one reason to have a vasectomy would be as a compassionate gesture to their female partner. In choosing vasectomy, one White male explained to his partner:

> I just kind of stepped up to the plate and said I would do this because you had been through so much, I felt like it was my turn to do that, or to volunteer to be the person that was going to do something about it.

A Black male expressed similar sentiments when he stated,

> Well I think the reason why I would choose [vasectomy] is she done already had three kids, she had been in labor and everything, she done been through a whole lot with her body.

One Latino man explained,

> [Vasectomy is] the best option for us because my wife . . . she got two babies and one surgery and now it is my time.

Infidelity. Men and women from all racial/ethnic groups recognized both positive and negative aspects of male sterilization with respect to infidelity. For example, men and women recognized that if unfaithful men had a vasectomy, they would not be causing pregnancies. One Black woman explained,

> They could screw whoever they want without getting them pregnant . . . they ain't got a whole bunch of illegitimate kids running around.

A Latino man confirmed such feelings when he stated, "There are many advantages also for those of us who are unfaithful, right? That we are not able to get another woman pregnant." However, some female participants perceived male infidelity as a negative aspect of vasectomy, noting that the lack of consequences with respect to pregnancy could lead to more infidelity and deception. When thinking about vasectomy, one Latino female stated, "Oh careful he will be off with someone else." Another woman followed up by stating that if men have vasectomies "they [can] be more unfaithful."

Presence of social support. Positive social support for vasectomy was noted only among White men and women. Some White participants were able to identify someone they knew who had a positive outcome with vasectomy. One White man stated,

> My dad had did it and he sort of had a positive feeling about it, you know, made the right decision. My stepdad had it done too.

Another White male described positive social support this way:

> Friends would encourage me if it was something I wanted and that I felt was good for me and my partner; they would certainly support me in that.

When asked his opinion about a man who had a vasectomy, one White male responded, "Smart guy." A White female responded to the same question by saying, "He's a real man."

Reasons Not to Select Vasectomy

Reasons not to select vasectomy included negative connotations of the word "sterilization," concern for loss of manhood, permanence, and lack of social support. These themes were present in both group and individual interviews.

Negative connotation of the word "sterilization." Men and women from all racial/ethnic groups reported negative associations with the word sterilization, with one Black man stating that sterilization is "like something forced upon a person [when they're not] from the right gene pool. . . . I think of government minds." One Latino male

reported that sterilization was a "form of punishment," and a Latino female stated that sterilization reminded her of "an animal being sterilized, not counted, not having a voice." A White male described his association:

> Historically, [sterilization] might've had a negative connotation if it's been forced in other countries and other time periods, but I think if it was used as a choice . . . then I would support that.

Loss of manhood. Both men and women reported concern about the impact of sterilization on a man's sense of masculinity. One Black man explained,

> The thought that I'm not going to be able to make babies no more as a man, it bothers my ego, you know what I mean, it makes me feel like I'm a little short of something. Short of being a man.

Women also acknowledged this threat to manhood, with one Latino female stating that

> [Men are] lions who don't want to be put out to pasture. You know, I think it's harder to convince a man because they've got that little machismo in their heart.

One White male explained, "I think maybe that there's this idea of virility for a man . . . And it's a thought of virility that they don't want to change by having a vasectomy."

Permanence. Men and women from all racial/ethnic groups discussed the potential for vasectomy regret. One White male explained,

> She knows that right now she doesn't want kids, but she wants the flexibility to be able to change her mind in the future, so I don't think she wants me to make any hard, final, lasting decisions that will make that choice for her or at least between us.

A Latino female reaffirmed these concerns when she stated,

> My reasons of not having vasectomy and also tubal ligation is because it's final, that I won't be able to have any more kids if I change my mind in the future.

Participants also recognized the instability of relationships. One Black male described the potential negative impact of a vasectomy on future relationships explaining,

> There might be someone else you want to have kids with. But you go and have a vasectomy, and you done messed yourself up for the next lady. And then she done throwed you in the wind.

Lack of social support around vasectomy. In contrast to the social support voiced among White participants, Black and Latino men and women reported a lack of social support and conversation around vasectomy. Black and Latino men expressed a fear of how they would be perceived by others if they had a vasectomy. One Black man said he would feel "afraid of being labeled as an outcast . . . an outsider" if he had a vasectomy. One Latino female explained the lack of social acceptance as the reason why her Latino partner did not want to get a vasectomy:

> He didn't want to feel like the weaker one of that blood line, 'cause like his dad would never do it, his uncles would never do it.

This lack of social acceptance also discouraged Black and Latino men from discussing vasectomy as a contraceptive option. One Black male explained why he would not talk about vasectomy:

> [Vasectomy] conflicts with my ability to be accepted in places where men are. I wouldn't dare talk about I want to be sterilized.

Black and Latino men also discussed how vasectomy was not common among their friends and family. One Latino male explained that his mother had her tubes tied because "in Mexico the person who has the operation is always the woman" and that he had "never heard about [an operation] for a man." Similarly, one Black male stated he had "heard of more women getting their tubes tied than [he'd] heard of men getting vasectomies . . . it's something men don't talk about."

Misconceptions

Misconceptions about sterilization also emerged including misinformation about sterilization reversibility, the procedure itself, and postprocedure sexual function.

Reversibility. Regarding reversibility, Black and Latino men and women discussed the perceived relative reversibility of female over male sterilization as a reason to choose female sterilization. One Black man commented that for tubal ligation,

> It's easy to just untie them, you know. So that's why I would choose her over mine . . . you can go back later on and decide you want to have more kids, okay, just get your tubes untied.

In comparison, vasectomy was viewed as "an irreversible process." Another Black man summarized,

> I would ask the woman to do it first before I'd do it because I feel like the man's is more permanent and hers can be reversed or undone.

These perceptions of easy reversibility did not emerge among White participants. In contrast, in one group of White men, several participants commented that vasectomy was reversible, while female sterilization was more permanent.

Vasectomy procedure. Men and women from all racial/ethnic groups had little knowledge about the vasectomy procedure. Some participants confused vasectomy with castration, with one White man explaining "my dad had a vasectomy . . . it sounds like [they] cut your balls off or something."

Men also reported feeling fearful of the procedure. When discussing his opinions about vasectomy, one Black man explained, "Someone with a knife cutting between your legs. Stressing me out, here man, you know. Sensitive area." A Latino man stated that, in general, men are afraid of medical procedures. Only one White male reported feeling fearful of vasectomy, stating,

> Vasectomies is one that I hear a lot of, but as far as the procedure, I'm not familiar with how it goes or what they do in the procedure, but the word itself sounds really kind of scary.

Sexual function. Finally, women and men from all racial/ethnic groups reported a fear of long-term effects of vasectomy on sexual function. One Latino man was concerned that "it will not get hard anymore . . . you will not be able to function in the same way." One Latino woman echoed these concerns stating that "the sexual appetite is not the same . . . when they are supposed to finish, they no longer finish." One White male explained,

> I know a couple guys that got [a vasectomy] done and they're limp dicks, you know what I mean, they cop to it. The wives left them and all kinds of stuff.

Discussion

The present study reveals reasons to select and reasons not to select vasectomy. Positive themes, or reasons men and women would choose vasectomy, include the importance of caring for one's current family and taking contraceptive responsibility. Negative themes, or reasons not to choose vasectomy, include negative associations with the word sterilization, perceived loss of manhood, and sterilization permanence. Regarding themes that emerged in specific racial/ethnic groups, Black and Latino men discussed a lack of communication and social support around vasectomy. Finally, participants from all racial/ethnic groups had misconceptions about the reversibility of female sterilization compared with male sterilization, what the vasectomy procedure entailed, and postprocedure sexual function.

Given the negative and positive themes that emerged around vasectomy, this study simultaneously provides insight into the observed low rates of vasectomy and also suggests opportunities to support vasectomy use in a racially diverse U.S. population. With respect to negative themes or barriers to vasectomy use, participants supported many misconceptions around female and male sterilization. In general, these misconceptions made female sterilization more favorable in comparison with male sterilization and may contribute to selection of female sterilization. These data suggest that health providers must provide comprehensive accurate counseling addressing these misconceptions, highlighting the decreased health risks associated with vasectomy, to enable men and women to make the most informed contraceptive decision. In particular, counseling should focus on the permanence of both methods of sterilization. The erroneous idea that female sterilization is reversible has been noted previously (Borrero, Lin, et al., 2009; Borrero et al., 2011). Misperception of female sterilization reversibility has the potential to contribute to future regret (Moseman, Robinson, Bates, & Propst, 2006). Thus, when counseling couples about sterilization, it is essential to consider whether a long-term reversible method, such as the intrauterine device (IUD) and subdermal implant, may be appropriate. Regarding vasectomy misinformation, one important step is integrating routine inclusion of vasectomy counseling for any man or heterosexual female in a long-term partnership that has completed childbearing. Counseling by a health care provider can increase awareness of vasectomy and dispel myths regarding the procedure and postvasectomy sexual function. While inclusion of vasectomy counseling is recommended by American Congress of Obstetricians and Gynecologists, limited data suggests that vasectomy counseling is not routinely done (American College of Obstetrics and Gynecology, 2003; EngenderHealth, 2001).

Since many women and men do not receive vasectomy counseling through their health care providers, increasing the visibility of vasectomy in nonclinical settings is an important avenue for vasectomy education. In particular, increasing conversation with those who have received vasectomy has been shown to be key to vasectomy acceptance (Mumford, 1983; Vernon, 1996). For example, in an EngenderHealth project based in Ghana, clinics used a media campaign strategy called "Get a Permanent Smile" to create awareness of and create a positive image for vasectomy (U.S. Agency for International Development,

2005). The media campaign featured satisfied vasectomy users to create awareness of and a positive image for vasectomy. In addition to this positive media messaging, the project included clinical training on vasectomy and initiation of a telephone hotline for vasectomy. During the project year, vasectomies increased by 350% over the previous year. Efforts to increase vasectomy use in the United States should include both positive messaging around vasectomy as well as promotion of vasectomy by male and female users of vasectomy.

An additional mechanism to support the consideration of vasectomy among couples desiring permanent contraception is emphasizing the positive themes around vasectomy found in this study, including that both men and women felt that use of this contraceptive option was one way to care for their current family. In addition, men expressed a desire to share the contraceptive burden as a compassionate gesture to their female partner for carrying previous pregnancies. For example, a project based in Brazil used the slogan "Vasectomy is an act of love" as the campaign theme. This media project included a television spot featuring a pair of animated hearts (one male and one female) highlighting the safety and efficacy of vasectomy and a radio piece featuring a father explaining vasectomy to his son, followed by the same slogan. During the 6-week campaign period, there was a 59% to 108% increase in number of vasectomies (Kincaid et al., 1996). While it is important to highlight positive narratives around male sterilization, this study also demonstrates an association of the word sterilization to forced sterilization. These associations are particularly relevant, given the historical context of forced sterilization of disenfranchised populations. This context is important to consider as health care providers promote vasectomy as a highly effective, safe method for interested men and women.

Finally, this study suggests some reasons for racial/ethnic differences of vasectomy use. Perceived reversibility of tubal ligation and overall awareness of vasectomy were different among our studied racial/ethnic groups. Among Black and Latino participants, perceived reversibility of female sterilization compared with male sterilization emerged as a reason to select female sterilization. This theme did not emerge among White participants and is consistent with a prior survey showing that Black women more often thought tubal sterilization reversal could easily restore fertility compared with White women (62% vs. 36%) and that a woman's sterilization would reverse itself after 5 years (60% vs. 23%; Borrero et al., 2007). Additionally, communication and positive social support for vasectomy was only discussed among our White participants. Increasing positive narratives around vasectomy, as discussed above, may be particularly important in increasing vasectomy acceptance and awareness in Black and Latino populations.

Limitations

Qualitative studies can provide in-depth insight on sensitive subject areas, but this study has several limitations. First, given the qualitative nature of the study, the data are dependent on the interactions between participants and moderator/interviewer. To minimize this limitation, this study design included both groups and individual interviews, recruited participants until thematic saturation, and employed rigorous qualitative techniques for analysis. Second, the participants included women and men in the San Francisco area, and the findings may not be generalizable to other regions of the country. The study also focused on low-income patients to focus on a group that has low use of vasectomy; however, this may also limit the generalizability. Finally, the questions asked regarding contraceptive decision making may have occurred several years ago for some couples, and they may not have accurately recalled their decision-making process.

Conclusion

The present study provides insight into the social context of vasectomy from both male and female perspectives among low-income Black, Latino, and White couples. While men and women from all racial/ethnic groups noted reasons to choose vasectomy including care of their current family and taking contraceptive responsibility, only White participants reported communication and positive social support around vasectomy. Reasons not to choose vasectomy were also discussed, including association of sterilization with forced sterilization and loss of manhood. Misconceptions, particularly regarding reversibility of female sterilization, the vasectomy procedure, and return to sexual function should be targeted during counseling. Efforts to improve awareness through media and health care professionals are necessary to improve acceptance of vasectomy for individuals and/or couples who have reached their desired family size. Improved visibility and knowledge of vasectomy can help ensure that men, women, and couples make an informed decision that includes all contraceptive options.

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