ORIGINAL ARTICLE

Perceptions of female sexual health and sexual dysfunction in a cohort of urban professional women in Abuja, Nigeria

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Abstract

Context: Data on sexual health behaviors, and the prevalence and risk factors for female sexual dysfunction (FSD) are rare, particularly from sub-Saharan Africa.

Aims: This study was to briefly investigate the perceptions of a cohort of adult urban female professionals about female sexual health and sexual dysfunction awareness.

Patients and Methods: Fifty female hospital staff attending an introductory seminar on FSD participated in this study by completing a 15-item questionnaire on some aspects of female sexual health. Questions asked ranged from sexual activity in the preceding 6 months, menopausal status, if they thought they had sexual dysfunction to their willingness to discuss an FSD with a sexual health physician if they had access to one.

Results: Over 50% (*n*=28) of the respondents had an idea about what FSD was before the survey. These respondents further defined FSD as either the inability of a female to respond to sex, a lack of urge to engage in sexual activities, or inability to attain orgasm. About half of the respondents (*n*=21) did not know that FSD could be managed; however, 70% of them felt comfortable with discussing FSD symptoms with a sexual health practitioner.76.9% of the respondents who thought they had symptoms of FSD in this series (*n*=10) were willing to see a sexual health expert if they had access to one.

Conclusions: This study provides a brief insight into FSD awareness amongst apparently healthy female workers of a health care facility and the need for further community-based studies on female sexual health issues in our society. Furthermore, it highlights the appropriateness of a comprehensive sexual medicine service in tertiary health care facilities in Nigeria for adequate screening and diagnosis of patients before appropriate treatment of FSD.

Key words: Female sexual dysfunction, female sexual health, perceptions, urban professional women

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Introduction

Interest in human sexuality began in the 18th century, but formal and more rigorous studies on sexual satisfaction and sexual practices were not published until the early 1900s. Alfred Kinsey's pioneering work on sexuality, in which he surveyed over 10,000 men and women age 16 and older, began in the late 30s and resulted in two ground-breaking publications: Sexual Behavior in the Human Male (1948) and Sexual Behavior in the Human Female (1953), otherwise known as the famous "Kinsey Reports."[1]

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In the mid-1960s, Masters and Johnson published their own seminal work characterizing the sexual response cycle.[2] Since then, numerous researchers have attempted to understand and to quantify normal and dysfunctional sexual responses using survey techniques.

Accurate estimates of prevalence/incidence are important in understanding the true burden of male and female

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sexual dysfunction (FSD) and in identifying risk factors for prevention efforts. This is the summary of the report by the International Consultation Committee for Sexual Medicine on Definitions/Epidemiology/Risk Factors for Sexual Dysfunction.[3]

The knowledge of the rates of occurrence of sexual dysfunctions and the primary risk factors for these conditions is very important to assist in assessing the risk and planning treatment and prevention programs in sexual medicine.

While progress has been made concerning both the number and quality of epidemiologic prevalence studies in sexual medicine; however, there is a paucity of studies of the incidence of these conditions.

The prevalence of FSD has been investigated in many recent studies; however, data from sub-Saharan Africa on the prevalence and risk factors for the condition are rare. There are even fewer studies[4-7] from Nigeria, which have attempted to investigate the problem.

Only recently, Ogbera and workers[8] and Olarinoye *et al.*[9] showed that diabetes significantly impaired the sexual performance of Nigerian women afflicted with the disease.

Women's sexual dysfunction includes reduced interest/incentives for sexual engagement, difficulties with becoming subjectively aroused and/or genitally aroused, and difficulties in triggering desire during sexual engagement. Frequently, all of these aspects are involved. Orgasmic disorder denotes sexual experiences consistently associated with high arousal but absence of orgasm. Other dysfunctions include pain and difficulty with attempted or completed intercourse or any attempts at vaginal penetration.[10]

Even when circulating androgens have been implicated in several domains of sexual response, they seem to be weakly related to symptoms, such as low sexual desire, poor sexual arousal, orgasm, and diminished well-being in postmenopausal women.[11]

Results from studies by Carvalho and Nobre[12] support the role of cognitive dimensions in the maintenance of women's sexual interest and suggest implications for assessment and treatment of sexual desire difficulties.

In a cross-sectional study of 102 consecutive women attending an urban gynecology clinic, female sexual dysfunction was associated with the presence of depression and urge urinary incontinence in women of low-income status living in an urban setting.[13]

In another series of 409 middle-aged women, logistic regression analysis determined that female age, postmenopausal status, partner's age, educational level, and the presence of erectile dysfunction and premature ejaculation in partner significantly increased the risk for female sexual dysfunction.[14]

Hypoactive sexual desire disorder (HSDD) is the most common female sexual dysfunction (FSD) affecting adult women of any age, including postmenopausal women.[15] It affects up to 1 in 10 US women.[16]

This current study was meant to evaluate the perceptions of sexual health and understanding of female sexual dysfunction in a group of adult females attending an FSD seminar.

Patients and Methods

The study was conducted during a female-only seminar on FSD at Asokoro District Hospital, Abuja, Nigeria. All attendees were female workers of the hospital and there were no restrictions on attendance either on the basis of educational qualification or job description.

The attendees were briefed on the purpose of the study, reminded that participation was voluntary, informed that a verbal consent will be obtained from participants and assured of the confidentiality of the information obtained from them.

All 50 female hospital workers who attended the seminar participated in the study by completing a 15-item self-administered questionnaire at the commencement of the seminar. The questionnaire, which was developed by the authors but had not been pretested, was used to evaluate the knowledge base of the respondents prior to the information provided at the seminar.

The questionnaire contained socio-demographic data and questions relating to female sexual health issues such as sexual activity in the preceding 6 months, menopausal status, if they were victims of female genital mutilation, if they thought they had sexual dysfunction, and their willingness to discuss such a dysfunction with a trained sexual health physician where one was available.

The data obtained were analyzed using the SPSS 11.0 computer statistical software, expressed as simple percentages and were appropriate presented in form of tables.

Results

The respondent's ages ranged from 27 to 49 years with their mean age being 38.82 ± 5.4 years. All 50 respondents had higher educational qualifications with the least qualification being the nursing diploma.

In all, there were 24 nurses (48%), 3 medical doctors (6%), 2 medical laboratory scientist/technologists (4%), and

21 general administrative cadre staff (42%). Furthermore, 84% of the respondents (n=42) were married leaving only 8 as either single or separated. Of this 16% who were not married, a quarter was sexually active-defined as being in a sexually active relationship in the last 6 months preceding the survey. All except 5 married respondents were sexually active.

Only seven (14%) respondents of the entire study population had reached menopause.

A little over half the respondents (n=28) claimed they knew what FSD was before the survey. When asked further to define FSD, these 28 respondents gave various responses ranging from inability of a female to respond to sex, a lack of urge to engage in sexual activities to inability to attain orgasm [Table 1].

Among the 28 women who thought they knew what FSD was, 20 (71.4%) claimed they had no sexual dysfunction, while only 8 thought they had an FSD. Of these eight respondents with symptoms, five had lack of desire/urge for sex, two had significant pain during sex (dyspareunia), and one had failure to attain orgasm.

There were 22 respondents who did not know what FSD was. Of this number, 15 claimed they had no sexual dysfunction, 5 thought they had an FSD, 1 could not tell if she had any FSD, and 1 respondent did not answer the question.

When asked to describe what symptoms of FSD they thought they had, 4 of the 5 respondents who thought they had an FSD could not describe their symptoms. The only one who could describe hers said she had reduced interest in sexual activities.

In all, there were a total of 13 respondents who thought they had FSD – eight from the group who claimed to know what FSD meant and five from the group who did not know what the condition was [Table 2]. This constituted 26% of the study population.

Table 1: Responses by respondents who claimed to know what female sexual dysfunction meant

Responses	No. of respondents	%
Inability to achieve orgasm	5	17.85
Not being sexually active	3	10.71
Lack of urge/desire for sex	10	35.71
Absence of sexual satisfaction after having sex/not enjoying sex	4	14.28
Sexual abuse/molestation/ forceful sex against ones wish	1	3.57
Inability to achieve conception after regular unprotected sex	1	3.57
Presence of pain during sex	1	3.57
Abnormal development of female reproductive organs	3	10.71
	28	

Table 2: Patients in the two groups with their presumed symptoms of female sexual dysfunction

Symptoms in those who knew what FSD meant	No. of patients
Lack of desire/urge for sex	5
Significant pain during sex (dyspareunia)	2
Inability to attain orgasm	1
Total	8
Symptoms in those who did not know what FSD meant	
Lack of desire/urge for sex	1
Those who could not describe their symptoms	4
Total	5

FSD = Female sexual dysfunction

Discussion

Our study which did not investigate the prevalence of FSD in the population cohort attending the seminar was an attempt to suggest however that even when sexual health is not a much talked about subject in our society, women do have - rightly or wrongly, their own perceptions.

Of the 28 subjects who claimed to know what FSD was, 82.1% (n=23) could be said to have a correct perception of the condition. The responses in the rest five subjects were however not correct. Interestingly, the response with the highest frequency was lack of desire or interest in sex as reported by 10 of the 28 respondents.

Furthermore, there were 13 respondents overall who thought they had FSD. 6 out of these 13 self-reported reduced sexual desire. This may suggest that desire difficulty is the most frequently encountered sexual dysfunction. A closer look at all these six respondents who had lack of desire/urge for sex revealed that four were older than 45 years of age and were menopausal, two were victims of female genital cutting and except for one respondent, the remaining five had refrained from active sexual activities in the 6 months prior to the survey even when all were married.

It is widely accepted that desire difficulty is the most common sexual difficulty experienced by women.[17] Hayes *et al.*[18] in their review further noted that the majority of difficulties last for less than 6 months with up to a third persisting for 6 months or more and that sexual difficulty do not always cause distress. Consequently, prevalence estimates will vary depending on the time frame specified by researchers and whether distress is included in these estimates. The implication is that absence of distress may preclude the reporting of FSD by a subject. This may probably explain the finding in our study where more people

in both groups (those who knew what FSD was and those who did not –20 out of 28 in the former and 15 out of 22 in the latter) claimed they had no FSD. One obvious limitation in our study is that we did not enquire for the presence of associated distress with probable FSD symptoms.

Close to half the respondents (21/50) did not know that FSD could be treated. When asked to name what treatment they knew existed for FSD, of the 29 respondents who answered that question in the affirmative, 7 choose drugs as an option, with 22 thinking counselling was a treatment strategy.

Overall, only 70% of the respondents felt comfortable with the idea of discussing FSD symptoms if they had one with a trained sexual health practitioner. However, of the 26% that reported symptoms of FSD in this series, 76.9% (10/13) were willing to discuss the condition with a sexual medicine expert if they had access to one.

It is believed that there are many more women, middle aged and older who desire continued sexual interest and activity. Buvat *et al.*[19] identified this trend in the French and reported that despite the number of sexual problems seen in the population, only a minority of individuals sought medical help for these disorders. This they claimed was largely due to believing that the problem was not serious, not being bothered by the problem, and/or a lack of awareness of available treatments. This situation could be true for Nigeria also, but however remains to be proved with more detailed community- and population-based studies.

In conclusion, this study has been able to highlight a fair degree of perception among women on female sexual health and sexual dysfunction issues in our society. This should be a cause for concern by our health care delivery planners who should see the need for more research and scientific reporting including long-term outcome studies on the assessment and management of women's sexual dysfunction.

The limitations of this study are the fact that it is a cohort study of a group of seminar attendees who are all members of the health team. Even at that, there was an uneven distribution of the study participants based on their job description as shown by a majority being administrative cadre staff. This has implications for future research where population-based studies with large sample size are required and should be encouraged to test such hypotheses.

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