

Original Research Article

Semen Quality Among Men Seeking Infertility Treatment in Tamale, Ghana.

ABSTRACT

Background: Standard semen analysis is the surrogate measure of male fertility in clinical practice. According to recent studies, there is a slight increase in percentage of couples who are facing infertility problems globally. This study determined the semen quality trends of men seeking infertility treatment in the Tamale Metropolis.

Methods: This is a retrospective cross-sectional study with data from archival records over a period of six years; from January 2015 to December 2020.

Results: A total of 785 semen analysis reports of men seeking infertility treatment over a period of 6 years were considered. In all, 187 (23.82%) had normozoospermia, 347 (44.20%) had oligozoospermia, and 251 (31.97%) had azoospermia. Out of the 785 subjects, 344 (57.91%) had abnormal semen parameters even though their semen volume was normal. Percentage abnormal motility, morphology and viability rose sturdily from 5.74%, 8.14%, and 12.59 in 2015 through 20.87%, 18.77%, 19.85% in 2017 to 26.85%, 27.95 and 21.55 respectively in 2020. Abnormal pH and volume also rose from 8% and 8.59 in 2015 to 23.69 and 24.91 respectively in 2020

The highest variances were seen in the age group 31-40 years ($p < 0.0001$). Males with hypospermia were 56% less likely to have abnormal sperm concentration than those with hyperspermia (OR=0.44; 95% CI=0.23–0.83; $p = 0.012$).

Conclusion: This study shows a high rate of abnormal semen quality of male partners of infertile couples. The trend of oligozoospermia increased during the past six years while the trend of normozoospermia remain fairly constant. Oligoasthenoteratozoospermia has increased consistently from 2015 to 2020, buttressing the fact that, male infertility is on the ascendancy.

Keywords: infertility, semen quality, oligozoospermia, azoospermia, morphology, motility, sperm count

INTRODUCTION

Male infertility is known to contribute to about half of all infertility cases. According to recent studies by the WHO, approximately 8-10% of couples are facing some kind of infertility problem. Semen quality is a significant factor which reflects male reproductive health. According to Jensen *et al.* (2002), low semen quality may be a potential contributing factor in reducing fertility rates and the use of assisted reproductive technology (ART) may improve the number of children born to such individuals. Meta-analysis show that there has been a 57% reduction in sperm concentration around the globe over the past 35 years, a 32.5% decline over the past 50 years in Europe, and a 72.6% decline found in Africa over the past 50 years (Sengupta, Nwagha, Dutta, Krajewska-Kulak, & Izuka, 2017).

In Ghana, studies have shown that the prevalence of male infertility is higher than females (Blay *et al.*, 2020). Base on the literature reviewed, there is a gap in knowledge on semen quality trends; the prevalence of normospermia, the relationship between semen volume and other semen quality parameters in the Tamale metropolis. Increasing male age is associated with increased time to conception. This reflects the age-related increase in acquired medical conditions, decreases in semen quality, and increasing rates of DNA fragmentation seen in sperm. Also, there is an association between the age of the male partner and the incidence of birth defects and chromosomal abnormalities (Dain *et al.*, 2011). Therefore, this study aims to determine the semen quality trends men seeking infertility treatment in the Tamale Metropolis.

Study Area and setting

The study was conducted in the Tamale Metropolis of the Northern region of Ghana. The Metropolis has five (5) hospitals, nine (9) health centers, and twenty-eight CHPS. Out of the five hospitals, one is a Teaching Hospital serving as a referral hospital for the Northern part of Ghana (GSS, 2014). The study employed a retrospective cross-sectional study design.

Data Collection Methods

Secondary data spanning the period of 2015 to 2020 were collected. Semen quality data was sourced from the databases of Tamale Teaching Hospital into a Microsoft Excel document-based on the variables of the study indicated in the structured extraction sheet. The extraction sheet consisted of variables such as year, age, and all semen parameters.

Data Management and Analysis

STATA version 16.0 statistical software and Microsoft Excel 2019 was used for data analysis. Frequencies and percentages were calculated for categorical data. Means and standard deviations were calculated for normally distributed continuous data. Trends in semen parameters over the study years were assessed using Microsoft Excel 2019. Independent t-test was used to analyze continuous variables and presented as tabulated means and standard deviations. Linear and multiple regression models were used to examine the relationship between age with each semen parameter while potential confounding factor were controlled. All statistical tests with p values < 0.05 were interpreted as statistically significant. Results were presented in tables and charts.

RESULTS

Distribution of semen parameters across the study duration

Table 1 depicts the distribution of semen analysis outcomes from 2015 to 2020 in the Tamale Metropolis. Of a total of 785 semen analysis report of men seeking infertility treatment analysed over a period of 6 years, 187 (23.82%) had normozoospermia, 347 (44.20%) had oligozoospermia, and 251 (31.97%) had azoospermia.

Yearly semen quality trends

Figure 1 shows a rise in the percentage of oligozoospermia cases over the 5 years period; thus, 35.50% in 2016, 40.60% in 2017, 47.43% in 2018, 53.63% in 2020. There was a decline in azoospermia cases from 38.27% in 2015 to 15.94% in 2020.

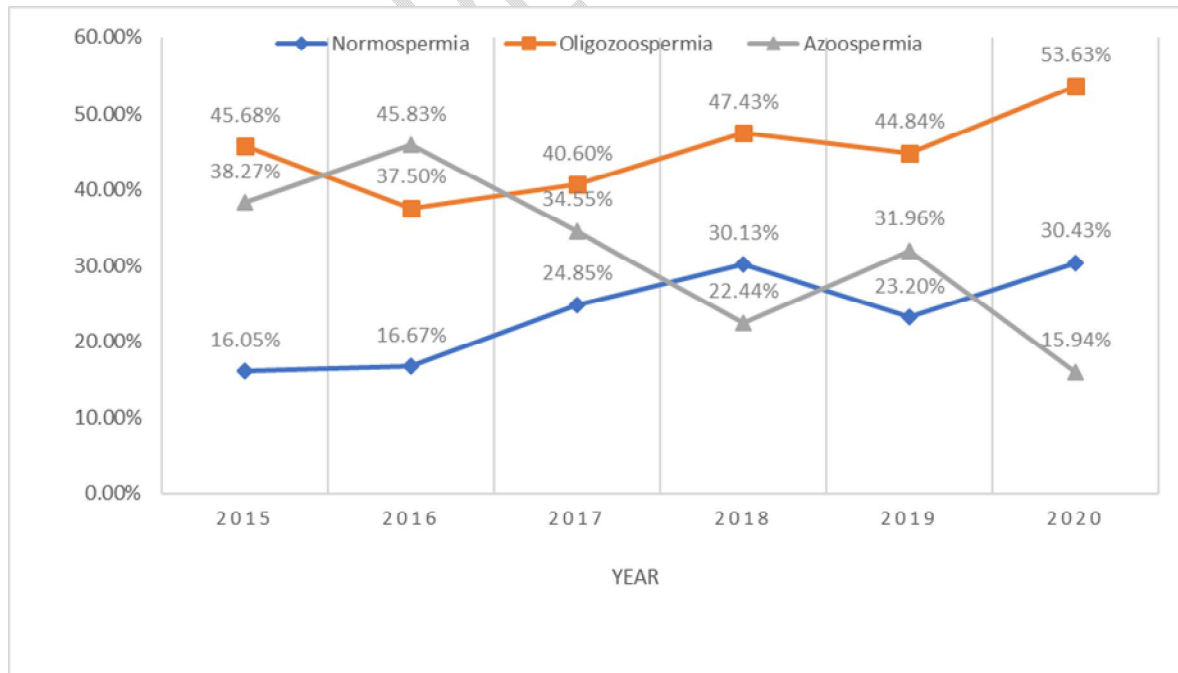


Figure 1: Yearly trend of sperm concentration in the last six years (2015-2020)

Comparison of semen parameters between normozoospermia and oligozoospermia

Table 1 compares semen parameters such as sperm concentration, volume, viability, pus cell, motility, morphology, and pH among subjects with oligozoospermia and normospermia. Subjects with normospermia had significantly higher percentage of sperm cells with normal morphology ((99.15±46.29%) compared with subjects with oligospermia (72.02±14.31%) ($p = 0.014$). Viability was higher in the normospermia group (78.60±29.24) compared with the oligozoospermia group (57.63±38.77) ($p = 0.023$) (Table 2).

Table 1 Comparison of semen parameters between normozoospermia and oligozoospermia

Category	Normozoospermia	Oligozoospermia	p-value
Volume	2.72±1.06	2.56±1.13	0.177
Viability	78.60±29.24	57.63±38.77	0.023
Pus cells	7.69±6.51	7.47±4.18	0.691
MOT	82.04±41.46	68.01±33.60	0.151
MOP	99.15±46.29	72.02±14.31	0.014
pH	8.08±0.44	8.11±0.50	0.616

* $p < 0.05$ is considered significant; MOT = Motility; MOP = Morphology.

Percentage of males with azoospermia, oligozoospermia and normozoospermia

Using WHO standard for semen normality (Butt & Akram, 2013b), a total of 187 subjects (23.82%) had normozoospermia (spermatozoa concentrations greater than 20 million per milliliter), 347 (44.20%) had oligozoospermia (spermatozoa concentration less than 20 million per milliliter), and 251 (31.97%) had no spermatozoa in the sediment of the ejaculate after centrifugation.

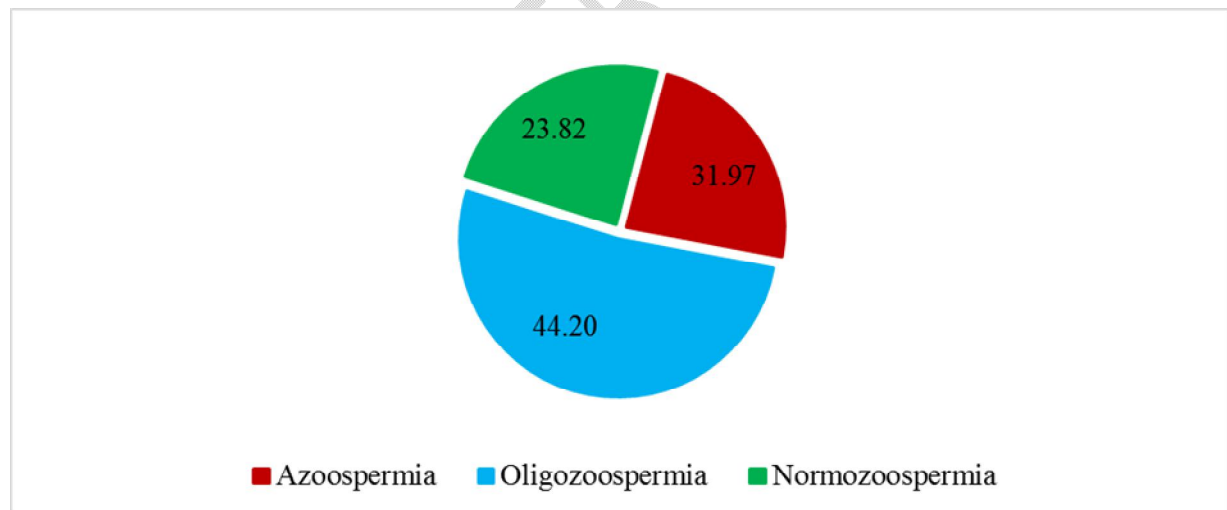


Figure 2: Percentage distribution of sperm concentration among participants

Relationship between age group and semen concentration

Table 2 compares semen analysis outcomes according to age groups. The mean age of the study subjects was 35.29±7.98. Only 14.74% of subjects >40 years had normal semen quality. The percentages of azoospermia and oligozoospermia were highest at 43.01% and 47.78% respectively between the ages of 31 to 40 years but are low at 25.81% and 24.88% respectively between the ages of 21 to 30 years. These differences were statistically significant ($\chi^2=26.71$, (diff=4), $p < 0.0001$).

Table 2: Relationship between age group and semen findings among males

variable	Semen Findings			χ^2 ; (diff); p-value
	Azoospermia n (%)	Oligozoospermia n (%)	Normozoospermia n (%)	
Age group (year)				26.71; (4), 0.000 *
21-30	48 (25.81)	101 (24.88)	80 (42.11)	
31-40	80 (43.01)	194 (47.78)	82 (43.16)	
>40	58 (31.18)	111 (27.34)	28 (14.74)	
Total	186 (100.00)	406 (100.00)	190 (100.00)	

* Statistically significant at $p < 0.05$; diff: Difference; χ^2 : Chi-square value

Univariate logistic regression analysis of age group and abnormal semen quality

Logistic regression analysis was conducted to ascertain the strength of association between age and abnormal semen quality. Results of the binary logistic regression indicated that, males within 31- 40 years were significantly 2 times more likely to have abnormal semen quality as compared to those within 21-30 years (OR = 1.79; 95% CI = 1.24 – 2.59; $p = 0.002$). Similarly, males above 40 years of age were significantly 3 times more likely to have abnormal semen quality as compared to those within 21-30 years (OR= 3.24; 95% CI = 2.00 – 5.26; $p < 0.0001$) (Table 3).

Table 3: Univariate logistic regression analysis of age group and abnormal semen quality

Variable	Abnormal semen quality		
	Odds Ratio	95% Confidence Interval	p-value
Age group (years)			
21-30	1		
31-40	1.79	1.24 – 2.59	0.002 *
>40	3.24	2.00 – 5.26	0.000 *

* Statistically significant at $p < 0.05$

Relationship between semen volume abnormal sperm concentration

Semen volume was categorized into hypospermia (<2ml), normospermia (2-5ml) and hyperspermia (>5ml). The majority of the subjects (58.22%) were normospermic, while only 41.78% had abnormal semen volume; this comprised 35.41% with hypospermia and 6.37% with hyperspermia (Table 4).

Table 4: Distribution of semen volume

Volume	Frequency (N=785)	Percentages (%)
Normospermia (2-5mls)	457	58.22
Hypospermia (<2 mls)	278	35.41
Hyperspermia (>5 mls)	50	6.37

Association between semen volume and abnormal sperm concentration

Pearson chi-square test analysis was conducted to establish the relationship between semen volume and abnormal sperm concentration (Table 5). The highest abnormal sperm concentration 344 (57.91%) was seen in normal semen volume (normospermia), followed by hypospermia 219 (36.87%). The bivariate analysis showed that, there was a statistically significant association between semen volume and sperm concentration (normal, and abnormal) ($\chi^2=6.57$, (diff=2), $p=0.037$).

Table 5: Association between semen volume and abnormal sperm concentration

Variable	Sperm concentration		X ² ; (diff); p-value
	Normal n (%)	Abnormal n (%)	
Semen volume			
Normospermia (2-5ml)	113 (59.16)	344 (57.91)	6.57; (2); 0.037*
Hypospermia (<2 ml)	59 (30.89)	219 (36.87)	
Hyperspermia (>5 ml)	19 (9.95)	31 (5.22)	

* Statistically significant at $p < 0.05$; diff: Difference; X²: Chi-square value

Univariate Logistic Regression analysis of semen volume and abnormal sperm concentration

To determine the strengths of association between semen volume and abnormal sperm concentration, logistic regression analysis was performed. The binary logistic regression revealed that significantly, males with hypospermia had 56% less chance than those with hyperspermia to have abnormal sperm concentration (OR=0.44; 95% CI=0.23–0.83; $p=0.012$) (Table 6).

Table 6: Univariate Logistic Regression analysis of semen volume and abnormal sperm concentration

Variable	Abnormal sperm concentration		
	Odds Ratio	95% Confidence Interval	p-value
Semen volume			
Normospermia (2-5ml)	0.82	0.57 – 1.17	0.277
Hypospermia (<2 ml)	1		
Hyperspermia (>5 ml)	0.44	0.23 – 0.83	0.012*

* Statistically significant at $p < 0.05$

Trend of abnormal semen parameters

Percentage abnormal motility, morphology and viability rose steadily from 5.74%, 8.14%, and 12.59 in 2015, through 20.87%, 18.77%, 19.85% in 2017 to 26.85%, 27.95 and 21.55 respectively in 2020. Abnormal pH and volume also rose from 8% and 8.59 in 2015 to 23.69 and 24.91 respectively in 2020 (figure 3).

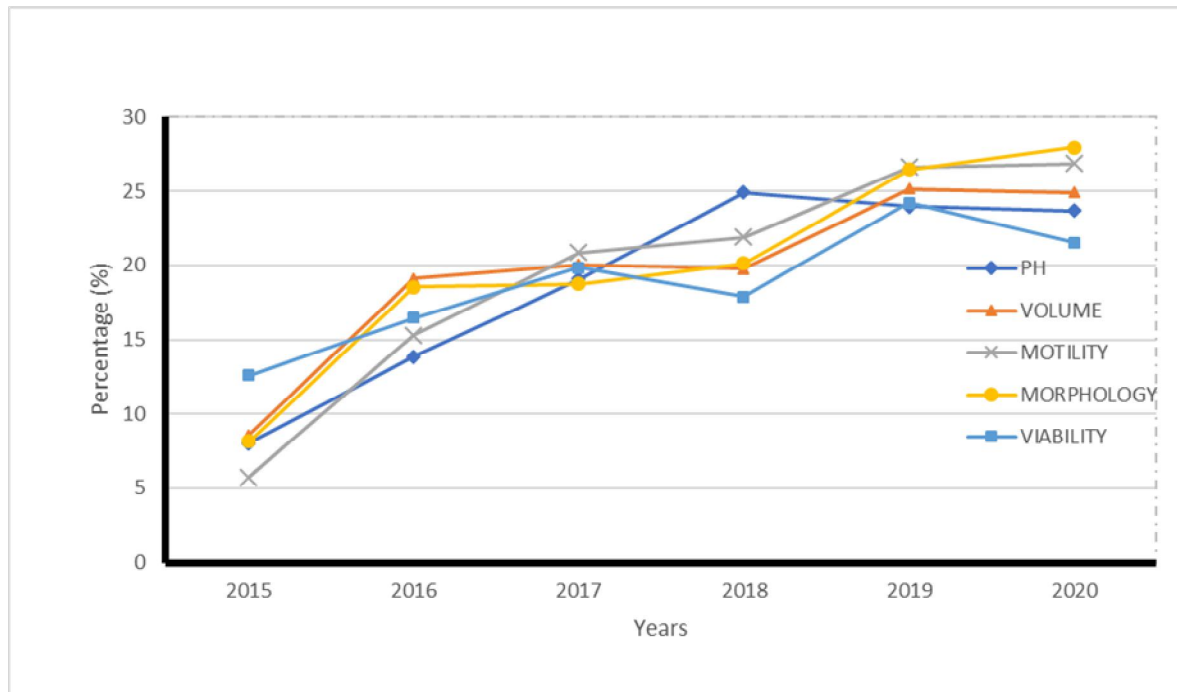


Figure 3, Percentage frequencies of abnormal semen parameters

DISCUSSION

Infertility has been a subject of debate and the female partners have always had to bear the brunt of the sociocultural connotations of this multifaceted issue (Milardi *et al.*, 2012). Advancements and progress made in novel assisted reproductive techniques established males to be equal, if not higher contributors to this complex problem (Li *et al.*, 2019). Despite education and enlightenment, the social attitude towards infertility results in much trauma, emotional instability and psychological stress, which in turn has an adverse bearing on the physiology of the individual, particularly in the northern Ghana social set-up, where there has been strong emphasis on child-bearing (Butt *et al.*, 2013). This study determined the semen quality trends in males seeking infertility treatment in Tamale from 2015 to 2020.

Semen analysis provides some insight into the pathology of the male genital tract (Butt *et al.*, 2013; Rikhasor *et al.*, 2001b). Being a hospital base study, the findings of this study should be carefully applied to the general population. Earlier studies in Ghana revealed that, the prevalence of male infertility is 15.8% and 11.8% in females (Blay *et al.*, 2020). Similar studies conducted by Samal *et al.* (2012) reported the incidence of male infertility as 62%, and 38% at Abakaliki in south eastern Nigeria by Ugwuja *et al.* (2008). Blay *et al.* (2020) concluded that, a good semen quality increases the probability of conception and the male factor is responsible for infertility about 90% of the time.

This study shows declining semen quality in Tamale for the last six years. Semen volume is significantly associated with sperm concentration (tables 4, 5 and 6). In this study, majority of the subjects had normospermia, followed by hypospermia, and few of the participants present with hyperspermia. Reduced ejaculated volume can reflect abnormalities in accessory sex gland's fluid synthesis ability (Corona *et al.*, 2012). It can also be indicative of a physical obstruction in the reproductive tract or in cases of incomplete retrograde ejaculation. In this study, mean ejaculate volume in normospermics was significantly higher than the mean ejaculate volume in oligozoospermic samples (Table 6). Subjects with hypospermia are significantly less likely to have abnormal sperm concentration than subjects with hyperspermia. This is because, hyperspermia led to a dilution of the sperm concentration, leading to lower sperm count in the hyperspermia group. The result is comparable to a study conducted in Sudan where majority of the subjects (89.7%) had normal semen volume, only 10.3% had abnormal semen volume (Ahmed *et al.*, 2009). The present study results are comparable with a study conducted in Nigeria in which majority of the subjects (91%) had normal

semen volume, only 9% had abnormal semen volume i.e 7.3% hypospermia and 1.7% hyperspermia (Nwafia *et al.*, 2006). The observed hypospermia may be related to insufficiency of the bulbourethral glands, seminal vesicles, vas-deference, seminiferous tubules in the testicles, epididymis and the prostate glands because these organs secrete seminal plasma (Frydman *et al.*, 2016). This result suggests that seminal fluid volume plays an important role in the etiology of male infertility.

Oligozoospermia is on the rise among subjects, especially among subjects above 31 years, but lower in subjects 30 years and below (table 3). The result of the present study reveals that, a higher percentage of participants had oligozoospermia compared with participants with azoospermia (figure 2, Table 2). This observation may be attributable to a myriad of causes including a decline in testosterone and testicular function, leading to a depression in spermatogenesis. In their study, Nsonwu-Anyanwu *et al.* (2019) observed a reduction in the antioxidation capabilities of Vitamin E and Glutathione, whose concentrations are lower in the blood of azoospermic and oligozoospermic participants. This leads to higher oxidative stress amongst infertile participants, resulting in damage to spermatozoa by reactive oxygen species (Bhardwaj *et al.*, 2000), resulting in oligospermia.

Various semen quality disorders responsible for infertility such as oligozoospermia and azoospermia recorded in this study are major contributory factors to infertility in Ghana, and are in agreement with earlier studies in Ghana by Gyasi-Sarpong *et al.* (2017) and Ikechebelu *et al.* (2003), Nwafia *et al.* (2006), Ugwuja *et al.* (2008) in Nigeria. These factors may be responsible for the poor semen analysis outcomes obtained by the use of conventional infertility treatment methods (Blay *et al.*, 2020a; Gyasi-Sarpong *et al.*, 2017). In many studies, the reported incidence of azoospermia ranges between 12.32% to 16% (Kumar *et al.*, 2015; Rikhasor *et al.*, 2001; Butt *et al.*, 2013; Samal *et al.*, 2012), and oligozoospermia approximately 33% (Jequier, 2010; Butt *et al.*, 2013; Kumar *et al.*, 2015; Samal *et al.*, 2012) which are lower compared to the findings of this study. The higher prevalence of oligospermia and azoospermia identified in this study compared to earlier studies could be attributable to the fact that this study is a hospital base study conducted amongst participants seeking treatment for infertility. They may already be known to have one deleterious semen dysfunction for which they seek treatment.

In addition, this study revealed that the overall trend in semen quality declined throughout the study period. Cumulatively, the frequencies of abnormalities detected in semen pH, volume, motility, morphology and viability increased steadily during the study period. Lower semen pH coupled with lower semen volume may indicate an impairment to the release of seminal plasma as a result of an obstruction. Higher seminal plasma pH can be attributed to infections of the reproductive system. Laboratory turn-around time also greatly impacts semen pH, such that after ejaculation, semen pH increases with delays in sample analysis. Abnormal pH reduces the sperm's ability to fertilize an ovum.

The result of this study shows that, oligozoospermia and azoospermia have the highest frequency among the age group 31 – 40 years and above. There is a statistically significant association between advanced male age (31–40 years and above) and abnormal semen quality (Table 3). This study finding is congruent with several earlier studies (Urhoj *et al.*, 2014; Das *et al.*, 2013; Oliveira *et al.*, 2014). A retrospective study conducted among 933 male partners of women attending the fertility clinic in Chandigarh, India by Baliyan *et al.* (2017) and in Nigeria by Owolabi *et al.* (2013) all reported an age-related decline in semen quality.

One plausible explanation for these results could be as a result of an age-related increase in reproductive tract oxidative stress and/or increased testicular germ cell death as older men may generate more sperm with DNA damages (Crosnoe *et al.*, 2013; Dain *et al.*, 2011; Frydman *et al.*, 2016). Oxidative stress within the testis and reproductive tract can damage sperm DNA, as well as, the sperm mitochondrial and nuclear membranes (Das *et al.*, 2013). Germ cell apoptosis during spermatogenesis is a normal event, however, this process may be less effective in older men resulting in the release of more DNA-damaged sperm (Kumar *et al.*, 2015; Samal *et al.*, 2012). Indeed, older male testes may have lower apoptotic frequencies than young adult's testes (Lirdi *et al.*, 2008). While apoptosis has been discovered in the testes of older men, no studies have been conducted to compare the rates of germ cell death in men of various ages (Park *et al.*, 2022). Studies also show that there is a 1.6% decrease in serum testosterone levels with age, with free and bioavailable levels reduce by 2-3% (Stanworth and Jones, 2008). Testosterone plays a major role in

semen production and maturation, hence, increase in age may lead to increase in abnormal semen quality (Stanworth and Jones, 2008).

Good sperm motility is a requisite for normal fertilization. Spermatozoa travel a long-distance to meet and fertilize the oocyte, so motility comes with sperm maturation in their passage through the epididymis. The process of epididymal sperm maturation occurs under the influence of epididymal proteins and other substances which produce structural and biochemical changes in the sperms. Thus, motility is chiefly a parameter of male infertility and the reason for intracytoplasmic injection (Owolabi *et al.*, 2013). Prostatic changes, including smooth muscle atrophy, may affect sperm motility (Harris *et al.*, 2011, Leisegang *et al.*, 2019).

The mean percentage of normal motile sperms is higher in normospermic samples as compared with oligozoospermic samples (Table 2). Although advancing techniques had somewhat overcome the problems of sperm motility in infertile couples, asthenozoospermia is still a common cause of human male infertility (Owolabi *et al.*, 2013). Sperm motility may be changing, as pertains to other sperm parameters and their relative levels may depend on the existing semen quality in the individual (WHO, 1992). Declining sperm motility could also be due to age-related transformations in accessory sex gland and epididymal function (Elzanaty, 2007, Henkel *et al.*, 2005).

CONCLUSION AND RECOMMENDATIONS

Semen pH, sperm motility, morphology, viability and concentration may be the most informative semen parameters used as measurement of infertility in Men. These parameters declined in this study over the study period as the frequency of abnormalities in these parameters increased over the study period.

Recommendations

1. There is the need for the incorporation of semen analysis into the national health insurance scheme for easy access and treatment of infertility in male partners.
2. Further studies are necessary to elucidate and classify role played by the various causes of male factor infertility such as varicocele, testicular infection (parasitic or viral), endocrine disorders, and disturbances of hypothalamic-pituitary-testicular axis.
3. There is an urgent need for advocacy for men to accept responsibility for their contribution to infertility and to reduce stigmatizing and ostracizing women for infertility.
4. There is also the need for advocacy for men to marry early if they desire raising children of their own.

Limitations

The limitation of this study is that, a large number of the subjects have incomplete records and hence could not be included in the study.

Consent (where ever applicable)

Consent was sought from each participant before being included in the study. Consent form was given to each participant to sign or thumb-print and confidentiality was assured. Subjects who did not give their consent were excluded from the study. A copy of the written consent is available for review by the Editorial office of your journal.

Ethical approval (where ever applicable)

Ethical clearance was given by the committee for human publication and research ethics of the University for Development Studies. All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the current October, 2013 amended Declaration of Helsinki

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