



Women's Sexual Health Journal

This Issue

Persistent Sexual Arousal Syndrome (PSAS) has garnered some much needed media attention through the efforts of Jeannie Allen, Founder of a PSAS support group (www.psas-support.com) and Lisa Martinez, Executive Director for The Women's Sexual Health Foundation. ABC's 20/20 did an informative piece that avoided sensationalism. Many sufferers saw that program and realized that they were not alone. The program was particularly disturbing in that one woman had over 40 electroconvulsive shock treatments (ECT) in an attempt to alleviate her PSAS. Although there has been a smattering of reports that ECT has been effective in a few cases, there has been no properly executed evidence-based peer-reviewed publication of the efficacy and safety of this treatment. The doctors promoting this treatment are pushing the limits of ethical behavior in my mind. One of the dangers of having an ill-defined syndrome is that there is a tendency for patients to grasp at any possible solution. This makes those patients particularly vulnerable to doctors who claim to have a "cure."

The Q and A section of this issue addresses vaginismus, another disorder that can be very frustrating to diagnose and treat. In a previous issue (January, 2005), we had a story about a woman who had been

through religious and psychological treatment before she found a physician who could help her.

The Sexual Medicine article in this issue was submitted by a medical group

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from Nigeria. Their survey was intended to gather data on sexual practices in young Nigerian women because of ever increasing concerns about the African pandemic of HIV/AIDS. Their results are important in that there are trends to earlier, unprotected sexual activities with multiple partners. They call for greater educational activities to promote safer sexual practices. *D. Ferguson*

A Woman's Story: PSAS

I'm a 60 year old grandmother, so some of this story is going to be a little hard to believe...it was/is for me, and I'm living it. Approximately 5-6 years ago, I started noticing some strange tingling in my genital area. It didn't seem particularly bothersome at first, so I merely blew it off. But as time went on, instead of going away, it grew more intense. What is this? Could this be....noooooo....I'm 55 years old....and

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Articles, letters, and questions may be submitted to the Editor, David Ferguson, at info@twshf.org.

nobody has this anyway. Or do they? Could it be possible be that I'm sexually aroused 24 hours a day, 7 days a week? That can't be....I'm a grandmother for Pete's sake! Even though I have a wonderful relationship with my husband of nearly 40 years, I've never had much of a sex drive. And even though this *feels* like arousal, I have no desire for intercourse. Who could I ask... who could I talk to? The truth was...NO ONE! I felt such embarrassment, I couldn't even discuss it with my own husband. What would I say...how would I begin to say it? So I kept it my secret.

The symptoms grew worse. There was intense throbbing like all the blood in my body had for some reason settled in my genitals. Could I stick a pin in my clitoris and let the blood flow out...would that relieve this unbearable pressure? Of course not; what could I be thinking. That's just it; I wasn't thinking....I was consumed with feeling. It's all I could think about. I couldn't concentrate on anything else, I didn't want to talk to family or friends, I didn't want to go outside the house... someone may be able to tell by looking just what kind of a weirdo I really am! I fell into a deep depression, I felt so alone. I couldn't do much of anything any more, not even sleep. I felt shame. By this time, I felt disgust toward myself; surely I had done something to cause this...but what? I had no purpose in life anymore. All I could think about was me. My poor husband had taken over all the household chores...all the shopping, even the cooking. He didn't deserve this. I decided there was only one thing I could do for him. I wrote him a letter. To this day I don't know exactly why I put the letter away, but thank God I did.

I was channel surfing during one of my sleepless nights, and something caught my eye on the Discovery Health channel. It was a woman in a Doctor's office describing symptoms *exactly* as I would describe mine!

And to my surprise, the condition had a name! Persistent Sexual Arousal Syndrome (PSAS). I felt validated again....I *wasn't* crazy, and after watching the program, I was able to sit down and for the first time discuss it with my husband. It was then we decided I should see my family doctor; after all, it was a medical condition with a name, right? He'd know what to do. He not only didn't know what to do, he had never heard of it. I shuddered with embarrassment and shame; I just wanted to get out of there and go home to the safety of my living room! But it WAS a medical condition with a name, so with much encouragement from my husband we decided to go to Iowa City where they have specialists. Not only that, it's a teaching hospital; they'll understand and know what to do. Boy, was I in for a surprise!

When I told the Doctor what my symptoms were and how I was sure it was Persistent Sexual Arousal Syndrome (PSAS) as I had seen it on TV and had found it on the internet, he told me he had never heard of such a thing! He then told me I needed an antibiotic for a yeast infection and to stop trying to diagnose myself from TV and the internet! He gave me somewhat of a 'lecture' on women trying to take things into their own hands! Well, strike 2 but I wasn't ready to quit.

I'd go to Des Moines to an OB/GYN (we don't have any in our small town), only this time I'd go to a woman. Talking woman to woman would be easier. I couldn't have been further from the truth. She not only hadn't heard of it, she appeared uncomfortable as I talked to her. I decided to give her a break and just leave...I was getting use to this! Somehow....and I don't really remember how it came about, someone mentioned the possibility that perhaps pudendal nerve damage may be the cause of PSAS. I heard of a Dr. in Minnesota who was working with patients with pudendal nerve damage, so I contacted

him. He appeared to have heard of PSAS and thought that it was worth seeing me. We drove to Minnesota and after a few tests, he felt I did indeed have some nerve damage. I went to Minnesota several times for injections into the pudendal nerve but they were of no benefit, so it was decided that surgery was the only way to go. I underwent bilateral pudendal nerve decompression surgery in October of 2004. That too, was unsuccessful, although I do have to say, the doctor said it can take up to 2 years for the nerve to “settle down,” so I guess I still have a bit of hope.

It seemed as though there just wasn't a treatment for this condition...the hell was to be permanent. My depression continued to grow worse. My doctor tried different pills...anything to help me settle down and relax....and something to sleep...I needed sleep so badly!

In May of 2005 I decided to see a Psychiatrist. I went to a Doctor in Des Moines and was a little shocked when he first walked into the room....he was just a baby! He took one look toward the calendar and said ‘Mother’s Day....I gotta get my mom a card! Hmmm...I thought. He’s a *real* person and was so nice. My first question was “I don’t suppose you’ve ever heard of PSAS have you?” I about fell off of my chair when his reply was “Yes!” We have worked well together. He reads materials I take to him...he has some ideas...a very good doctor/patient relationship. I then read from a doctor on the internet that researches PSAS that electroconvulsive therapy (ECT) had helped one woman with PSAS, and he felt it had great promise. I talked to my doctor in Des Moines about it, and although he had reservations, he did feel my deep depression warranted the ECT (after many trial medications), so maybe I’d get a double benefit. I had my fingers crossed! I have to say, that after many weeks of ECT, my

depression IS much improved, but my PSAS remains virtually unchanged. I continue to this day to experience some memory loss from the ECT which is a side effect.

I still see my doctor in Des Moines. He continues to work with me, and we both seek to find an answer to this curse. I have my good days and my bad days. I have promised my family I will NOT consider suicide again as a solution, but there are days I want to. Without the support group on the internet, I don’t know what I’d do. We’re just all hoping there’s relief for us....the sooner the better. *Anonymous*

Questions and Answers

Q--- I would like to have a better understanding of vaginismus. What is it, and how can it be treated?

A--- We will address some of the physical and emotional aspects of vaginismus and potential treatments.

Vaginismus: The Physical and Emotional Side and Some Solutions

Vaginismus is defined as the recurrent or persistent involuntary spasms of the muscles of the outer part of the vagina that limits the ability to have intercourse. Treatment may involve some trial and error. So it is not unusual for women and their partners to express frustration during the treatment period.

Emotional Side

First of all you are not alone. Other women have had vaginismus, and it is not a punishment. Loss of sexual desire is not uncommon with vaginismus, because no one likes to have sexual intercourse if it is going to be painful.

Make sure that your partner understands vaginismus is a physical problem. Your partner may think not wanting to have sex is just a way to say you are not interested in continuing the relationship. Also, your partner needs to understand that vaginismus is treatable, but it takes time. There is no quick fix. Partner involvement in the treatment of vaginismus is very important.

It is recommended that a certified AASECT sex therapist be part of the treatment team. The therapist can evaluate the emotional aspects of vaginismus and whether it has impacted the relationship, creating negative attitudes toward sexuality. Depression and anxiety also must be addressed by the therapist before and during treatment.

Support Groups

Find a community or online support group such as

<http://health.groups.yahoo.com/group/vaginismus/>

<http://health.groups.yahoo.com/group/1vaginismus/>

Physical Side

Vaginismus can be treated. Find a group of professionals who understand vaginismus and have expertise in the diagnosis and treatment. The team should include at least a gynecologist, a physical therapist, and a psychotherapist. The gynecologist should make sure that the vulvar pain is not due to another gynecologic condition such as an abnormality of your hymen, a dermatologic condition (lichen sclerosis, lichen planus, etc.) or neurologic problem. The gynecologist may order compounded medications if necessary, or give trigger point injections. The physical therapist

should be a person who specializes in pelvic floor problems and can evaluate your pelvic floor, plus devise an individual plan including but not restricted to massage, biofeedback, dilators, and other treatments. The psychotherapist should preferably be an AASECT certified sex therapist who has worked with pain patients before. The treatment of vaginismus requires a multi-disciplinary approach.

Vaginismus can be found in patients who have never been sexually active or can start at anytime during a woman's life. Below are some of the methods that may be used to treat vaginismus.

Kegel Exercises

Kegel exercises may be recommended. These exercises help to gain control over your pelvic and vaginal muscles. Kegel exercises involve repeated tightening and releasing of the pelvic muscles that control the flow and stopping of urination.

Pre-Insertion Therapy

Typically, a woman will begin pre-insertion therapy by looking at her vulva and learning the names and locations of the various body parts. Once she is comfortable looking at her vulva, she can proceed to touching these areas. The next step may be insertion therapy.

Insertion Therapy

Some women find finger insertion (either their own or someone else's) easiest, while others find it easier to insert objects such as a Q-tip, tampon with applicator, or small dilator. It is largely a matter of individual preference, and for some women, a matter of much trial and error. Some find the services of a gynecological physical therapist

(physiotherapist) more beneficial with this therapy. The physical therapist may recommend the use of lidocaine to minimize discomfort.

For those who are unable to insert anything, not even a tampon, you could first try to insert your (well-lubricated - KY jelly, for example) middle finger up to the first knuckle (while lying down, knees drawn up and over a foot apart). Depending on the woman, this can take 10 minutes or more at the first try. Feel free to re-lubricate your finger as often as you wish. The key is to do a few Kegels first and insert during the relaxation phase, while breathing out slowly (or singing a slow song!). Once you have mastered this, you should try to insert up to the second knuckle. You may encounter a "wall" at this point. Try not to feel overwhelmed and discouraged. Give it time and practice with these techniques. Or try the following: wiggle your finger around until you find a position which enables the finger to make further progress. A second trick at this point is to keep slight pressure on the vaginal wall until you are able to slide your finger in a little further.

Once you are able to insert a finger fully, try and insert two fingers at the same time. You might then consider going to a gynecological physical therapist, or involving your spouse/partner in the treatment, or embarking on dilation therapy as outlined in the next paragraph.

Dilation therapy.

Acquire dilators of varying sizes. Start with the dilator with the narrowest width and work with it. Follow the tips for the finger insertion mentioned in the previous paragraphs until you are able to fully insert it. This can be a matter of minutes, or months. Then proceed to the next widest

dilator, until you are able to fully insert that. Keep going until you are able to fully insert a dilator the width and length of an erect penis. Then, attempt intercourse in a variety of positions until you find the position that best works for you. Try being on top for starters. The on top position may give you better control.

Calendar for 2006

July 12 - 15 [International Society of Sex Research](#) , Amsterdam, Netherlands.

September 21 [Second European Female Sexual Dysfunction Conference](#), London, UK

October 11 - 14 [North American Menopause Society Annual Meeting](#) , Nashville, Tennessee.

October 21 - 25 [62nd Annual Meeting of the ASRM](#) , New Orleans, Louisiana.

November 9 - 12 [The Society for the Scientific Study of Sexuality \(SSSS\)](#) , Las Vegas, Nevada.

Sexual Medicine Article

A STUDY OF SEXUAL BEHAVIOR AMONG NIGERIAN WOMEN

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ABSTRACT

OBJECTIVE: To study the pattern of sexual behaviors of Nigerian women in view of the HIV/AIDS pandemic.

METHODOLOGY: A community-based study among women, 15–49 years. Data were obtained using a standard questionnaire and applied on 2001 respondents.

RESULT: Sexual experience was 45%, 79% and 96% among women aged 15–19 years, 20-24 years and over 30 years respectively. The median age at first sex was lower in rural areas. Only 3% of respondents reported having multiple sex partners and was significantly associated with marital status and level of education. 14.8% of sexually active women were on contraceptives.

CONCLUSION: The high level of sexual activity without concurrent contraceptive use calls for strategies to promote contraceptive use and safer sexual behavior.

Keywords: Sexual behavior, Nigerian women, Contraception.

INTRODUCTION

Unplanned pregnancy, unsafe abortion, HIV/AIDS and other sexually transmitted infections are some of women's most important public health issues today. Global estimates of annual incidence of sexually transmitted diseases show that rates are not only increasing but also are highest in Sub-Saharan Africa.^{1,2,3} In Nigeria, the prevalence rate of HIV/AIDS has been found to be steadily increasing³. In 1998, the incidence of abortion in Nigeria was found to be 25/1000 of women in the reproductive age (15-49 years) and it is estimated that, annually, over 20,000 women die from complications of unsafe abortion^{4,5}. This poor reproductive and sexual health status could be the result of a proportionately high level of risky sexual behavior especially among young adults.

In 1998, the sexual health survey of primary school pupils aged 14 years and above in rural Tanzania was carried out. One hundred and fourteen of the 9,283 of them were found to be pregnant, 14 were HIV positive, 83 were positive for Chlamydia and 12 were found to have gonorrhoea⁶. In other parts of the world, previous studies have shown that almost all women over 20 years have had sexual intercourse and one quarter to half of young women aged 15-19 years have had sexual experience^{7,8}. These precise figures have helped to plan adequately for the reproductive health needs of the communities and to tailor family planning services to the different age groups.

In Nigeria, the need for culturally appropriate interventions to respond to sexual risks has been recognized and some studies on sexual activity have been carried out. The sexual activity among adolescents in Edo state of Nigeria was found to be high. By age 20 years, over 90% of young people have become sexually active. Furthermore, these young adults have been reported to

engage in sex with multiple partners and not to practice barrier contraception especially for their first sexual exposures⁹. Another study in the South Western Nigeria found that a large number of out of school adolescents working in motor parks engaged in sex¹⁰. More of such studies are needed to identify the reproductive and sexual health needs and to plan appropriate interventions.

Around the world, trends in sexual behavior revealed that there has been a drop in the age at first intercourse over the last 50 years. In the 1950s, less than 10% of young persons had sexual intercourse. Today the age at first sex of many of 16-19 years olds is 16.⁷

In Nigeria the median age at first intercourse in the females in Edo state was found to be 17 years and 16.9 years was reported by the Federal Ministry of Health^{4,11}. Trends over the years if known would help to determine areas where we can modify the available reproductive health programs and facilities to meet the sexual health needs of our adolescents.

The objectives of this study included:

- To examine sexual activity of women in Nigeria.
- To examine the factors associated with multiple sex partners in Nigerian women.
- To examine trends in first sexual intercourse of Nigerian women.
- To relate sexual activity with contraceptive use or non-use.

MATERIALS AND METHODS

Sample Size: This was primarily a descriptive study. The aim was to estimate any given population parameter with a specified level of precision and confidence. The level of confidence was specified as 95% and the tolerable error margin was 5%. Several specifications for p were made

based on the study objectives. The largest sample size, which satisfied all objectives, was used. The expression for cross-sectional descriptive studies: $n = Z^2 (100-p)p / d^2$ was used and a sample of 323 respondents were needed. The sample sizes were adjusted further to compensate for non-response rate of 20% thus the final minimum sample size was 480 per State.

Selection of Respondents: Four States, were randomly selected for the study, one each from the four health zones - Anambra from Health Zone A in the Southeast, Oyo from Health Zone B in the Southwest, Kaduna from Health Zone C in the Northwest and Bauchi from Health Zone D in the Northeast. A multi-stage cluster sampling design was employed to select the respondents. In each health zone, two local government areas (one urban and one rural) were randomly selected. Two hundred and fifty (250) women in the reproductive age group (15-49 years) from each LGA were included in the survey. Enumeration Areas (EAs) served as the Primary Sampling Unit (PSU) in the LGAs. These are geographic clusters that have been clearly demarcated by the National Population Commission. A systematic sampling approach was used to select ten EAs from each LGA. In each EA, a random starting point was determined in the field by the supervisor using a community landmark such as Village Square, church or a mosque. Eligible respondents were consecutively recruited and interviewed until the required sample size for the selected EA was achieved. Only one eligible respondent was interviewed per household. If a household had more than one eligible respondent, only one was randomly selected. A total of 2001 respondents were interviewed in the year 2002, and these were fairly evenly distributed between rural and urban areas.

Data Management: The Epi info statistical software was used for data entry, validation and analysis. Frequency distribution tables were generated for all categorical variables. The measures of location and of variability were determined for quantitative outcomes such as age, age at first sex and number of sexual partners.

To determine whether differences in means between contraceptive users and non-users were statistically significant, the independent student's test was used if variances were homogenous. Where variances were found not to be homogeneous, the non-parametric analog, the Mann Whitney U-test was the test of choice. Differences and associations yielding p-values of 0.05 or less were considered statistically significant.

RESULTS

A total of 2001 respondents were interviewed and they were fairly, equally distributed between rural and urban areas.

Table 1: The Proportion of sexually experienced women in Nigeria in various age groups and locations.

Table 2: Percentage distribution of Sexually abstinent women in various age groups ($n=354$).

Table 3: Percentage of reasons for sexual abstinence in Nigerian women ($n=354$).

Table 4: Age at first sex of women in rural compared with urban locations.

Table 5: Number of sex partners in various age groups.

Table 6: Sexual Activity versus Current Contraceptive Use or Non-Use.

Table 7: Association between some independent variables and sex with multiple partners.

Table 8: Logistic Regression of the relationship between some independent variables and sex with multiple partners.

Figure 1: Percentage of Respondents with multiple sex partners by marital status.

Figure 2: Multiple sex partnership by level of education.

The age distribution of respondents is shown in Table 1. The highest number was in the age group 20-24 years (22%), followed closely by 15-19 years (19.6%). The least number of respondents came from age group 35-39 years (12.4%).

Generally, most of the women have had sexual intercourse with men (78.3%). More than 96% of the women over the age of 30 years have had sexual experience. Forty five percent of women aged 15-19 and 79.1% of women aged 20-24 years have had sex with men. The proportion of sexually experienced young women varied between the regions. In the Northeast, sexual experience was especially high in women 15-19 years (84.7%) but in the other regions the rates ranged from 32-36.8%. In the Northwest, 21.1% of the young women in the urban location were sexually experienced compared with 46% in the rural area. Also in the Southwest, 30.9% in urban compared with 52.4% in the rural location were sexually experienced. In women aged 20-24 years, sexual experience ranged from 67.2% in rural Northwest to 90.5% in rural Northeast.

As expected, the majority of the women who abstained from sex were in the age group 15-19 years and in most cases the reasons for abstinence were religious beliefs, young age, family size and fear of

pregnancy (Tables 2 and 3).

The lowest age at first sex recorded was 6 years and this was in rural Northeast. Generally, the age at first sex was lowest in the lowest age group and highest in the higher age groups (Table 4). The median age at first sex was generally lower in the rural than urban areas, although the trend of increased age with increased age group was similar.

Of the 1647 sexually experienced respondents, 47 (3%) reported having multiple sex partners. The median number of sex partners was 1 (Table 6) while the mean number of sex partners was greater than 1 in all the age groups (Table 5). Association of multiple sex partners with age, location, religion, level of education and marital status examined by bivariate analysis (Table 7), and logistic regression (Table 8) showed significant association with only marital status and level of education. Divorced women were most likely to have multiple sex partners followed by single women. Married women were the least likely to have multiple sex partners (figure 1). The higher the level of formal education, the higher the rate of reporting multiple sexual partners.

With regard to sexual activity, women who were currently on contraceptives were compared with those not currently on contraceptives. Only 15% of sexually active women were on contraceptives. In both groups, sexual activity was found to be quite high and the mean number of current sexual partners was more than 1. The median age at first sex was earlier in those on contraceptives.

DISCUSSION

Nigeria is said to be a young population so it is not surprising that the largest group of the women interviewed were those aged 15 to 24 years¹². As expected, most of the women interviewed

have had sexual intercourse. In the young population 45.4% of women aged 15-19 years and 79.1% of those 20 - 24 years old have had sex with men. The variation in the figures from region to region and from rural to urban locations could be because Nigeria is a multi ethnic group with diverse social-cultural background. In the Northeastern part of the country where 84.7% of girls aged 15-19 years were sexually active, girls marry as early as 12 years old and even some of them are betrothed at birth. In the eastern part where 32% of girls in the same age group are active sexually, the girls marry quite late partly because they are in school and also because of the problem of high bride price. By virtue of location, the urban girls probably had more access to sex education hence the relatively lower rate of sexual experience. The high rates of sexual experience in the young population in the rural areas, shows the need for sexuality education and youth friendly reproductive health facilities. A previous study in the southwest Nigeria reported a sexual activity of 66% in females between 12 and 26 years who were found in market and motor parks. STDS were detected in these girls hence the need for sexuality education, clinical services, and counseling for these groups of persons¹⁰. Religious counseling may have a lot of influence on their behavior as a large number of those who abstained from sexual intercourse in this study gave religion as the reason.

The minimum age at first sex in this study was 6 years. This situation calls for a critical look at rape and sexual coercion, which occurrence has been found to be quite high, and could result in unintended pregnancy or sexually transmitted infection¹³.

The median age at first sex varied between 15 and 17 years among the different age groups, and was found to be generally earlier in rural areas. This has serious

reproductive health implications, as those in the rural areas are more likely to be ignorant of safe sexual practices during the time of their sexual debut. This is more so as there is often paucity of medical facilities in the rural areas for necessary intervention. Recently, around the world, age at first sex was found to be 16 years and a gradual or sharp reduction in the median age at first sex in the last 50 years has been observed⁷. In a study carried out in Australia, a drop from 20 to 18 years over 4 decades was reported¹⁴. It could be that, as it is speculated in India, family traditional and moral values, which were once held dear, are no longer able to prevent premarital sex and adolescents have become more liberal in their attitude.

The report that only 3% of women had multiple sex partners is similar to that of the 2003 National Reproductive health survey. Even though the median number of sex partners in this study was 1, the mean number was greater than 1. This was because a small number of women reported a high number of sex partners. These were probably women who for economic reasons, exchanged money or gifts for sex, representing a high risk group, or worse, a potential reservoir of sexually transmitted diseases.

Multivariate analyses showed that women were more likely to engage in sex with multiple sex partners if they were divorced or never married or had a high level of education. There is a need for intervention to promote safer sexual behavior and to reduce the likelihood of transmission of HIV and other STDs especially among this group of women.

Only 14.8% of the women were currently on contraceptive although the level of sexual activity was high also in those not on contraceptives. Since low level of contraceptive use is associated with a high rate of unintended pregnancy, strategies to

promote contraceptive use are called for and these should take into consideration women as young as 15 years¹⁵.

In this study, Nigerian women including the young were observed to have a high level of sexual activity, median age at first sex in girls aged 15-19 years was 15 years, single women engaged in sex with multiple sexual partners and level of contraceptive use was low. There is therefore need to devise strategies to promote contraceptive use and for interventions to promote safer sexual behavior to reduce the likelihood of transmission of HIV and other STDs.

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Tables and Figures are presented on pages 12 through 16.

Table 1: The Proportion of sexually experienced women in Nigeria in various age groups and locations

		15-19	20-24	n(%)		25-29	30-34	35-39	40-49	Total
Age distribution of all Women		392 (19.6)	440 (22.0)	323 (16.1)	282 (14.1)	249 (12.4)	308 (15.4)		1994	
%ages of sexually experienced women		178 (45.4)	348 (79.1)	297 (92)	273 (96.8)	245 (98.4)	299 (97.1)		1640	
Proportion of sexually experienced women in various age groups by zone										
Southeast	33/103 (32.0)	77/107 (72)	52/57 (91.2)	53/55 (96.4)	67/68 (98.5)	107/110 (97.3)	389/500 (77.8)			
Southwest	28/76 (36.8)	74/102 (72.5)	83/96 (86.5)	74/79 (93.7)	61/63 (96.8)	76/81 (93.8)	396/497 (79.7)			
Northwest	45/128 (35.29)	92/120 (76.7)	80/86 (93)	57/59 (96.6)	43/43 (100)	61/62 (98.4)	378/498 (75.9)			
Northeast	72/85 (84.7)	105/111 (94.6)	82/84 (97.6)	89/89 (100)	74/75 (98.7)	55/55 (100)	477/499 (95.6)			
Sexually experienced Women rural (R) vs Urban(U)										
Southwest	R 12/40 (30)	34/46 (73.9)	23/25 (92)	28/28 (100)	42/43 (97.7)	66/68 (97.1)	205/250 (82.0)			
	U 21/63 (33.3)	43/61 (70.5)	29/32 (90.6)	25/27 (92.6)	25/25 (100)	41/42 (97.6)	184/250 (73.6)			
Southwest	R 11/21 (52.4)	44/62 (71.0)	55/59 (93.2)	38/40 (95)	29/29 (100)	34/38 (89.5)	211/249 (84.9)			
	U 17/55 (30.9)	30/40 (75)	28/37 (75.7)	36/39 (92.3)	32/34 (94.1)	42/43 (97.7)	185/248 (74.6)			
Northwest	R 33/71 (46.5)	49/56 (87.5)	41/41 (100)	28/28 (100)	19/19 (100)	34/34 (100)	204/249 (81.9)			
	U 12/57 (21.1)	43/64 (67.2)	39/45 (86.7)	29/31 (93.5)	24/24 (100)	27/28 (96.4)	174/249 (69.9)			
Northeast	R 40/46 (87)	55/57 (96.5)	38/39 (97.4)	46/46 (100)	28/28 (100)	34/34 (100)	241/250 (96.4)			
	U 32/39 (82.1)	50/54 (92.6)	44/45 (97.8)	43/43 (100)	46/47 (97.9)	21/21 (100)	236/249 (94.8)			

Table 2: Percentage distribution of sexually abstinent women in various age groups (n=354)

Age Group (Years)	Percentage of Women (%)
15 - 19	60.4
20 - 24	25.9
25 - 29	7.3
30 - 34	2.5
35 - 39	1.1
40 - 49	1.1

Table 3: Percentage of reasons for sexual abstinence in Nigerian women (n=354)

Reasons	Percentage of Women (%)
Religion	28.80
Too Young	18.10
Family Value	16.10
Fear of Pregnancy	15.20
Fear of STDs	5.40
Still in School	1.70
Health Reasons	0.02
Others	10.70

Table 4: Age at first sex of women in rural compared with urban locations

AGE	No. of Women	RURAL			URBAN			Range of age at first sex	
		Mean age at first sex	Median age at first sex	Range of age at first sex	No. of Women	Mean age at first sex	Median age at first sex		
15 - 19	95	14.89	15		8 - 19	82	15.98	16	9 - 23
20 - 24	177	16.59	17		9 - 24	164	17.08	17	6 - 24
25 - 29	149	17.52	17		10 - 28	135	17.90	17	9 - 30
30 - 34	133	17.03	16		10 - 28	123	18.22	17	17 - 11
35 - 39	112	18.07	17		9 - 36	118	17.37	16	8 - 28
40 - 49	152	16.98	16		10 - 51	122	18.42	18	8 - 35

Table 5: Number of sex partners in various age groups

AGE GROUPS OF WOMEN	TOTAL NO. SEX PARTNERS	MEAN NO. OF PRESENT OF SEX PARTNERS	RANGE OF NO.
15 - 19	161	1.137	6 - 13
20 - 24	320	1.075	1 - 11
25 - 29	279	1.118	1 - 10
30 - 34	246	1.024	1 - 4
35 - 39	217	1.120	1 - 16
40 - 49	254	1.024	1 - 3

Table 6: Sexual Activity versus Current Contraceptive Use or Non-Use

	No (%) of Women	Sexual Intercourse within			No. of Sex Partners Present	Age at Life time	first sex Years
		4 weeks	1 -3 months	4 -6 months			
Currently on Contraceptive	244 (14.8)	161 (66)	43 (17.6)	19 (7.8)	1.219	2.506	17.9
Not on Contraceptive	1403 (85.2)	803 (57.7)	190 (13.6)	80 (5.7)	1.050	1.606	17.1
1647							

Table 7: Association between some independent variables and sex with multiple partners

Variable	X ²	df	p-value
Age Group	15.1	5	0.009
Location (Urban/Rural)	8.81	1	0.003
Level of Education	33.03	6	<0.001
Marital Status	6.58	5	<0.001
Religion	19.8	7	0.06

Single respondents were significantly more likely to have multiple partners than the married.

Table 8: Logistic Regression of the relationship between some independent variables and sex with multiple partners

Variables	OR	95% CI	Regression Coefficient	SE	Z-Statistic	p-value
Age	1.0086	0.9722 – 1.0464	0.0086	0.0188	0.4571	0.6476
Locality	1.4271	0.7594 – 2.6821	0.3557	0.3219	1.1048	0.2692
Marital Status	52.5364	19.9446 - 143.7056	3.9804	0.5038	7.9009	0.0000
Education	2.0962	1.0205 – 4.3057	0.7401	0.3673	2.0152	0.0439
Religion	0.7042	0.3481 - 1.4244	-0.3507	0.3594	-0.9757	0.3292

Sex with multiple partners was positively associated with higher level of education.

Figure 1: Percentage of Respondents with multiple sex partners by marital status

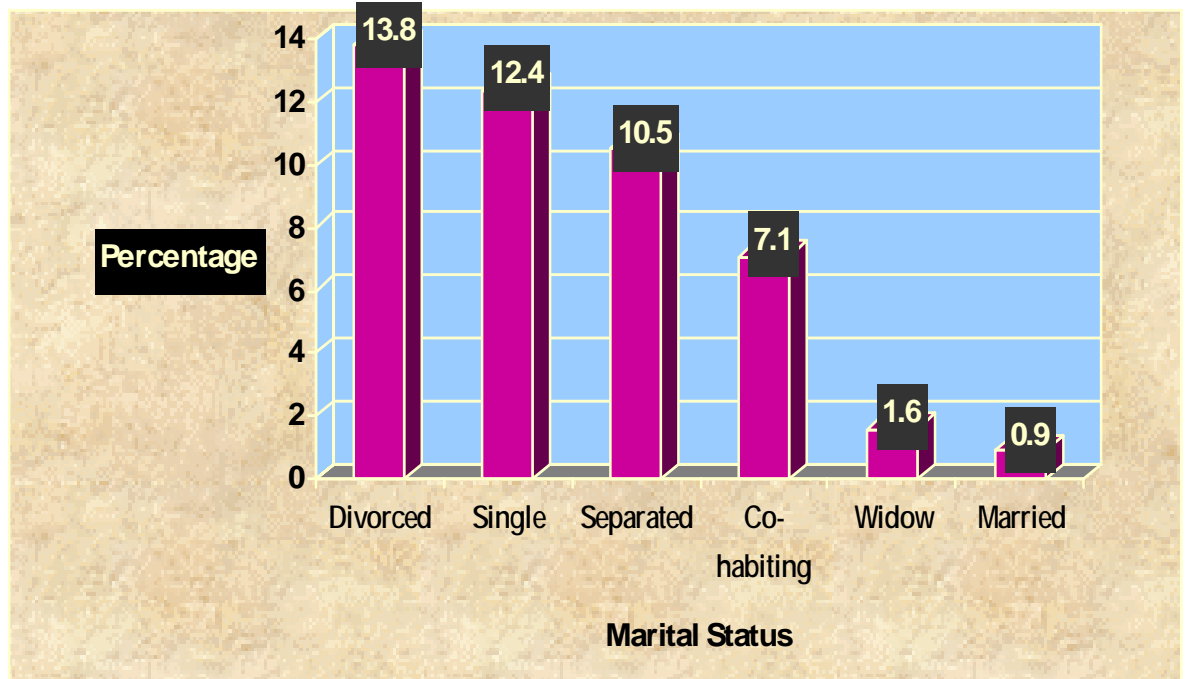
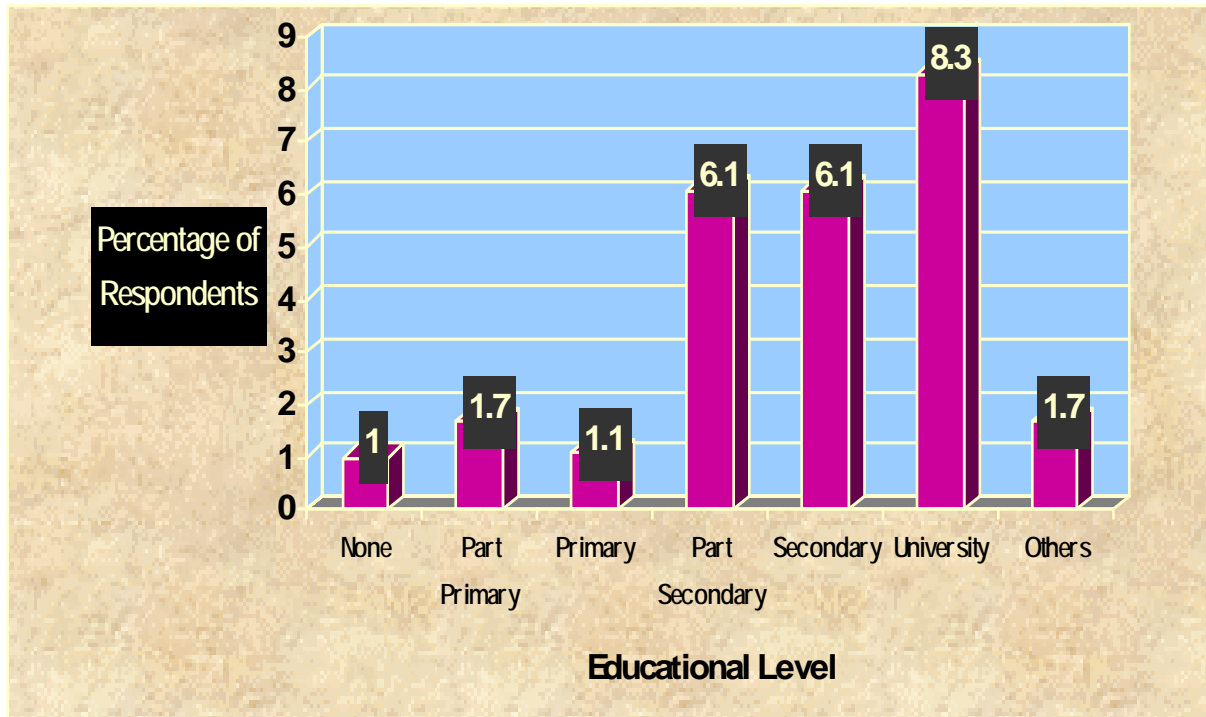


Figure 2: Multiple sex partnership by level of education



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