

SOCIO-DEMOGRAPHIC FACTORS AND
MALE REPRODUCTIVE HEALTH
CHALLENGES IN EKITI STATE,
NIGERIA.

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CERTIFICATION

This is to certify that OTUKOYA MARIE OMOLARA of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, carried out a Research on the Topic “SOCIO-DEMOGRAPHIC AND MALE REPRODUCTIVE HEALTH CHALLENGES IN EKITI STATE,NIGERIA” in partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision.

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DEDICATION

The project is dedicated to God almighty and my lovely parent Mr and Mrs A.O Otukoya for their unrelenting support, care and love.

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ABSTRACT

This study examines the socio demographic factors and male reproductive health challenges in the study area using primary data. Two hundred and fifty (250) respondents were randomly selected in two Local Government Authorities in Ekiti State. Data obtained were analyzed using a combination of univariate, bivariate, and multivariate logistics regressions.

The study reveals that 6.00% of the respondents had general knowledge about male reproductive health challenges and 19.2% had one or more reproductive health challenges. Among reproductive health challenges mentioned by the respondents includes prostate cancer, low libido, painful intercourse, diabetes, premature ejaculation etc. findings revealed that there is significant relationship between socio demographic characteristics and male reproductive health challenges. The study concludes that age, religion, education, ethnicity are important factors in male reproductive health challenges ($p < 0.005$). The study suggests that men should have access to reproductive health service in the study area.

KEYWORDS: REPRODUCTIVE HEALTH, PROSTATE CANCER AND LOW LIBIDO.

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

Reproductive health challenges involve the mixture of issues with physical, psychosocial and demographic components (Arduca, 2003; Amidu et al, 2011). Its multi-faceted impacts account for the attention it attracts globally. According to Ndong, 2015, "reproductive health normally has been synonymous with women health", and the reproductive health of men has witnessed little attention. Researchers and health planners have opined that better outcome for reproductive health programmers might be predicted if men had been concerned. Hawkes, 2012 indicated that the remedy of male reproductive health issues may encourage more women to seek medical attention and therefore enhance general reproductive fitness. Additionally, reproductive health status is strongly linked to the awareness, attitudes and seeking behaviour of men towards their health.

Besides the incidence of male reproductive health challenges which include contraception, sexual disorder and other challenges have implications on both individual, sexual partner or companion and the society. Male's reproductive health challenges have remained a worrisome ailment whilst its prevalence rate is extraordinarily hidden. Its damaging consequences are visibly un-ignorable within the family and the society (Geidam et al, 2008). Most usually, men facing reproductive health situations together with sexual disorder, contraception have lower desire for sexual urge, experience erectile disorder or dysfunction, issue in reaching orgasm and numerous other defects which might disrupt sexual urge together with different unfavorable outcomes which includes sterility, infertility (Rust et al, 1988; Dunn, Croft & Hackett, 1999; Arduca, 2003; Murat et al, 2005; Warwick, 2006).

Reproductive health care is the second most accepted health care hassle in Africa. However, the concept of reproductive health care had focused on women disregarding men's health. As a consequence, some sicknesses like sexual impotence and erectile disorder that deserve better attention are trivialized despite the fact that they are crucial in economic productivity, family balance and sexually transmitted illnesses control which include HIV/AIDs, cancers.

Male reproductive health refers to health problems particular to human male anatomy which mostly relate to systems such as male genitalia or to conditions due to hormones which might occur either in children or adults. Reproductive health also implies that people should be capable of having safer, responsible, satisfying and more secure sexual intercourse lifestyles. In addition is the capability to reproduce and the liberty to decide if, when and how often to achieve this. Men must have access to the appropriate reproductive health care services which includes sexual and reproductive medications and the implementation of health programs to buttress the important of reproductive health. Reproductive health should be checked through a lifecycle approach because it might influence men from infancy to old age. The lifecycle approach includes the challenges humans face at one-of-a-kind instances in their lives such as family planning services, sexually transmitted diseases and early diagnosis and treatment of reproductive health challenges such as services on health through education systems, involvement of male in family planning, awareness of reproductive health service and gender equity need to be reinforced and availability of essential health resources including contraceptives and medicines also need to be supported (UNFPA, 2008).

The prevalence of male reproductive health challenges is estimated that three-quarters of married men have experienced one form or the other of reproductive health diseases. 28% of men experience burning urination. In 2007, more than 19,000 males were diagnosed with prostate

cancer while nearly 3,000 men died from prostate cancer. Testicular cancer is rated as the second most common cancer in men aged between 18 and 39. In addition, nearly 700 men were diagnosed with testicular cancer (Purva, 2007; Bayer health care, 2008; Amidu et al, 2011). More than a third (34%) of men aged over 40 years report having one or more reproductive health problems. All of these were more common amongst older men and 17 percent had clinically diagnosed reproductive challenges (Laumann et al, 1999; Dunn, Das & Das, 2004; Bayer healthcare, 2008; Purva, 2007; Amidu et al, 2011). However, there may be a whole reticence in reporting or lack of knowledge about the symptoms due to ignorance or low productivity of male reproductive health services especially in most developing countries. About 10-20 percent of men who are victims of testicular cancer, for instance, take part much less in sexual activity with consequent demanding situations in their relationship either to the family or sexual partner (Schover, Leslie & Eschenbach, 1985; Dunn et al, 1999; Geidam, Yawe, Adebayo & Idrisa, 2008).

Among the outcomes of male sexual dysfunction is unstable relationship in which the partner is unfaithful, stress and anxiety, and early or premature death of the victims (Schover et al, 1985; Rust et al, 1988; Dunn et al, 1999; John & Sharon, 2006; Bodenmann, Ledermann & Bradbury, 2007; Geidam et al, 2008). Male sexual dysfunctions (along with impotence and untimely ejaculation) are predominantly related to sexual dissatisfaction and, amongst women, the extent of break up in relationship is at increase while their partners have sexual challenges than whilst the women have sexual challenges themselves (Rust et al, 1988; Dunn et al, 1999; Murat et al, 2005).

Most male reproductive health challenges remain knotty because men work to make ends meet, to provide for their households, dedicating time to pleasing family and friends (Brett,

2010). There is however the need for the man to at some point reach out and advise that he desires time to himself to nurse or get nursing for his reproductive health. This research is to allow men take into account that taking time for their personal health. It further provides an explanation for men's reproductive and the need to encourage early prevention of sexual challenges and the effective forms of prevention.

1.1 Statement of the Problem

Most men have diverse health needs and issues. Some of these have been acknowledged and documented in diverse researches and studies. These include issues such as HIV/AIDS, sexually transmitted infections/diseases (STIs/STDs), sexual behavior, family planning service and involvements of male in family planning and contraceptive incentives. Unlike women whose sexuality issues are typically replied and instructions on womanhood given (via the mothers, senior women teachers at schools, social media and so forth) men are anticipated to recognize everything about masculinity – growing up, body changes, sexual health, and many others. They fend for themselves and are viewed by many as simply economic providers.

Hitherto, wherever male reproductive problem is mentioned, it is usually within the context of the duties that they perform, without taking cognizance of the fact that challenges of reproductive health affect men too (Caldwell, 1996; Biddlecom & Greene, 1997; Sternberg & Hubley, 2004). Studies have shown that men are eight times more likely to transmit STD, HIV/AIDS and some others health issues due to their adventures of having unprotected intercourse with numerous companions. A 2002 statistics shows that men are mostly the transmitter of STIs to their companions.

Most programs in Africa have focused on women's sexual health. However this study is concerned with the knowledge of common male reproductive health challenges and the impact of

socio demographic characteristics on male reproductive health challenges in Ekiti State, Nigeria.

1.2 Research Questions

1. What is the level of knowledge about common male reproductive health challenges in Ekiti state, Nigeria?
2. What are the socio-demographic factors on male reproductive health challenges in Ekiti State, Nigeria?
3. What are the measures used by men in Ekiti State to reduce the risk and occurrence of male reproductive health challenges?

1.3 Research Objectives

The research objectives of the study are:

1. To examine knowledge of common male reproductive health challenges in Ekiti State, Nigeria;
2. To examine the reproductive health seeking behavior of men in Ekiti State, Nigeria; and,
3. To examine the relationship between socio-demographic characteristics (age, ethnicity, education attainment, occupation and religion) and male reproductive health challenges in Ekiti State, Nigeria.

1.4. Justification of the Study

Male's reproductive health challenges have remained worrisome. It cannot be denied and the damaging effects are visibly not ignorable in the circle of relatives and the society. Men with issues of reproductive health are discriminated against as the challenges are assumed to be adverse or dangerous (in one way or the other) to the survival of a person or might be a serious problem both to the relationship with the partner, society, family, organization and even to

human development. Men have precise reproductive health needs that historically have not been addressed (DHHS, 2003; Isiugo-Abanihe, 2003; Sternberg & Hubley, 2004). Efforts have been tailored in the direction of addressing men's reproductive health. While it is believed that the severity and nature of this sickness vary between socio-economic demographic characteristics, family history, environment, reputation i.e. social reputation, cultures and religion perception towards the health challenges have not been helpful.

This study promotes further research on male reproductive fitness which has been disregarded. It is believed that the way government, non-private organization and general public can help to reduce occurrence rate of male reproductive health challenges. This study is therefore intended to provide information that will help improve the reputation of reproductive health within the communities sampled by means of bringing to the fore the socio-demographic characteristics consisting of the age, social status, tribe, religion, education in relationship with male reproductive health challenges.

Conscious efforts are actually essential in the direction of highlighting and meeting the reproductive health needs of men. What are the inherent challenges men faces in phrases of their reproductive health needs and what facilities are available to satisfy these needs? On one hand, men are in most instances, carriers of primary deadly illnesses. They accumulate more partners over their lifetime because they are sexually exploratory (Barick, 2010). Normally maximum advances towards reproductive health incidence are usually from men and they may be consequently initiators than otherwise. Therefore, numerous voiceless reproductive health needs are suspected to be for men people, and the hope is that this research will expose the unmet needs of male reproductive health. However, men can also be vulnerable to unintended fatherhood, STIs and different form of deformity in reproductive health etc. due to the fact

they're more likely to be misinformed about sexuality and reproductive health. They do not ask questions in most cases and are continually ready and willing to engage in sexual interest on every occasion the possibility comes for such category of gender, the outcome of this study and its utilization pays off. This instead of best encouraging them to assume certain duties and responsibilities to assist women in understanding their health desires could enhance equity in reproductive health services. In particular, men's challenges on this regard should consequently occupy a priority position for the reason that without them some different problems of reproductive health experienced by women won't have arisen. This study highlights the prevalence of men reproductive health, provided possibility for all social health providers and government in developing country especially Africa and direct their service to the affected person appropriately and also to analyze, document and give an explanation for the socio-demographic factors that influence men reproductive health.

1.5 Definition of Terms

1. **Infertility:** male infertility means inability to make a woman fertile i.e. inability of a man to produce due to low or poor quality of sperm. Infertility might be caused by undescended testicle, infections in the testicle or prostate, and drugs such as anabolic steroids or anti-seizure medications.
2. **Prostate cancer:** this is also known as carcinoma of the prostate, which is the development of cancer in the prostate, a gland in the male reproductive system. Most prostate cancers are slow growing; however, some grow relatively quickly. The cancer cells may spread from the prostate to other parts of the body, particularly the bones and lymph nodes. It may initially cause no symptoms. In later stages it can lead to difficulty urinating, blood in the urine, or pain in the pelvis, back or when urinating.
3. **Reproductive health:** Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with

the reproductive processes, functions and system at all stages of life.

4. **Sexual dysfunction:** Sexual malfunction or sexual disorder is difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

2.1 Concept of Male Reproductive Health Challenges

According to the United Nations (1999) and Lamb and Siegel (2004), reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of diseases or infirmity in all matters relating to the reproductive system and its functions and processes. Reproductive health includes the gender equality right (female and male) and access to safe, effective, affordable and acceptable methods of family planning of their choice and also according to United Nations, 1995, it is the techniques, group of methods and services that contribute to the well-being of an individual. Some components of reproductive health include sexual behavior, sexual dysfunction, contraception and family planning.

Specifically, male reproductive health challenges could be perceived as all problems that are associated with the male reproductive health system. It could be defined, according to International Conference on Population and Development (ICPD), Cairo, 1994 as a state of a man's physical, mental, and social wellbeing in all matters relating to the reproductive systems, at all stages of his life (ICDP, 1994; Caldwell, 1996; Family Health International, 2009). A good male reproductive health implies that the man is able to have a satisfying and safe sex life, and possesses the capability to reproduce, coupled with freedom to decide if, when, and how often to do so in conjunction with his spouse. It includes information about access to safe, effective, affordable, and acceptable methods of family planning of his choice, and the right to appropriate health-care services that enable men to safely overcome all reproductive health dysfunctions (ICDP, 1994). On one hand, reproductive health conditions are basically measured by a

combination of self-reporting, clinical examinations and laboratory analyses. However, the perception of individuals and the society (i.e. community) of what is healthy and unhealthy reproductive status is crucial to reporting, diagnosis, treatment and management of reproductive health disease. In addition, the tolerance or stigmatization and health seeking behavior of respondents are related to health status of the victims and their relationships in the society (Lamb & Siegel, 16 2004). This is real since most of these conditions might not affect a man's general functioning. In addition, because of limited access to medical services in less developed nations, majority of men are unaware of having a definite illness until it shows up in their sexual incapability and wife's infertility (Sternberg & Hubley, 2004; Warwick, 2006).

Few researchers have paid attention to male reproductive health due to the fact that focus has been on the female reproductive health. There are reproductive challenges associated with males in terms of mental, physical, emotion and sexual health due to limited access to medical services in less developed nations. A lot of men are unaware of their having a definite illness until it shows up in their sexual incapability and wife's infertility (Sternberg & Hubley, 2004; Warwick, 2006). The major reason for limited information about male reproductive health challenges is due to the fact that men fail to pay attention to their health due to ignorance of their reproductive health and feel embarrassed to take bold steps in seeking solution.

Generally, male reproductive health problems relate to difficulties encountered at any stage of the reproductive health act (that is, malfunctioning in reproductive health activities, arousal, orgasm, impotency, testicular infections, etc) which could manifest in gonorrhoea, HIV/AIDS, erectile dysfunction, infertility, etc. The presence of any of these diseases could directly or indirectly distort or inhibit men from enjoying their sexual activity and or production of offspring (Warwick, 2006; Paul, 2006). The appalling emergence of innumerable reproductive

health therapists/consultants and the drive for new reproductive health information especially in sub-Saharan African region of the world is a pointer to the preponderance of such problems and the desire of the victims in seeking solution. Therefore, there is a need to bring to limelight by way of documentation the hidden reproductive health problems being experienced by men in order to provide effective solutions and stem the various forms of embarrassment, confusions and discontentment associated with the problems. To provide comprehensive solutions to male reproductive challenges, a thorough assessment must be done. In this regard Ekiti State, Southwestern Nigeria was used to understand the relationship between male reproductive health challenges and social demographic characteristics. Therefore the study focused on analysis of the reproductive health challenges and the coping strategies employed by the affected parties.

Male reproductive health challenges could be threats to the achievement of Millennium Development Goals (MDGs) especially in the areas of morbidity and mortality reduction (Wusu&Isiugo-Abanihe, 2008). Thus, it is important to bring out and explain the interrelationships between fundamental issues of life that can impinge on continuity of life, for example, male reproductive health challenges and socio demographics. It is anticipated that the interrelationship discovered would help policy makers, programme planners, community/opinion leaders and governments and also health service providers, as it were, in decision-making and the formulation of appropriate policies to improve the wellbeing of the families and their communities.

Men's reproductive health difficulty is not status related but often occurs when a man is in at puberty when want to engage in sexual relationship or married. The problems may begin early in a person's life or it may develop after an individual has previously experienced enjoyable and satisfying sex. The problem may develop gradually over time or could occur suddenly as a

total or partial inability to participate in one or more stages of the reproductive act. Irrespective of the causes and timing, the imprints of this disability on marital life are enormous and cannot be overemphasized. For example, Rust *et al* (1988) investigated the relation between marital unhappiness and reproductive health dysfunctions and observed that the relationship between marital happiness and reproductive health condition was stronger in men than in women.

It is known that men are notorious for failing to pay attention to their health, and in most cases when wrongs are discovered about their reproductive parts, they often feel embarrassed to take bold steps in correcting them or seeking for solution (FHI, 2009). However, if action is not taken to resolve any wrong discovered on any part of the body, it can degenerate into total debility of not only the affected part(s) but also the entire body. Men's understanding about reproductive health is considered marginal. Men are always reluctant to use reproductive health services and they know even little about their own or women's sexuality. Men hardly communicate about sexuality in their relationships and often believe many sexual myths without regard for family planning programmes because they see them as a conspiracy to undermine their power (FHI, 2009).

Substantial volumes of literature have therefore covered female reproductive health problems like infertility, STI, HIV/AIDS and breast cancer in the face of dearth of information on their male counterparts (Martine, 1999; Pelto, 1999; Saraswati& Leonard, 2000). Where there are seemingly related studies on male reproductive health, they were not considered as priority issues. For example, the report of a survey sponsored by USAID in 1996 indicated that the funding agency (USAID cooperating agencies) lacked clear guidance on the priority that they should place on this issue. That what is required is models about how to integrate men into existing programme in a way that can enhance services to women (Interagency Gender Working

Group (IGWG), 1998). The priority remained unclear until recently and the vacuum created has not been filled in terms of adequate understanding of the impact of male reproductive health in the society especially within the family. Studies that could therefore enhance the bridging of this gap should be encouraged.

In addition, considering the danger inherent in male reproductive health challenges, a planned effort was made this study to unravel male reproductive health challenges in order to prevent the inevitable dangerous consequences associated with such problems such as untimely death due to frustration, loneliness, couple separation, violence at home, disharmony, divorce, to mention but few. Notwithstanding the perceived general reluctance on the types and severity of reproductive health challenges that men face, this research aimed at finding the prevalence of male reproductive health problems, especially as being experienced among the men in the South-Western Nigeria, Ekiti State as the case study.

Until recently, family planning and reproductive health services of female have been the major focus. In the past, this focus made sense since most family planning methods were female dependent, and women were disproportionately affected by the negative consequences of unintended pregnancy and sexually transmitted infections (Robert, 2007). Again, with the onset of the AIDS epidemic, reproductive health professionals have increasingly concentrated on female reproductive health with relatively little or insignificant attention being paid to the male's aspect of reproductive health. Therefore, in order to reduce the reproductive health challenges, it is important to examine the incidence and prevalence of such reproductive health problems and their degrees of threats to relationships within the family, society and a nation as whole. This study is not advocating for the supportive role of the male in family planning or reproductive health (Zulu, 1998). This is believed to have been extensively covered by other studies. This

study precisely assessed the threat to family existence by the male reproductive health challenges.

Men's reproductive health needs are numerous. Men begin having sexual intercourse as early as 15 or less in the developing world and remain sexually active for over a period of 10 years before marriage. Between these periods several things transpire and necessary guide is needed on their sexual behavior. It should be noted that among the crucial and potential consequences of sexual activity for men is contacting or transmitting sexual diseases. In analyzing men reproductive health needs, Sonfield (2002) indicated that one in six American men who are in age group of 15-49 experience genital herpes while about 500-600 cases of Chlamydia and gonorrhea are reported annually. However, up to 50 percent and 30 percent of these diseases respectively are not reported annually among men in their 20s. Although, most of the men's reproductive health diseases are not ordinarily visible or with noticeable symptoms, the damaging effects are fatal and could include sterility, vulnerability to HIV/AIDS or other unwanted STIs that could endanger their partners' pregnancies or further health and fertility (Sonfield, 2002).

Men generally suffer lack of awareness of their reproductive health needs, they face unplanned pregnancy, early fatherhood (Flanigan, Huffman & Smith, 2002; Action Health Incorporated, 2009), involvement in multiple partners, many wives as the case in Nigeria and other regions in sub-Saharan Africa (Isiugo-Abanihe, 1994 and 2003). They engage in cohabitations, low usage of condom at first intercourse, first birth and many desire no more children.

Till date, little attention is paid to these challenges both from the government and other stakeholders. There exist several women's health centers but there are relatively no equivalent

health facilities for men, and where they exist, the facilities are often underutilized. The most recent data suggested that men make up only two percent of the clients in the federally funded family planning programmes in United States of America. The data indicated that many times, the services for men are housed in settings where the staff lack training in male sexuality and reproductive health and where providers' attitudes about men's involvement in reproductive health may compromise the quality of service delivery (Greene & Lindsay, 2005; Robert, 2007). Men's reproductive health is just as important as women's reproductive health. The question is, 'why is not as important to men' The consensus has it that men's reproductive health is often times neglected by men who do not have someone to nudge them towards the doctor, nurture them, care for or about them because men do not pay attention to their health in general. Men need to pay attention and give attention to their reproductive health concerns, even if they do not care to.

A man's reproductive health in good shape ensures he can continue to provide, entertain, nurture and party. A man with good reproductive health means he will not suffer and will not have to share his suffering by being begrudgingly dependent on other people because he neglected his reproductive health issues or concerns. Issues such as the AIDS epidemic have reinforced the urgency of encouraging men to take responsibility for their own sexual and reproductive health and that of their partners (Salem, 2004). Despite global recognition at the level of international agreements, many countries have not developed large-scale programs that reach out to men concerning their reproductive health on how is affecting their physical, emotional, psychological wellbeing.

According to statistics men often ignore their reproductive health, most men involve in risky sexual behavior by not using contraceptive, endangering their reproductive health by

having issue with their contraception, sexuality, infertility and sexually transmitted diseases which lead to some other issues such as gonorrhea, HIV/AIDS and so on and also transmit it to their partners. Men's reproductive health concerns are shown, in general terms, through statistics. The WHO (2008) observed that reproductive and sexual ill health accounts for 14 % of the global burden of ill health for men and also men are four times less-likely to visit their doctor than women. However, 30% of all men experience some form of sexual issue (sexual dysfunction), while 25% of men under the age of forty ejaculate before they would like to (premature ejaculation).

When it comes to their health, men are often times late to respond to a number of symptoms. Yet this is never more so than when the issue is directly related to their reproductive health. There are a countless number of journals and magazines that are geared specifically towards dealing with men's sexual health. The publications are filled with a large amount of information in regards to this topic, but men remain reluctant to consult their doctor in the event they are experiencing symptoms that might be an issue.

There are several things that may hinder a man's sexual health. Some of these include activity level, diet, injury, or psychological disorders. Still, these issues are not the only things that can hinder a man's reproductive health. There are real conditions that may present serious issues for a man if they remain undiagnosed or untreated. Some of these conditions include the following: infertility, epididymitis, penis disorders, prostate problems, testicular problems, erectile dysfunction, premature ejaculation and sexually transmitted diseases. Any one or all of these conditions may cause an issue with a man's sexual health and most men can be treated fairly easily. There are things that men can also do to get the general diagnosis of their overall health levels. The majority of men put up with their dysfunctions while not understanding that

there are simple remedies for most conditions. For example, premature ejaculation can safely and easily be managed with treatment using tramadol, a non-controlled substance that can be purchased online, the medication is also far less expensive than Viagra.

Men can simply make changes to their exercise, diet, or overall fitness levels in order to maintain their health, or they may seek the needed and recommended treatments that a doctor prescribes for them if a complication is detected. Eating nutritionally balanced food, managing stress levels and monitoring the consumption of alcoholic beverages is a great idea. This is because, men in general, are less likely to access healthcare and they often lack accurate information about their reproductive healthcare. This is to say that information about male reproductive health needs and the need to seek for such is absent or inadequate. The task and responsibility is therefore on the new generation of demographers and health stakeholders to ensure that adequate information is readily accessible to men in the developing nations and the world at large.

2.1.2 Millennium Development Goals (MDGs) and Male Reproductive Health Challenges

The goals of Millennium Development were depended upon the basic assumption that the world at large possesses the capability of improving the lives of its inhabitants including reproductive health conditions. The goals were captured under eight goals of development as identified and agreed upon by the 189 Nations including 147 heads of state and governments of those nations in World Millennium Summit organized by UN and held in Cairo in September, 2000. The action plan for the achievement of these set goals led to the commissioning of UN Millennium Project that focused on, among other things, population and reproductive health within the context of MDGs. The underlining basis of the project is to utilize the inherent potential of international community in addressing the challenge of extreme poverty around the world.

However, despite, the fact that the MDGs contain no clearly spelt-out target on sexual and reproductive health, apart from its call for unhindered access to services related to it, the emerging UN millennium projects recognized that MDGs cannot be achieved, especially in low-income economies, without special attention being focused on population issues (UNDP, 2005). The projects gave credence to maternal-child mortality reduction, treatment of STI and HIV/AIDS. It also specifically indicated that access to reproductive health and service are essential to poverty/hunger eradication, achievement of gender equality, women empowerment and other MDGs; and that where disparities in access is prominent, it is both the symptom and the contributor to poverty and gender inequality.

Hitherto the MDGs, the gender biased in health policies, disproportionate public investment on health, gaps in maternal healthcare and sexual health services were conspicuous in virtually all developing nations, including some middle-level income economies. However, the MDGs do not portend any ray of hope as well. The omission of male reproductive health among the goals implies the omission of a dominant party in reproductive health system. This therefore misrepresents the assurance that programmes emanated therein could achieve gender equality. This situation is apt to conjecture that gender equality objective could be a mirage without addressing systematic challenges relating to the promotion of sexual and reproductive health especially as it relates to men. General expectations were such that strategic plans would have been deployed in the developing countries to include male reproductive health in their health policies. This hope is yet to be fulfilled, as there is no clear line of action or known policy on male reproductive health in Nigeria and most countries of sub-Saharan Africa currently. Therefore, it could be inferred that the scope of sexual and reproductive health as envisioned by MDGs and UN Millennium project (including other adjunct groups) has been on universal access

to sexual reproductive health services, family planning, safe motherhood, treatment of HIV/AIDS, education and (only) men involvement.

The omission of male reproductive health poses a great limitation to MDGs realization, taking into cognizance that reproductive health is not one-gender (or single-sex) based. Besides, it is obvious that universal access is not achievable without ensuring a balance of action between the two sexes. Male reproductive health has long been neglected or forgotten. Thus, a wake-up or re-awakening in the 21st century is expedient. Male inclusion in reproductive health is important to millennium development goals (RHPWG, 2004). It is no gainsaying, that universal access to SRH services and information are integral part of the instruments to fight STI/HIV/AIDS, and however the duo must be mutually reinforcing (UNDP, 2005). Effective access can be recorded if segregation and treatment are made on various challenges experience by different categories of gender. However, since women's and girls' reproductive health challenges have been well-entrenched and covered till date, a diversification to males would be monumentally rewarding, not only in terms of equal gender empowerment but also for sustainable development in general.

2.2.0 Overview of Male Reproductive Health Challenges

Men's reproductive health challenges are diverse in nature. They go beyond issues of sexually transmitted diseases (STD) services and family planning. They are embodiment of, but not limited to, sexual dysfunction, prostate cancer, andropause, low testosterone, infertility, testosterone misuse and hypospadias. They also include Testicular Dysgenesis Syndrome (TDS) like testicular cancer; which result in couples' infertility, infection of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), stigmatization, etc; with possible concomitant effects of severance of family relationship (Willson, 2001; Kate, Susmita&Rumeli, 2004; Bezeruk&Cassy, 2005; Andrology Australia, 2007). Peculiarity of reproductive health

challenges related to men range from erection difficulty, rapid or delayed ejaculation, uneven reproductive health status, performance or sexual incompatibility with partner, feeling of pressure by their spouse's sexual level and so on (Kate *et al*, 2004; Bezeruk&Cassy, 2005; Andrology Australia, 2007).

Succinctly put, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health problem relates to impairment in any or all the processes, functions and reproductive system that may prevent or disturb a man and his spouse to have a responsible, satisfying and safe sex life (United Nations, 1994a; United Nations, 1995; Stan, 1996; Lamb & Siegel, 2004; WHO, 2004; Siegel, 2012). This might or might not make them incapable to reproduce and enjoy the freedom to decide if, when and how often to do so (WHO, 2004; WHO, 2010). A male reproductive health challenge could therefore be described as any condition that affects any stage of the sexual response cycle of a man (Eyler& Biggs, 2007; Lentz, 2007). Few of the common ones are described below:

2.2.1. Sexual Problems

A sexual problem known as sexual dysfunction refers to a problem during any phase of the sexual response cycles that prevents men from experiencing satisfaction from sexual intercourse. Sexual dysfunction in men can be as a result of physical or psychological problem. Erectile dysfunction manifests in impotence, transient erectile problems and premature ejaculation. Premature ejaculation involves the inability of a man to exert voluntary control over ejaculation and difficulty to resume intercourse for undetermined period of time. The general causes of impotence are usually diseases, drug side effects and injury. It has been observed that any disorder that impairs blood flow in the penis has the potential to cause impotence in men (Christian, 2006; Warwick, 2006; Andromeda Andropology Center, 2010).

The probability of experiencing impotency increases with increase in age. Studies have confirmed that while it is not an inevitable sickness that every man must experience, about 5 percent of men at the age of 40 are more likely to experience impotence and between 15 and 25 percent of men at the age of 65 could likely experience it (Healthcarenet, 2005; Christian, 2006; Warwick, 2006; Andromeda Andropology Center, 2010). However, impotence is treatable in all age groups and normal sexual activity could resume after successful treatments.

Also, male sexual dysfunction can sometimes be caused by disorders such as high blood pressure, vascular disease, heart disease, nervous system disorders, depression as well as side effects from some medications (Healthcarenet, 2005; Christian, 2006; Warwick, 2006; Andromeda Andropology Center, 2010). Sexual health and function are important in determining a man's quality of life. Other causes of erectile dysfunction include, but are not limited to, the following: stage fright (performance anxiety), the fear of failure that can induce stress, which makes a man unable to satisfactorily relax and simply enjoy making love. It also includes low self-esteem, communication difficulties, unresolved marital issues, long withdrawal, cardiovascular disease, medications (like some drugs used for treating hypertension, anxiety, depression), alcohol, low hormone levels, obesity and diabetes (Jack, 2001). However, possible solutions to erectile dysfunction include but not limited to prompt treatment of an erectile problem because the longer it lasts the more difficult it is to resolve. A successful treatment of erectile dysfunction could improve sexual intimacy, marital satisfaction, improve quality of sexual life and relieve symptoms of depression (NKUDIC, 2005).

2.2.2 Testicular Cancer

It is known as cancer of the testes. It occurs when germ cells (the cells that become sperm) experience abnormal growth. Germ cells, like stem cells, have the potential to form any cell in the body. Normally, this ability is dormant until the sperm fertilizes an egg. When germ cells become cancerous, they multiply unchecked; forming a mass of cells called a tumor, and invades normal tissue (American Cancer Society, 2005; National Cancer Institute (NCI), 2005; Paul, 2006).

The Males Advocates for Responsible Reproductive Sexuality (MARS) asserted that testicular cancer is the number one cancer causing death among males of 13-35 years of age (American Cancer Society, 2005; National Cancer Institute (NCI), 2005; MARS, 2007). It is also believed to be the commonest kind of cancer among men aged 18-30 years. While it is curable in the majority of cases, the cure rate drops to around 50 percent if it is left too late without treatment (Paul, 2006). Globally, cases of testicular cancer have risen to 70 percent in the last 20 years (American Cancer Society, 2005). While it is the 14th most common type of cancer globally, it is the major cause of death among men aged 20 to 34 years. Testicular cancer can appear any time after puberty and about one in every 500 men is affected with the disease in the world all over. But with increasing proportion in incidence of this disease (about 70 percent in the last 20 years) about 90 percent of them can be cured if treated very early (National Cancer Institute, 2005; American Cancer Society, 2005; MARS, 2007).

Despite the fact that the specific causes of this disease are not yet known, researchers have suspected chemicals used in the manufacture of cosmetics and plastics/food cans. Some other causes include wearing tight trousers (including tight underpants) that can raise the temperature because high temperature can encourage growth of cancerous cells. Family history

of testicular cancer, congenital abnormalities and kidney problems are among other suspected causes (National Cancer Institute, 2005; American Cancer Society, 2005; Paul, 2006). Regular self-examination is considered the best way to for early intervention.

2.2.3. Prostate Cancer

This is the most common disorder face by men in their reproductive health. Prostate cancer is a frequent cancer diagnosis in American men. Although it is rare in people under the age of 40, it becomes more common in older men, and almost half of men over the age of 70 are thought to have it, but for many men this cancer will not seriously impact their health. About 200,000 men in this country are diagnosed with prostate cancer every year, and about 30,000 die of the disease, making it the second most deadly cancer in men after lung cancer. Approximately one in every six men will be diagnosed with this cancer at some time during his lifetime. The prostate – one of the components of a man's sex organs – is a walnut-sized gland in young men. But with age, the prostate slowly increases in size, and this can cause problems. For men, the older you get, the more likely you are to have problems with your prostate gland.

The prostate is wrapped around the urethra, which is the tube that carries urine out of the body when you urinate. In men, the urethra also carries semen, the fluid that contains sperm, out of the body during ejaculation. The prostate adds specialfluids to the semen when a man ejaculates, and muscles in the prostate gland contract to force the semen out of the body. Frequent or painful urination is often a sign of a prostate problem, especially in older men. Most men over the age of 50, most often encountered the prostate disease called benign prostatic hyperplasia (BPH). Men having BPH, their prostate enlarged to the point that it begins to squeeze the urethra. This prevents urine from flowing easily from the bladder to the outside of the body.

Although this condition is benign—the prostate tissue is not cancerous—it can still cause serious problems requiring treatment. Prostatitis (inflammation of the prostate) is the most common prostate disease. It may be caused by a bacterial infection or have no identifiable cause. Either way, it can produce severe pain, burning, and disability. Prostatitis occurs in older men, as well, but is less common.

Prostate cancer, a sometimes fatal disease, usually causes few symptoms unless it has spread to other parts of the body, such as the bones. It is easily curable in its early stages. It is extremely common in older men, and many have undetected prostate cancer for many years, eventually dying of unrelated conditions.

2.2.4. Male Infertility

Male infertility refers to a male's inability to cause pregnancy in a fertile female. In humans it accounts for 40-50% of infertility. Infertility is commonly due to deficiencies in the semen, and semen quality is used as a surrogate measure of male fecundity. It affects approximately 7% of all men. The clinical definition of male infertility is the presence of abnormal semen parameters in the male partner of a couple who have been unable to conceive after 1 year of unprotected intercourse (Dohle 2010).

The World Health Organization defines male factor infertility as the presence of one or more abnormalities in the semen analysis, or the presence of inadequate sexual or ejaculatory function (Rowe 2004). In 50% of involuntarily childless couples, a male infertility associated factor is found together with abnormal semen parameters (Dohle 2010). Male fertility requires normal sperm production and sperm transport, and adequate sexual performance, functions that require

normal levels of testosterone. Male infertility can be due to a number of factors, including abnormal spermatogenesis; reproductive tract anomalies or obstruction; inadequate sexual and ejaculatory functions; and impaired sperm motility (Patki 2004; Isidori 2005; Dohle 2010). In 30-40% of men, no cause for infertility is found (Dohle 2010). However, in such men, semen analysis reveals a decreased number of spermatozoa (oligozoospermia), decreased sperm motility (asthenozoospermia) and many abnormal forms of sperm (teratozoospermia) (Dohle 2010). Factors that alter spermatogenesis include endocrine disturbances such as low testosterone levels, exposure to medicines or environmental toxins, varicocele, increased scrotal heat, systemic diseases, smoking and alcohol, and testicular torsion and trauma (Cherry, 2001; Kunzle, 2003; Shefi, 2006; Arap, 2007). Erectile and ejaculatory dysfunction may be associated with psychological factors, hypogonadism, spinal cord disease, and metabolic and vascular conditions such as diabetes (Dohle, 2010). Sperm motility can be reduced in immotile cilia syndrome or in the presence of antisperm antibodies (Arap, 2007).

Treatment for male infertility should be targeted to the etiological factors whenever possible, and includes hormonal treatment, hormonal modulators, corticosteroids, antioxidants, and surgery. Assisted reproductive techniques are often the fastest and most effective method to achieve pregnancy regardless of the aetiology (Isidori 2005; Dohle, 2010)

2.3.0 Theoretical Framework

There are no common theories of male reproductive health challenges. While this is assumed to be a great oversight from researchers, the sensitive nature of the diseases involved could as well be the fundamental underlying factor. Theory of reasoned action was reviewed proposed by Ajzen and Fishbein in 1975 and 1980. The theory suggests that a person's behavioral intention depends on the person's attitude about the behavior and subjective norms (Ajzen&Fishbein,

1975; Hale *et al*, 2003). It argues that if a person intends to exhibit a behavior then it is likely that the person will do it. That is to say, if the man is intending to have himself examined, abide by medical dictates/prescriptions on his reproductive health or seek further information on RH, the likelihood that he will do so will be very high compared to a situation where the man is not interested in the matter at all. Succinctly put, the probability of a husband's exposure to medical examinations or tests is contingent upon the level of his interest in his marital relationship and other affairs relating to his reproduction.

The components of the theory of reasoned action (TRA) comprise of three general constructs namely, behavioral intention, denoted as BI, attitude represented by A, and subjective norm which is symbolized as SN. It is thus represented mathematically as $BI = A + SN$. Where BI, A and SN are as defined above (Azjen&Fishbein, 1975; Hale *et al*, 2003). It could therefore be conjectured that the behavior of a man in response to his reproductive health is contingent upon his personal attitude and the perception of those he respects around him toward the health defect(s) he is suffering from. The Family Health International (FHI) affirmed that the men's attitudes and behaviors with respect to women's health are more pronounced in the area of STDs prevention and treatment. It indicated that no prevention programme can be effective without adequate enlightenment of both partners and that a change in the high-risk sexual behavior is considered a more potent weapon in this regard (FHI, 2009). Therefore, the assessment of contributions of male reproductive health challenges to high-risk sexual behavior would be relevant in this age as a fundamental potent strategy of stemming the tide of sexually transmitted diseases especially among couples.

However, since the perception of those around him is also dependent upon the culture of the community they live in, the behavior of the man was therefore assessed as it is being

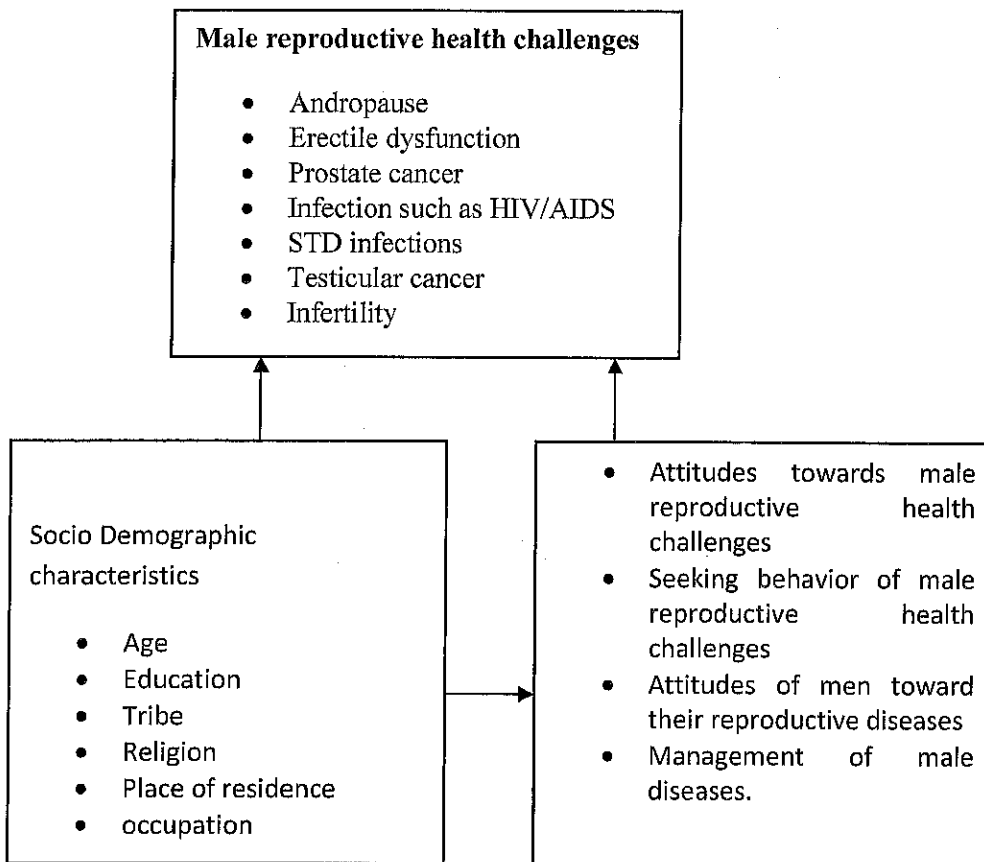
influenced by the culture of the community and specific disposition of the community toward such reproductive challenge(s). In a community where impotency constitutes a stigma or where prostate cancer is a taboo, the victim would prefer dying with it than exposing himself. In that regard, seeking a cure or medical advice would not only be difficult but the last thing to imagine.

The behavioral intention measures a person's relative strength of intention to perform a behaviour. Attitude consists of beliefs about the consequences of performing the behaviour multiplied by his or her valuation of these consequences. Subjective norm is therefore seen as a combination of perceived expectations from relevant individuals or groups along with intentions to comply with these expectations. A man's personal predisposition is therefore a vital factor in assessment, adherence and treatment of disease he is experiencing.

2.4.0 Conceptual Framework

The conceptual framework is designed to outline the expected interrelationships between male reproductive health challenges and socio demographic characteristics. It is meant to provide a better insight into the various linkages between male productive health challenges and socio demographic characteristics.

Figure 1: Conceptual Framework - diagram designed for the study of male reproductive health challenges



Several studies have investigated a range of overlapping risk factors in relation to male reproductive health. These include socio-demographic characteristics (such as age, education, socio-economic status), lifestyle factors (such as alcohol consumption, smoking, physical activity) and biomedical risk factors (such as heart disease, diabetes, drug therapies) (Kretser DM, 2005). Age is consistently associated with increased prevalence of lower urinary tract symptoms, erectile dysfunction and benign prostatic hyperplasia (BPH) while some older men may consider poorer reproductive health a consequence of the ageing process, younger men express high levels of concern about developing reproductive health problems in later years.

Most studies focus on erectile disorder as the predominant male reproductive health disorder. It has therefore been proposed that the assessment of erectile function may provide a useful indicator for earlier detection and treatment of other life-threatening conditions. Education exposes men to modern ideas that could shape their reproductive health against tribe culture or tradition and their implications. In some instances, an educated man may snub some taboos and harmful practices such as male circumcision as a result of their enlightenment. Education is capable of changing ideas and behavior it is assumed that men could easily grasp the opportunity in sex education and information which might encourage them to go for test or take appropriate action if challenges are discovered so to prevent or manage reproductive health disorder by going for counseling (reproductive health service) than the uneducated that would be ignorance and die untimely death and also education influences the cultural and religion values in reproductive health behavior discouraging male circumcision. The place of residence is also an important variable that can influence reproductive health issues. Research confirmed that the migrant group is more vulnerable to HIV/AIDS and other diseases that can impair the reproductive system (Delius, Kibombo and Neema, 2003).

2.5.0 Hypothesis

H₀: Socio-demographic characteristics (age, ethnicity, religion, education and occupation) might influence male reproductive health challenges.

H₁: Socio-demographic characteristics (age, ethnicity, religion, education and occupation) might not influence male reproductive health challenges.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In this chapter, the approach used to carry out the research work is explained. This consists of the research design, study location, study population, sample size and sampling procedure, data collection methods, as well as the methods of data analysis.

3.1 Research Design

The study involves cross-sectional descriptive survey. The study was conducted among men in Ado-Ekiti LGA and Oye-Ekiti LGA in Ekiti State. In both approaches, the study made no attempt to control the objects and variables studied. The survey was conducted using a structured questionnaire. All measures came in term of demographic variables relating to male reproductive health challenges and also regression analyses were employed to show the outcome variable. The study was carried out in Ekiti State, the southwestern part of Nigeria. Total number of 250 copies of the questionnaire were administered.

3.2 Study Location

Ekiti State is one of the six new states created on 1st October 1996 by the then Provisional Ruling Council and announced by the then Head of State, General Sani Abacha in a national broadcast to mark Nigeria's 36th independence anniversary. This makes Ekiti State one of the thirty six states of the Federal Republic of Nigeria today. It was carved out of the former Ondo State, which itself came out of the old Western State created in 1967. It is now made up of Ekiti Central, Ekiti North, Ekiti South and Ekiti West Divisions. Before its creation, Ekiti State had twelve Local

Government Areas but, at its creation, four more Local Government Areas were created, bringing the number to sixteen. The capital of Ekiti is Ado-Ekiti. Its motto is 'fountain of knowledge' but now renamed land of honour.

3.3 Data Collection Methods

Data were collected with the aid of self-administered pre-coded designed questionnaires developed from review of relevant recent literatures. The questions were written in English language the appropriateness of format and wording of the questionnaire was also designed in a way to make the questions easy to understand for the respondents.

3.4 Method of Data Analysis

After retrieving all the questionnaires, the survey data were analyzed statistically using Statistical packages for social sciences(SPSS)version 20. The information supplied by the respondents were checked for inconsistencies and where there are open-ended questions, responses were categorized and re-coded. Three statistical analytical techniques were used for data analysis to achieve the objectives of the study and they are: Univariate, bivariate and multivariate analysis. The univariate level of analysis features descriptive statistics such as frequencies and percentage distribution was used to show the association between the dependent variable(male reproductive challenges) and the socio-demographic characteristics of the respondents and in situation where variables were measured in interval scale, descriptive statistics such as mean, mode, and standard deviation were used to describe the variables and also examined with the use of odds ratio at P-value of <0.05 and 95% confidence interval.

Bivariate analyses were done using series of cross-tabulation. Cross tabulation statistics were used to test the influence of socio demographic characteristics on the outcome variables (male reproductive health challenges).

Correlation of the socio-demographic factors that are significantly associated with male reproductive health challenges at the bivariate level are considered in the multivariate level of analysis. For the multi variate analysis, the logistic regression is used to highlight factors associated with male reproductive health challenges so as to achieve the general objective of the study.

3.5 Target Population

The target respondents for this study are males resident in Oye and Ado Local Government Areas of Ekiti. These men are within the age group of 15-59.

CHAPTER FOUR

ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter is devoted to analysis and presentation of data. The study focused on men with reproductive health challenges and socio-demographic factors using Ekiti State in the South West geopolitical zone of Nigeria. A structured questionnaire was designed to focus on three segments which include background of the respondents, awareness/knowledge of common male reproductive and their seeking behaviour.

Quantitative data from the survey were analyzed using Statistical Package for Social Sciences (SPSS) and the results are presented at: univariate, bivariate and multivariate analyses. The univariate features frequency distributions, the bivariate analysis focuses on series of cross-tabulations that were performed to identify the patterns of relationships between identified reproductive health challenges and socio-demographic factors. The hypotheses formulated were tested under the multivariate analysis where logistic regression analytical procedure was employed.

4.1.1 Uni variate Analysis

Frequency distribution is employed to determine the background and level of knowledge of the respondents about male reproductive health challenges in the study area, Ekiti State.

TABLE 4.1 SOCIO-DEMOGRAPHIC CHARACTERISTIC OF THE RESPONDENT

<i>Variables</i>	<i>Frequency</i>	<i>Percentage (%)</i>
	<i>(N = 250)</i>	
Age		
15 – 19	48	19.2

20 – 24	104	41.6
25-29	44	17.6
30-34	17	6.80
35-39	25	10.0
40-44	12	4.8
Total	250	100
Marital Status		
Single	196	78.4
Married	54	21.6
Total	250	100.0
Religion		
Catholic	34	13.6
Other Christian	176	70.4
Muslim	39	15.6
Traditional	1	0.4
Total	250	100.0
Education		
No Formal Education	6	2.4
Primary	4	1.6
Secondary	26	10.4
Tertiary	214	85.6
Total	250	100.0
Ethnicity		

Yoruba	214	85.6
Hausa	1	0.4
Igbo	11	4.4
Other	24	9.6
Total	250	100.0
Occupation		
Public Worker	10	4.0
Self Employed	33	13.2
Artisan	23	9.2
Student	165	66.0
Others	19	7.6
Total	250	100.0
Place of Residence		
Urban	99	39.8
Rural	150	60.2
Total	249	100.0

FIELD SURVEY 2016

Table above revealed the socio-demographic characteristics of the respondents. Majority, (41.6%) of the respondents belonged to the age group 20 – 24, and 60.2% of them live in rural area. With regards to their ethnic group, 85.6% of the respondents are Yoruba while 78.4% were single at the time of the survey. While 85.6% of the respondents attained tertiary education,

66.0% of them are student. This study also revealed that majority of the respondents is Christians (70.4%).

TABLE 4.1.2

Table 2. Knowledge of Identified Male Reproductive Health Challenges Apart From STD And HIVs

<i>Variables</i>	<i>Frequency</i>	<i>Percentage (%)</i>
	<i>(N = 250)</i>	
General Knowledge of any Reproductive Challenges		
Yes	15	6.0
No	235	94.0
Andropause		
Yes	64	28.2
No	163	71.8
Low Libido		
Yes	70	29.9
No	164	70.1
Castration		
Yes	81	34.6
No	153	65.4
Diabetes		

Yes	182	77.8
No	52	22.2
Testicular Cancer		
Yes	67	29.5
No	160	70.5
Prostate Cancer		
Yes	83	36.6
No	144	63.4
Premature Ejaculation		
Yes	118	52.0
No	109	48.0
Painful Intercourse		
Yes	124	59.1
No	86	40.9
Other Diseases		
None	236	94.4
Stomach Pain	7	2.8
Syphilis	7	2.8

Field survey 2016 (multiple responses allowed)

Table above revealed the respondents' general knowledge on male reproductive health challenges. 6% of respondents have some knowledge of male reproductive health challenges. 28.2 % have knowledge about andropause, 29.9% about low libido; 29.5% about testicular cancer.36.6% of the respondents are knowledgeable about prostate cancer; 52.0% about

premature ejaculation; and 59.1% about painful intercourse. Diabetes is the most well-known reproductive health challenge among respondents. The prevalence rate of contracted disease from the table shows that 19.2% of the respondents have contracted one disease or the other while 80.8% have not contracted any of the diseases identified.

Table 4.2.3. Ever Contacted Male Reproductive Health Challenges

<i>Variables</i>	<i>Frequency</i>	<i>Percentage (%)</i>
	<i>(N = 250)</i>	
Contacted Reproductive Health Disease		
Yes	48	19.2
No	202	80.8
Total	250	100.0
Erectile dysfunction		
Yes	26	10.4
No	204	89.6
Low sperm count		
Yes	11	7.3
No	140	92.7
STD/HIV		
Yes	5	3.5
No	136	96.5

Painful Ejaculation		
Yes	18	12.8
No	123	87.2
Gonorrhoea		
Yes	34	24.1
No	107	75.9
Castration		
Yes	81	34.6
No	153	65.4
Diabetes		
Yes	182	77.8
No	52	22.2
Low libido		
Yes	40	28.2
No	163	71.8

Field survey 2016

The table above shows that 19.2 % of men in both Oye and Ado have issues with their reproductive healthy especially diabetes which might be caused by age, genetics and lifestyle factors. 34.6% have experienced castration, 24.1%gonorrhea, and 12.8%painful intercourse.28.2 % of the respondents have experienced low libido.

4.2 Bivariate Analysis

Chi square was performed to show relationship between socio-demographic characteristics which is the independents and male reproductive challenges which is dependents.

Table 4. 2.1 Relationship between Socio-demographic characteristics of respondents and Male Reproductive Health Challenges

<i>Variables</i>	Contacted Reproductive Health Disease			χ^2	p – value
	Yes <i>n = 48 (%)</i>	No <i>n = 202 (%)</i>	Total <i>N = 250 (%)</i>		
Age					
15-19	6 (12.50)	42 (20.79)	48 (19.20)	18.4704	0.002
20-24	14 (29.17)	90 (44.55)	104 (41.60)		
25-29	17 (35.42)	27 (13.37)	44 (17.60)		
30-34	2 (4.17)	15 (7.43)	17 (6.80)		
35-39	8 (16.67)	17 (8.42)	25 (10.00)		
40-44	1 (2.08)	11 (5.45)	12 (4.80)		
Marital Status					
Single	37 (77.08)	159 (78.71)	196 (78.40)	0.0608	0.805
Married	11 (22.92)	43 (21.29)	54 (21.60)		
Religion					
Catholic	16 (33.33)	18 (8.91)	34 (13.60)	20.4866	0.000
Other Christian	28 (58.33)	148 (73.23)	176 (70.40)		
Muslim	4 (8.33)	35 (17.33)	39 (15.60)		
Traditionalist	0 (0.00)	1 (0.50)	1 (0.40)		

Education					
No Formal Education	4 (8.33)	2 (0.99)	6 (2.40)	15.0890	0.002
Primary	1 (2.08)	3 (1.49)	4 (1.60)		
Secondary	0 (0.00)	26 (12.87)	26 (10.40)		
Tertiary	43 (89.58)	171 (84.65)	214 (85.60)		
Ethnicity					
Yoruba	45 (93.75)	169 (83.66)	214 (85.60)	10.3796	0.016
Hausa	1 (2.08)	0 (0.00)	1 (0.40)		
Igbo	2 (4.17)	9 (4.46)	11 (.40)		
Other	0 (0.00)	24 (11.18)	24 (9.60)		
Occupation					
Public worker	1 (2.08)	18 (8.91)	19 (7.60)	22.7205	0.000
Self-Employed	2 (4.17)	31 (15.35)	33 (13.20)		
Artisan	12 (25.00)	11 (5.45)	23 (9.20)		
Student	32 (66.67)	133 (65.84)	165 (66.00)		
Others	1 (2.08)	18 (8.91)	19 (7.60)		
Place of Residence					
Urban	18 (37.50)	81 (40.30)	99 (39.76)	0.1267	0.722
Rural	30 (62.50)	120 (59.70)	150 (60.24)		

Table above revealed the male reproductive health challenges of respondents with respect to their socio-demographic characteristics. 41.60% of respondents who experienced challenges in their reproductive health fall within the age group of 20 to 24 years. Rural residents contacted reproductive health diseases more than urban residents (62.50%). 93.75 percent of respondents who contacted diseases are Yoruba, while 66.67% of respondents who are students had contacted one or more of the reproductive health challenges as at time of survey. With respect to respondent's level of education, respondents with tertiary education have contacted diseases more than respondents from other educational class (89.58%). 58.33% of the respondents who contacted diseases are Other Christian.

4.3 Multivariate Analysis

The binary logistic regression was performed to determine the relative importance of the different categories of the independent variables in relations to ever contacted male reproductive health challenges which are dependent.

Table 4.3: Binary Logistic Regression for the socio demographic characteristics and male reproductive health challenge

	SE	OR	95% CI		p-value
			Lower	Upper	
Age (in Group)					
15-19		1.00			
20-24	1.331	1.955	0.514	7.425	0.325
25-29	2.373	3.368	0.846	13.403	0.085

30-34	210.521	86.808	0.748	10065.450	0.066
35-39	433.962	229.561	5.647	9332.644	0.004
40-44	11398.85	4414.705	27.995	696176.6	0.001
Marital Status					
Single		1.00			
Married	0.322	0.231	0.015	3.555	0.293
Religion					
Catholic		1.0 (R.C)			
Other Christian	0.063	0.094	0.025	0.347	0.000
Muslim	0.014	0.011	0.001	0.141	0.001
Traditional	1				
Education					
No Formal Education		1.0 (R.C)			
Primary	1				
Secondary	1				
Tertiary	11.264	7.104	0.318	158.935	0.216
Ethnicity					
Yoruba		1.0 (R.C)			
Hausa	1				
Igbo	3.689	2.588	0.158	42.321	0.216
Other	1				
Occupation					
Public Worker		1.0 (R.C)			

Self Employed	65.797	29.591	0.379	2311.2	0.128
Artisan	3750.599	1770.988	27.8959	112432.2	0.000
Student	191.506	104.383	2.864	3804.388	0.011
Others	20.455	9.365	0.130	677.163	0.306
Place of Residence					
Urban		1.0 (R.C)			
Rural	0.353	0.805	0.341	1.902	0.621

Field survey 2016

The table above reveals the likelihood ratio of the logistic regression that age contributes to male reproductive health challenges. For instance, using the age of 15-19 as a reference category (1.00), the age group of 20-24, 25-29, 30-34, 35-39, 40-44 with (OR=1.955, P-value =0.325), (OR=3.368, P-value=0.085), (OR= 86.808, p-value=0.066), (OR=229.561, P-value =0.004), (OR=4414.705, P-value =0.001).

The likelihood ratio of the logistic regression in the above table revealed that marital status contributes to male reproductive health challenges. In addition taking single as a reference category (1.00) married men are less likely to have male reproductive health challenges with (OR=0.231, P-value=0.293).

The likelihood ratio of the logistic regression in the above table revealed that religion also contributes to male reproductive health challenges. In addition taking Catholic as a reference category (1.00) both other Christian, Muslim and traditional are less likely to have male reproductive health challenges with (OR=0.094, P-value=0.000 and OR=0.011, P-value= 0.001).

The likelihood ratio of the logistic regression in the above table revealed that education also contributes to male reproductive health challenges. In addition taking no formal education as a reference category (1.00), respondents with tertiary education are more likely to have male reproductive health challenges with (OR=7.104,P-value=0.216).

The likelihood ratio of the logistic regression in the above table revealed that ethnicity also contributes to male reproductive health challenges. In addition taking Yoruba ethnics group as a reference category (1.00) Hausa and other ethnics group are more likely to have male reproductive health challenges with (OR=2.588,P-value=0.216).

The likelihood ratio of the logistic regression in the above table revealed that occupation also contributes to male reproductive health challenges. In addition taking those who are public worker as a reference category (1.00) self employed, artisans and students are more likely to have male reproductive health challenges with (OR=29.591,P-value=0.128,OR=1770.988,P-value=0.000,OR=104.383,P-value =0.011,OR=9.365, P-value=0.306).

The likelihood ratio of the logistic regression in the above table revealed that place of residence also contributes to male reproductive health challenges in Ekiti State. In addition taking urban residents as a reference category (1.00), the rural area are more likely to have male reproductive health challenges with (OR=0.805 P-value=0.621).

4.4 Test of Hypothesis

This is to test the level of relationship between socio-demographic factors and male reproductive health challenges. These include:

Hypothesis One:

Ho : age does not influence male reproductive health challenges

H1: age influences male reproductive health challenges

Critical region: at 0.05 level of significance, Reject Ho if p value $<0,05$, Hence accept if otherwise.

Pearson 184704	Pr =0.002
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Decision rule: since p value (0.002) <0.05 , therefore we reject the Null hypothesis and conclude that there is a significant relationship between age and reproductive challenges i.e. age influence men to have reproductive health challenges.

Hypothesis Two

Ho: marital status does not influence male reproductive health challenges

H1: marital status influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject Ho if p value $<0,05$, Hence accept if otherwise.

Pearson chi2 =0.0608	Pr =0.805
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Decision rule: since p value (0.805) $>$ 0.05, therefore we accept the Null hypothesis and conclude that there is no significant relationship between marital status and reproductive challenges i.e. marital status cannot influence men to have reproductive health challenges.

Hypothesis Three

Ho: religion does not influence male reproductive health challenges

H₁: religion influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject Ho if p value $<$ 0.05, Hence accept if otherwise.

Pearson chi ² =20.4866	Pr =0.000
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Decision rule: since p value (0.002) $<$ 0.05, therefore we reject the Null hypothesis and conclude that there is a significant relationship between religion and male reproductive health challenges i.e. religion influences reproductive health challenges in men.

Hypothesis Four

Ho: education does not influence male reproductive health challenges

H₁: education influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject Ho if p value $<$ 0,05, Hence accept if otherwise.

Pearson 15.0890	Pr =0.002
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Decision rule: since p value is $(0.002) < 0.05$, we reject the Null hypothesis and conclude that there is a significant relationship between education and reproductive challenges i.e. education can influence men to have reproductive health challenges.

Hypothesis Five

Ho: ethnicity does not influence male reproductive health challenges

H₁: ethnicity influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject Ho if p value < 0.05 , Hence accept if otherwise.

Pearson 10.3796	Pr =0.016
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Decision rule: since p value $(0.002) < 0.05$, therefore we reject the Null hypothesis and conclude that there is a significant relationship between ethnicity and reproductive challenges i.e ethnicity can influence men to have reproductive health challenges.

Hypothesis Six

Ho: occupation does not influence male reproductive health challenges

H₁: occupation influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject H_0 if p value $<0,05$, Hence accept if otherwise.

Pearson $\chi^2=22.7205$	Pr =0.000
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Decision rule: since p value $(0.002)<0.05$, therefore we reject the Null hypothesis and conclude that there is a significant relationship between occupation and reproductive challenges i.e occupation can influence men to have reproductive health challenges.

Hypothesis Seven

H_0 : place of residence does not influence male reproductive health challenges

H_1 : place of residence influence male reproductive health challenges

Critical region: at 0.05 level of significance, Reject H_0 if p value $<0,05$, Hence accept if otherwise.

Pearson $\chi^2= 0.1267$	Pr =0.722
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Decision rule: since p value is $(0.002)<0.05$, we reject the Null hypothesis and conclude that there is a significant relationship between place of residence and reproductive challenges i.e. place of residence can influence men to have reproductive health challenges.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

The study considered socio demographic factors and male reproductive health challenges in Ekiti State. Oye-Ekiti and Ado-Ekiti constituted the two local governments used as case study. As a quantitative technique, 250 copies of a structured questionnaire were distributed among men within the age bracket of 15 to 59. The study examined the prevalence of male reproductive health challenges in the study area. Univariate, bivariate and multivariate analyses were used as the statistical techniques with the use of SPSS. The univariate analyses revealed the frequency distribution of socio-demographic characteristics of the respondents. In the bivariate analysis, cross tabulation identified the level of association between socio-demographic factors such as age, ethnicity, education, occupation etc. and male reproductive health challenges while the multivariate analysis, with the use of logistic regression, specified the effects of socio-demographic characteristics on male reproductive challenges.

5.1 Summary of Findings

The study showed that men in their old ages are less likely to experience challenges in their reproductive health compared to those in younger age group. This is because most young men engaged in high risk of sexual behaviour by having multiple partners, cohabitations and unprotected sex. These endanger their health and make them susceptible to STDs, gonorrhoea and all other forms of health issues.

With regard to religion, Christians are most likely to have issues in their reproductive health than Muslims as most of them do not focus on male reproductive health issues that arise during lifecycles. Men without formal education are exposed to health dangers as they are usually ignorant of their reproductive health and may not have access to the reproductive health services. On the hand other, educated men have little knowledge and assess medications.

Artisans and students also have issues with reproductive health due to environmental or chemical exposure or overuse of alcohol. Ethnicity has a positive association with male reproductive health challenges as Yoruba and Igbo are likely to have male reproductive health challenges than the Hausa. The study also showed the level of awareness of male reproductive health challenges is very low.

5.2 Conclusion

Male reproductive health is very important. The normal working of the male reproductive systems plays a key role in many areas of well-being. For a healthier life, men need to know how their reproductive system works and what diseases can affect their reproductive system. With this in view, this study focused on the socio-demographic factors associated with challenges in men reproductive health. It also ascertained the knowledge and prevalence level of male reproductive challenges. The study also identified ever contacted male reproductive health challenges such as low libido, prostate cancer, diabetes and others in two local governments in Ekiti state was. The study also identified that male reproductive health challenges are influenced by age, education, ethnicity, religion and occupation while there is not association between marital status and male reproductive health challenges.

This study highlighted that lifestyle factors that men engage in, such as risky sexual behaviour cause sexually transmitted diseases which bring about more than 25 diseases to men reproductive system. In fact, smoking and taking hard drug affect men's health and lead to testicular or prostate cancer. Culture or tribe according to the findings is one of the socio-characteristics that influence male reproductive health challenges.

5.3 Recommendations

The study recommends the need for men to be aware of their reproductive health. We observed that most men do not have good idea of how their body works. They are also unaware of diseases that can affect their reproductive health. In view of this, the study recommends the following:

1. The use of the media to communicate and inform men on their reproductive health knowledge, attitudes and behaviour.
2. Men should have access to reproductive health service across the state without discrimination or feel embarrass.
3. There is need for reproductive health providers to address both old and young men towards reproductive health issues and how it can be managed
4. Men should try to do routine medical check-up so as to monitor their healths as they grow up and again if they detect anything wrong on their body system they should sum up their mind and seek for medical attentions.

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APPENDIX

QUESTIONNAIRES

Code no -----

Topic: Male Reproductive Health Challenges in Ekiti State

Dear respondent,

I am a student of the department of Demography and Social Statistics, Federal University Oye-Ekiti. I am here to research on MALE REPRODUCTIVE HEALTH CHALLENGES IN EKITI STATE. I would be grateful if you could participate by answering some questions. All information supplied will be treated with utmost confidentiality. Your identity will be protected and will never be linked with any of the information you give.

Thank you.

Section: 1 (Demographic characteristics)

No	Questions	Categories
Q101	Age	<ol style="list-style-type: none"> 1. 15-19 2. 20-24 3. 25-29 4. 30-34 5. 35-39 6. 40-44 7. 45-49 8. 50-54 9. 55-59
Q102	Marital status	<ol style="list-style-type: none"> 1. Single 2. Married 3. Divorced
Q103	Religion affiliation	<ol style="list-style-type: none"> 1. Catholic 2. Other Christian 3. Muslim 4. Traditional
Q104	Education	<ol style="list-style-type: none"> 1. No formal education 2. Primary 3. Secondary 4. Tertiary
Q105	Tribe	<ol style="list-style-type: none"> 1. Yoruba 2. Hausa 3. Igbo 4. Other
Q106	Occupation	<ol style="list-style-type: none"> 1. public worker 2. self employed 3. artisan 4. student 5. others

Section: 2 (knowledge of male reproductive health challenges)

Q201. Which reproductive health diseases have you heard or known apart from STD, AIDS/HIVS? (Tick all that apply)

Reproductive health diseases	Yes	No
1. Erectile dysfunction		
2. Low libido		
3. Castration		