INNOVARE JOURNAL OF SOCIAL SCIENCES

Vol 9, Issue 4, 2021

ISSN - 2347-5544

Research Article

MALE SEXUAL DYSFUNCTION: A PSYCHOSOCIAL HEALTH PROBLEM IN ZIMBABWE

CHINONDO MERLLINGTON, ZINYEMBA LIZZY, NJOVU PETER

Social Workers. Email: lizzyzinyemba@gmail.com

Received: 28/03/2021, Revised And Accepted: 18/06/2021

ABSTRACT

Objectives: The problem of male sexual dysfunction is on the increase in Zimbabwe with not much clinical evidence on people's understanding of the topic under study and their treatment options. In trying to understand male sexual dysfunction the study was guided by the following objectives: to examine the incidence of male sexual dysfunction and to explore community perceptions on male sexual dysfunction.

Methods: In trying to answer the above stated objectives the study triangulated quantitative and qualitative research approaches making use of a survey, focus group discussions and key informant interviews as data collection methods.

Results: The study found out that most people were not aware that male sexual dysfunction was a health problem that required medical attention resulting in most people resorting to

traditional herbs in their quest for sexual satisfaction. The study further out that people had varied knowledge on the prognosis and understanding of male sexual dysfunction.

Conclusion: The research concludes that as a result of the stigma that is associated with male sexual dysfunction disorders a lot males end up resorting to indigenous diagnosis and treatment. The study therefore recommends a multi-disciplinary team to achieve all-inclusive management of the problem under study. Awareness and literature on male sexual dysfunction should be provided to reduce stigmatization of male sufferers at all levels.

Keywords: Male sexual dysfunction, Desire disorders, Orgasmic disorders, Erectile disorders, Sexual arousal disorders.

 DOI: http://dx.doi.org/10.22159/ijss.2021v9i4.41662. Journal homepage: https://innovareacademics.in/journals/index.php/ijss

INTRODUCTION

Sex is one of the most sensitive subjects that can be a nightmare to ponder for men with sexual dysfunction. Sexual dysfunction has been reported to be a phase that prevents individuals, mainly over 40 years of age, from experiencing sexual satisfaction [1]. Sexual dysfunction can either be physical or psychosocial in origin or a combination of both. Psychosexual dysfunction is when one cannot get sexual satisfaction, mainly as a result of a number of psychological factors such as depression, anxiety, prior abuse or rape, and guilt among others [1,2]. The main types of psychosocial dysfunctions common among men are usually associated with erectile dysfunction, arousal dysfunction, and orgasmic dysfunction and desire disorders. This paper, therefore, brings out male sexual dysfunction under these four main domains.

Desire disorder mainly consists of compulsive sexual disorder which is mainly as a result of much occupation on sexual fantasies, or low sexual desire disorder which is usually as a result anxiety, stress, depression, or hormonal changes [1].

Orgasmic disorders occur when someone has difficulty reaching orgasm after stimulation. It is usually treated with the assistance of psychiatric help and treating underlying causes [3,4]. Ejaculation disorders are quite common in men who will be having premature ejaculation, delayed ejaculation, and retrograde ejaculation. Its treatment mainly varies depending on the cause of the ejaculation ranging from couple sexual therapy and psychological therapy among others [2].

Sexual arousal disorders are mainly characterized by lack of sexual fantasies leading to decreased sexual desire. DSM-IV further notes that there is inability to maintain or attain responses to sexual arousal. Sexual arousal disorders are defined as a stage in which physical, sensory, and emotional signs trigger the brain to release acetylcholine which, in turn, releases nitric oxide into the arteries of the penis leading them to expand and fill with blood until they are full and firm allowing the penis to become erect and stiff [1,5]. Its signs and symptoms are usually no sexual desire, less sexual thoughts, reduced sexual excitement, reduced arousal from internal or external cues, and less initiation of sexual activity. Studies have also shown that to increase sexual arousal men have to manage anxiety, improve foreplay; have a good quality sleep, regular exercises, and herbal remedies among others [3,5].

In most African societies, men's reproductive health leads to a number of psychosocial health problems such as marital instability, disintegration of the family, and gender-based violence which in most cases leads to separation, divorce, and consequent social ills in the community [6].

The problem of male sexual dysfunction is attributed to a number of diverse factors which include sociodemographic factors, sexual orientation, attitudes of men, and cultural differences [2]. In most third world countries, discussions about sex are often seen as propagators of sexual immorality among youths and seen as taboo. This attitude in third world countries makes it difficult for men suffering from male sexual dysfunction to discuss their sexual health problems with others, worse more seeking treatment [6].

METHODS

The research was exploratory in nature, which triangulated qualitative and quantitative research approaches. A survey was used to collect quantitative data while focus group discussions and key informant interviews were used to collect qualitative data. The study targeted men who were sexually active in Harare, Mbare district ward 4 for the survey. There are 7870 males and 7157 females in this ward [7]. Systematic random sampling was used to identify 770 males for the survey. While both men and women from the same ward were targeted for focus group discussions. Convenience sampling technique was used

to identify respondents for focus group discussions. The focus group discussions were divided into two main cohorts by sex and age. The age cohort formulated three groups of males which were the young, the middle aged, and elderly males and females. Two focus group discussions were conducted for each cohort to validate the data hence a total of 12 focus group discussions were conducted. These groups facilitated easy interaction of group members as they were respondents of the same sex and age taking into cognizance the sensitivity of the subject matter. The study also targeted key informants such as traditional healers, medical doctors, social workers, psychologists, psychiatrists, religious leaders, and traders of sexual stimulating herbs. Purposive sampling technique was used to identify 12 key informants from the targeted key informants. Quantitative data were analyzed using SPSS while qualitative data were analyzed using *en vivo* [8].

Authority to conduct the study was sought from the Deputy Director in the Office of the District Administrator, Harare Central District, Mbare West Region. In carrying out the research, all activities of the researcher were guided by a set of research ethics. The researcher ensured that informed consent was duly obtained and maintained; confidentiality was maintained throughout the entire research process. Beneficence was also observed so as to ensure that the research contributes toward the benefit of the society and through the same ethical value; participants were encouraged to be honest with their contributions [9,10].

RESULTS

A total of 770 people managed to participate in the survey with 30% being from the age group of 18–29 years. These were followed by the age group of 30–39 years recording 27%. A significant drop is also felt from the age groups that followed recording 20%, 10%, 10%, and 3% from the 40–49 years to 50–59 years which had the same percentage with the age group of 60–69 years and the lowest age group was the 70++ age group, respectively. The study results showed that the problem of male sexual dysfunction was cross-cutting across all age groups, with the younger age group being affected more with issues of male sexual dysfunction as compared to men of the older age group.

Most of the respondents 40% were widowed, while 33% of the respondents reported to be married and 20% of the respondents were divorced. The least percentage was from the single respondents that recorded 7% as indicated in Table 1. The marital status of the respondents was also insignificant as all men were experiencing problems related to male sexual dysfunction regardless of marital status.

Table 1: Percentage distribution of respondent's demographic characteristics

Age of respondents	%
18–29 years	30
30–39 years	27
40–49 years	20
50–59 years	10
60–69 years	10
70 +++ years	3
Total	100
Marital status	
Single	40
Married	33
Divorced	20
Widowed	7
Total	100
Religion of respondents	
Moslem	7
African tradition religion	23
Christianity	70
Total	100
Employment	
Self employed	53
Formally employed	30
Unemployed	17
Total	100

n=770

On asking their religion, most of the respondents 70% indicated that they were Christians as compared to 7% who reported that they were Moslems with the remaining 23% being from the African traditional religion.

Most of the respondents 53% were self-employed while 30% reported to be formally employed. The lowest numbers of participants 17% were unemployed, as shown in Table 1.

Most of the respondents 43% showed that they had a normal erectile condition with a slight drop of 40% that had a mild erectile dysfunction. There was a significant drop being experienced by those with severe erectile sexual dysfunction who were 17%. The quantitative findings were in line with qualitative findings where most of the participants from focus group discussions were concurring to the notion that most men were normal when it came to erectile sexual functioning. The qualitative findings went further to bring out the fact that severe erectile sexual dysfunction was as a result of infidelity resulting in the erectile sexual dysfunctional condition being induced by traditional herbs to capacitate a man's sexual prowess. This was believed to be caused by a cultural procedure carried out using traditional herbs to cause a complete erectile dysfunction so as to prevent men from engaging into any form of sexual intercourse with any other women. Most women reported that when men engage in extramarital affairs; it creates an opportunity for other women to use herbs which cause men not to function sexually when with other women. It was interesting to also note that key informants were of a different view as they reported that men could not clarify between normal, mild, and severe erectile dysfunction. It was also interesting to note that some of the key informants were not all in agreement with the above started sentiments, as some of them believed that it was possible to reverse the procedure if it was due to African traditional medicines; especially if one knew the herbs that were used so as to reverse the erectile sexual dysfunction using counter herbs. Most of the key informants who believed this notion, however, concurred to the fact that there was an equal probability between failure and success.

One middle-aged male respondent noted that "…it was not a common phenomenon for men to experience erectile sexual dysfunction unless those men had been bewitched…."

Most males 63% reported that they had a normal intercourse satisfaction while only 23% reported to have low intercourse satisfaction. The least percentage 14% was from the respondents that had high intercourse satisfaction as indicated in Table 2. The quantitative findings were congruent with the qualitative findings where it was a common theme in the focus group discussions that most males had a normal intercourse satisfaction. Some of the respondents, however, noted that high intercourse satisfaction was very low due to the socioeconomic stress-related challenges many people were going through in Zimbabwe, which were worsened by the economic and social effects of the coronavirus disease 2019 pandemic. It was also interesting to note that the normal intercourse satisfaction was also attributed to the frantic efforts by both males and females to ensure intercourse satisfaction as some women were reported to be using herbs such as "ndorani" which were meant to ensure a warm body temperature, especially in winter, and "chimhamandara" herbs for vasoconstriction of the vaginal canal. On the other hand, men were also reported to be using herbs such as "vhukavhuka" to increase sensitivity.

One elderly female respondent noted that, "A lot of people made a lot of effort to ensure that there was intercourse satisfaction in any sexual relationship despite the widely advertised negative side effects of making use of traditional herbs."

When a female key informant (traditional herbalist trader) was encourage to comment further, she indicated that intercourse satisfaction encompasses everything including sexual desire while emphasizing

Table 2: Percentage distribution of respondents male sexual dysfunction

Erectile sexual dysfunction	%
Normal erection	43
Mild erectile dysfunction	40
Severe erectile dysfunction	17
Total	100
Intercourse satisfaction	
Normal intercourse satisfaction	63
Low intercourse satisfaction	23
High intercourse satisfaction	14
Total	100
Orgasmic dysfunction	
Normal ejaculation	30
Premature ejaculation	40
Delayed ejaculation	18
Retrograde ejaculation	12
Total	100
Sexual desire	
Normal sexual desire	40
Low sexual desire	35
High sexual desire	25
Total	100
Arousal sexual disorder	
Normal sexual arousal	36
High arousal sexual disorder	40
Low arousal sexual disorder	24
Total	100
Male sexual performance with psychosocial problems	
Normal sexual performance	25
Low sexual performance	57
High sexual performance	18
Total	100
Effect of traditional herbs on male sexual performance	
Normal sexual performance	17
Low sexual performance	3
High sexual performance	80
Total	100

n=770

that it was even difficult for sufferers themselves to pinpoint the exact level of desirable satisfaction apart from the fact that she observed that individual needs differ from a person to person. She then included a multiple of common conditions in her following comment:

".Most men and women who are concerned with improving intercourse satisfaction use African traditional herbs such as 'vhukavhuka,' 'chipikiri,' 'ndorani,' 'mukudza,' and in addition women use 'chimhandara' to improve on intercourse satisfaction while 'mukudza' is used for penile enlargement; 'chipikiri' increases the desire to engage in sexual romance."

A significant number 40% of the respondents reported to have premature ejaculation while 30% reported to be having a normal ejaculation. The lowest numbers 24% and 6% were reported from male participants that had delayed ejaculation and retrograde ejaculation, respectively. The qualitative findings further explained the main reasons behind premature ejaculation to be most common during the first round of sexual intercourse hence as the number of rounds one was to have during sexual intercourse increased the more sexual ejaculation normalized. Some of the respondents, on the other hand, reported that most men were now using herbs such as "dambarefu" that delayed ejaculation.

When asked if they knew much about retrograde ejaculation, most of the respondents reported that it was rare and resulted from traditional magic which causes male sexual organs to disappear such that men will not be able to see any of his organs such as the penis and testis. The condition was reported to affect men who refuse to meet agreed payments for sexual intercourse and those who extend sessions using force. Since women usually encounter a lot of sexual violence where men can extend intercourse sessions and refuse to pay for further services rendered, women were reported to protect themselves through seeking compelling systems like the retrograde ejaculation from traditional healers. This was meant to instill fear and forcibly make men comply with payments.

One young male respondent had this to say, "…in commercial sex one had to make sure that they enjoy their money which they would have paid for hence delayed ejaculation is ideal…."

When asked about sexual desire, the majority of the respondents 40% reported to have a normal sexual desire while 35% indicated that they had a low sexual desire the remaining 25% reported that they had a high sexual desire. Contrary to the quantitative findings, the qualitative findings indicated that most men have normal sexual desire with only men who make use of herbs being reported to have a high sexual desire.

The study also found out that most of the respondents 40% had a high arousal sexual disorder, with 36% having a normal sexual arousal and 24% reporting to have a low arousal sexual disorder. The qualitative data, on the other hand, indicated that it was not a common phenomenon for men not to be aroused hence most of the respondents were of the view that most men had a high sexual arousal. However, key informants were of a different view as they indicated that some men had low sexual arousal due to stress and increase in age.

One respondent had this to say, "…the eye has no boundaries...hence one cannot help but to be sexually aroused…."

When asked about sexual performance, most of the respondents 57% reported that they had a low sexual performance, while 25% reported to have a normal sexual performance. The lowest figure 18% were recorded from men that reported to have a high sexual performance. On the contrary, the quantitative findings were of the view that a high sexual performance could only be achieved when making use of traditional herbs. The key informants also added by reporting that most people make use of aphrodisiacs to improve sexual performance which, on the other hand, resulted in addiction.

The research further asked the effect of making use of traditional herbs to address male sexual dysfunction, and the quantitative findings revealed that most of the respondents 80% had high sexual performance with the aid of traditional herbs, while 17% indicated that they had a normal sexual performance when they made use of traditional herbs. Finally, only 3% indicated that they had a low sexual performance even when they made use of traditional herbs. The qualitative findings further revealed that the use of herbs promoted sexual performance while having psychosocial problems. The qualitative findings further revealed that nearly all prevailing male sexual dysfunctions could be cured by traditional herbs.

It was quite common in all the focus group discussions that the use of herbs was mainly due to the patriarchal systems in countries like Zimbabwe. The key informants also felt that the psychosocial problems could get out of control resulting in multiple doldrums and melancholies which include domestic violence and all other forms of abuses that affect the general well-being and happiness of men and the significant others, thereby increasing incidences of male sexual dysfunction. Most participants of the focus group discussions felt that psychosocial health problems associated with male sexual dysfunction could result in a number of problems such as extramarital affairs, domestic violence, suicide, alcohol abuse, child neglect, separation, murder, boredom, lack of self-confidence, loss of esteem, loss of job, and depression to mention but a few. Key informants, on the other hand, also included negative side effects such as depression, mood swings, eating disorders, anxieties, mental illness, and drug addiction.

DISCUSSION OF FINDINGS

The major theme that came out of the study was the different prognosis of male sexual dysfunction as a health problem which led to the different treatments options that were available in the

communities. The common diagnosis by people of the African traditional system was also seen to be associated with a lot of social stigma resulting in men deterring from seeking medical health. African societies have strong cultural beliefs associated with sociocultural explanation of illness which tends to contradict the medical notion of illness [11,12]. Taking into cognizance that the "kusungwa" phenomenon epistemologically creates an image which inflicts more pain that is both socially and psychologically unbearable to the male sufferer and his partner as the condition is only known to be associated with phenomenological image of indulging in extramarital sexual intercourse [13,15].

The gravity of the problem of male sexual dysfunction also showed the need to properly deal with the problem of male sexual dysfunction at all levels in the society so as to avoid the negative social effects of the health problem [11,14]. A lot of scholars have called for a comprehensive management of psychosocial health problems. Such an approach will be able to address the cultural dilemmas and significantly reduce male sexual dysfunction. This has been seen as the only way in which the problem at hand and its effects can be addressed.

In the quest to solve the problem of male sexual dysfunction the study brought out that indigenous herbs were mainly used as compared to the other sources of treatment, this could be as a result of the prognosis of the disease, counseling, and the cultural social effects that surround the health problem. Other scholars, on the other hand, saw male sexual dysfunction as a health problem that required well-known medical and psychological solutions [2,11].

CONCLUSION

The study finally concludes that males are not conversant, with the etiology and prognosis of male sexual dysfunction resulting in most males resorting to the easily immediate treatments of male sexual dysfunction, which, in most instances, are closer to the community as compared to conventional health care. The research, therefore, recommends the need for scientifically proving indigenous claims of male sexual dysfunction, from its prognosis to its treatment so that people will make use of safe methods in their search for solutions to male sexual dysfunction. It is only after the scientific inquiry that effective awareness campaigns can be conducted to disseminate information to the larger populace.

REFERENCES

1. Campbell MM, Stein DJ. Sexual dysfunction: A systematic review of South African research. S Afr Med J 2014;104:440-4.
2. Irwin GM. Erectile Dysfunction. Prim Care 2019;46:249-55.
3. Wittmann D, Mehta A, Northouse L, Dunn R, Braun T, Duby A, *et al*. True sexual recovery study protocol: A multi-institutional collaborative approach to developing and testing a web-based intervention for couples coping with the side-effects of prostate cancer treatment in a randomized controlled trial. BMC Cancer 2017;17:1-13.
4. Wylie K. Erectile dysfunction. Adv Psychosom Med 2008;29:33-49.
5. Ramlachan P, Campbell MM. Male sexual dysfunction. S Afr Med J 2014;104:447.
6. Sanuade OA. Community perceptions on the role of sexual activity on stroke: A qualitative study exploring the views of Ghanaian local community residents. BMC Public Health 2019;19:717.
7. Zimstat. Census 2012 Preliminary Report. Harare; Zimbabwe National Statistics Agency; 2013
8. Campbell A, Taylor BJ, McGlade A. Research Design in Social Work. Qualitative and Quantitative Methods; 2017. Available from: https://www.unicef.org/about/annualreport/files/afghanistan_coar_2013.pdf.
9. Akaranga S, Makau B. Ethical considerations and their applications to research. A case of University of Nairobi. J Educ Policy Entrepreneurial Res 2016;3:1-9.
10. Athanasius E. Reproductive Health Policy for Seychelles Ministry of Health; 2012. p. 1-46.
11. Dwulit AD, Rzymski P. The potential associations of pornography use with sexual dsyfunctions: An integrative literature review of observational studies. J Clin Med 2019;8:914.
12. Graham CA, Mercer CH, Tanton C, Jones KG, Johnson AM, Wellings K, *et al*. What factors are associated with reporting lacking interest in sex and how do these vary by gender? Findings from the third British national survey of sexual attitudes and lifestyles. BMJ Open 2017;7:1-22.
13. McCabe MP, Sharlip ID, Lewis R, Atalla E, Balon R, Fisher AD, *et al*. Incidence and prevalence of sexual dysfunction in women and men: A consensus statement from the fourth international consultation on sexual medicine 2015. J Sex Med 2016;13:144-52.
14. Muhammad S, Kabir S. Methods of Data Collection July 2016; 2018. p. 201-76.
15. Rajiah K. Psychological impotence: Psychological erectile dysfunction and erectile dysfunction causes, diagnostic methods and management options. Sci Res Essays 2012;7:446-52.