

Demographic Issues in Nigeria:

Insights and Implications

Edited By

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This book is dedicated to Prof. Uche C. Isiugo-Abanihe for his unparalleled contributions to the development of demography in Nigeria.

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Chapter 2

Impacts of Male Reproductive Health Diseases on Conjugal Satisfaction in Nigeria and Wives' Coping Strategies

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Abstract

The impact of male reproductive health challenges within the conjugal relationship and their management have not been conspicuous in the literature till date. This study examined the incidence of male reproductive health diseases and conjugal satisfaction among married women in Lagos and Osun State Nigeria. The data for the study were extracted from a 2010 survey of 435 couples in the southwest Nigeria. Data obtained were analyzed using a combination of univariate and binary logistic. The common male reproductive health challenges identified include erectile dysfunction (10.5%), gonorrhea (12.7%), low sperm count (0.1%), testicular cancer (6.3%), prostate cancer (3.2%) and prostate cancer (1.6%). Where the husbands experience erectile dysfunction, prostate cancer or gonorrhea, the couples are 0.064, 0.898 and 0.583 times (respectively) less likely to enjoy marital satisfaction than where the diseases are absent. It recommends establishment of robust specialized reproductive healthcare services to cater for health needs of men who may be experiencing sexual problems in order to engender stability in family and stable nation. The study concludes that marriage counselors, social workers and other health officials need to focus on erectile dysfunction, gonorrhea and prostate cancer as major determinants of sustainable marital satisfaction.

Key words: Male reproductive health diseases, sexual, conjugal relationship, coping strategies

Introduction

The theory of marriage presents conjugal relationship as a market where each party tries to satisfy him/herself as much as possible over certain expected gains and that any disappointment in this regard introduces strain into the marriage (Becker, 1973; Keeley, 1974; Keeley, 1979). The theory considered quantity of children, love, recreation, quality

meal, companionship, income and health status including sexual relationship as marital gains and lubricants for enduring marital relationship (Becker, 1973). Thus, intimacy in marriage and bearing of children has remained life-long aspirations of couples especially in sub-Saharan African region (Isiugo-Abanihe, 1994 and 2003; Togunde & Newman, 2005; Mayer & Trommsdorff, 2010). However, the presence and nurturing of sexual diseases coupled with the preponderance of divorce, separations, barrenness and family violence among couples highlights rarity of conjugal bliss in recent times.

Nearly two million divorce cases were reported in 2010 in China and the annual rate has been 7.65 percent (Adegoke, 2010). In United States of America, the divorce rate was 3.6 per 1,000 population in 2010 (Center for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS), 2011) and remains as high as 5.5 percent in Sweden and between 80 and 151 per 1,000 marriages in Italy (Vignoli & Ferro, 2009). Other reports indicated that about 32 percent of marriages in developed countries are terminated before their fifth anniversary and 62 percent do so before their 10th anniversary (Martin & Bumpass, 1989; U.S. National Centre for Health Statistics, 1993 and 2010; U.S. Census Bureau, 2011). Nowadays, two parent families are becoming less common in some parts of the world especially in America, Europe Oceania and sub-Saharan Africa though more predominant in Asia and Middle East (World Family Map, 2014). Similarly, couples without children are rampant reaching 33 percent in Austria, 55 percent in Denmark and 36 percent in France (Hantrais, Philipov & Billari, 2005). Specific rates are difficult to establish for sub-Saharan African countries.

Till date, Nigerians marry to have children and marriage has meaning only when a child is born and more often if the child survives. Marital fertility is thus essential, childlessness is often regarded as an aberration, and the victims are often pitied or stigmatized (Isiugo-Abanihe, 1994). There is general decline in marital stability and the number of times that people marry is increasing coupled with high rate of multiple partnerships in Nigeria like other traditional African countries (Isiugo-Abanihe, 1994 and 2003). In the same vein, the incidence of male reproductive health challenges is real and up to three-quarters of married men experience one form or the other (Purva, 2007; Bayer Healthcare, 2008). Twenty-eight percent of men experience burning on urination and 17 percent had clinically diagnosed sexual problems (Purva, 2007; Bayer Healthcare, 2008; Amidu, Owiredun, Gyasi-Sarpong,

Woode & Quaye, 2011). However, there is a complete reticence in reporting or lack of knowledge about the symptoms.

Generally, marital dissatisfaction, whether due to reproductive health defect of the husband or other reason has dysfunctional and disruptive impact on the society. Stability in family will engender stable nation. What is extremely needed in sub-Saharan Africa region is the desire to forge unity among citizenry in order to ensure national or regional stability and concerted efforts should be devoted to that. While the issues related to family, marriage, divorce and female reproductive health have been exhaustively discussed in the literature, little or nothing has been said on what would happen to the wife if the husband has sexual difficulties or diseases or in reality and what will the wife do if her husband is faced with reproductive health challenges. The study thus aimed at estimating the influence of male reproductive health challenges on conjugal relationship in the context of African cultural setting where there is high priority on child bearing. It is designed to identify the proportion and the characteristics of married wives with husbands that have reproductive health challenges in the study location. The study is also meant to determine the coping strategies of the wives in situation where the husbands have reproductive health challenges. These are done to enhance enduring conjugal relationship irrespective of the circumstance of the husbands.

Literature Review

Male reproductive health disease is conceptualized as infection, illness, disorder and condition that affects the functioning of the male reproductive system at all stages of life (National Institute of Health (NIH), 2014). As adapted from the various definitions of reproductive health (Caldwell, 1996; Family Health International, 2009; Lamb & Siegel, 2004; Spielberg, 2007; United Nations, 1994), it used here to refer to as any state of partial or complete physical, mental and social ill-being of a man in all matters relating to his reproductive system, their functions and processes. This concept covers the rights to be informed and to have access to safe, effective, affordable and acceptable reproductive health services that can contribute to reproductive well-being of the man (Lamb & Siegel, 2004; Stan, 1996; Siegel, 2012; United Nations, 1994). The married couple employed is meant to designate a man and a woman who are socially sanctioned for more or less permanent relationship and are duly recognized by themselves and their community as husband and

wife. They are joined together with exclusive lifetime bonds (Biddlecom & Greene, 1997; Isiugo-Abanihe, 1994).

Among couples in this part of the world, expectations are naturally high in terms of quantity of children, love, recreation, quality meal, companionship, income, health status including spontaneity of sexual relationship (Becker, 1973; Keeley, 1974; Keeley, 1979). Besides, African culture dictates reproduction of children as evidence of the fruitfulness of the marriage. In Yoruba tradition, the ethnic group where this study was conducted, like other ethnics in Africa, fertility is paramount in conjugal relationships and represents sustenance of lineage through legitimate and responsible procreation (Alaba, 2004). Also, in an attempt to perpetuate this lineage or get somebody to look after family's domestic works, marriage and parenthood are therefore supported and revered (The African Guide, 2011). Thus, in this region, inability of any couple to bear children could be considered as abnormal and might 'devalue' the couple in their community (Orubuloye, 2000; Kamuzora 1987; Warwick, 2006).

Components considered paramount to male reproductive health could include sexual behaviour, sexual dysfunction, Testicular Dysgenesis Syndrome (TDS), sexually transmitted diseases (STD), HIV/AIDS services, family planning, fatherhood and infertility services, to mention but few (Stan, 1996; Arduca, 2003; Siegel, 2012). Several of these components have been extensively covered but focusing only on women with little reference to men involvement. However, the fact that the majority of these components do not occur to women in isolation implies that both women and their partners are involved. Also, the dominant roles men play in many of these components make male sexual challenge dangerous to harmonious and satisfactory marital relationship.

Studies have confirmed that men with sexual reproductive challenges have lower desire for sexual activity, experience erectile dysfunction, have difficulty in achieving orgasm and several other defects that are capable of disrupting marital and sexual happiness including other damaging effects such as sterility (Rust *et al*, 1988; Arduca, 2003; Murat, Hamdullah & Zeynep, 2005; Warwick, 2006). About 10-20 percent of men who are victims of testicular cancer, for example, participate less in sexual activity with concomitant challenges in their marital lives (Schover, Leslie & Eschenbach, 1985; Geidam, Yawe, Adebayo & Idrisa, 2008). Other consequences of male sexual dysfunction could also include wife's separation or

divorce in addition to its link with stress and anxiety in over one-quarter of the victims (Schover *et al*, 1985; Rust *et al*, 1988; Geidam, Yawe, Adebayo & Idrisa, 2008). Men's sexual dysfunctions (such as impotence and premature ejaculation) are noted to be predominantly associated with marital dissatisfaction and, among women, the level of marital discord is higher when their partners have sexual challenge than when the women have sexual problem themselves (Rust *et al*, 1988; Murat *et al*, 2005).

While it is possible to endure these circumstances, the pressure from the extended family members or the exigency of traditional expectation of bearing of children could exert negative influences on the marital relationship. Although, extended families have existed in many cultures throughout the world for a long time but it is more entrenched in Africa particularly in the sub-Saharan region. Despite the diffusion of western culture and industrialization which has emphasize individualism over collectivism and has weakened extended family grouping in several regions, the bond of extended family is still strong in sub-Saharan Africa (Barnes, 1970; Isiugo-Abanihe, 2004; The African Guide, 2011). In modern society, a conjugal family is considered as consisting of only the husband and wife, with or without children. It is expected that the adaptation of this kind of family structure would imply relationship among the adult partners and their children either by birth or adoption thereby making the spouses and their children prime important. In African culture, this relationship is entwined principally to the extended relatives of both adult partners that have culminated into patrilineal traditional families (Barnes, 1970; Stephens, 1982). Nigeria, being a patriarchal society, the eldest man thus enjoys supremacy over decision-making on crucial issues such as childbearing, number of children, mediation in quarrel or disagreement between spouses and intimate relationship between them (Wusu & Isiugo-Abanihe, 2003).

Besides, studies have confirmed that emotional support from extended family can positively or negatively influence relationship satisfaction for both married and cohabiting couples (Pimentel, 2000; Ubesekeera & Jiaojiang, 2008). In Nigeria, like other regions of sub-Saharan Africa, the benefits of extended families are overwhelming especially in terms of income, employment and other social-intergenerational transfers and are crucial mechanisms for coping socially and financially by their children (Barnes, 1970; Stephens, 1982). They specifically play dominant roles in financial input, companionship, security in terms of their living arrangement (where many adults live together). They also render assistance in times of illness, stress and participate in domestic chores, looking after younger grand children while

the parents work and provide love, comfort and stability to them (Barnes, 1970; Stephens, 1982). In return, grandparents are appreciated for their wisdom and advice due to their experiences. Thus, their views and opinion have become obligations for the children irrespective of their marital statuses. Besides, the consanguine kin group or bloodline, where line of descent is traced through the male members of the family (Abekhale, 2010) has paved way for patriarchy and the patrilineal system. In this system, the eldest especially the one with the most dominant social status have supreme authority over the clan (Barnes, 1970; Stephens, 1982) and controls the affairs of both his/her immediate family and that of the whole clan or kinship. Thus, the influence of extended family on fertility or other reproductive issues becomes crucial in the analysis of male reproductive health challenges.

In another perspective, the general attitudes of Africans towards parenthood and childlessness presents parenthood as a fulfillment of life and that those that live without children empty and considered less rewarded by nature. This, therefore, makes reproductive health a crucial issue of concern to both the immediate family and the extended families. Thus, childlessness or inability of any daughter-in-law to give birth to a living child is considered abnormal (Amoo, 2012a; Isiugo-Abanihe, 1994; Ombelet *et al*, 2008). In this regard, as a member of the same community, the wife becomes naturally uncomfortable if she experiences infertility either through her husband's or through her own reproductive health challenges. Reproductive health challenges reduce fertility or cause infertility and could as well impact on child spacing and paternal mortality (Warwick, 2006, Siegel, 2012). The consequences of these challenges are threats to the conjugal relationship. Thus, the need for critical appraisal of male reproductive health challenges within conjugal relationship.

Research Design

The study adopted quantitative research technique in the data gathering. It specifically employed structured interviews among 435 couples. They were selected following a 'key-informant-leading approach' within 16 wards of the two Local Government Areas (LGAs) selected from Lagos and Ogun States in the Southwest geopolitical zone of Nigeria. The two states were randomly selected among the five states that have highest proportions of divorced and separated in the country according to the national census result of 2009 (National Population Commission, 2009). In addition, the two states selected have similar ethnic profiles, homogenous cultural affiliates and are bounded by a common Yoruba language.

The key informants were mostly volunteered personnel from modern and orthodox health centers and community leaders. Also, participation was voluntary, without given out any incentive for participation and those who agreed to participate were made to sign consent form. Anonymity was assured by not writing the names of the participants on the questionnaire.

The statistical determination of representative sample size followed Taro Yamane's sampling formular denoted as $n = N[Z(\frac{d-c}{2e})]^2 / [N - 1 + [Z(\frac{d-c}{2e})]^2]$ (Yamane, 1967; Amoo, 2012b). Where, N denotes the population from where the sample is meant to be selected, the 'Z' is z-score for the confidence interval selected. The 'd' and 'c' are the probability measures indicating (in this study), the presenece of male reproductive health disease (denoted as 1) and the absence of reproductive health disease which equal to zero (i.e. c = 0). Simply put, the 'd' and 'c' are the upper and lower limits of the range of occurrence of the event. The 'n' is the estimated sample size. Therefore, given the population of the two states as 9,113,605 (Lagos State) and 3,751,140 (Ogun State), the estimated sample equals 384 per state. However, due to finance and other logistics challenges, equal half of the estimated sample were taking from each state. Also, in order to cater for field's and other errors, a buffer of up to 13 percent was added resulting into 435 couples. Overall, the total respondents covered included 136 wives with husbands that have reproductive health challenges while others' husbands are not with any of the reproductive health diseases.

In the data analysis, file was split between respondents with husbands that have reproductive health challenges (regarded as the experimental group) and the control group where the husbands are not experiencing reproductive health diseases. The descriptive analysis covers the two groups while the multivariate analysis centers on the experimental group where husbands have reproductive health problems. Frequency distribution was used to present background information about the respondents. Bivariate analysis provided information on distribution of respondents by selected indicators of marital satisfaction while binary logistic regression was employed to estimates the effects of male reproductive diseases on conjugal satisfaction. The results are presented in tables.

Results and Discussion

Demographic profile of the respondents

The demographic profile of the respondents is presented in Table 1. The general age characteristics revealed that the majority of the respondents are in their prime age of life characterized with a mean age of 28 years. Specifically, respondents in age groups 15-24 years and 25-34 years represent 32.9, 45.5 percent respectively of the total sample as indicated in Table 1. Out of 435 wives captured, only 136 respondents (33.1 percent) have husbands with reproductive health challenges. Among this group, wives in the youngest age group (15-24 years) constitute 14.7 percent while the next older age group accounts for 44.1 percent of the total population. Out of 31.3 percent with husbands that have reproductive health challenges, 41.2 and 36.0 percent have attained primary and secondary education respectively. Only 12.5 percent have not attended any regular school among the wives where husbands have reproductive health problems.

Parity level shows that majority of the respondents (46.3 percent) whose husbands have reproductive health challenges have zero parity. The general pattern revealed lower parity level among those who have husbands with reproductive health challenges compared with the control group whose husband have no reproductive health challenges as shown in Table 1. Similar observation was made in terms of desired family size. Almost two-third (69.8 percent) desired 1-4 children among those with husbands with reproductive health challenges coupled while 19.9 percent desired higher fertility level (5 children and above). Where the challenges do not exist, 67.3 percent desires 1-4 children and 27.8 percent would prefer up to five children and above while a total of 35 (8 percent) wives refused to answer the question.

The specific male reproductive health challenges identified include erectile dysfunction, gonorrhea, low sperm count, testicular cancer, prostate cancer and prostate cancer. The proportion of respondents who have husbands with erectile dysfunction constitutes 33.8 percent which however translated into 10.5 percent of the total sample. Wives with husbands that have gonorrhea are 37.8 percent but represents only 12.7 percent of the total coupled surveyed. The proportion with low sperm count is 1.5 percent, testicular cancer (13.2%), prostate cancer (10.2%) and those with other types are just 5.0 percent. These latter group include those with genital herpes and other STIs. Overall, more than one-third of wives

whose husbands have reproductive health challenges have lower rate of sexual intercourse with their spouses.

The result also revealed that almost four-fifth (79.1 percent) of the total respondents were working as at the time of the survey while the remaining one-fifth were areeither full time housewives, full time students or are currently unemployed. This is in consonance with the 19.8 percent unemployment rate indicated for the nation (National Bureau of Statistics (NBS), 2010; National Population Commission (NPC), 2009; Onuba, 2010). The group of respondents identified as executive officers, chief executives of organizations is only 7.8 percent (Table 1). About 29.4 percent belongs to the clerical cadre while the artisans, skilled and unskilled workers constitute 41.8 percent.

Table 1. Percentage distribution of respondents by socio-demographic profile and husbasnds' reproductive health status

Selected Variables	Where Husbands have Sexual health disease		Husbands have no Sexual health disease		Total	
	No	%	No	%	No	%
Age Group						
15-24 years	20	14.7	123	41.1	143	32.9
25-34 years	60	44.1	138	46.2	198	45.5
35 years and above	56	41.2	38	12.7	94	21.6
Total	136	100	299	100	435	100
Religious Affiliation						
Christianity	61	44.9	167	55.9	228	52.4
Islam	50	36.8	99	33.1	149	34.3
Traditional	25	18.4	33	11.0	58	13.3
Occupational Status						
Executive Level	9	6.6	25	8.4	34	7.8
Clerical Officer	44	32.4	84	28.1	128	29.4
Artisan/Skilled/Unskilled	63	46.3	119	39.8	182	41.8
Housewife/Unemployed	20	14.7	71	23.7	91	20.9
Total	136	100	299	100	435	100
Educational Attainment						
No Schooling	17	12.5	34	11.4	51	11.7
Primary Education	56	41.2	55	18.4	111	25.5
Secondary Education	49	36.0	114	38.1	163	37.5
Tertiary Education	14	10.3	96	32.1	110	25.3
Total	136	100	299	100	435	100
Children Ever Born (CEB)						
Zero/No Child	63	46.3	36	12.0	99	22.8
1-2 children	51	37.5	62	20.7	113	26.0
3-4 Children	15	11.0	99	33.1	114	26.2
5 children and above	3	2.2	63	21.1	66	15.2
No Response	4	2.9	39	13.0	43	9.9
Total	136	100	299	100	435	100
Duration of Marriage						
Less than 5 years	66	48.5	115	38.5	181	41.6
5-9 years	62	45.6	110	36.8	172	39.5
10-15 years	8	5.9	74	24.7	82	18.9
Total	136	100	299	100	435	100
Desired Family size						
1-2	7	5.1	153	51.2	160	36.8
3-4	88	64.7	48	16.1	136	31.3

5 and above	27	19.9	83	27.8	110	25.3
No Response	14	10.3	15	5.0	29	6.7
Total	136	100	299	100	435	100
Frequency of Intercourse/month						
Once	60	44.1	94	31.4	154	35.4
Twice or more	26	19.1	132	44.1	158	36.3
Seldom	16	11.8	26	8.7	42	9.7
No Response	34	25.0	47	15.7	81	18.6
Total	136	100	299	100	435	100

Source: Field survey 2010

Mean age of respondents (All) = 28 years

Male Reproductive health diseases and spousal relationship

Table 2 indicated the level of spousal relationship where the husbands have reproductive health problems and where there is none. Although, there are several ways of measuring inter-spousal relationship (Kayla, 2010), the study only feature those indicators considered relevant to this study and specifically using personal assessment of the wives concerned. Among these variables are marital happiness, closeness and frequency of discussing sexual matters.

Marital happiness is conjectured as a perceived positive feeling about the marriage by each spouse that can likely enhance marital satisfaction. Similarly, marital satisfaction is the perceived level of happiness and support experienced by each spouse and fundamental to the dissolution or retention of marital relationship. It is also a potent ingredient in predicting and maintaining or preserving a functional marriage (Kayla, 2010). Observation from the wives also indicated that majority of the wives of husbands with sexual challenges indicated their unhappiness (66.9%) with their current marriage. As expected, the outcome of analysis of this variable for their counterparts is very low (22.7%). The proportion who indicated satisfaction with their marriages are 77.3 percent and belong the category without reproductive challenged husbands.

The level of husband/wife closeness is observed to be low where husband have reproductive health diseases compared to the control group where the diseases are not prevalent. While 65.4 percent of the wives of husbands indicated low or lack of close relationship with their husbands, 74.6 percent indicated the opposite where husband have never experienced sexual disease. The rate of discussing sexual matters among the couples is general observed to be low, however, it is abysmally lower among couples where husbands have reproductive health diseases compared to their counterparts where such diseases are claimed to be absent. Notwithstanding the present level of civilization, sexual matters are still very sacrosanct in sub-Saharan African region (Becker, 1976; Biddlecom & Greece, 1997; Nick, 2010).

Several coping strategies were indicated by the wives who are currently married to husbands with reproductive health challenges. Relatively one in every five wives indicated they seek help from relations to sustain the marriage especially in managing whatever conflict arise from the husband's reproductive health problem. While 37.5 percent of the wives of

husbands with reproductive health problem consult family doctors or their spiritual heads, certain proportion of the wives have considered quitting the relationship. Few of the respondents (8.8%) have resigned to fate and would regard the situation as their 'destinies' of the burned they must bear. Other strategies include soliciting for sexual partners (2.9%), regrets or self-blame (6.6%), confrontation (4.4%) and sex therapy (5.1%).

Table 2. Male Reproductive Challenges and Spousal Relationship

Selected Indicators of Marital Harmony	Where Husbands have Sexual health diseases		Husbands have no Sexual health diseases		Total	
	No	%	No	%	No	%
Reproductive Diseases						
Erectile dysfunction	46	33.8	NA	-	46	33.8
Gonorrhea	51	37.5	NA	-	51	37.5
Low sperm count	2	1.5	NA	-	2	1.5
Testicular cancer	18	13.2	NA	-	18	13.2
Prostate cancer	14	10.3	NA	-	14	10.3
Others	5	3.7	NA	-	5	3.7
Total	136	100	NA	-	136	100
Level of Couple's Closeness						
Close	47	34.6	223	74.6	270	62.1
Not Close	89	65.4	76	25.4	165	37.9
Total	136	100	299	100	435	100
Rate of discussing sexual issues with spouse						
Very often	11	8.1	77	25.8	88	20.2
Often	6	4.4	133	44.5	139	32.0
Not often	17	12.5	74	24.7	91	20.9
Not at all	102	75.0	15	5.0	117	26.9
Total	136	100.0	299	100.0	435	100.0
Wife's feeling about her marriage						
Happy	45	33.1	231	77.3	276	63.4
Not Happy	91	66.9	68	22.7	159	36.6
Total	136	100	299	100	435	100
Coping Strategies						
Self-blame	9	6.6	NA	-	9	6.6
Resigned to fate/Self-controlling	12	8.8	NA	-	12	8.8
Invite Relations/Seek support	30	22.1	NA	-	30	22.1
Consult Doctor/Spiritual heads	51	37.5	NA	-	51	37.5
Plan separation/Detachment	17	12.5	NA	-	17	12.5
Fight seriously/Confrontational	6	4.4	NA	-	6	4.4
Try other sexual partners	4	2.9	NA	-	4	2.9
Sex therapy	7	5.1	NA	-	7	5.1
Total	136	100	NA	-	136	100

Source: Field survey 2010

Logistic regression illustrating the effects of male reproductive diseases and conjugal satisfaction

The model formulated tested the impact of male reproductive health challenges on conjugal satisfaction using binary logistic regression analysis. However, suspected confounding factors such as demographic variables were adjusted for in the logistic analysis. The basic idea behind this is to confirm whether these characteristics moderate the relationship between marital satisfaction and the presence of reproductive health challenges. Succinctly put, to affirm whether changes in these background variables can predict a subsequent change in marital satisfaction notwithstanding that the husband is experiencing reproductive health disease.

From the result of the analysis, the common coping strategies identified among the wives range from “resignation to fate”, “seek support”, “confrontational attitude”, “consulting family doctors/spiritual heads” and “personal therapy”. The logistic regression indicated that all approaches employed by the wives are negatively associated with marital satisfaction except “consultation with family’s doctor/spiritual heads and sex therapy. However only the former shows a significant relationship at (p -value = 0.000). While the beta value recorded for sex therapy indicated high value ($\beta = 1.075$), it is on its own an inconsequential factor towards engendering conjugal satisfaction (Fileborn, Thorpe, Hawkes, Minichiello, Pitts & Dune, 2014) especially where the husband is experiencing sexual challenges (Table 3). The observation with family doctor could be true because the family doctor is mostly judged a confidant in family matters especially when it concerns with fertility/infertility and sexual problems (Hahn, Feiner & Bellin, 1988; Yahi, 2004). Evidences from the hypothesis tested shows that, where the husbands experience erectile dysfunction, gonorrhea, prostate or prostate cancer, the couples are 0.064, 0.583 and 0.898 times (respectively) less likely to enjoy marital satisfaction compared with others where such diseases are not present (see Table 3). However, only erectile dysfunction and low sperm count are statistically significant at p -values of 0.005 and 0.053 respectively (Table 3).

The result on intervening variables revealed that all occupational categories have significant negative relationships with conjugal satisfaction where the husbands have sexual health problems (Table 3). This implies that occupation or occupation categories are not key determinants of marital satisfaction where sexual health problem exist. Similarly, higher

educational attainment is found to be negatively associated with couple's satisfaction among those whose husbands have sexual health challenges.

Working wives, irrespective of positions they occupy, would less likely enjoy marital satisfaction where the husbands have reproductive health challenges. This revelation could be true because the problems of prostate cancer, low sperm count and gonorrhea directly affect sexual activity and fecundability of the wife which is the ultimate priority as far as the marriage is concerned (Warwick, 2006). This suffice to conjecture that, in a culture where infertility is decorated with stigma or regarded as a curse (Isiugo-Abanihe, 2003; Warwick, 2006), it is logical that the couple especially the wife would not be comfortable with husband's sexual challenge. Sexual intercourse is considered as the cement that binds conjugal relationship together and that failure of the husband (in this regards) introduces strain, worries and frustrations into the marriage (Burnett, 2006; Bayer Healthcare, 2008; Amidu, *et al*, 2011). Thus, sexual dysfunction or problem in sexual health of the husband portends great danger to couple's marital satisfaction.

Conclusion and Recommendations

The study concludes that education, occupation and intervention of family doctors/spiritual heads are vital to enduring marital satisfaction among the couples where the husbands have sexual problems. Stability in family will engender stable nation. Conjugal dissatisfaction affects the entire family which is the most elementary fabric of the society. If the family is in disarray, it is unlikely that the individuals and collectivities which are themselves products of such institution will possess the moral, intellectual and necessary oneness and enablement to accomplish the national developmental goals. Thus, it is paramount for marriage counselors, social workers and other health officials to focus on erectile dysfunction and low sperm count as major determinants of sustainable marriage and marital happiness. Governments and other stakeholders should focus on massive public awareness on male sexual diseases in order to promote enduring conjugal relationship. The author therefore suggests robust specialized reproductive healthcare services for effective servicing of the health needs of men who may be experiencing any sexual problem. Finally, the prevalence of these challenges in the study locations should be seen as window of opportunity for therapists to find solutions.

Table 3. Logistic Regression estimates of the effects experience of male reproductive diseases, demographic characteristics, coping strategies and on conjugal satisfaction

Selected Variables	B	S.E.	Wald	df	Sig.	Exp(B)
Reproductive Diseases						
No Reproductive Diseases	RC					
Experienced Testicular Cancer	0.364	0.579	0.395	1	0.530	1.439
Experienced Prostate Cancer	-0.107	1.353	0.006	1	0.937	0.898
Experienced Andropause	0.446	0.697	0.409	1	0.522	1.562
Experienced Erectile dysfunction	-2.747	1.038	7.004	1	0.008	0.064
Experienced Gonorrhea	-0.540	0.461	1.374	1	0.241	0.583
Low Sperm Count	1.106	0.577	3.676	1	0.053	3.023
Other STIs	0.645	0.684	0.889	1	0.346	1.905
Age Group						
35 years and above	RC					
15-24 years	3.323	.461	51.908	1	0.000	27.733
25-34 years	1.699	.392	18.799	1	0.000	5.467
Religious affiliation						
Traditional	RC					
Christianity	2.974	.906	10.783	1	0.001	19.567
Islam	2.153	.909	5.616	1	0.018	8.611
Occupation						
Housewife/unemployed	RC					
Senior Executive Officer	-5.762	1.234	21.802	1	0.000	.003
Middle/Manager/Officer	-4.392	1.230	12.752	1	0.000	.012
Clerical Staff/Other Officer	-5.100	1.109	21.147	1	0.000	.006
Artisan/Skilled labourer	-4.468	1.056	17.908	1	0.000	.011
Unskilled/Shop Asst	-3.674	1.054	12.144	1	0.000	.025
Education						
No Schooling	RC					
Up to Primary School	1.561	0.423	13.650	1	0.000	0.210
Up to secondary school	-2.274	0.351	42.061	1	0.000	0.103
Up to University	-1.284	0.327	15.409	1	0.000	0.277
Coping Strategies						
Self blame	RC					
Resigned to fate/Self-controlling	-0.060	0.545	0.012	1	0.913	0.942
Invite Relations/Seek support	-0.957	0.602	2.527	1	0.112	0.384
Consult Doctor/Spiritual heads	2.818	0.765	13.560	1	0.000	16.742
Plan separation/Detachment	-0.765	0.708	1.166	1	0.280	0.465
Fight seriously/Confrontational	-19.520	11.335	0.000	1	0.999	0.000
Try other sexual partners	-0.154	0.719	0.046	1	0.830	0.857
Sex therapy	1.075	0.727	2.189	1	0.139	2.930
Constant	4.652	1.130	16.956	1	0.000	104.772
-2 Log likelihood = 344.911			Cox & Snell R Square = 0.380			
Nagelkerke R Square = 0.527			Overall Percentage = 81.9			
Source: Field survey 2010			RC = Reference Category			

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