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Communication and sexuality in a Nigerian community

J.E.N. OKONKWO (1), R. UWAKWE (2), C. OBIONU (3) and C.V. OKONKWO (4)

(1) Department of Obstetrics and Gynecology, Nnamdi Azikiwe University Teaching Hospital, P.M.B. 5025, Nnewi, Nigeria
(2) Department of Psychiatry, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria
(3) Department of Medicine, University of Nigeria Teaching Hospital, Enugu, Nigeria
(4) Department of Mathematics/Computer Sciences, Nnamdi Azikwe University, Awka, Nigeria
Address for correspondence: Dr J.E.N. Okonkwo, 18 Second Avenue, Trans-Ekulu, PO Box 8282, Enugu, Nigeria

Abstract

The traditional lack of interest in discussing sexuality creates a problem in doctor–patient communication, and this can affect patient management adversely. The dearth, ease or comfort in discussing sex was examined by a self-administered questionnaire to respondents, mainly medical students, nurses and paramedics, 20–70 years of age, who were not seeking treatment for sexual problems. The respondents were mainly of Igbo extraction from Eastern Nigeria. Factors considered include age, sex, religion, marital status, and education. The results show that 71.9% of all the respondents indicated that they would like to be able to discuss freely whereas 28.1% never really bothered; 40.9% of all the respondents could discuss sex with anybody whereas 59.1% could not; 75% in the married group discussed sex freely with their spouses or friends and 25% were unable to do so. Education showed a very significant influence on the ability to discuss sex freely. It is suggested that a systematic approach to education, especially sexual health education, may be a major way to combat the prevailing cultural inhibition.

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Traditionally there is a general lack of interest in discussing sexuality; most cultures have shrouded sexuality with privacy and fear [1–3]. Such uneasiness creates a vacuum concerning a subject that deals directly with a vital sphere of human existence and touches on health, moral values and even legal sanctions. Although many patients experience anxieties about their sexual lives, they find it just as difficult as health professionals to initiate such discussions [4,5].

Despite the fact that the public has been inundated with books, magazines, movies and television shows about sex which should create some openness in sexuality discussions, experience in our clinic reveals that patients confuse science with morals, stemming from personal discomfort, lack of professional exposure or the paucity of programmed sexual information. This lack of interest in discussing sexuality can create problems in doctor–patient communication which can adversely affect patient management.

This report examines the dearth, ease or comfort in discussing this subject among respondents not seeking treatment for sexual problems. It is part of a stratified cross-sectional study designed to identify problem areas, the acceptability or non-acceptability of discussing this topic and possible promoting or hindering influences.

Materials and methods

The human sexuality questionnaire (HSQ) was specifically developed for the study. It is a 106-item self-reporting questionnaire, with an additional 14 questions on demographic characteristics. The questionnaire was divided into several areas: source of sex education, contraception, definition of sex, trends in sexuality, sexual dysfunction (problems) and willingness/ability to discuss sex freely, including attraction to the opposite sex partner. The questions in these areas, however, were spread throughout the questionnaire, thus providing a convenient means of assessing knowledge about attitudes to and practice of sex.

The questions were based on the information about sexuality commonly provided in most general texts and as summarized in the Fourth Revision of the Diagnostic and Statistical Manuals of Mental Disorders DSM-IV, APA (1994). Validation was satisfactorily established by peer review.

The questionnaire was administered to doctors (registrars) and final-year undergraduate medical students of the University [illegible]geria (UNTH), Nnamdi Azikiwe University, Nnewi (NAUTH) and the Un[illegible] of Benin (UBTH). Selection of respondents in each class was by rando[illegible]ling. In addition, a non-medical student populati[illegible]e study sites had [illegible]estionnaire administered following random sampling[illegible]nymity was mainta[illegible]d and the comp[illegible]uestionnaires retrieved. Every respondent consented to the study. Analysis was by comparisons of averages and proportions between the various groups; Student's *t*-test and χ^2 tests were used.

Results

Altogether, 250 questionnaires were distributed. In total, 113 questionnaires were acceptably completed by respondents whose ages ranged from 20 to 70 years; 64.6% (73) were female; 35.4% (40) were male. Forty-nine questionnaires were rejected because of obvious inconsistencies such as non-agreement between age and birth date; 88 questionnaires were lost. Not all the questions were answered by all respondents. Table 1 shows the demographic data: 67.9% were married for the first time and 25.1% were single; 65.2% had received tertiary education, 25.9% secondary and others only primary or no education. All were of Igbo extraction and all of Christian faith.

Seventy-five per cent freely discussed sex with their spouses and/or friends while 25% were unable to do so freely; 40.9% could discuss sex with anybody whereas 59.1% could not. On the other hand, 71.9% would like to be able to discuss sex freely with their spouses while 28.1% were not bothered either way. Forty respondents indicated what topics they would like to discuss, and these include sexual techniques, what sex is all about, sexual response and satisfaction, sex education, sex and pregnancy, orgasm, and the implications of free sex and family planning. Table 2 shows the effect of education on the ability and willingness to discuss freely; p value = 0.00066503. Of the 69 respondents between the ages of 20 and 35, 31 did discuss sex freely whereas 38 were unable to do so. Between the ages of 36 and 70, 14 respondents discussed sex freely whereas 25 were unable to do so (Table 3). Twenty-four of the 71 female respondents discussed sex freely whereas 47 were unable to do so. On the other hand, 21 of the males were able to discuss sex freely whereas 18 were unable to do so.

In considering religious influences on the responses, the figures were subjected to statistical analysis. The calculated value of $\chi^2 = 2.69$ is less than the critical value (at $p < 0.05$) of 3.84; hence, there is no significant difference between the mean response of free thinkers and strictly religious groups in discussing sexuality. Interestingly, of the 65 respondents who were uncomfortable discussing sex freely with anybody, 25 admitted to coitus before marriage yet were inhibited in responding to the question on achievement of orgasmm with first coitus. The effect of marital status on the ability to discuss freely is shown in Table 4. Among the 57 who responded, 41 discussed sex freely whereas 16 did not. This was, however, not very significant (p = 0.188580).

Discussion

It is within the younger age groups that the sexual revolution is making its greatest strides [6–9]. By contrast, there was some apathy among the older respondents in discussing sexuality (see Table 3). Levin *et al.* observed that one problem that concerned couples was to keep alive the physical attraction that had originally brought them together. Sooner or later – and for some husbands and wives it happens with dismaying swiftness – the magnetism of their bodies seem to lose much of its

Table 1. Demographic data

Datum	*Female*	*Male*
Age (years)*	32 ± 9.112	36 ± 10.100
Tribe/race	Igbo/black	Igbo/black
Education:		
None	1	1
Primary	4	0
Secondary	14	6
Tertiary	31	8
Religion:		
Catholic	31	8
Anglican	9	6
Other	1	2
Occupation:		
Semiskilled/skilled manual	3	0
Clerical/sales/technician	9	1
Administrator/minor professional	3	2
Manager or midlevel professional	2	0
Medical doctor	9	5
Medical student	19	5
Annual income (naira):		
5000–10 000	2	0
11 000–15 000	3	1
16 000–20 000	1	0
21 000–25 000	4	0
> 26 000	9	45
Marital status:		
Single	7	4
Divorced	3	1
Widowed and single	0	1
Widowed and remarried	1	0
First marriage	39	1
No. of children in marriage:		
0	26	11
1	3	1
2	6	1
3	5	0
4	8	1
5	5	1
6	2	1
7	1	2
8	2	1
Upbringing:		
Strictly religious	18	4
Free thinking	26	7

*Date of birth used to countercheck age

Table 2. Education and free discussion

Education	*Free discussion*	*Restricted discussion*	*Total*
None	0	3	3
Primary	2	4	6
Secondary	23	4	27
Tertiary	30	8	38
Total	55	19	74

Table 3. Age and willingness to discuss sex

Age (years)	*Willing*	*Unwilling*	*Total*
20–25	10	0	10
26–30	12	6	18
31–35	8	0	8
36–40	5	3	8
41–45	3	3	6
46–70	4	7	11
Total	42	19	61

$p = 0.07898202$

Table 4. Effect of marital status on discussion of sex

Marital status	*Discussing freely*	*Not discussing freely*	*Total*
Divorced and remarried	3	1	4
First marriage	60	13	73
Single	16	0	16
Widowed and remarried	2	0	2
Widowed and single	1	1	2
Polygamous	1	1	2

force. Neither partner may say anything about it but both are likely to be distressed by what appears to be a gradual decline in sexual excitement [1]. We would have expected easy verbalization of this problem at least in the older age group, but, despite the importance of this issue to their health care, many women and men find it difficult to talk even to their physician about sexual issues, let alone discuss it with others. In fact, many physicians are uncomfortable discussing sexual issues with their patients [6–9].

Our results highlight this problem: 59.1% of our respondents could not discuss sex with anybody while 71.9% would like to be able to do so with their spouses; 75% were able to discuss sex only with their spouses or friends and 25% were unable to discuss sex even with their own spouses. According to Frank *et al.*, approximately 60% of women questioned in the United States of America had concerns about their sexuality [10]. Theirs, however, is a different problem in that they were able to discuss and admit their problem. The problem here is that of initiating discussion at all, let alone admitting that a problem exists. Many cultural barriers, like male dominance over females, polygamy, forced 'dumbness' [11] imposed on women, female passivity and low status of women contribute to the communication gap.

Good communication is essential to patient assessment and treatment. How can we achieve this in the area of sexuality? It is known that many sexual variables exert influences on patients and on the care they receive. These external influences include psychological, genetic, biologic, social, and economic issues. Also, factors that affect individuals' perception of disease and their means of coping with illness include: education, attitudes, understanding of human reproduction and sexuality, family history of disease, and, in some cases, need for attention [12–14]. Cultural factors, socioeconomic status, religion, ethnicity, and sexual preference are important considerations in understanding a patient's response to his or her care in both illness and health. We believe that religion and education bear heavily on this problem; consequently, we considered the effects of these two factors on this problem. The data were subjected to the χ^2 test. The null hypothesis was not rejected since the calculated value of $\chi^2 = 2.69$ was less than the critical value at $p < 0.05$. The observed difference in the mean response of free thinkers and those with a strictly religious upbringing, with respect to discussing sexuality, might be attributed to chance. Education, on the other hand, had a very significant positive effect on both respondents raised as free thinkers and those who had had a strictly religious upbringing ($p = 0.00066503$). Education on sexuality is therefore a necessity. Levin, in the preface to Masters and Johnson's *The Pleasure Bond* stated it all: "To choose to ask questions and learn the truth about sex is a personal choice. To evaluate answers is a personal necessity. To be comfortable with what one learns and to utilise what one knows in the establishment of an enduring sexual relationship is a lifelong quest" [1]. This is a necessity, especially in medical practice.

Many physicians in our cultural setting have anxiety about discussing sexual issues with their patients and believe that they lack the required basic skills to provide sexual counselling. The PLISSIT model [15] has been useful in approximately 80 90% of sexual concerns [16] in the developed world. The culture of the developing world means that different opinions, norms and values affect behavior [17]. Some

actions that would undoubtedly be effective in the Western world are not as effective, or may even be counterproductive, in developing countries. One effective way to approach this problem is to develop insight into the effective ways of approaching the individual or the community on matters of health education – in this case, human sexuality – such that the patients can translate what is being discussed into their own cultural terms in order to give appropriate responses. A policy formulated and based on further research into the cultural values of people in this part of the world will be of immense value to understanding and curbing the sexual excesses prevalent in this AIDS-infested era.

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Resumé

Le manque traditionnel d'intérêt à parler de sexualité crée un problème de communication entre médecin et patient, ce qui peut avoir des incidences défavorables sur le traitement de ces derniers. Cette réticence, la facilité ou l'aisance à discuter de questions sexuelles ont été examinés à l'aide d'un questionnaire auquel ont elles-mêmes répondu les personnes interrogées, surtout des étudiants en médecine, des infirmières et du personnel paramédical âgés de 20 à 70 ans, qui ne sollicitaient pas un traitement pour des problèmes

sexuels. Les répondants étaient pour la plupart d'origine Igbo du Nigéria oriental. Les facteurs pris en considération comprenaient l'âge, le sexe, la religion, l'état matrimonial et l'éducation. Les résultats indiquent que 71,9% des participants ont fait savoir qu'ils souhaiteraient pouvoir discuter librement tandis que pour 28,1%, cela n'avait réellement pas d'importance. 40,9% des sujets pouvaient parler de questions sexuelles avec n'importe qui tandis que 59,1% ne le pouvaient pas. 75% dans le groupe de gens mariés discutaient librement de questions sexuelles avec leur époux ou leurs amis et 25% n'étaient pas capables de le faire. Le degré d'instruction s'est révélé avoir une influence très significative sur la capacité de discuter librement. On suggère qu'une approche systématique de l'éducation, en particulier de l'éducation en matière de santé sexuelle, pourrait être un moyen essentiel pour lutter contre l'inhibition culturelle prédominante.

Resumen

La tradicional falta de interés en tratar la sexualidad crea un problema en la comunicación entre médico y paciente, lo cual puede afectar adversamente el tratamiento del paciente. La falta, facilidad o comodidad en el tratamiento de las relaciones sexuales fue examinada mediante un cuestionario autoadministrado a entrevistados, principalmente estudiantes de medicina, enfermeros y personal paramédico de 20 a 70 años de edad, y que no solicitaban tratamiento por problemas sexuales. Los entrevistados eran principalmente de origen Igbo de la región oriental de Nigeria. Los factores considerados comprendieron edad, sexo, religión, estado civil y educación. Los resultados señalan que el 71,9% del total de entrevistados indicaron que desearían tratar el tema libremente, mientras que al 28,1% no le preocupaba realmente. El 40,9% del total de entrevistados podían tratar las relaciones sexuales con cualquiera, mientras que el 59,1% de los entrevistados no podían hacerlo. El 75% de los entrevistados en el grupo de casados trataban las relaciones sexuales libremente con sus cónyuges o amigos, y el 25% de los integrantes de este grupo no podían hacerlo. La educación señalaba una influencia muy significativa sobre la capacidad de tratar el tema libremente. Se sugiere que un enfoque sistemático de la educación, especialmente la educación sobre salud sexual, podría ser una forma importante de combatir la inhibición cultural predominante.