

Sexual Dysfunction—A Silent Hurt: Issues on Treatment Awareness

Olushola Abejide Adegunloye, FWACP* and Grace Gwabachi Ezeoke, FWACS†

*Department of Behavioural Sciences, University of Ilorin Teaching Hospital, Ilorin, Kwara State, Nigeria; †Department of Obstetrics & Gynaecology, University of Ilorin Teaching Hospital, Ilorin, Kwara State, Nigeria

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ABSTRACT

Background. The magnitude of sexual health problems and availability of treatment options in the local environment is yet to be documented; thus, there is an urgent need for this, as sexual dysfunction may be a real social and psychological problem, needing urgent attention.

Objective. The aim of this study was to investigate the prevalence of sexual dysfunction and pattern of sexual health seeking behavior, among secondary school teachers in Ilorin, Kwara State Nigeria.

Methods. 450 teachers were invited to complete an anonymous self-administered sociodemographic questionnaire, as well as three other instruments measuring human sexuality and general mental health status.

Main Outcome Measures. The survey instrument used were the International Index of Erectile Function (IIEF-5), a modified Sexual Activity Questionnaire (SAQ), and the General Health Questionnaire -30 (GHQ -30). Result were compared with established normative data, and validated cut-off scores that were available.

Results. A total of 417 teachers (93%) responded to the questionnaire. The following prevalence rates were found: female anorgasmia (40%), lubrication failure (30%), dyspareunia (12%), erectile dysfunction, premature ejaculation and male orgasmic disorder (23% each), loss of sexual desire (24%), sexual life dissatisfaction, and relationship dissatisfaction six months prior to interview (10% each), and GHQ-30 scores were significant in sexual dysfunction in both genders, except for female anorgasmia and premature ejaculation in males. However, a presence of psychiatric morbidity was significantly found in overall sexual life dissatisfaction, as well as relationship dissatisfaction. The pattern of sexual health help-seeking behavior showed that majority (53%) do not seek treatment. Of these 53%, many (44%) gave the reason that they thought it transient, ignorance of hospital treatment service (30%), and fear of stigma (26%); also, among those that sought treatment, 46% chose alternative medicine.

Conclusion. The prevalence of sexual dysfunctions found in this study is comparable to those reported in earlier Nigerian studies. Despite this and the significant “psychiatric morbidity” experienced in sexual difficulties, apparently no health services have been specially designed to address sexual dysfunction among the teacher’s group or the general population at large. This study therefore draws urgent attention to the need for services geared towards alleviating sexual problems, more professional and patient education are recommended. **Adegunloye OA and Ezeoke GG. Sexual dysfunction—A silent hurt: Issues on treatment awareness. J Sex Med 2011;8:1322–1329.**

Key Words. Prevalence; Epidemiology of Sexual Dysfunction; Treatment-Issues; Stigma; Sexual Satisfaction; Relationship Satisfaction

Introduction

Sexuality plays an integral role in health, quality of life, and general well-being [1]. Sexual dysfunction is an important aspect of sexual health that is prevalent in the population and may be frequently undetected [2]. Studies from Europe

and other countries have shown that there is reluctance by patients to report sexual problems, and doctors rarely ask patients about these problems during a routine consultation [2–4].

Sexual problems are particularly distressing to individuals. It may be an integral symptom of other psychiatric disorders (e.g., depression), an

acquired medical condition (e.g., diabetes mellitus, cardiovascular disorders), or a side effect of pharmacological treatments (e.g., antidepressants, antihypertensives, etc.). Sexual dysfunction could also arise from the process of aging, habits, and lifestyle. Obesity and mutilating surgeries may have deleterious effects on self-image and sexuality, thus leading to sexual dysfunction. Furthermore, interpersonal factors involving conflicts with partner or the stress of the diagnosis of infertility can also lead to sexual problems [5–18].

It has been observed in some developed countries that there is a high prevalence of sexual problems in the general population [3,4]; however, this has been difficult to determine, as a significant proportion of people refrain from discussing the problem, and the proportion of those who actually seek help is unknown [3,4].

Sexual dysfunction may severely affect the quality of life of patients, but studies in Nigeria are scarce [19]. The relative dearth of research into this area, in Nigeria and Africa might be a reflection of the sociocultural “silence” given to issues relating to sex, in spite of the fact that sexual dysfunction may be a real social and psychological problem in the local environment needing urgent attention [19,20].

This study was therefore conducted to provide the basic epidemiological data base, which may be of value in resource allocation vis-à-vis provision of appropriate health resources for sexual health problems. The study may also help increase awareness of both health professionals and the public concerning treatment issues in sexual dysfunction as related to availability and accessibility of services.

In view of these, the present article is focused on an educated group whom we hope would be able to volunteer useful information. Furthermore, teachers were chosen, in view of their easy accessibility in groups (schools). This article therefore was designed to examine the help seeking behavior of teachers with sexual dysfunction in secondary school in Ilorin, Nigeria.

Methods and Outcome Measures

Study Setting

Ilorin is the capital of Kwara state. It is divided into three local government areas, Ilorin East, Ilorin West, and Ilorin South. It is inhabited predominantly by the Yorubas, one of the major ethnic groups in Nigeria. Other groups (i.e., Ibo, Hausa, and the minority ethnic groups) are also well represented. Ilorin has a population of about 566,000,

and covers a land mass of about 690 km [21]. It is situated between the Northern and Southern parts of the country. It was upgraded to the status of a provincial headquarters in 1967. There are several educational, social, as well as health care facilities to cater for the needs of the inhabitants in Ilorin.

Administrative Procedure

Permission to conduct the study was obtained from appropriate authorities, such as the Kwara State Ministry of Education, school boards, and the principals of the selected schools.

Study Population

The study population comprised of a sample of secondary school teachers in Ilorin, Kwara State Nigeria. There are 72 secondary schools in Ilorin, with teaching staff strength of 2,176, with 1,052 being male and 1,124 being female [22].

Sample Size Determination

A list of secondary schools was collected from the Kwara State Ministry of Education. The schools were already listed according to their Local Government Areas. Using this list, the first of every three schools in the local government area was selected, giving 24 schools. To make up a population of statistical significance, within the selected schools, only consenting teachers were given the self-administered questionnaire. Stratified random sampling method was used in taking into consideration the presence of both genders, i.e., every other consenting male and every other consenting female. Fisher's formula for calculating minimum adequate sample size [23], was used, which gave a sample size of 326, but 450 respondents were recruited to correct for attrition.

Sampling Method

A stratified random sampling method was used to determine the respondents to take the self-administered questionnaire. From a list of all the secondary schools in Ilorin, every third school located in each of the three local government areas (LGAs) in Ilorin was selected. At the selected schools, only teachers who gave informed written consent were recruited into the study.

Instruments

Each respondent completed a self-administered schedule comprising of a proforma for collecting sociodemographic and clinical characteristics, such as presence of diagnosed diabetes mellitus, sexually transmitted infections, cardiovascular dis-

orders, cancers, as well as surgeries involving the genital organs, damage to the spinal cord, or any physical deformities and the age at which it occurred. Also orthodox and traditional medication used in the last 6 months was sought for, as well as use of psychoactive drugs.

The questionnaire also included modified items from the International Index of Erectile Function (IIEF-5) [24]; such items included: in the last 6 months, how often respondents were able to get an erection during sexual activity; if there is erection, how often was it hard enough for penetration, how difficult was it to maintain your erection to completion of intercourse and during intercourse/sexual stimulation, how often did you ejaculate? Some items from the Sexual Activity Questionnaire (SAQ) [25] were also included. These include: in the last 6 months, for an average month, how often do you usually have sexual intercourse? Have you encountered difficulties? How would you rate your level of sexual desire? Questions to measure satisfaction with intercourse, sexual relationship, as well as satisfaction with overall sex life were also included. Other items of the questionnaire were included by the authors to address corresponding domains of female sexual function, e.g., frequency of lubrication, presence of pain, and ability to achieve orgasm. Also, the 30-item version of the General Health Questionnaire (GHQ-30) was to screen respondents for psychiatric morbidity. GHQ-30 is a self-administered screening instrument, designed to detect current diagnosable psychiatric morbidity in a community sample, clinical setting, and occupational setting; it is designed to cover four identifiable elements of distress, namely, depression, anxiety, social impairment, and hypochondriasis; thirty symptoms are rated according to whether they have been experienced “not at all,” “the same as usual,” “rather more than usual,” or “much more than usual” in the previous few months (6 months for this study) [26,27].

GHQ scoring method (0-0-1-1) was adopted, and each item was scored 0 (not at all or the same as usual) or 1 (rather or much more than usual), giving a maximum score of 30. Individuals scoring 4 or more were considered to have psychiatric morbidity in accordance with previous studies [26].

Administration of Questionnaire

A snapshot cross-sectional survey using the self-administered pilot-tested questionnaire was

carried out among consenting eligible respondents. While administering the questionnaire, respondents were reassured of the confidentiality of their responses as anonymity of the questionnaire was done. In addition, it was ensured that they did not discuss their responses with each other while filling the questionnaire. The questionnaires were hand collected thereafter.

Pilot Testing

This was carried out on 28 consenting teachers in a school not included in the main study. The questions were generally well understood and could be completed in 20 minutes, which was acceptable to the majority of the respondents.

Data Analysis

Data was analysed using Epi-Info Version 6.02 computer software (Micro Computers USD Incorporated, Stone Mountain, GA, USA). The total scores for GHQ-30 were calculated with a cut off point of four [27]. Only simple frequency tables were generated.

Results

Sociodemographic Characteristics

There was a 93% response rate. The ages of the respondents ranged from 20 to 65 years, with a mean of 36.4 years $S.D \pm 8.7$ years. In terms of age distribution, ≥ 30 year's age group had more respondents, 309 (74%), while the <30 years had 108 (26%). The gender distribution showed a representation of males to be 58%, and females 42%. Most of the respondents were married (77%), while the single, divorced, and widowed group accounted for 18, 4, and 1%, respectively (shown on Table 1).

Medical Problems

Medical and surgical problems among the respondents are illustrated on Table 1. Among 346 respondents, only 3 (1%) reported being previously diagnosed to have diabetes mellitus, among which only one was on treatment. Sexually transmitted infection (STI) was reported by 39 (11%) respondents out of 345, of which only 33 (85%) had treatment. Three hundred and forty-four responded to the questionnaire item on heart problems, with 11 (3%) having some form of heart problems. Eight (73%) of this number were receiving treatment. None of the respondents reported cancer involving the genitals. Only one (0.3%) of the 347 respondents reported trauma involving the genitals, while only 2 (1%) reported trauma to the spinal cord.

Table 1 Socio-demographic characteristics

Variables	n	% of N
(1) Socio-demographic characteristics		
Age (N = 417)		
<30 years	108	26
≥30 years	309	74
Gender (N = 394)		
Male	230	58
Female	164	42
Marital status (N = 413)		
Married	320	77
Single	74	18
Divorced	16	4
Widowed	3	1
Ethnic group (N = 312)		
Hausa	14	5
Ibo	34	11
Yoruba	232	74
Others	32	10
(2) Medical problems		
(a) Diabetes mellitus (N = 346)	3	0.9
(i) Being treated	2	67
(ii) Not being treated	1	33
(b) Sexually transmitted diseases (STD) (N = 345)	39	11
(i) Being treated	33	85
(ii) Not being treated	1	2
(iii) Missing data	5	13
(c) Cardiac problems (N = 334)	11	3
(i) Being treated	8	73
(ii) Not being treated	3	27
(d) Genital neoplasm	—	—
(e) Genital surgery	—	—
(f) Genital trauma (N = 347)	1	0.3
(g) Spinal cord damage (N = 347)	2	1
(h) Physical deformity (N = 346)	5	1
(i) Other forms of illness (N = 346)	50	14
(j) Orthodox medication (N = 344)		
(i) Analgesic	115	34
(ii) Hematenics	90	27
(iii) others	74	22
(k) Traditional medicine (N = 343)	33	10
(l) Substance use (N = 343)		
(i) Cigarette	12	3.0
(ii) Cannabis	1	0.3
(iii) Cocaine	1	0.3
(iv) Heroin	1	1.3
(v) Alcohol	31	9.0
(m) Use of drug in (L) above to aid sex (N = 336)	6	2

N = total number of respondents on each item; n = number of observed responses on the particular variable; % of N to the nearest whole number, or one decimal place.

Substance Use Among Respondents

The pattern of substance use is illustrated on Table 1. Cigarette smoking was reported by 12 (3%) of 343 respondents, but only 9 of the 12 (75.0%) indicated their level of consumption. Three (33%) smoked 1–3 sticks/day, while 6 (67%) smoked above 5 sticks/day. The mean was 4.6 sticks/day (SD ± 2.1). Only one respondent each reported ever using cannabis, cocaine, and heroin out of 343 respondents.

Thirty-one (9%) of the 336 respondents reported alcohol use, but only 9 (29.0%) subjects indicated their level of consumption per day. Seven (78%) took 1–3 bottles of beer/day, while 2 (22%) reported taking above 3 bottles of beer/day. In terms of consumption per week, 8 (90%) took 1–7 bottles of beer/week, and 1 (10.0%) took more than 7 bottles of beer/week. In terms of bottles/month, 9 (69%) took 1–10 bottles/month, and only 4 (3%) took more than 10 bottles/month (Table 1). Only 6 (2%) of the respondents reported using their drug habit to aid sexual performance.

Prevalence of Sexual Dysfunctions

The most common sexual dysfunction among the female respondents was anorgasmia (40%), lubrication failure (30%), and dyspareunia (12%). Among the male respondents, erectile disorder, premature ejaculation, and orgasmic disorder were reported as 23% each. Lack or loss of sexual desire was reported by 24% respondents, intercourse dissatisfaction (23%), while overall sexual life and relationship dissatisfaction accounted for 10% each (shown on Table 2).

Previous Treatment

Only 51 (12%) of the total respondents indicated a response to the question on whether they have

Table 2 Prevalence of sexual dysfunction and treatment modalities

Variables	n	% of N
(a) Prevalence of sexual dysfunctions		
1. Lack or loss of sexual desire (N = 312)	74	24
2. Lubrication failure (N = 123)	37	30
3. Female dyspareunia (N = 121)	14	12
4. Female orgasm disorder (N = 110)	44	40
5. Male erectile disorder (N = 201)	46	23
6. Premature ejaculation (N = 214)	50	23
7. Male orgasmic disorder (N = 205)	48	23
8. Intercourse dissatisfaction (N = 323)	82	23
9. Overall sexual life dissatisfaction (N = 320)	31	10
10. Relationship dissatisfaction (N = 298)	29	10
(b) Treatment modalities		
1. Have you sought treatment? (N = 51)		
Yes	24	47
No	27	53
2. Types of treatment (N = 24)		
i. Orthodox	13	54
ii. Traditional	7	29
iii. Spiritual	4	17
3. Reasons why treatment was not sought (N = 27)		
i. Fear of stigma	7	26
ii. Believed it was transient	12	44
iii. Not aware of hospital facilities	8	30

N = Total number of respondents on each item; n = no of observed respondents on the particular variable; % of N—to the nearest whole number.

Table 3 Sexual dysfunctions and GHQ-30 scores

Variables	<4	≥4	RR*	95% of CI	χ^2	P value
Frequency of intercourse/month (n = 234)						
<10	0 (0)	4 (100)	0.00	0.00–0.00	178.27	0.000
≥10	230 (100)	0 (0)				
Desire Level (n = 329)						
Very low-low	33 (15)	67 (62)	0.24	0.17–0.34	73.88	0.000
Moderate/high	188 (85)	41 (38)				
Lubrication (n = 120)						
Almost never/never	9 (11)	27 (71)	0.15	0.08–0.30	41.81	0.000
Sometimes/always	73 (89)	11 (29)				
Ease of penetration (n = 121)						
Never easy (i.e., painful)	4 (4)	6 (25)	0.16	0.05–0.54	8.48	0.004
Sometimes always easy	93 (96)	18 (75)				
Orgasm frequency in females (n = 115)						
Almost never/never	36 (88)	8 (40)	0.95	0.52–1.72	0.01	0.939
Sometimes/always	59 (62)	12 (60)				
Erection frequency (n = 201)						
Almost never/never	10 (8)	36 (51)	0.15	0.08–0.28	47.13	0.000
Sometimes/always	121 (92)	34 (49)				
Maintenance of erection to the end (n = 220)						
Sometimes/always difficult	170 (99)	43 (90)	1.10	1.00–1.22	7.64	0.006
Almost never/never difficult	2 (1)	5 (10)				
Ejaculation frequency (n = 231)						
Almost never/never	14 (8)	22 (41)	0.19	0.11–0.35	31.45	0.000
Sometimes/always	163 (92)	32 (69)				
Intercourse satisfaction (n = 325)						
Almost never/never satisfactory	22 (10)	60 (58)	0.17	0.11–0.27	82.92	0.000
Sometimes/Always satisfactory	199 (90)	44 (42)				
Overall satisfaction (n = 277)						
Almost never/never	9 (4)	21 (28)	0.16	0.08–0.34	28.26	0.000
Sometimes/always	192 (96)	55 (72)				
Relationship satisfaction (n = 299)						
Almost never/never	7 (3)	22 (28)	0.11	0.05–0.25	38.46	0.000
Sometimes/always	214 (97)	56 (72)				

n = Number of respondents; CI = confidence interval; % of N in row brackets to the nearest whole number; P value = Probability; χ^2 = chi-squared value; *RR = Relative Risk for scorers ≥4.

sought treatment for a sexual problem in the past. Of the 24 respondents who specified the type of treatment received, 13 (54%) had orthodox treatment, 7 (29%) had traditional treatment, while 4 (17%) had spiritual treatment.

Of the 27 respondents who answered “no” to the question whether they had sought treatment for their sexual problems, 7 (26%) gave their reason as fear of stigma, 12 (44%) believed it was a transient problem, and 8 (30%) claimed that they were not aware of hospital facilities for the problem (Table 2).

The high GHQ-30 scorers (i.e., ≥4) were significantly overrepresented in the various sexual dysfunctions, except in premature ejaculation in males, where the reverse was found (shown on Table 3).

Discussion

These data are part of a larger study. It assesses the help-seeking behavior among people with sexual dysfunction in the sample population. The high

response rate (93%) obtained in this study may be due to the fact that an educated group was targeted, and the steps that were taken to ensure confidentiality of responses.

Sexual health help-seeking behavior may be seen as part of health literacy, which in itself may be defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions” [28]. Limited health literacy may refer to marginal health literacy, inadequate health literacy, or both. This may have several undesirable health-related outcomes, such as inappropriate use of hospital facility and increased cost of care [29–31]. In Nigeria, there is an apparently low literacy level and a large proportion of the population may benefit from campaigns to improve literacy in all sectors of life, particularly the health sector [32]. This may promote in the people healthy lifestyles, appropriate health-seeking behaviors with the ability to make right choices, and appropriate use of the existing health care facilities, as well as advising

policy makers on health resources allocation and man-power development [32,33].

In this study, it was only 12% of the total respondents that answered the questionnaire item on treatment sought. This may be a reflection of the cultural “silence” given to issues of sexual problems. It is, however, not surprising that 53% of those that answered the item on “treatment sought” did not seek any intervention measures, because 44% of them believed it may be transient, while 30% claimed ignorance of hospital facility where treatment may be obtained—in spite of the fact that there are many easily assessed medical facilities in the study setting. This may imply that when they (as patients) visit the hospital, sexual issues are not discussed with their clinicians [3,4], nor are the clinicians asking about possible sexual complications of their illness, side-effects of its medications, or their lifestyle [34]; this may be attributed to lack of time for in-depth sexual history taking by the primary physicians, and lack of secondary care referral system available, as well as, patients’ reluctance to discuss these issues in general practice [35]. The fear of stigma was reported by 26% of the respondents, which is a major concern in our study setting, as people who suffer from sexual problems are despised and stigmatized and called derogatory names especially among the males. (This may include calling those with erectile dysfunctions names such as “February” [an incomplete month to represent a man whose sexual function is not optimal] and “esinu we” [back translation: a horse in a book—literal meaning: a still horse] in the Yoruba cultural setting). This makes people shy away from possible sources of health care, hence the need for confidentiality. Information about this needs to be made available in advance to increase trust and confidence in assessing sexual health services [36].

Fifty-four percent of respondents who sought treatment received orthodox care, but of note is the finding that 46% of the respondents who sought help for their sexual dysfunction chose alternative medicine; this choice might be due to preference of alternative medicine over the orthodox, or it may be for financial reasons, as alternative medicine may seem to be cheaper, or it may be due to ignorance of services provided by hospitals on sexually related matters. As alternative medicine provides services for a significant proportion of the population in developing countries [37], there is a need for organizing joint awareness-raising campaigns with the alternative care givers;

it is the general goal of health education to improve the health knowledge and attitudes of individuals, and thereby promote personal behaviors that will lead to optimal health and wellness. Furthermore, medical treatment of sexual dysfunction will result in increasing numbers of patients seeking help from their clinicians. So there is a need for understanding of sexual dysfunction and how to address this in primary care [38].

The finding of psychiatric morbidity as evidenced by a GHQ score ≥ 4 in most sexual dysfunction, intercourse dissatisfaction, and overall sexual life dissatisfaction could be a reflection of the degree of distress caused by sexual difficulties or the effect of probable distress causing a “dysfunction.” This may make it necessary for clinicians to probe their patients for a probable sexual problem, since patients may be reluctant to report this.

In conclusion, the study showed a prevalence rate of sexual dysfunction ranging from 10 to 40%, and majority of respondents (88%) were silent on treatment issues. Of those who responded, 53% did not seek treatment for the belief that it was transient (44%), ignorance of treatment in a hospital facility (30%), and fear of stigma (26%), while 46% of those who sought treatment choose alternative medicine.

Clinical Implication and Recommendation

All clinicians should pay more attention to possible sexual problems in all their patients by taking detailed sexual history, as patients may be reluctant to bring up such issues. Currently little or no emphasis is placed on the sexual health of patients during doctor–patient interaction in clinics in this country. It is recommended that special clinics be set up for sexual problems, and they could be multidisciplinary in nature, with a good and well-established referral pattern, as there are no such services in the country presently.

It is also recommended that sexual health education should be included in the curriculum of training for medical students and all cadres of medical personnel, as sexual dysfunction may have far-reaching consequences on the general well-being of patients. This is currently underemphasized in educational curriculum in the country, which may be a reflection of the “cultural silence” on sexually related issues other than HIV/AIDS in recent times. Furthermore, there is a need for awareness campaign programs for the general public. Both governmental and nongovernmental

organizations should be encouraged to form outreach programs to sensitize the public on sexual problems, as there are no such programs in the country at the moment. Also, helplines and websites should be made available for people with sexual dysfunctions to get counseling services, such as to ensure confidentiality for shy people or those who are afraid of being stigmatized by their attendance of a sexual dysfunction clinic.

Limitations

The use of some items from the Sexual Activity Questionnaire, in conjunction with items from the IIEF-5 in our environment, may need to be validated; however, the sample population was quite literate and no problems with understanding of test items were encountered.

The need for arbitrary subdivision (e.g., in age <30 and ≥ 30 [the choice of 30 years as cut-off was also based on the fact that by the age of 30 years, most people in our culture are married or expected to be married, particularly the females], frequency of sexual intercourse of <10 per month and ≥ 10 per month), and the need to merge some questionnaire responses (e.g., sometimes/always, almost always, never/never) as result of small cell size could have introduced some bias.

This study was carried out among secondary school teachers (i.e., the educated), and education may have an impact on sexual functioning, which may limit generalization of findings from this study, as well as, the fact that majority of the respondents (74%) were from one ethnic group (Yoruba). Due to the very personal nature of questions asked, a few teachers refused to participate fully in the study despite adequate information and assurance on confidentiality, hence some questionnaire items were not supplied. Missing data may have introduced errors to the result. Also variable on the questionnaire may be answered with social desirability in mind, thereby introducing bias.

Many of the findings could have been enriched by the inclusion of in-depth interviews and/or focused group discussions, as well as carrying out multivariate analysis.

Corresponding Author: Olushola Adegunloye, FWACP, Department of Behavioural Sciences, College of Health Sciences, University of Ilorin, Ilorin, Kwara, Nigeria, 240001. Tel: +2348033701859; E-mail: solalami@yahoo.com

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Statement of Authorship

Category 1

(a) Conception and Design

Olushola Abejide Adegunloye

(b) Acquisition of Data

Olushola Abejide Adegunloye

(c) Analysis and Interpretation of Data

Olushola Abejide Adegunloye; Grace Gwabachi Ezeoke

Category 2

(a) Drafting the Article

Olushola Abejide Adegunloye

(b) Revising It for Intellectual Content

Grace Gwabachi Ezeoke

Category 3

(a) Final Approval of the Completed Article

Grace Gwabachi Ezeoke; Olushola Abejide Adegunloye

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