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Socio-Economic Profile and Sexual Health Problems among Adults In Owerri-North, South-East Nigeria.

Stella Osuji, Sally Ibeh, Greg Iwuoha,
Department Of Public Health,Federal University Of Technology Owerri, Imo State,Nigeria
Corresponding Author: Stella Osuji

***Abstract**: Sexual functioning of older adults is an important aspect of quality of life, which cannot be overlooked. This study adopted a cross-sectional descriptive survey design to investigate sexual health problems of adults aged 40-75 years and their socio-economic profile in Owerri-North Local Government Area of Imo State, South-Eastern Nigeria. A multi-stage sampling technique was used to select three hundred and ninety six (396) adults (163 males and 233 females) from both urban and rural dwellers, that participated in the survey. A Socio-Economic Profile And Sexual Health Problems Questionnaire (SEPASHPQ), developed by the researchers, with a reliability co-efficient of 0.70, using Crombach Alpha technique, was used to obtain data. Descriptive statistics (frequency and percentages) and inferential statistics (Chi square test of significance) were used for data analysis at 0.05 alpha level. Findings established that significant relationships exist between sexual health problems and socio-economic profile of adults in Owerri-North Local Government Area, Imo state, South-Eastern Nigeria. Notable significant relationships were revealed between sexual health problems and occupation, level of education and religion. Based on the conclusion, it was recommended among others, that hospitals and health centers should be well equipped and adequately staffed with experienced health professionals so as to effectively respond to sexual health problems of adults.*

***Keywords:** Sexual dysfunction, sexual health, sexuality, sexual response, socio-economic profile.*

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I. Introduction

Public health practice is said to be faced with increasing challenges associated with sexual health. The Federal Ministry of Health (FMOH, 2005), described sexual health as part of reproductive health which includes healthy sexual development, equitable and responsible relationship, sexual fulfillment and freedom from illness.

The World Health Organization (WHO, 2006), defined sexual health as a state of physical, emotional, mental and social wellbeing and relation to sexuality, not just the absence of disease, dysfunction or infirmity. WHO (2005), submitted that:

Sexual health can be attained and maintained if the sexual rights of all people be recognized and upheld, the rights to sexual freedom, sexual autonomy, sexual integrity and safety of the sexual body, sexual privacy, sexual equity and the right to sexual pleasure.

Sexual health, according to Coleman (2009), is an approach to sexuality founded in accurate knowledge, personal awareness and self-acceptance such that one's behavior and emotions that one congruent are integrated within one's wider personality. This implies that sexual health affirms sexuality as a positive force enhancing other dimensions of one's life.

Sexuality, which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction, is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors and relationships (WHO, 2012). As expressed by Samuel (2010), sexuality is part of the total person; physical, emotional, social, intellectual and spiritual. It is therefore experienced and expressed in all that we feel, think and do in our everyday life.

WHO(2004), identified different health concerns about sexual health during adulthood. These include genital pain or endometriosis, sexual trauma or violence, sexual dysfunction, mental health issues related to sexual health, the onset of perimenopause etc. Many people want and need to be close to others as they grow old. With ageing, this may mean adopting sexual activity to accommodate physical, health and other changes. For some, this may include the desire to continue an active, satisfying sex life.

That notwithstanding, normal ageing brings physical changes in both men and women, which sometimes affect the ability to have and enjoy sex. For instance, as a woman ages, her vagina can shorten and narrow and her vaginal walls can become thinner and a little stiffer, with less vaginal lubrication. These changes could make certain types of sexual activity, such as vaginal penetration painful or less desirable. Similarly, as men get older, impotence or erectile dysfunction (the loss of ability to have and keep an erection) becomes more

common. Erection may not be as firm as it used to be and the loss of erection after orgasm may happen more quickly or it may take longer before another erection becomes possible.

Some illnesses such as joint pain due to arthritis, diabetes, depression, stroke or disabilities, medicines and surgery can affect ability to have and enjoy sex. Loss of bladder control or leakage of urine is more common as people, especially women grow old. Extra pressure on the belly during sex can cause loss of urine.

Sexual health problems are health problems that affect sexuality, sexual relationship as well as the possibility of having pleasurable and safe sexual experience, free from coercion, discrimination and violence (WHO,2006). Sexual health problems vary widely, ranging from conditions that are perceived as part of life to those that constitute a threat to wellbeing and even to life (WHO,2012). The report noted that all of the problems demand attention from all segments of society including the health sector both through prevention and appropriate comprehensive care.

Addressing sexual health problems and finding solutions to them are crucial not only because they undermine sexual health, and the general health of individuals, family or society but also because their presence might also precipitate other health problems that constitute adverse consequences in the individual or the larger community (WHO,2012). Pereira, Nardi and Silva (2013) described sexual dysfunction as impairment in the sexual response cycle or the presence of pain associated with intercourse. The authors then categorized sexual dysfunction into four: desire disorder, arousal disorder, orgasm disorder and pain disorder.

The prevalence of sexual dysfunctions has been established and the problem of sexual syndromes has recently been highlighted for some population. For instances, Amber, Bieber and Diamond (2012), reported that 18% to 41% of women had difficulty reaching orgasm and it is the most common female problem across the globe.

Sexual health problems have been shown to significantly affect adult self-esteem and quality of life and could cause emotional distress, leading to relationship problems. They have been correlated with lower levels of life and with other health problems like heart diseases, hypertension, diabetes, associated medications and high indices of anger and depression. The HIV/AIDS pandemic has brought to public attention the extreme seriousness of sexually transmitted infections. About one million people are reported to die each year from reproductive tract infections (STIs) other than HIV/AIDS (Pan American Health Organization, PAHO & WHO, 2012).

Socio-economic factors are society-related economic factors that determine health, including employment, education and income (Staff, 2012). Employment state vis-a-vis one's occupation impacts on one's health, since this determines one's income. Employment also determines the kind of health challenges that may be experienced by an individual. For instance, people who work in mines are highly exposed to chemicals and dust inhalations, making them to be susceptible to lung infections and cancer, which may predispose them to sexual health problems (Arnold & Doctoroff, 2013).

Similarly, radiologists are often exposed to all kinds of radiations thereby making them more likely to suffer from cancer and genetic mutations that might culminate into impotence. On the other hand, people with physically active jobs/lifestyles such as farmers, sports coaches, community workers and priests /pastors, will have greater community involved and therefore be less prone to suffer sexual health problems compared to those with less physically active jobs.

Education influences not only one's choice of employment, but also directly impacts health. According to Staff (2012), people who have lower levels of education will also have lower levels of sexual health education and hence will more likely have sexual health problems since they lack information on such challenges.

Income, especially on a regular basis, through work or investment influences and helps to determine one's level of health. For instance one with higher income can afford to consult a physician to recover from sexual health problems while one from a lower socio-economic background cannot and may prefer trado-medicare thereby endangering one's health. High income earners can therefore afford to access better health facilities than lower income earners who may find it difficult to do so. Thus, a higher income provides one with a better choice.

These notwithstanding, certain sexual health problems predisposing factors and some medical conditions are age-related. For instance, hypertension, cancer and diabetes are commonly present in persons aged 40 and above. Cancer is reported among male adults in chemical and radiation industries, fish industries and aluminum industries because of their continuous inhalation of the chemicals used in the work place. Diabetes is reported among male adults in transportation, manufacturing /production industries, and business owners because of their high level of smoking, obesity, lack of exercise and less access to nutritious food.

Women experiencing psychosocial work stress report cases of type 2 diabetes which damages the nerves and blood vessels including those needed for good sexual functioning and also inhibits blood flow to the genitals which leads to less vaginal lubrication, less sexual desire as well as lack of sexual response.

Adults are supposed to enjoy sexual health and even when there are sexual health problems, they should be managed well to obtain good quality of life. However, many adults, irrespective of their socio-

economic profile, face sexual health problems which they find embarrassing to discuss with health care professionals and their partners, even when quality of life is threatened. This study therefore investigated the relationship between common sexual health problems and socio-economic profile of adults in Owerri-North Local Government Area, Imo State, South-East Nigeria.

Specifically, the objectives of the study were to:

1. Determine the socio-economic profile of adults in Owerri-North Local Government Area, Imo State.
2. Ascertain the common sexual health problems experienced by adults in Owerri-North Local Government Area, Imo State.
3. Verify the relationship between sexual health problems and socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

To achieve the above stated objectives, the following research questions were raised:

1. What is the socio-economic profile of adults in Owerri-North Local Government Area, Imo State?
2. What are the common sexual health problems experienced by adults in Owerri-North Local Government Area, Imo State?
3. What is the relationship between sexual health problems of adults in Owerri-North Local Government Area, Imo State and their socio-economic profile?

To further guide the achievement or the objectives, the following null hypothesis was formulated and tested at 0.05 level of significance:

H_{01}: There is no significant relationship between sexual health problems and the socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

II. Material and Methods

This study adopted a cross-sectional descriptive survey design which is ideal for gathering data to describe the current state of sexual health problems vis-a-vis the socio-economic profile of adults in Owerri-North, Imo State, for the purpose of drawing conclusion about the variables on the population (Frankfort-Nachmias & Nachmais, 2006).

Study Design: This study employed descriptive survey design.

Study Location: This study was carried out in Owerri North Local Government Area of Imo State Owerri North is a Local Government Area of Imo State, Nigeria with headquarters at Uratta. It has an area of 198 square km with a population of 93,093 males and 82,302 females at the 2006 census. The postal code of the area is 460.

Study Duration: January 2018 to April 2019

Sample size: 396 Adults from 40years – 75years old.

Sample size calculation: The sample size was determined using Taro Yamane's (1967:886) formula for determination of sample size which states that in a finite population, when the original sample collected is more than 5% of the population size, the corrected sample size is determined by using the Yamane's formula.

$$n = \frac{N}{(1 + N (e^2)}$$

Where n = Sample size, N = Study Population, E = Confidence Margin (0.05) at 95% confidence

Total population of adults within the age barrack of 40-75years old =

Therefore, using the formula Taro Yamane's formula

$$= \frac{37300}{1 + 37300 (0.05)^2}$$

Total sample size = 395.7 ≈ 396.

Subjects and selection method: A multi-stage sampling technique which also involved stratifying Owerri-North Local Government Area, into semi-urban and rural communities was used. Simple random sampling technique was then used to constitute a sample of three hundred and ninety six (396) adults (163 males and 233 females) from clusters of both semi-urban and rural communities in Owerri-North Local government Area of Imo State that participated in the study. Taro Yamen's formula was earlier used to determine the minimum sample size from the target population of adults in the study area aged between 40-75 years. A multistage sampling technique was used to select the study sample. In stage one, the Local Government was clustered into existing autonomous communities. The autonomous communities were made up of rural and semi urban autonomous communities. Simple random sampling was used to select thirty percent of semi-urban and rural autonomous communities and 5 rural autonomous communities were selected which include, Awaka, Agbala, Emii, Obibiezena and Ulakwa while 3 semi-urban autonomous communities were selected which include Egbu, Naze and Amakaohia and the proportional sample size from each of the selected autonomous communities were gotten using proportional stratified sampling technique. The second stage was the determination of the sectors of

the autonomous community to commence the selection of the households. It was gotten by dividing the autonomous community into four sectors and selecting the first sector to commence with by simple random sampling. After which, a bottle was spinned to select the direction to move.

The third stage was the selection of respondents from the communities by systematic random sampling technique. The determined sampling interval for each of the selected autonomous communities was employed. The first household (entry) was selected through simple random sampling (balloting) and thereafter, the sampling interval was maintained until the desired number of respondents was gotten.

Procedure methodology

A written informed consent was obtained from Institutional Review Board (IRB) of School of Health Technology, Federal University of Technology, Owerri for review and approval from Local Government Chairman of Owerri North LGA A socio-economic profile and Sexual Health Problems Questionnaire (SEPSHPQ) designed by the researchers was used to obtain data. This consisted of twenty seven (27) structured items made up of two sections. Section A of the instrument elicited socio-economic profile data of the respondents while section B consisted of twenty seven (27) short structured items which were used to provide answers to the research questions raised in the study.

The instrument was face and content validated by a team of experts in the field of Public Health. The questionnaire was submitted to the supervisor and two other experts in the field of Public Health. The instrument was vetted to ensure its appropriateness in relation to language, clarity, adequacy of content and ability to elicit accurate information in relation to the purpose of the study. Based on the criticisms and suggestions made by the experts, the initial drafts of the instrument were modified.

A pilot study of the instrument on twenty (20) adults from a non-participating Local Government Area with similar characteristics with the study group yielded a reliability co-efficient of 0.70, using Cronbach Alpha technique. This indicated that the SEPASHPQ instrument was valid and reliable for the study.

A face-to-face method was adopted by the researchers with the help of four research assistants, trained for this purpose by the researchers, in administering the questionnaire to the respondents to ensure 100 percent retrieval. The items were read and explained to the respondents to enable them choose appropriate options that applied to them. The administration and collection of the questionnaire spanned through a period of 3 months.

Data collected were analyzed using descriptive statistical tools of frequency and percentages which provided answers to the research questions while the Chi Square Statistics tested the null hypothesis, at 0.05 level of significance. Data analysis was performed using the Statistical Package for Social Sciences (SPSS) version 21 and Microsoft Excel 2010.

III. Results

Socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

The result in table I shows that 227(57.3%) of the respondents were aged between 40-49 years, 92(23.2%) were aged 50-59 years while 74(18.7%) were 60-69 years old. Only 3(0.8%) were at least 70 years old.

With respect to gender, 233(58.8%) were females while 163(41.2%) were males. In terms of marital status, table I further displayed that 221(55.8%) were married 170 (42.9%) were single while 4 1.0%) were widowed.

Educationally, 375(94.7%) had tertiary education, 12(3.0%) had secondary education while 6(1.5%) had no formal education. Three (3) respondents or 0.9% had primary education.

With respect to occupation, 196(49.5%) of the respondents were civil/public servants, 72(18.2%) were traders or business people, 49(12.4%) were farmers while 41(10.4%) were students. Thirty three (33) or 8.3% of the respondents were artisans while 5(1.3%) where unemployed.

In terms of religion, table I also showed that 389 (98.2%) were Christians while 7(1.8%) were Muslims. Other religions such as Traditional religion etc were not represented.

Table I: Socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

Socio-Economic profile	Frequency (N= 396)	Percent (%)
Age in years		
40 -49	227	57.3
50 – 59	92	23.2
60 -69	74	18.7
70+	3	0.8
Total	396	100
Gender		
Male	163	41.2
Female	233	58.8
Total	396	100

Marital Status		
Single	170	42.9
Married	221	55.8
Divorced	1	0.3
Widowed	4	1.0
Total	396	100
Education Level		
Primary	3	.9
Secondary	12	3.0
Tertiary	375	94.7
Non-formal	6	1.5
Total	396	100
Occupation		
Farming	49	12.4
Business/ Trading	72	18.2
Civil/ public servant	196	49.5
Artisans	33	8.3
Students	41	10.4
Others	5	1.3
Total	396	100
Religion		
Christianity	389	98.2
Islam	7	1.8
Traditional	0	0.0
Total	396	100

Sexual health problems of adults in Owerri-North Local Government Area, Imo State.

The results in table 2 indicated that out of 163 male respondents, 123(75.5%) never experienced poor/weak erection while 33(20.2%) sometimes experienced poor/weak erection. Sixty four (64) or 39.3% identified sickness as the cause of poor erection, 35(21.4%) are not happy with their sexual partners while 27.6% could not identify the cause of their poor /weak erection.

In the females, 120(51.5%) never experienced poor/delayed sexual arousal, 59(23.3%) sometimes experience it while 42(18%) always experience poor/delayed sexual arousal. Furthermore, 83(35.6%) acknowledged that sickness is the cause of poor/delayed sexual arousal, 28.3% think that it is as a result of not being happy with their sexual partners while 35(15%) thinks that it is due to emotional upset.

With respect to experiencing orgasm, 210(53.0%) of the respondents experience orgasm during sexual intercourse while 53(13.4%) never experience orgasm during sexual intercourse. Forty one (41) or 10.4% of the respondents admitted that they have suffered from one form of sexually transmitted infection (eg gonorrhea, candidiasis, trichomoniasis, syphilis, HIV etc) in the last six months.

The relationship between common sexual health problems and socio-economic profile of adults in Owerri-North is determined using hypothesis one (Ho_1):

There is no significant relationship between sexual health problems and the socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

Table 2: Sexual health problems of adults in Owerri-North Local Government Area, Imo State.

Sexual Health Problems	**Number**	**Percent (%)**
Do you have poor/weak erection (for men)? (n=163)		
Never	123	75.5
Sometimes	33	20.2
Non response	7	4.3
Total	163	100
What do you think is the cause of poor erection (for men)? (n=163)		
Not happy with sexual partner	35	21.4
Sickness	64	39.3
Use of medicinal drugs	16	9.8
Surgery	1	0.6
Emotional upset	1	0.6
Do not know why	45	27.6
Others	1	0.6
Total	163	100
Do you experience poor/delayed sexual arousal (for women)? (n=233)		
Never	120	51.5
Sometimes	59	23.3
Always	42	18.0
Non response	12	5.2
Total	233	100
What do you think is the cause poor/delayed sexual arousal (for women)? (n=233)		
Not happy with sexual partner	66	28.3
Spiritual attacks (eg witchcraft projections from enemies, etc)	3	1.3

Sickness	83	35.6
Use of medicinal drugs	17	7.3
Emotional upset	35	15.0
Do not know why	24	10.3
Others	3	1.3
Non response	2	0.9
Total	233	100
How often do you climax or experience orgasm during sexual intercourse?		
Never	53	13.4
Sometimes	96	24.2
Always	210	53.0
Non response	37	9.3
Total	396	100

Sexual health problems and socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

A Chi Square test of significance was used in testing the hypothesis and the results are presented in table 3. The results in table 3 showed that significant relationship exists between sexual health problems and respondents' age 40-49 years ($P<0.001$, $X^2 = 47.205$). Significant relationship also exist between sexual health problems and gender ($P<0.006$, $X^2 7.528$), education ($P<0.017$, $X^2 = 10.144$), occupation ($P<0.001$, $X^2 = 89.264$) and religion ($P<0.001$, $X^2 = 13.518$). A closer look at table 3 further showed that the highest proportion of those who experienced sexual health problems were within the age bracket of 40-49 years where 67 (29.5%) of the respondents indicated that they have had sexual health problems. Similarly, more males 40(24.5%) experienced sexual health problems than the females 32(13.7%).

Educationally, half of the respondents, (6 or 50%) with secondary education indicated that they had experienced sexual health problems. With respect to occupation, sexual health problems were found highest among business people/traders (39 or 54.2%), followed by public/civil servants (32 or 16.3%). It was also found higher among few Islamic participants (5 of 7 or 71.4%) compared to the Christians (67 of 389) or 17.2%.

These results indicated that hypothesis one (Hoi) was rejected showing that significant relationship exists between sexual health problems and social economic profile of adults in Owerri-North, Imo State.

Table 3: Sexual health problems and socio-economic profile of adults in Owerri-North Local Government Area, Imo State.

Socio-economic Factors	Total	Experience of Sexual Health Problems				Chi-square (χ^2)	p value
		Yes	Percent (%)	No	Percent (%)		
Age in years							
40 -49	227	67	29.5	160	70.5		
50 – 59	92	0	0.0	92	100		
60 -69	74	5	6.8	69	93.2		
70+	3	0	0.0	3	100		
Total	396	72	18.2	324	81.8	47.205	<0.001
Gender							
Male	163	40	24.5	123	75.5		
Female	233	32	13.7	201	86.3		
Total	396	72	18.2	324	81.8	7.528	<0.006
Current marital Status							
Single	170	39	22.9	131	77.1		
Married	221	33	14.9	188	85.1		
Divorced	1	0	0.0	1	100		
Widowed	4	0	0.0	4	100		
Total	396	72	18.2	324	81.8	5.269	0.153
Education Level							
Primary	3	1	33.3	2	66.7		
Secondary	12	6	50.0	6	50.0		
Tertiary	375	65	17.3	310	82.7		
Non-formal	6	0	0.0	6	100		
Total	396	72	18.2	324	81.8	10.144	0.017
Occupation							
Farming	49	1	2.0	48	98.0		
Business/ Trading	72	39	54.2	33	45.8		
Civil/ public servant	196	32	16.3	164	83.7		
Artisans	33	0	0.0	33	100		
Students	41	0	0.0	41	100		
others	5	0	0.0	5	100		
Total	396	72	18.2	324	81.8	89.264	<0.001
Religion							
Christianity	389	67	17.2	322	82.8		
Islam	7	5	71.4	2	28.6		
Total	396	72	18.2	324	81.8	13.581	<0.001

IV. Discussion

The findings of this study indicated that significant relationship exits between sexual health problems and age ($P<0.001$, $X^2= 47.205$). Sexual health problems were prevalent among respondents within the age bracket of 40-49 where 67 (29.5%) indicated having had sexual health problems. There was a significant relationship between sexual health problems and gender ($P<0.006$, $X^2=7.528$). The male respondents (24.5%) experience more sexual health problems then the females (13.7%). This finding buttresses the findings of Yakubu (2017) which reported that females experienced slightly lower sexual health problems than men. The finding however, disagrees with global prevalence rate of sexual health problems which stands at between 20-30 percent for men and 40-45 percent for women. Amber at al (2012), reported that 18% to 41% of women had difficulty reaching orgasm and that it is the most common sexual health problem across the globe.

Level of education also has a significant relationship with sexual health problems ($P<0.017$, $X^2 = 10.144$). The respondents in the secondary education category (6 or 50%) indicated that they have experienced sexual health problems at one time or the other within the last six months. This finding is in consonant with the study of Van Zon, Reijneveld Mendes de Leon and Bultman (2017), which showed evidence that low level of education is highly associated with poor health status. Staff (2012), reported that people who have lower levels of sexual health education and will more likely have sexual health problems since they may lack information on such challenges.

With respect to occupation, a significant relationship was also indicated between sexual health problems of the adults and their occupation ($P<0.001, X^2=89.264$). Table 3 revealed that the traders (54.2%) had sexual health problems followed by the civil/ public servants (6.3%).

A significant relationship was also established between sexual health problems of the adults and their religion ($p<0.001$, $X^2 = 13.581$). The Islamic respondents (71.4%) had sexual health problems as against 17.2% of Christians.

V. Conclusion

The result of this study highlighted significant relationships between common sexual health problems and socio-economic characteristics of adults. Reasonable proportion of adults experience sexual health problems that cut across gender, age, level of education and religion. Based on the findings of this study, it was concluded that the factors that contribute to sexual health problems be properly addressed through adequate health promotion practices and intervention both at state and national levels

VI. Recommendations

Based on the findings of this study the following recommendations were made:

1. Hospitals and health centers should be well equipped and adequately staffed with experienced health professionals so as to adequately respond to sexual health problems of adults.
2. Health–promoting behaviors and interventions should be encouraged for early identification of sexual health problems including regular check-ups and screening, testicular self-scans as well as reduced cost of treat

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