



RESEARCH PAPER

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Andropause: Awareness, severity of symptoms experienced and coping self-efficacy among Boholanos

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Key words: Andropause, Awareness, Coping self-efficacy, Severity of symptoms, Testosterone

<http://dx.doi.org/10.12692/ijb/26.1.130-140>

Article published on January 06, 2025

Abstract

This study aims to determine the level of awareness, degree of symptoms experienced of andropause, and coping skills employed by male Boholanos aged 40 to 59. A descriptive-correlational research design was used in this study employing cross-sectional methods. The selection of respondents for this study employed purposive sampling, aligning with the objectives of the study. The researcher utilized the standardized questionnaires which permissions from authors were obtained thru emails. In determining the severity of symptoms experienced, the Male Self-Assessment Questionnaire (MASSQ) of Dr. Abdolrahim Asadollahi was utilized. To determine the coping strategies employed by the respondents, the researcher utilized the Coping Self-Efficacy Scale of Dr. Margaret A. Chesney. The findings revealed that respondents with higher level of awareness were those who have experienced more severe andropause symptoms, while majority of those who were slightly or not aware of andropause were those who do not experience andropause symptoms. It also revealed that awareness was significantly linked to their coping mechanisms. Notably, those with a high level of awareness consistently applied coping styles, whereas individuals with low awareness tended not to engage in coping behaviors.

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Introduction

Men typically struggled with sleep difficulties, waking up too early and a decrease in libido as they grew older. They would also bemoan the fact that they and their spouses were no longer sleeping in the same bed and were, instead, living as siblings. Many stated that their desire for sex had significantly decreased, while others said they felt as like they had run out of energy. They saw that their muscles were getting less dense and more quickly exhausted, and that their physical strength had decreased. Their general sense of annoyance and dissatisfaction was further compounded by their growing susceptibility to irritability and depression. Studies have shown that testosterone levels usually start to drop around the age of forty, a process called andropause (Asadollahi *et al.*, 2013). A person's ability to carry out daily chores may be restricted or impaired by a variety of symptoms that result from this drop in testosterone. Pommerville and Zakus (2006) contended that men's "andropause" is not clinically or scientifically equal to women's menopause. Rather, they recommended referring to this condition as Partial Androgen Decline in the Aging Male (PADAM) or Androgen Decline in the Aging Male (ADAM). However, Martelli *et al.* (2021) assert that Late Onset Hypogonadism (LOH) is the most current and often used nomenclature for this syndrome.

Approximately 12.3 out of every 1,000 males reported signs of the andropause over the course of a year, according to a Massachusetts study. Global research shows that approximately 480,000 older men experience male menopause annually, with symptoms increasing and happening more frequently over time (Mohammadi *et al.*, 2023). Furthermore, studies indicate that over 70% of males over 40 may eventually have andropause-related symptoms (Adebajo *et al.*, 2007). There are more than 10,000 publications on women's climacteric (or menopause) than there are on men's (Adebajo, 2007). Menopausal men have been the subject of about 1:100 published research compared to menopausal women (Hirokawa, 2012).

Many facets of men's health are impacted by andropause. It could be linked to low blood testosterone levels that cause metabolic syndrome, type 2 diabetes, an increased risk of bone fractures (osteoporosis two times more), an increased risk of death from cardiovascular disease (two or three times more) (Wang *et al.*, 2009). The most significant and prevalent sign of hypogonadism in men is erectile dysfunction and diminished desire. Previous reviews have indicated that 83.3% of men over 60 experience sexual dysfunction, which negatively impacts their quality of life (Novák *et al.*, 2002). Low self-esteem, anxiety, and sadness may result from this condition, which could harm their sexual partner's relationship (Odu *et al.*, 2014).

Despite its importance, studies have shown that there is a low level of knowledge and awareness about andropause among individuals in Iran, Asia, Europe, and America, including in cities such as Meybod and Rasht, Iran (Mazloomi Mahmoodabad *et al.*, 2021; Samipoor *et al.*, 2017). Additionally, research conducted in Nigeria has found that a significant percentage of participants in different years - 76.4% in 2003, 45.1% in 2006, and 43% in 2014 - were not aware of the condition of andropause (Odu *et al.*, 2014).

Reyes *et al.* (2004) performed a survey among doctors in the Philippines. The study's findings indicated that most doctors believed that males might experience andropause and that more education was needed to address andropause and its treatment among Filipino doctors.

The significant occurrence of key risk factors associated with andropause among healthy individuals highlights the need to enhance social conditions that greatly impact the quality of life for middle-aged men (Samipoor *et al.*, 2017). Raising awareness about andropause should be a central element of health planning. Limited research has addressed this topic, indicating a need for further studies to explore andropause-related issues and complications. It is essential for society, healthcare

institutions, and universities to educate the public and promote widespread understanding of this critical issue (Samipoor *et al.*, 2017).

This study aims to fill the information gaps regarding andropause in various countries, with a specific focus on the Philippines, particularly in Bohol. It will address the necessity for information dissemination and health interventions. The results of this research will assist health educators in developing their curriculum for Maternal and Child Care and Primary Health Care, as andropause symptoms can impact family dynamics. Additionally, policymakers can utilize the findings to design community health initiatives for men dealing with andropause symptoms. Future researchers may also learn about the study's limitations and use this knowledge to conduct more rigorous research.

Materials and methods

Research design

This study employed a descriptive-correlational research design with cross-sectional method. Correlational designs involved the systematic investigation of the nature of correlations, or associations, between and among variables, as opposed to straightforward cause-and-effect links. For correlational designs, cross-sectional designs were typical. The association between changes in one or more variables and changes in another variable or variables were examined using these designs, this is known as co-variance. Correlation analysis was used to look at the linkages or associations' direction, degree, amplitude, and strength. Variables were kept constant while data were gathered all at once using the cross-sectional approach (Polit and Beck, 2021).

Research participants

The respondents were the 40-59 years old men from the first district of Bohol, according to the Provincial Planning Development Office of Bohol there are 15 towns in the first district PPDO Bohol (2024), these towns were ranked according to

lowest population with the chronic diseases specified in the inclusion and exclusion criteria the first 5 towns with the lowest cases were Calape, Cortes, Corella, Sikatuna & Catigbian these were the locations of the respondents. A sample size of 382 respondents using the Raosoft calculator were established after thoroughly considering the total population of the towns in the first congressional district of Bohol. The aim was to ensure that the sample effectively represented the variety of experiences and viewpoints associated with andropause. They were identified from the list obtained from the rural health units (RHU). The selection of respondents for this study employed purposive sampling, aligning with the objectives of the study. They were selected based on the following inclusion criteria: male ages 40 to 59 years old, willing to volunteer as respondents of this study, not currently in acute physical and mental conditions. Exclusion criteria include those that were taking any drugs that can affect libido including testosterone and sildenafil, having chronic diseases including heart disease, diabetes, any type of cancer, prostate disease. Respondents who were identified from the RHU list were randomly selected.

Research instrument

The questionnaires used in this study include 1.) Sociodemographic Questionnaire, 2.) The Male Andropause Symptoms Self-Assessment Questionnaire (MASSQ) and 3.) The Coping Self-Efficacy Questionnaire. The Male Andropause Symptoms Self-Assessment Questionnaire (MASSQ) was developed by Dr. Abdolrahim Asadollahi and colleagues in 2013. This instrument consisted of 25 questions that evaluate andropause symptoms. The items in the questionnaire were categorized into somatic, psychological, behavioral and sexual. The validity and reliability of the questionnaire were determined by Asadollahi and colleagues and the Cronbach α was reported to be 0.89. The researcher obtained the necessary permission to use the standard instrument by contacting the author via email.

To evaluate coping self-efficacy of the respondents, the researcher employed the Coping Self-Efficacy Scale created by Dr. Margaret Chesney and her colleagues in 2006. The Coping Self-Efficacy scale is a 26-item assessment tool used to determine an individual's level of comfort engaging in coping mechanisms when faced with challenges in life. The questionnaire has been grouped to three factors such as problem-focused coping strategies, stopping unpleasant emotions and thoughts, and seeking support from friends and family. The CSE questionnaire has been shown to be a reliable and consistent measure of a person's self-efficacy in dealing with various situations. It has also been proven to measure different types of coping skills, and its results were associated with improved mental well-being and reduced distress over time. The scale is a valuable tool for researchers, as it allows them to assess a person's ability to cope effectively with life challenges and track changes in this ability over time (Chesney, 2006). Additionally, permission to use the scale has been granted by Dr. Chesney, allowing for its use in this research study.

Data collection/gathering

The researcher adhered to the ethical requirements when conducting research such as seeking proper permission from proper authorities, secured written signed informed consent from the respondents. Anonymity and confidentiality of the respondent's personal data and responses were observed in the entire research process. The respondents and the collected data were anonymized using codes and was stored in a locked folder and flash drive. Moreover, minimum government health protocols were followed during RHU visit and during the data-collection period.

Data analysis

The data collected were analyzed using descriptive statistics, including frequency counts, percentages, means, and standard deviations. Frequency and percentage analysis were used to create profiles of the respondents, while weighted means were used to

assess their level of awareness. Chi-square tests were also applied to examine the relationship between the respondents' profiles and their level of awareness.

Additionally, a Pearson product-moment correlation was used to investigate the strength and direction of the relationship between two continuous variables. The coefficient, r , measures the strength and direction of the relationship, ranging from -1 (perfect negative correlation) to +1 (perfect positive correlation). A value of 0 indicates no correlation between the two variables.

Results and Discussion

This research included a total of three hundred eighty-two (382) males aged between 40 and 59 from District 1 of Bohol Province, achieving a response rate of 100% (Table 1). Most participants were middle-aged adults, predominantly in the 40 to 44 age group (31.15%). Most respondents were high school level (41.62%). Nearly half (45.81% or 175 individuals) were classified as skilled workers, indicating that a significant number had received specialized training. Regarding marital status, a large portion of the respondents were married, totaling 288 individuals or 75.39%. In terms of their economic situation, 317 respondents, or 82.98%, reported earning less than 20,000 pesos per month. When it came to smoking and drinking habits, the majority did not smoke, comprising 157 individuals or 41.10%, followed by rare smokers at 30.37% and those who smoke occasionally at 22.77%; only 5.76% indicated they smoke regularly. More than half of the respondents, 200 or 52.36%, reported rarely consuming alcohol, while 81 participants, or 8.12%, stated they drink alcohol frequently. Only 49 respondents, or 12.83%, claimed to never consume alcohol.

The study revealed that all respondents had a limited awareness of andropause, reflected in a composite mean score of 2.02, indicating minimal knowledge on the topic (Table 2). This finding aligns with the research conducted by Mazloomi Mahmoodabad *et al.* (2021) in Meybod, Iran and Samipoor *et al.* (2017) in Rasht, Iran.

Table 1. Respondents' profile (n = 382)

Respondents' profile in terms of age		
Age	Frequency	Percentage (%)
40 - 44	119	31.15
45 - 48	72	18.85
49 - 53	98	25.65
54 - 59	93	24.35
Total	382	100.00
Respondents' profile in terms of education		
Education	Frequency	Percentage (%)
Never gone to school	6	1.57
Elementary	127	33.25
High school	159	41.62
College	64	16.75
Post college	26	6.81
Total	382	100.00
Respondents' profile in terms of occupation		
Occupation	Frequency	Percentage (%)
Laborer and unskilled worker	167	43.72
Skilled Worker	175	45.81
Professional	38	9.95
Managerial (Manager/Supervisor)	2	0.52
Total	382	100.00
Respondents' profile in terms of marital status		
Marital status	Frequency	Percentage (%)
Single	53	13.87
Married	288	75.39
Widowed	25	6.54
Divorced/Annulled	2	0.52
Separated	14	3.66
Total	382	100.00
Respondents' profile in terms of economic status		
Economic status	Frequency	Percentage (%)
Less than P20,000	317	82.98
P20,000 - P30,000	54	14.14
More than P30,000	11	2.88
Total	382	100.00
Respondents' profile in terms of smoking		
Smoking	Frequency	Percentage (%)
Never	157	41.10
Rarely	116	30.37
Sometimes	87	22.77
Always	22	5.76
Total	382	100.00
Respondents' profile in terms of drinking alcohol		
Drinking alcohol	Frequency	Percentage (%)
Never	49	12.83
Rarely	200	52.36
Sometimes	102	26.70
Always	31	8.12
Total	382	100.00

Generally, all men reported experiencing mild symptoms associated with andropause. When categorized into somatic, psychological, behavioral, and sexual symptoms, the respondents indicated a slight presence of these symptoms (Table 3). Among the four groups, men reported higher levels of somatic symptoms, with a composite mean of 2.20, followed by

psychological symptoms (2.18), sexual symptoms (2.11), and behavioral symptoms (2.10) respectively.

Specifically, among the somatic symptoms, sleep problems (such as difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness) had the highest weighted

mean of 2.34. Under psychological symptoms, an increased need for sleep and often feeling tired were the most reported items, with a weighted mean of 2.41. In terms of sexual symptoms, a decrease in the

number of morning erections was the most frequently reported item, with a weighted mean of 2.17. Lastly, among behavioral symptoms, falling asleep after dinner had the highest weighted mean of 2.12.

Table 2. Respondents' level of awareness about andropause (n = 382)

Indicator	Weighted mean	Descriptive rating
I am aware that ...		
1. andropause is a male menopause?	2.09	Slightly Aware
2. andropause is exactly like menopause?	2.13	Slightly Aware
3. andropause is caused by a reduction in sexual hormones level in men?	2.17	Slightly Aware
4. alopecia is one of the andropause symptoms?	1.96	Slightly Aware
5. aging is accompanied by experiencing andropause?	2.22	Slightly Aware
6. reduction in sexual inclination is one of the andropause symptoms?	2.10	Slightly Aware
7. impotence is one of the andropause symptoms?	2.09	Slightly Aware
8. nervousness is one the andropause symptoms?	1.95	Slightly Aware
9. lack of energy is one of the andropause symptoms?	2.06	Slightly Aware
10. hot flashes is an andropause symptom?	1.93	Slightly Aware
11. excessive sweating is an andropause symptom?	1.90	Slightly Aware
12. beard growth reduction is a symptom of andropause?	1.90	Slightly Aware
13. muscle mass and muscle strength loss are symptoms of andropause?	1.99	Slightly Aware
14. obesity is a predisposing factor of andropause?	1.92	Slightly Aware
15. alcohol use is a predisposing factor of andropause?	1.99	Slightly Aware
16. andropause symptoms are controllable and treatable?	1.90	Slightly Aware
17. medical treatment is used in controlling andropause?	1.94	Slightly Aware
18. Andropause can be diagnosed via signs and symptoms?	2.14	Slightly Aware
19. Andropause can be diagnosed through blood test?	1.94	Slightly Aware
20. Andropause is followed by complete fertility loss?	2.02	Slightly Aware
Composite Mean	2.02	Slightly Aware

Table 3. The Respondents' severity of self-assessed andropause symptoms (n = 382)

Indicator	Weighted mean	Descriptive rating
Somatic		
1. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	2.27	Mild
2. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	2.12	Mild
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	2.34	Mild
4. Physical exhaustion/lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less; of having to force oneself to undertake activities)	2.29	Mild
5. Decrease in beard growth	2.05	Mild
6. I notice a decrease in strength and endurance.	2.16	Mild
7. I notice a decrease in my ability to play sports.	2.19	Mild
Composite Mean	2.20	Mild
Psychological		
8. Decline in feeling of general wellbeing (general state of health, subjective feeling)	2.08	Mild
9. Increased need for sleep, often feeling tired	2.41	Mild
10. Irritability (feeling aggressive, easily upset about little things, moody)	2.34	Mild
11. Nervousness (inner tension, restlessness, feeling fidgety)	2.26	Mild
12. Anxiety (feeling panicky)	2.27	Mild
13. Decrease in muscular strength (feeling of weakness)	2.26	Mild
14. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	2.07	Mild
15. Feeling that you have passed your peak	1.99	Mild
16. Feeling burnt out, having hit rock-bottom	2.10	Mild
17. I notice decreased enjoyment of life.	2.21	Mild
18. I Feel like I'm losing height.	2.05	Mild

19. I notice a lack of energy.	2.16	Mild
Composite Mean	2.18	Mild
Behavioral		
20. Fall asleep after dinner	2.12	Mild
21. I am sadder and/or more grumpy than usual.	2.09	Mild
Composite Mean	2.10	Mild
Sexual		
22. I have decreased sex drive (libido).	2.13	Mild
23. Decrease in ability/frequency to perform sexually	2.14	Mild
24. Decrease in the number of morning erections.	2.17	Mild
25. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	2.01	Mild
Composite mean	2.11	Mild
Aggregate mean	2.15	Mild

Table 4. The respondents' coping self-efficacy (n = 382)

Indicator	Weighted mean	Descriptive rating
I am aware that ...		
Problem-Focused Coping		
1. Talk positively to yourself.	2.48	Rarely
2. Sort out what can be changed, and what cannot be changed.	2.50	Sometimes
3. Find solutions to your most difficult problems	2.81	Sometimes
4. Break an upsetting problem down into smaller parts.	2.67	Sometimes
5. Leave options open when things get stressful.	2.44	Rarely
6. Make a plan of action and follow it when confronted with a problem.	2.76	Sometimes
7. Develop new hobbies or recreations.	2.55	Sometimes
8. See things from other person's point of view during a heated argument.	2.57	Sometimes
9. Try other solutions to your problems if your first solutions don't work.	2.67	Sometimes
10. Think about one part of the problem at a time.	2.49	Rarely
11. Stand your ground and fight for what you want.	2.63	Sometimes
12. Resist the impulse to act hastily when under pressure.	2.62	Sometimes
Composite Mean	2.60	Sometimes
Positive Emotions and Thoughts Coping		
13. Keep from getting down in the dumps.	2.56	Sometimes
14. Take your mind off unpleasant thoughts.	2.87	Sometimes
15. Look for something good in a negative situation.	2.81	Sometimes
16. Keep from feeling sad.	2.86	Sometimes
17. Stop yourself from being upset by unpleasant thoughts.	2.69	Sometimes
18. Make unpleasant thoughts go away.	2.62	Sometimes
19. Visualize a pleasant activity or place.	2.55	Sometimes
20. Keep yourself from feeling lonely.	2.55	Sometimes
21. Pray or meditate.	2.82	Sometimes
Composite Mean	2.70	Sometimes
Positive Family and Friends Support Coping		
22. Get emotional support from friends and family.	2.58	Sometimes
23. Make new friends.	2.54	Sometimes
24. Get friends to help you with the things you need.	2.47	Rarely
25. Do something positive for yourself when you are feeling discouraged.	2.66	Sometimes
26. Get emotional support from community organizations or resources.	2.41	Rarely
Composite Mean	2.53	Sometimes
Aggregate Mean	2.61	Sometimes

With respect to Coping Self-efficacy the researcher used the standardized questionnaire (Table 4). The questionnaire was grouped into three. The problem-focused coping, positive emotions and thoughts coping, positive family and friends support coping. Majority of the respondents applied the coping mechanisms sometimes. Among the three groups it was the positive emotions and thoughts coping that was mostly used. There were

three indicators under problem focused coping which were rarely applied by the respondents these were talked positively to yourself, leave options open when things get stressful, think about one part of the problem at a time. While rarely also under positive family and friends support coping which were got friends to help you with the things you need and get emotional support from community organizations or resources.

Table 5. The relationship between respondents' profile to andropause awareness, severity of andropause symptoms and coping self-efficacy (n = 382)

Relationship between respondents' profile and andropause awareness						
Variables	Computed chi-square value	df	p-value	Level of Significance	Decision	Interpretation
Age * Awareness	10.247	9	.331	.05	Accept H ₀	Not significant
Educational Background * Awareness	18.943	12	.090	.05	Accept H ₀	Not significant
Occupation * Awareness	12.927	9	.166	.05	Accept H ₀	Not significant
Marital Status * Awareness	21.732	12	.041	.05	Reject H ₀	Significant
Economic Status * Awareness	3.958	6	.682	.05	Accept H ₀	Not significant
Smoking * Awareness	6.961	9	.641	.05	Accept H ₀	Not significant
Drinking * Awareness	19.561	9	.021	.05	Reject H ₀	Significant
Relationship between respondents' profile and severity of andropause symptoms						
Variables	Computed chi-square value	df	p-value	Level of Significance	Decision	Interpretation
Age * Severity	20.674	12	.055	.05	Accept H ₀	Not Significant
Educational Background * Severity	16.777	16	.400	.05	Accept H ₀	Not significant
Occupation * Severity	17.355	12	.137	.05	Accept H ₀	Not significant
Marital Status * Severity	17.443	16	.358	.05	Accept H ₀	Not significant
Economic Status * Severity	2.656	8	.954	.05	Accept H ₀	Not significant
Smoking * Severity	17.977	12	.116	.05	Accept H ₀	Not significant
Drinking * Severity	19.029	12	.088	.05	Accept H ₀	Not significant
Relationship between respondents' profile and coping self-efficacy						
Variables	Computed chi-square value	df	p-value	Level of Significance	Decision	Interpretation
Age * Coping	6.599	9	.679	.05	Accept H ₀	Not significant
Educational Background * Coping	30.296	12	.003	.05	Reject H ₀	Significant
Occupation * Coping	17.787	9	.038	.05	Reject H ₀	Significant
Marital Status * Coping	22.607	12	.031	.05	Reject H ₀	Significant
Economic Status * Coping	5.537	6	.477	.05	Accept H ₀	Not significant
Smoking * Coping	13.749	9	.132	.05	Accept H ₀	Not significant
Drinking * Coping	38.553	9	.000	.05	Reject H ₀	Significant

The test of hypotheses on the correlation between respondents' profiles and knowledge of the andropause is shown in Table 5. It shows that the only factor substantially correlated with respondents' awareness of the andropause were their marital status and frequency of alcohol consumption. It was discovered that married people showed more awareness than single or divorced people do. Additionally, it has been observed that men who drank alcohol more frequently were less cognizant of andropause. This implies that to increase men's knowledge of the andropause, healthcare campaigns

and interventions could be customized to consider factors like marital status and particular drinking habits.

The findings of the test of hypotheses on the correlation between the profile of respondents and the intensity of andropause symptoms are also shown in Table 5. It demonstrates that all the null hypotheses were accepted, suggesting that the demographic and health-related behaviors looked at in this study have no bearing on how severe andropause symptoms were in men. This suggests

that the intensity of andropause symptoms may potentially be influenced by factors that have yet to be investigated.

Lastly, Table 5 presents the results of the test of hypotheses on the relationship between respondents' profile and health habits to coping mechanisms. The table reveals that the respondents' educational background, occupation, marital status, and frequency of alcoholic drinking were linked to their coping mechanism towards andropause. This implied that males with higher educational attainment and with managerial or professional occupations were

linked to more informed and proactive coping strategies. The data indicated varying levels of coping across different marital status categories. It was discovered that married men exhibited higher levels of coping than people in other categories of marital status. The result additionally revealed that married males exhibited a heightened capacity for coping with andropause. In terms of respondents' frequency of alcoholic drinking in relation to their coping mechanisms, it was noted that those who drank frequently were found to rarely apply coping styles, while individuals with infrequent drinking habits tended to employ coping styles more frequently.

Table 6. Relationship between respondents' awareness, severity of andropause symptoms and coping self-efficacy

Variables	Computed r-value	p-value	Level of significance	Decision	Interpretation
Awareness *Severity	.573	.000	.05	Reject H ₀	Significant
Awareness * Coping	.305	.000	.05	Reject H ₀	Significant
Severity * Coping	.243	.000	.05	Reject H ₀	Significant

Table 6 shows the results of the test of hypotheses on the relationship between respondents' awareness of andropause and severity of andropause symptoms experienced. Particularly, it tells that respondents with higher level of awareness have experienced more severe andropause symptoms, while majority of those who were slightly or not aware of andropause do not experience andropause symptoms. Thus, this could imply that increased severity in andropause symptoms prompt individuals to seek more information about andropause.

Table 6 also reveals that respondents' awareness was significantly linked to their coping mechanisms. Notably, those with a high level of awareness consistently applied coping styles, whereas individuals with low awareness tended not to engage in coping behaviors. Thus, heightened awareness prompt individuals to adopt strategies to cope with the challenges they experienced on andropause.

Finally, Table 6 reveals a substantial correlation between the respondents' usage of coping techniques and the intensity of their andropause symptoms. When compared to individuals with less or no

symptoms, those with more severe symptoms showed a higher level of engagement with coping techniques. This suggests that people used more coping mechanisms in response to the severity of their symptoms.

Conclusion

Given the strong correlation between awareness of andropause, symptom severity, and coping strategies, it is crucial to identify and reach out to individuals who may lack knowledge about these symptoms. Specifically, singles, widowed individuals, and those who were separated, along with those who consume alcohol regularly, could greatly benefit from a targeted health awareness program designed to enhance their understanding of andropause symptoms. By increasing awareness, these individuals will be better equipped to adopt effective coping mechanisms and manage their symptoms more successfully.

To achieve this, it is recommended to incorporate the discussions on andropause into Maternal and Child Care and Primary Health Care courses, recognizing that andropause symptoms can significantly affect family dynamics.

Additionally, it is recommended to develop a community-based Health Teaching Program specifically tailored to address the needs of those identified as less aware. This program should focus on educating participants about andropause, available coping strategies, and resources for support.

To ensure the program's effectiveness, it is necessary to conduct monitoring and evaluation of its impact on participants, to be able to make necessary adjustments and maximize its benefits.

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