Journal of Pharmacognosy and Phytochemistry

Available online at www.phytojournal.com

E-ISSN: 2278-4136
P-ISSN: 2349-8234
www.phytojournal.com
JPP 2022; 11(2): 46-59
Received: 17-01-2022
Accepted: 23-02-2022

Kyokusiima Naome Kapere
Faculty of nursing and Health Sciences, Bishop Stuart University, P.O Box 09 Mbarara, Uganda

Maud Kamatenesi Mugisha
Ethnobiology Laboratory, Bishop Stuart University, P.O Box 09 Mbarara, Uganda

Otwine Anne Tweheyo
Faculty of nursing and Health Sciences, Bishop Stuart University, P.O Box 09 Mbarara, Uganda

Waisindye Noah
Ethnobiology Laboratory, Bishop Stuart University, P.O Box 09 Mbarara, Uganda

Corresponding Author:
Kyokusiima Naome Kapere
Faculty of nursing and Health Sciences, Bishop Stuart University, P.O Box 09 Mbarara, Uganda

Community perceptions on the use of traditional medicine among people experiencing sexual dysfunctions in Greater Mbarara, western Uganda

Kyokusiima Naome Kapere, Maud Kamatenesi Mugisha, Otwine Anne Tweheyo and Waisindye Noah

Abstract
In Uganda, studies have indicated that up to 52% of the sexually active population aged 18 to 70yrs experience different sexual dysfunctions and it is predicted that the prevalence of dysfunctions will increase dramatically by 2050. The study investigated community perceptions about the use of traditional medicine among people experiencing sexual dysfunctions in Greater Mbarara, western Uganda.
The study aimed to examine the common sexual dysfunctions which exist among people, identifying the common beliefs associated with the use of traditional medicine remedy for treatment of sexual dysfunction, carry out an Ethno-botanical documentation of commonly used herbal medicines in the treatment of sexual dysfunctions and determine the relationship between the use of traditional medicine remedy and treatment of sexual dysfunctions among people.
Using a cross-sectional survey design, data was captured from a sample of 103 respondents through questionnaire approach. The respondents were selected using both purposive criteria and simple random technique. Data was analyzed using SPSS to generate descriptive statistics for quantitative data and inferences from qualitative data.
Different sexual dysfunctions existed and were common among both men and women in the society. Commonest among men were; pain during penetration, erectile disorder, short erections, lack of sexual arousal and premature ejaculation. Whereas those among women included; lack of sexual arousal, lack of orgasm, atrophic vaginitis, short orgasms and dyspareunia. It was established that most people shy away from the use of herbal remedies for treatment of sexual dysfunctions because of the commonly held beliefs associated with the use of herbal medicine. Most used herbs by men included *Acacia abysinica* Scheele, *Dichrostachy scinerea* L, *Coffea arabica*, *Citropsis articulata*, *Mondia whiteii* Skeels, *Impetiens* sp, *Rumex abyssinicus*, *Allium cepa* L. , *Albizia coriaria* welw and main mode of administration was oral using water, food, tea and porridge. Minor modes of administration included nasal inhalation of fumes.
The use of traditional herbs is significantly associated with the treatment of sex dysfunctions for both men and women however, there's need for collaboration between health professionals and traditional medicine practitioners to further identify and scientifically test on the efficacy of the identified medicinal plants being used by targeted communities in management of sexual dysfunction among women and men.

Keywords: Sexual dysfunction, herbal medicine, ethnobotanical documentation

Introduction
Sexual dysfunction is difficulty experienced by an individual or a couple during any stage of sexual cycle in normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm (Nolen, 2014) [41]. It has a profound impact on an individual's perceived quality of sexual life (Hughes *et al*., 2013) [31]. Having health sexual life is paramount concern for pleasure, wellbeing and safety. This is characterized by a positive and respectful attitude. A well-functioning sex life among individuals or couples engenders social and psychological well-being, and is beneficial to physical health (Günzler and Berner, 2012) [25]. Positive sexual expression is fundamental to individual identity and couple relationship (Hendrickx *et al*., 2013) [28].
According to existing prevalence estimates, a significant number of people worldwide experience difficulties meeting sexual expectations from partners. Sexual dysfunction problems are increasingly becoming common globally. Roughly 46% of men and 55% of women globally have reported at least one or two persistent sexual function problems (Günzler and Berner, 2012) [25].

Sexual dysfunctions have increasingly impacted on the well-being of individuals and their partners (Dyer and das Nair, 2013) [18]. The dysfunctions have further resulted in profound and complex personal and relationship issues (Carr, 2009) [10]. In the short term they can cause frustration and distress; in the longer-term, dysfunction issues lead to anxiety, depression, harmed relationships and disruptions to other areas of life (Choi *et al*., 2012) [11] including separation and divorce or polygamy.

Thus sexual problems have become an important impediment to quality of life (Abdullahi, 2013) [1]. A significant proportion of sexual difficulties have remained unresolved; while many people have avoided sex because of their problems while only a few actually seek for help (Arhinful, 2011) [3]. The common sexual dysfunctions among females include; lack of orgasm, lack of sexual arousal, pain, vaginismus and dyspareunia while those common for men include; premature ejaculation, lack of sexual arousal and erectile dysfunction.

Herbal medicine is the prevalent form of traditional and complementary medicine use in Sub-Saharan Africa (Arhinful, 2011) [3]. Reasons for its popularity is attributed to its low cost, accessibility, alignment with patient's cultural and religious values, and perceived efficacy and safety as well as dissatisfaction with conventional healthcare (Berner and Günzler, 2012) [5]. Despite the popularity of traditional and complementary medicine, evidence of its safety and efficacy still remains inconclusive. As with most countries in Africa, traditional medicine use is common with considerable amount of the population using it to treat various health conditions such as malaria, diarrhea, and respiratory infections and hypertension and sexual disorders (Berry and Berry, 2013) [6].

In Sub-Saharan Africa, sexual dysfunctions have long existed as far as the 15th century but have currently started to attract a considerable interest (Bitzer and Brandenburg, 2009) [8], not only from the media but from the medical profession and the pharmaceutical industry. Several socio-cultural trends underlie this recent interest. Although the 20st Century, is currently witnessing an increase in the sexualisation of societies, rapidly changing gender roles, liberalization of laws regarding sexual practices and more open discussions about sex, there is still heritage of repression, lack of clear education and negative perceptions about the use of herbal medicine. The ongoing lack of education and knowledge as well as negative perceptions about traditional herbal has left many people in sub-Saharan feeling uncomfortable and inadequately informed about the use of locally available medicinal plants to address sexual dysfunctions and hence enhance sexual functionality and health (Cohen and Venhuis, 2013) [13].

In Uganda, studies have indicated that up to 52% of the sexually active population aged 18 to 70yrs experience different sexual dysfunctions and it is predicted that the prevalence of dysfunctions will increase dramatically by 2050 unless some critical measures are taken (Dahilig and Salenga, 2012) [15]. Although these dysfunctions are considered benign, and may not mean a total loss of sexual satisfaction for some, they often contribute to anxiety, stress, depression and low self-esteem among individuals and couples. Personal relationships are negatively affected and a poor quality of life is inevitable (Kamatenesi-M, 2002) [35, 36]. To some cultures it has been assumed to be a natural aspect of aging and therefore a misfortune that must be accepted. This assumption is not always correct as sexual dysfunctions may occur as a result of specific illnesses like Diabetes Mellitus, Coronary Artery Disease; or as the consequence of the treatment of other diseases like Hypertension. Sexual dysfunctions can also occur a result of physical, psychological, socio-economic and cultural factors (Kamatenesi-M, 2004) [37].

Traditional medicines are diverse health practices, approaches, knowledge and beliefs that incorporate plant based medicines, spiritual therapies, manual techniques and exercises which are applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness (WHO, 2011). In the Uganda, traditional medicine has been adapted outside its indigenous culture to "Complementary "or "Alternative" medicine (Shah *et al*, 2012) [46]. People have developed unique indigenous healing traditions adapted and defined by their culture, beliefs and environment, which satisfied the health needs of their communities all over the century (WHO, 2005). The increasing widespread use of traditional medicine has prompted the government to promote the integration of traditional medicine and complimentary or alternative medicine into the national health care system of the country and to encourage the development of national policy and regulations as essential indicators of the level of integration of such medicine within a national health care system (WHO, 2011).

Pharmacological advances in the management of sexual dysfunctions have stimulated more interest and use of locally available herbs. Traditional medicine, also called botanical medicines or phyto-medicines, refer to herbs, herbal materials, herbal preparations, and finished herbal products that contain parts of plants or other plant materials as active ingredients (WHO, 2011). It is believed that the aphrodisiac substance found in herbs increases sexual desire.. In different parts of the country, men and women have continued to use herbs to enhance sexual health even when they don't have any therapeutic attributions towards sexual functionality (Garba *et al.*, 2013) [21]. However, there is a rich history in almost all cultures that using substances derived from plants changes sexual experience. Examples of such plants include; *Mondia whitei*, *Allium cepa*, *Capsicum frutescens*, and *Zingiber officinale.*

Although a large portion of the country's population are aware of different herbs and their benefits towards sexual health, their use in addressing the rising prevalence of sex dysfunctions remains low all over the country. The reception and perception given to herbs has remained generally poor as many associate them to witch craft as wellbeing un-health (Kaadaaga *et al*., 2014) [33].

In Greater Mbarara, sexual dysfunctions are increasingly becoming high across all sexually active ages and carry more stigmas among both married and un-married partners (Kaadaaga *et al*., 2014) [33]. This high prevalence of sexual dysfunction justifies the escalating levels of marriage breakups and infidelity among couples. The etiology of these dysfunctions is multifactorial and are believed to be related to; (1) diseases such as diabetes, high blood pressure, atherosclerosis, obesity, neurological diseases, menopause, erectile dysfunction, cancer, endocrine alterations, surgical treatment, and use of drugs, and (2) psychological causes (Kaadaaga *et al*., 2014) [33]: individual factors (personality, low self-esteem, history, religious beliefs, depression, fatigue, anxiety, stress, fears, frustration); interpersonal factors (poor communication, low confidence, fear of intimacy with others), and psychosocial factors (performance anxiety, sexual traumas, surreal response expectations, among others) (Kakudidi *et al*., 2000) [34]. To address sexual dysfunctions in

the area, Herbal medicine has been promoted as an integral part of "traditional medicine" so as to increase community use of medicinal plants to enhance sex life. This has largely been achieved by different extensive radio and television programs as well as the use of other media platforms. However, despite the vast knowledge people have on the benefits of herbal medicine, its use for sexual enhancement has totally remained low due to perceptional differences. This study is intended to investigate the perceptions about the use of traditional medicine among couples experiencing sexual dysfunctions.

Problem Statement

Male and female sexual dysfunction is becoming common health problem in Uganda and elsewhere affecting all ages in the society. In recent years, the unfulfilled desire for sex has been a subject that has increased public interest with respect to improved sexual functions among female and male couples. It is indicated that up to 52% of the sexually active population aged 18 to 70 experience different sexual dysfunctions and prevalence is predicted to increase drastically by 2050 in both developed and developing countries unless critical measures are put in place (Kaadaaga *et al*., 2014) [33]. Caused by different physical, psychological, job and lifestyle factors such as feeding habits, sexual dysfunctions account for 63% relationship and marriage break ups and 69% partner infidelity (Kaadaaga *et al*., 2014) [33].

In Greater Mbarara, the question of sustaining marriages and relationships through proper sexual functioning is consequently becoming an issue of significance. The number males and females couples complaining about sexual dysfunctions are on arise (*Kaadaaga et al*., 2014) [33]. Though herbal medication is being promoted as one of the strategies to address the current trend of sexual dysfunctions. Only a few individuals and couples have tried traditional herbs to enhance sexual performance (Kaadaaga *et al*., 2014) [33].

Many people in greater Mbarara have not used herbal medicine despite the vast knowledge they have on it in managing different body illnesses and dysfunctions. Studies conducted across the globe have linked low adoption to herbal medicine to factors including but not limited to perceptions, religion and beliefs. It was against this background that the study was conducted to assess people's perceptions about traditional medicine use among couples experiencing sexual dysfunctions in Greater Mbarara.

Purpose of the study

The overall purpose of the study was to assess the perceptions about traditional medicine use among people in community experiencing sexual dysfunction, and measures of promoting herbal use on a wide spectrum in greater Mbarara.

Objectives of the study

1) To examine the common sexual dysfunctions which exist among people in Greater Mbarara.
2) To identify the common beliefs associated with the use of traditional medicine remedy for sexual dysfunctions.
3) To document the commonly used herbal medicines and their use in the treatment of sexual dysfunctions.
4) (iv) To determine the relationship between the use of traditional herbal remedies and sexualdysfunctions among people in Greater Mbarara.

Methodology

Study Design

A cross sectional survey design using both quantitative and qualitative methods for data collection and analysis was applied. This design was ideal for the study since it enabled collection of data from a cross section of the target population as represented by the study sample, all at one point in time to obtain un-biased information using preferred sampling techniques. The qualitative approach was applied to capture ideas, opinions, feelings, attitude and views on the subject matter using interviews and open ended questions from the questionnaire while quantitative approaches was used to capture quantifiable data using closed ended questionnaire. The use of quantitative and qualitative approaches in this study was appropriate because social life and human actions and inactions are highly complex.

Study area

The study was conducted in Greater Mbarara. In August 2014, the national population census put the population at 545,600 of which 60% were female and 40% male. The area was chosen because of the high rate marriage/relationship failures which perhaps result from different sexual problems despite the vast knowledge on herbal medicines.

Study population

The study targeted married couples who included Mothers 'and Fathers 'union members, traditional herbalists, Elderly people and unmarried people like singles mothers. Traditional herbalists and elderly persons who had other knowledge or experience about sex dysfunctions. These different categories of people provided the required information needed to address the subject matter.

Sample Size and Determination

The target number of respondents was drawn using a sample determination table by Krejcie and Morgan at 95% level of confidence, with 5% as the tolerable error. In this case the sample was determined as follows;

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	**377**

75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	1000000	384
Note N is Population Size, S is Sample Size Source: Krejcie and Morgan, 1970									

Table 3.1: Respondent categories and sampling procedure

Respondent category	Target Sample size	Sampling technique
Dysfunction patients	33	Simple random sampling
Couples	50	Simple random sampling
Traditional herbalists	5	Purposive sampling
Elders	15	Purposive sampling
Total	103	

Sampling technique
Hallet (2012) described sampling as the process of choosing subjects with in the target population to be included in the study in such a way that the selected sample elements represent the population. Non-probability technique was used to select the respondents. Simple random sampling technique was used to identify the couples experiencing sexual dysfunctions, traditional leaders and elders in the community. Since potential these respondents were difficult to trace due to sensitivity of the subject, the researcher identified these potential respondents in the population and asked to recruit other people. These steps were repeated until the needed sample size was achieved.

Data Source
Married and non-married couples were the main source of primary data in the study. In addition, Traditional herbalists, and elders provided data as key Informants.
Secondary data was gathered from scholarly books. Secondary sources included published and unpublished information about the subject matter. The information was collected from books, articles, records, journals, reports.

Data collection methods
The study applied questionnaire and interview methods during primary data data collection.

Questionnaire
A semi-structured questionnaire that had both closed ended and open ended questions was designed and used to generate quantifiable information from couples. The questionnaire was translated into local language to make the questions more simple, clear and understandable to the respondents. Questions captured information on common sexual dysfunctions among people community, beliefs associated with the use of herbal medicine; and commonly used traditional medicines and their use in the treatment of sexual dysfunctions.

Interview method
To capture in-depth information on the topic, interviews were conducted to enable the researcher get information from the key informants using interview guide. The information gathered through key informants' was used to harmonize and supplement the data collected from members of the local community through questionnaire.

Research instruments
Data collection instruments included;

- Questionnaire for both married and non-married couples
- Interview guide for different key informants (traditional leaders and elders in the community).

Questionnaires
A standard structured instrument on sex dysfunctions was used to capture information form men and women. The questionnaire consisted of closed and open ended questions that were translated into local language with help of language interpreters. The translation was done to allow the respondents answer questions related to the study phenomenon in their respective languages. The questions were open and closed ended in nature to promote sharing of stories and experiences, thus allowing participants to determine the flow and direction of the conversation.
To answer questions on sexual dysfunctions, an International Erectile function questionnaire and Female Sexual Function Index (FSFI) were designed and used for both males and females in the society, respectively.

Interview guide
An interview guide involves presentation of oral verbal stimuli and reply in terms of oral verbal responses. Oral personal interviews that involved face to face contacts or conversation using an interview guide were used to capture opinions and views from different key informant categories. This helped the researcher to capture supplementary information on the subject under investigation. Interviews were used because they helped in generating first hand and reliable data.

Data quality
Validity of Instruments
To establish content validity of instruments, the researcher consulted experienced and skilled researchers, course mates and the research supervisor. The instruments were then pilot tested on an appropriate sample of 15 community members in separate divisions from study area. Results from the field helped in identifying the gaps where modifications were made to the instruments.

Reliability of Instruments
An instrument is reliable if it measures consistently what it is supposed to measure. Even if it is administered by other researchers, it should produce the same results. In this study, the test-retest method was used to establish the instruments' reliability. In addition; the alternate form reliability method was used.

Ethical clearance and considerations
This research was approved by Bishop Stuart University Graduate School. Ethical approval was obtained from the BSU Ethics Review Committee. Thereafter, a research permit was obtained from the graduate school coordinator prior to the study. Administrative authorization to carry out the study was sought from the Mbarara municipal council administration. Informed consent was obtained from study participants prior to their enrollment into the study. Participation in the study was voluntary and confidentiality of

the information from the study participants was maintained throughout the study. In addition, codes were used to maintain anonymity of all participants and keep their information confidential.

Data Analysis

Information obtained from the structured questionnaires was correlated during data analysis. Data was then captured in Microsoft Excel and then exported to Statistical package for social (SPSS) Version 16.0 to generate descriptive statistics and inferential statistics. Techniques for summarizing data for continuous variables were used such as mean, variance and standard deviation while frequencies and percentages were generated for categorical variables. Objectives one, two, three and four were analyzed using descriptive statistics to generate frequency counts and summary statistics. To analyze the relationship between the use of traditional herbs and sex dysfunctions among people in the society, Pearson correlation coefficient were used to interpret relationships. A significance level of the test was set at 0.05 at 95% confidence interval.

Limitations of the study

Respondents' bias; some respondents delayed answering questionnaires because most of them were away to the market places, gardens and thus were hard to trace. This was solved by appealing to them for cooperation and regular follow up.

Lack of enough funds; funds were needed especially in purchasing stationery, research transport, typesetting, printing and photocopying. This problem was addressed by appealing to well-wishers and family members for support.

Information bias; the respondents approached were reluctant in giving out information due to the sensitivity of the topic under the study. This was solved by assuring respondents that the information provided would be for academic purposes and would be treated with utmost confidentiality.

Response Rate

A total of 103 respondents responded to data collection tools making a response rate of 100% which was in line with in Mugenda and Mugenda's (2003) that prescribed significant response rate for both statistical and descriptive analysis established at a minimal value of 50%. This commendable response rate was made possible after the researcher personally administered the questionnaire and made further visits to collect the filled questionnaire.

The table 4.1 below shows the targeted categories of respondents versus the actual number that was obtained during the research process.

Table 4.1: The Response Rate

Variable	N	%
Adults	33	32
Married Couples	50	48.5
Traditional herbalists	5	4.9
Elders	15	14.6
Total	103	100.0

As shown in table 1 above, the target sample was 103 respondents and the actual number of respondents obtained was 103. Among these, 32% were adults, 48.5% couples, 4.9% traditional herbalists, and 14.6% elders. The rate at which respondents responded was determined by factors like mood, workload and time.

Socio-demographic Characteristics

The major demographic characteristics considered included; gender, age, marital status, education level, and religion. The purpose for collecting respondent background information was to help the researcher find out their influence on use of traditional herbal medicine.

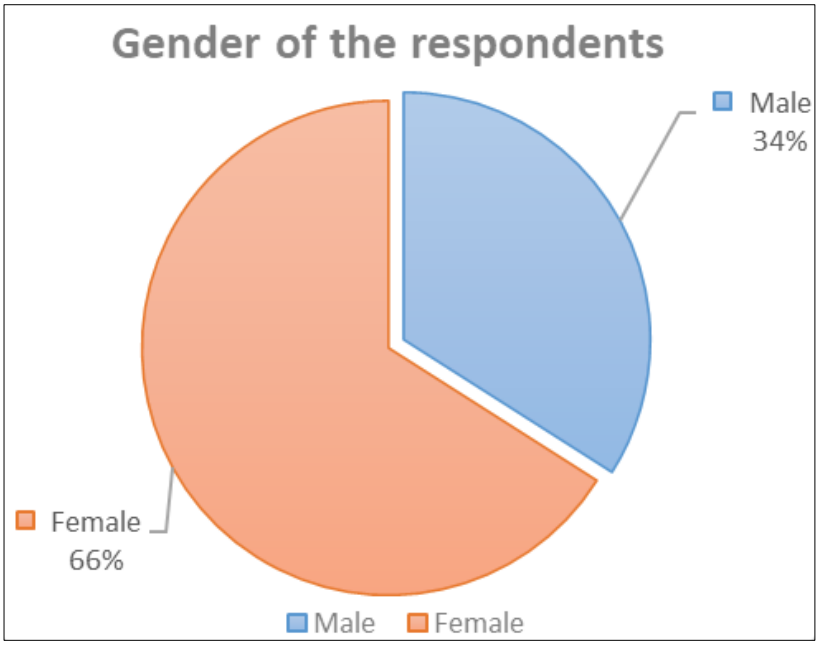

Fig 1: Distribution of respondents by gender

According to the findings in figure 4.1 above, 66% of the respondents surveyed were female and 34% male. There was an observed gender difference between study participants where female dominated the study compared to males.

Table 4.2: Descriptive Statistics of Age in Years

	N	Minimum	Maximum	Mean	Std. Deviation
Age in years	103	18	64	33.53	14.960
Valid N (list wise)	103	18	64	35.53	14.960

According to the results in table 4.2, average age distribution was 35 years with a minimum of 18 and maximum of 64 years. Majority of the respondents were aged 18 -33 years.

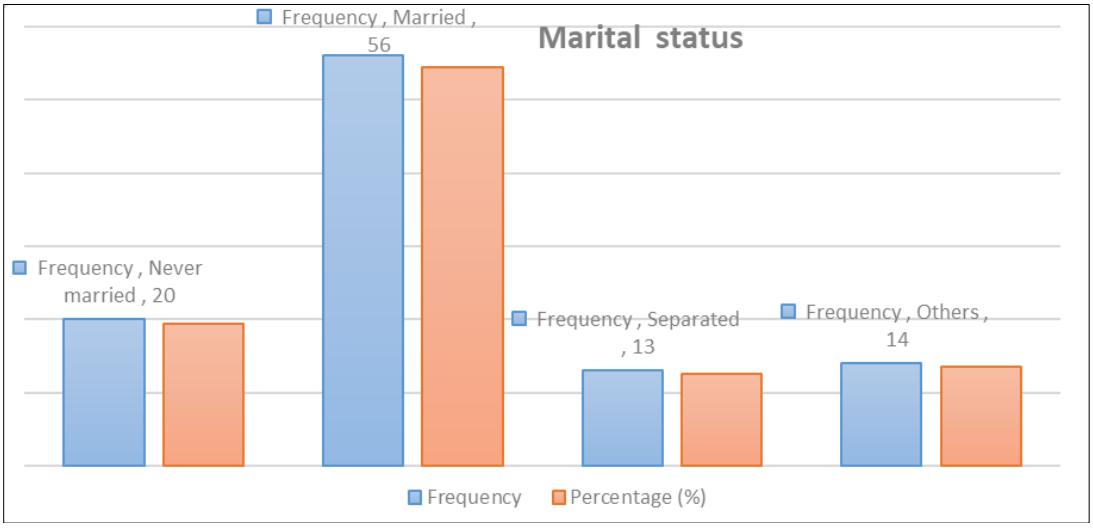

Fig 2: Distribution of respondents by marital status

Figure 4.2 above showed that more than a half 54.4% of the respondents were married, 19.4% never married, 12.6% had separated and 13.6% comprised of others who were cohabiting and divorced.

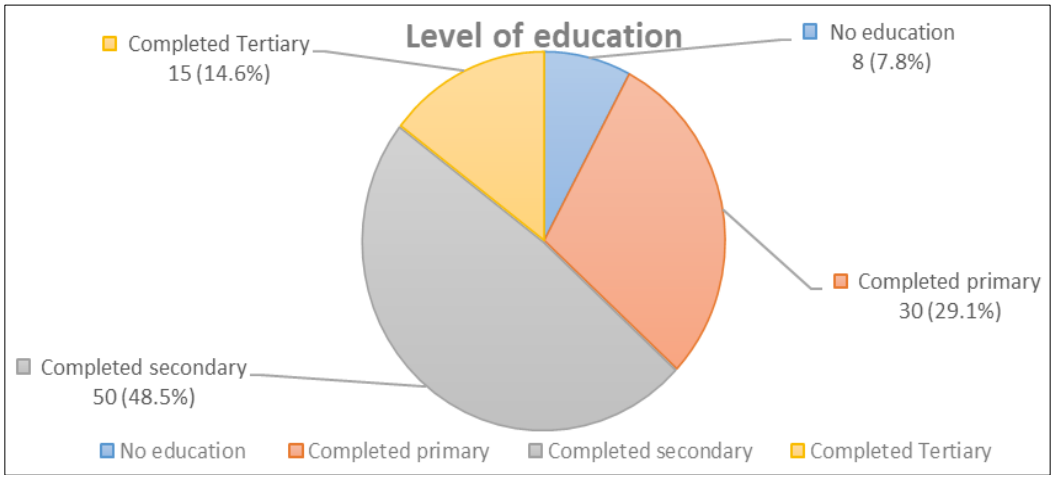

Fig 3: Distribution of respondents by level of education

Regarding education, most 48.5% respondents had completed secondary, 29.1% primary, 14.6% tertiary while 7.8% had none formal education.

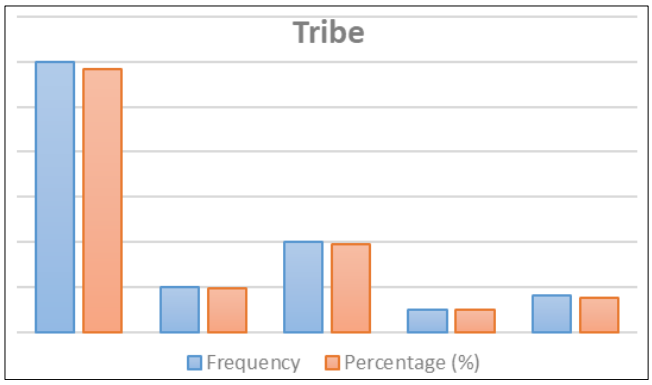

Fig 4: Distribution of respondents by tribe

According to the results in figure 4.4 above, more than a half 58.3% of the respondents were Banyankole, 19.4% Bakiga, 9.7% Baganda, 7.7% belonged to other tribes like Bakonjo, Rwandese and bahima while 4.9% were Batoro.

Research Question One: Common Sexual Dysfunctions Reported among the Population

This section of the study addresses research question one which sought to examine the common sexual dysfunctions which exist among the population of study in Mbarara district. Multiple responses were captured and analyzed through descriptive statistics. Multiple responses occurred as a result of respondents mentioning specific sexual dysfunction more than two times.

Table 4.3: Common Sexual Dysfunctions which were reported among Males (Multiple Responses)

Category	Sexual dysfunctions	N	%	Cum %
Male	Erectile disorder	68	22.6	22.6
	Pain during penetration	75	24.9	47.5
	Premature ejaculation	40	13.3	60.8
	Lack of sexual arousal	58	19.3	80.1
	Short lasting erections	60	19.9	100.0
	Total	301	100.0	

Results in table 4.3 above, showed that pain during penetration (24.9%) was the most common sexual dysfunction among male, followed by erectile disorder 22.6%, short lasting erections 19.9%, lack of sexual arousal 19.3% and premature ejaculation 13.3%.

Table 4.4: Common Sexual Dysfunctions which Existed among Females (Multiple Responses)

Category	Sexual dysfunctions	N	%	Cum %
Female	Lack of orgasm	67	22.8	22.8
	Sexual pain (dyspareunia)	40	13.6	36.4
	Lack of sexual arousal	78	26.5	62.9
	Lubrication (atrophic vaginitis)	64	21.8	84.7
	Short orgasms	45	15.3	100.0
	Total	294	100.0	

Table 4.4 showed that (26.5%) of the respondents cited lack of sexual arousal as the commonest sexual dysfunction among female, followed by lack of orgasm 22.8%, vaginal lubrication 21.8%, short orgasm and sexual pain (dyspareunia) 36.4%.

Table 4.5: Causes of reported Sexual Dysfunctions among People (Multiple Responses)

	Causes	N	%	Cum %
Valid	Masturbation	20	7.8	7.8
	Alcohol consumption	26	10.1	17.9
	Cigarette smoking	33	12.8	30.7
	Stress	43	16.7	47.4
	Poor balanced diet	25	9.7	57.1
	Medical conditions	38	24.9	71.9
	Breastfeeding	15	5.8	77.7
	Family planning	31	12	100.0
	Total	257	100.0	

Regarding the causes of sexual dysfunctions among people in the society, most 14.8% of the respondents cited medical conditions (like diabetes, hypertension and cancer), 16.7% cited stress related issues like anxiety, fatigue, , 12.8% mentioned cigarette smoking, 12% family planning methods, 10.3% other factors, 10.1% alcohol consumption, 9.7% poor diets while 7.8% cited consistent masturbation.

Research Question Two: Common Beliefs Associated with the Use of Traditional medicine eemedies for Sexual dysfunctions among married Couples

This section of the study addresses research question two which sought to identify the common beliefs associated with the use of traditional medicine remedy for sexual dysfunctions. Respondent's opinions were captured through multiple responses and analyzed using descriptive statistics as in Table 4.6 below;

Table 4.6: Common beliefs associated with the use of traditionall Medicine remedies for Sexual dysfunctions (Multiple Responses)

	Variable values	N	%	Cum %
Valid	Connected to witchcraft	64	27.7	27.7
	Associated with supernatural spirits	33	14.3	42
	Connected to misfortune	27	11.7	53.7
	They are ineffective	18	7.8	61.5
	For the un-educated	39	16.9	78.4
	They are un-clean	50	21.6	100.0
	Total	231	100.0	

According to the findings in table 4.6 above, majority 27.7% of the respondents generally believed that traditional herbal medicine use was connected to witchcraft, 21.6% assumed herbal medicines were un-clean, 16.9% believed they were for the un-educated group in the society, 14.3% alleged they were associated with supernatural spirits, 11.7% said they were connected to misfortune while 7.8% alleged they were ineffective.

Research Question Three: Commonly Used Herbal Medicines and their Use in the Treatment of Sexual Dysfunctions.

In this section of the study respondents were questioned to identify the commonly used herbal medicines and their use in the treatment of sexual dysfunctions. Respondent's opinions were captured and analyzed using descriptive statistics as in Table 4.7 and 4.8 below;

Table 4.7: Herbs Used by Males in the Treatment of Sexual Dysfunctions

Local name	Scientific Name	Family	Parts used	Mode of preparation	Administration	Dysfunction treated
Mairungi	*Catha edulis* (Vahl) Forssk	Celastraceae	L, ST	Chewing	Oral by chewing fresh leaves and young stem.	Erectile dysfunction
Munyinya	*Acacia abysinica* Hochst ex.Benith	Fabaceae	T, B	pounding, boiling	Oral	Erectile dysfunction
Muremanjojo	*Dichrostachys cinera* Wight eArn	Fabaceae	T, B	pounding, boiling	Oral	Premature ejaculation
Mwani	*Coffea Arabica* L.	Rubiaceae	S, SE	roasting, chewing	oral as a beverage	Premature ejaculation
Muboro	*Citropsis articulate* Willd ex Spreng	Rutaceae	B,R	pounding, boiling, chewing	Oral as beverage in tea	Delayed ejaculation
Mulondo	*Mondia whiteii*	Apocynaceae	R	chewing, boiling, pounding	Oral in water, in tea and in food	Erectile dysfunction
Entungwa baishaija	*Impetiens* sp	Balsamm Inaceae	WP	chewing, boiling	Oral	Erectile dysfunction
Omusisa	*Albizia coriaria* Welw	Leguminosae	L, ST	Decoction drunk	Oral	Lack of sexual

						arousal
Katunguru	*Allium cepa* L.	Amaryllidaceae	L, RT	chewing, cooking	oral in water and in food	Erectile dysfunction
Muziiko	Molinda citrifolia Benth	Rubiaceae	B, R	pounding, boiling	Oral	Premature ejaculation

Key: T (trees); S (shrubs); H (herbs); H-CL (herb-climber); ST (stem); B (bark); L (leaves); R (roots); RT (root-tuber); FR (fruit); SE (seeds); WP (whole plant).

According to the results in table 4.7 above, Key informant interviews were held with 15 elders and 5 Traditional Health Practitioners operating across Mbarara district. Qualitative results or verbatim opinions captured on herbs used by Males in the treatment of sexual dysfunctions. From interviews the commonly used male herbs in the treatment of sex dysfunctions identified included; Mairungi (*Catha edulis*), Munyinya (*Acacia cieberiana* Scheele), Muremanjojo (*Dichrostachy scinerea* L.), Mwani (*Coffea* spp.), Muboro (*Citropsis articulata*), Mulondo (*Mondia whiteii* Skeels), Entungwabaishaija (*Impetiens* sp.), Mufumbagyesi (*Rumex abyssinicus*), Katunguru (*Allium cepa* L.) and Omusisa (*Albizia coriaria* wel). The used of herbs differed in terms of preparation, administration and sexual dysfunction treated.

For example, Mairungi (*Catha edulis*), was among the common herbs used by Males in the treatment of sexual dysfunctions. It is prepared and administered orally chewing fresh leaves and young stem and used in treating erectile dysfunction. Munyinya (*Acacia cieberiana* Scheele), prepared through pounding and boiling, administered orally in water and food, used in treating erectile dysfunction. Muremanjojo (*Dichrostachys scinerea* L.) was prepared by pounding and boiling, administered orally and used in the treatment of premature ejaculation. Mwani (*Coffea* spp.) was prepared by roasting and chewing, administered orally as a beverage, and used in the treatment of lack of sexual arousal and premature ejaculation. Muboro (*Citropsis articulata*), was prepared by pounding, boiling and chewing, administered orally as beverage in tea, and used in treating erectile dysfunction and premature ejaculation. Mulondo (*Mondia whiteii* Skeels) was prepared by chewing, boiling and pounding, administered orally in water, tea and food, and used in the treatment of erectile dysfunction. Entungwabaishaija (*Impetiens* sp.), was prepared by chewing and boiling, administered orally in water and food, and used in treating erectile dysfunction. Mufumbagyesi (*Rumex abyssinicus*) was prepared by decoction drunk, administered orally in water, and used in treating lack of sexual arousal. Katunguru (*Allium cepa* L.) was prepared by chewing, cooking, administered orally in water and food, and used in the treatment of erectile dysfunction. Omusisa (*Albizia coriaria* wel) was prepared by pounding or boiling, administered orally in water, and used in treatment of premature ejaculation.

Table 4.8: Herbs Used by Females in the Treatment of Sexual Dysfunctions

Local name	Scientific name	Family	Parts used	Mode of preparation	Administration	Dysfunction treated
Rukaka	Aloe vera L	Aloeaceae	WP	Cooking	Oral	Lack of orgasm Lubricates
Katunguru	*Allium Cepa L.*	Amaryllidaceae	ST, L, RT	chewing, cooking	oral in water and in food	Lubricates
Mukanja	*Rhus vulgalis* Meikle	Anarcadiaceae	B, R, L	chewing, boiling	oral	Detoxifies
Mulondo	*Mondia wightei* (Hook.f) Skills	Apocynaceae	R	chewing, boiling, pounding	Oral in water, in tea and in food	Lack of orgasm Lubricates
Mukyora (Mugabagaba)	*Senna didyomobotrya* Fresen.	Fabaceae	L, R	chewing, boiling	Oral	Lack of sexual arousal
Mwitanzoka	*Cassia occidentals* L.	Fabaceae	L, R	chewing, boiling	Oral	Atrophic vaginitis
Omukarara	*Fluerggea Sp.*	Phylanthaceae	L, R	pounding, boiling	Oral	Sexual pain (Dyspareunia)
Akaihabukuru	*Macrotyloma axilare* (wight & Arn) Verdc	Fabaceae	L, RT	pounding, boiling	Oral	Lack of orgasm Lubricates
Munywamaizi	*Tarrena Pavettoides* Harv. Simm	Rubiaceae	B, L, R	pounding,	Oral boiling	Lack of orgasm Lubricates
Engyenyi	*Tragia brevispica* Plum	Euphorbiaceae	WP	pounding, boiling	Oral	Lack of sexual arousal Lack of libido

Key: T (trees); S (shrubs); H (herbs); H-CL (herb-climber); ST (stem); B (bark); L (leaves); R (roots); RT (root-tuber); FR (fruit); SE (seeds); WP (whole plant).

Table 4.8 above presented qualitatively analyzed results on herbs used by females in the treatment of sexual dysfunctions. Results indicated that there were numerous herbs used by female in treating different sexual dysfunctions as presented and discussed below; *Aloe vera* L. was among the commonest herbs revealed. It is prepared through cooking, administered orally in water and food, and used in treating lack of orgasm and lubrication. *Allium cepa* L. prepared through chewing, or cooking, administered orally in water and food, used in treating luck of lubrication. *Rhus vulgaris* Meikle was prepared by chewing or boiling, administered orally and used in treating lack of orgasm. *Mondia whitei* Skeels was prepared by chewing, boiling and pounding, administered orally in water, tea food, and used in treating lack of orgasm and lubrication. *Cassia occidentalis* L. was prepared by chewing or boiling, administered orally in water, and used in the treatment of Atrophic vaginitis. *Flueggea virosa*), was prepared by pounding or boiling, administered orally in water and food, and used in treating sexual pain (Dyspareunia) and lubrication. *Macrotyloma axillare* was prepared by pounding or boiling, administered orally in water and food, and used in treating lack of orgasm and lubrication. *Tarenna graveolens*) was prepared by pounding, administered orally in water, and used in treating lack of orgasm and lubrication. *Tragia brevipes* Pax. was prepared by pounding or boiling, administered orally in water and used in treating lack of sexual arousal and libido.

Research Question Four: Relationship between the Use of Sex Herbs and Treatment of Sex Dysfunctions among People.

This section of the study address research question four which sought to determine the relationship between the use of sex herbs remedy and sex dysfunctions among people. Pearson correlation was used to test for the association between herbs and treatment of specific sexual dysfunctions among male and female as presented in Tables 4.9 and 4.10 below;

Table 4.9: Relationship between Male Herbs and Treatment of Sex Dysfunctions

		Male sexual dysfunction treated				
Male sexual herbs		**Erectile dysfunction**	**Pain during penetration**	**Premature ejaculation**	**Lack of sexual arousal**	**Short lasting erections**
Catha edulis	r sig.	.514 .062	.790 .000*	.800 .001*	.921 .000*	.015 .790
Acacia cieberiana Scheele	r sig.	.541 .004*	.526 .174	.689 .025*	.755 .019*	.982 .001*
Dichrostachy scinerea L	r sig.	.791 .002*	.045 .836	.896 .000*	.088 .937	.984s .000*
Coffea spp	r sig.	.627 .001*	.015 .726	.879 .003*	.856 .002*	.118 .548
Citropsis articulata	r sig.	.742 .002*	.801 002*	.916 .000*	.753 .015*	.206 .698
Mondia whiteii Skeels	r sig.	.742 .001*	.006 .736	.821 .002*	.994 .000*	.114 .981
Impetiens sp	r sig.	.651 .025*	.702 .013*	.076 .913	.690 .002	.970 .000*
Albizia coriaria welw	r sig.	.851 .002*	.993 .000*	.113 .491	.834 .003*	.195 .700

N =103
r = Pearson correlation (Sig. 2-tailed)
*. Correlation is significant at the 0.05 level (2 tailed)

Results in table 4.9 above presented Pearson correlation estimates that were used to interpret the association between male herbs and treatment of sexual dysfunctions. Significant associations were 1% and 5% level of significance respectively. From the analysis, *Catha edulis* has a significant association with the treatment of pain during penetration (r=.790, p-value=.000), premature ejaculation (r=.800, p-value=.001) and lack of sexual arousal (r=.921, p-value=.000).

Similarly, *Acacia abyssinica* Scheele had association with the treatment of sexual dysfunctions like erectile dysfunction (r=.541, p-value=.004), premature ejaculation (r=.689, p-value=.025), lack of sexual arousal (r=.755, p-value=.019) and short lasting erections (r= .982, p-value=.001).

Results further indicated that *Dichrostachsy cinerea* L. was significantly ``associated with treatment of dysfunctions like erectile dysfunction (r= .791, p-value=.002), premature ejaculation (r= .896, p-value=.000), and short lasting erections (r= .984, p-value=.000).

The analysis of findings indicated that *Coffea* spp. had a significant associated with the treatment of erectile dysfunction (r= .627, p-value=.001), premature ejaculation (r= .879, p-value=.003), and lack of sexual arousal (r= .856, p-value=.002) respectively.

More so, revealed that *Citropsis articulata* herb was significantly associated with treatment of erectile dysfunction (r= .742, p-value=.002), pain during penetration (r=.801, p-value=.002), premature ejaculation (r= .916, p-value=.000), and lack of sexual arousal (r= 753, p-value=.015).

Findings showed that *Mondia whiteii* Skeels had a significant association with the treatment of erectile dysfunction (r= .742, p-value=.001), premature ejaculation (r= .821, p-value=.002), and lack of sexual arousal (r= .994, p-value=.000).

Results revealed that *Impetiens* sp. was significantly associated with the treatment of erectile dysfunction (r= .651, p-value=.025), pain during penetration (r= .702, p-value=.013), lack of sexual arousal (r= .690, p-value=.002), and short lasting erections (r= .970, p-value=.000).

Lastly, *Albizia coriaria* welw was significantly associated with the treatment of erectile dysfunction (r= .851, p-value=.002), pain during penetration (r= .993, p-value=.000), and lack of sexual arousal (r= .834, p-value=.003).

Table 11: Relationship between Female Herbs and Treatment of Sex Dysfunctions

		Female sexual dysfunction treated				
Female sexual herbs		**Lack of orgasm**	**Sexual pain (dyspareunia)**	**Lack of sexual arousal**	**Dryness (atrophic vaginitis)**	**Lack of libido**
Allium cepa L	R sig.	.65 .012*	.305 .152	.539 .638	.935 .000*	.649 .010*
Rhus vulgaris Meikle	R sig.	.999 .000*	.701 .026*	.239 .487	.963 .000*	.541 .019*
Mondia whitei Skeels	R sig.	.521 .036*	.978 .001*	.344 .154	.831 .001*	.220 .875
Tarenna graveolens	R sig.	.851 .002*	.993 .000*	.113 .491	.834 .003*	.195 .700
Aloe vera	R sig.	.603 .002*	.045 .833	.010 .983	.711 .013*	.847 .003*
Flueggea virosa	R sig.	.279 .260	.588 .005*	.882 .001*	.124 .352	.484 .480
Macrotyloma axillare	R sig.	.609 .000*	.889 .003*	.989 .000*	.178 .634	.225 .394

N =103
r = Pearson correlation (Sig. 2-tailed)
*. Correlation is significant at the 0.05 level (2-tailed).

Results presented in table 4.10 above were correlation estimates between female herbs and treatment of sexual dysfunctions. Significant associations were 1% and 5% level of significance respectively. From the analysis, *Aloe vera* L. had a significant association with the treatment of lack of orgasm (r=.603, p-value=.002), dryness (atrophic vaginitis) (r=.711, p-value=.000) and lack of libido (r=.847, p-value=.003).

Similarly, *Allium cepa* L. had a significant association with the treatment of lack of orgasm (r=.655, p-value=.012), lubrication (atrophic vaginitis) (r=.935, p-value=.000) and lack of libido (r=.649, p-value=.010).

The analysis also indicated that *Rhus vulgaris* Meikle had a significant association with the treatment of lack of orgasm (r= .999, p-value=.000), sexual pain (dyspareunia) (r= .701, p-value=.026), dryness (atrophic vaginitis) (r= .963, p-value=.000) and lack of libido (r= .541, p-value=.019).

Results indicated that *Mondia whiteii* Skeels was significantly associated with the treatment of lack of orgasm (r= .521, p-value=.036), sexual pain (dyspareunia) (r= .976, p-value=.001), and dryness (atrophic vaginitis) (r= .831, p-value=.001).

More so, results indicated that *Tarenna graveolens* had a significant association with the treatment of lack of orgasm (r= .851, p-value=.002), sexual pain (dyspareunia) (r= .993, p-value=.000) and dryness (atrophic vaginitis) (r= .834, p-value=.003).

Results showed that *Flueggea virosa* had a significant association with the treatment of sexual pain (dyspareunia) (r= .588, p-value=.005) and lack of sexual arousal (r= .882, p-value=.001).

Results revealed that the use of *Tragiabrevipes* Pax. was significantly associated with the treatment of sexual pain (dyspareunia) (r=.969, p-value=.000), lack of sexual arousal (r=.742, p-value=.002), and dryness (atrophic vaginitis) (r=.730, p-value=.003).

Lastly, use of *Macrotyloma axillare* was significantly associated with the treatment of dysfunctions like lack of orgasm (r=.609, p-value=.000), sexual pain (dyspareunia) (r= .889, p-value=.003) and lack of sexual arousal (r= .989, p-value=.000).

Discussions

Common Sexual Dysfunctions which Exist among People

The study identified the common sexual dysfunctions which existed among people in the study area. For example, the common sexual dysfunctions found in men included; pain during penetration, erectile dysfunction, short erections, lack of sexual arousal and premature ejaculation. In addition, the sexual dysfunctions common to women included; lack of sexual arousal, lack of orgasm, vaginal lubrication, short orgasms and sexual pain (dyspareunia). These conditions differed amongst individuals due to factors like level of masturbation, alcohol consumption, tobacco smoking, stress, feeding habits, medical conditions and family planning. These study findings are in line with Rayner *et al*., (2011) [44] who stated the inability for women to become physically aroused during sexual activity often involves insufficient vaginal lubrication. This inability also may be related to anxiety or inadequate stimulation. In addition, researchers are investigating how blood flow problems affecting the vagina and clitoris may contribute to arousal problems.

Findings are also comparable to findings by Shah *et al*, (2012) [46] who revealed that pain during intercourse can be caused by a number of problems, including endometriosis, a pelvic mass, ovarian cysts, vaginitis, poor lubrication, the presence of scar tissue from surgery, or a sexually transmitted disease. A condition called Vaginismus is a painful, involuntary spasm of the muscles that surround the vaginal entrance. It may occur in women who fear that penetration will be painful and also may stem from a sexual phobia or from a previous traumatic or painful experience.

Findings concurred with Herbert, (2012) [29] who stated that compulsive sexual behaviors (CSBs) constitute a wide range of complex sexual behaviors that have strikingly repetitive, compelling, or driven qualities. They usually manifest as obsessive-compulsive sexuality (*e.g*. excessive masturbation and promiscuity), excessive sex-seeking in association with affective disorders (*e.g*. major depression or mood disorders), addictive sexuality (*e.g*. attachment to another person, object, or sensation for sexual gratification to the exclusion of everything else), and sexual impulsivity (failure to resist an impulse or temptation for sexual behavior that is harmful to self or others such as exhibitionism, rape, or child molestation).

Common Beliefs Associated with the Use of Herbal Medicine Remedy for Sexual Dysfunctions

The study came out with different common beliefs associated with the use of herbal medicine remedy for sexual dysfunctions. Use of herbal medicine remedy for sexual dysfunctions was found to be associated with witchcraft, supernatural spirits and misfortune, although some other people in the community perceived them to be ineffective, unclean and for the un-educated group in the society. The way people in the community viewed use of herbal medicine differed with family upbringing, gender, age, level of education, economic status and cultural history of specific herbs. These study findings are comparable to findings by Giovanni, (2015) [22] who argued that the utilization of traditional medicines is widespread in sub Saharan Africa, where up to 80% of the population relies on it for a variety of health needs. Alongside its affordability, accessibility and availability, the acceptability dimension of herbal medicine has long been recognized. Herbal medicines are claimed to be culturally acceptable because such systems are aligned with historical circumstance, local beliefs and values, to the extent that modern systems are insufficient or unacceptable under certain conditions. Whilst the idea that ‘culture’ affects medicines utilization is a standard principle upon which social scientists and researchers base assumptions and form models, the complexity of formally measuring and quantifying ‘culture’ has until very recently dissuaded scholars from exploring statistically its role in shaping economic behavior.

Findings are also in line with Fruhauf *et al*., (2012) [20] some healers may employ the use of charms, incantations, and the casting of spells in their treatments. The dualistic nature of traditional African medicine between the body and soul, matter, and spirit and their interactions with one another are also seen as a form of magic. Onwuanibe, 2013 gave one form of magic the name "Extra-Sensory-Trojection." This is the belief among the Ibos of Nigeria that medicine men can implant something into a person from a distance to inflict sickness on them.

Commonly Used Herbal Medicines and their Use in the Treatment of Sexual Dysfunctions

The study came up with a list of different herbs and their use in the treatment of sexual dysfunctions. The commonly used male herbs in the treatment of sex dysfunctions included; *Aloe*

vera, *Flueggea virosa*, *Allium cepa Mondia*, *whiteii*, *Urtica massaica*., *Vernonia cinerea*, *Rhus vulgaris*, *Tarenna graveolens*, *Cassia occidentalis*, *Tragia brevipes* and *Macrotyloma axillare*. These vegetative products are at times mixed with non- vegetable materials such as rock salt, Clay soil (*mumbwa*) and Ash (*Vvu*) to make the final products for consumption. Methods used in the preparation of these home-made TMs included boiling plant parts (leaves, stems or roots) in water and straining, smoking, roasting, crushing raw leaves and mixing with cold water and at times chewing (stems, bark, leaves and roots). Intake of raw material if not thoroughly cleaned was hazardous to the patients. Local measures such as smoking, roasting and steaming were proved to be safer before herbs were extracted. These herbs were administered orally in water, food, tea, porridge, and milk, oral as a beverage, inhaling fumes, and taking them in raw form. Use of these different herbs treated male dysfunctions like erectile dysfunction, premature ejaculation, and pain during penetration and short erections. These findings are comparable to findings by (Herbert, 2012) [29] who said a list of medicinal plants both cultivated and wild-harvested are greatly utilized by men for managing sexual impotence and erectile dysfunction in western Uganda. Erectile dysfunction and sexual impotence are old problems and traditionally the indigenous knowledge had ways of treating or managing these conditions associated with male reproductive system. The medicinal plants used such as *Citropsis articulata, Cannabis sativa*, *Cleome gynandra* and *Cola acuminata* are frequently utilized. Some of these plants (*Citropsis articulata, Cola acuminate*) are already under sale for treating these conditions.

Findings are also comparable to findings by Sohil *et al*., (2013) [49, 50] who argued that herbal medicines used in the management of sexual impotence and erectile dysfunction are mainly prepared by pounding, chewing and boiling and are mainly orally administered. The traditional healers treat sexual impotence and erectile dysfunction by prescribing some of these herbs in tea or using local beers, fermented milk and porridge. Some herbs are herbs are roasted or smoked such as coffee before administration. The dispensing of herbal medicines used in sexual impotence and ED using local beers, fermented milk and porridge possibly the alcoholic content improves on the kind of active chemicals extracted than water alone.

The commonly used female herbs in the treatment of treatment of sex dysfunctions included; *Aloe vera*, *Flueggea virosa*, *Allium cepa*, *Mondia whiteii*, *Urtica massaica*, *Vernonia cinerea*, *Rhus vulgaris*, *Tarenna graveolens*, *Cassia occidentalis*, *Tragia brevipes* and *Macrotyloma axillare*. These female herbs were either taken raw or prepared through boiling, straining, smoking, roasting, crushing of parts (like leaves, stems, roots, bark or whole plant). Most female herbs were orally administered in water, food, tea, porridge, milk, or as a beverage while others were inhaled as fumes, and chewed raw. These herbs were applied independently or mixed to treat a specific dysfunction or multiple dysfunctions. Administering different herbs treated female dysfunctions like lack of lubrication, lack of sexual arousal, lack of orgasm, atrophic vaginitis and sexual pain (dyspareunia). These study findings are in line with findings by Laurent and Simons, (2009) who said herbal medicine, in general, has revealed properties that contribute to increasing the activity of specific hormones that act on the libido. Some herbal medicines stood out, including *T. terrestris*, for increasing testosterone serum levels, and *E. longifólia*, which also leads to an increased biosynthesis of several androgens; ginseng, which increases energy levels and stimulates smooth muscle relaxation with nitrous oxide; Maca (*L. meyenii*), which improves sexual performance, in addition to having androgenic effects; and Mondia *whitei* (ginger), which improves the libido and erection. Kubmarawa *et al*., (2013) [38] demonstrated the effectiveness of a hypo caloric, hyperproteic and hypolipidaemic diet on the libido, improving sexual and erectile functions, as well as increasing testosterone levels. Herbal medicine previously studied in human beings have demonstrated positive effects on the libido, indicating a promising field of action for nutrition as a support in treating sexual dysfunctions.

Relationship between the Use of Sex Herbs Remedy and Sex Dysfunctions among People

The study determined the relationship between the use of sex herbs remedy and sex dysfunctions among people. For example male herbs like *Aloe vera*, *Flueggea virosa*, *Allium cepa Mondia whitei*, *Urtica massaica*, *Vernonia cinere*, *Rhus vulgaris*, *Tarenna graveolens*, *Cassia occidentalis*, *Tragia brevipes* and *Macrotyloma axillare* wight & Arn Verdc) significantly treated male dysfunctions like erectile dysfunction, premature ejaculation, pain during penetration and short erections. These study findings are in line with Dyer and das Nair, (2013) [18] argued that herbal medicine has played a significant role in health care delivery. It is estimated that approximately 80% of the world's population rely on traditional medicine, in one way or the other, for health care. Moreover, an estimated 80% of the people in developing countries and 80% of Africans rely on herbal medicine to meet their primary health care needs. The annual global market for herbal medicines in year 2000 was over US$60 billion and is growing steadily at a rate of fifteen to twenty five percent.

Herbs used in management of female sexual dysfunction significantly treated dysfunctions like lack of lubrication, lack of sexual arousal, lack of orgasm, atrophic vaginitis and sexual pain (dyspareunia). These study findings are in line with Goldbeck-Wood (2010) [23] who said Herbs that are used for medicinal purposes come in a variety of forms. Active parts of a plant may include leaves, flowers, stems, roots, seeds, and berries. They may be taken internally as pills or powders, dissolved into tinctures or syrups, or brewed in teas and concoctions.

Conclusions

The study concluded that there were sexual dysfunctions common to both men and women in the society. Sexual dysfunctions common to men included; pain during penetration, erectile disorder, short erections, lack of sexual arousal and premature ejaculation while for women included; lack of sexual arousal, lack of orgasm, atrophic vaginitis, short orgasms and dyspareunia. These conditions were caused by numerous factors including level of masturbation, alcohol consumption, tobacco smoking, stress, feeding habits, medical conditions and family planning use. Secondly, the study concluded that there were common beliefs associated with the use of herbal medicine remedy for sexual dysfunctions such as; their connectivity to witchcraft, supernatural spirits and misfortune as well as being ineffective, unclean and for the un-educated group in the society.

The study further concluded that there were numerous herbal medicines both cultivated and wild-harvested that was used by both men and women for managing sexual dysfunctions.

Administered orally in water, food, tea, porridge, milk, as a beverage, inhaling fumes, and taking them raw; these herbs treated dysfunctions like erectile disorder, premature ejaculation, and pain during penetration and short erections for men; and lack of lubrication, lack of sexual arousal, lack of orgasm, atrophic vaginitis and dyspareunia for women.

In conclusion, there was a relationship between use of traditional herbalremedies and sex dysfunctions among people. Male herbs like *Aloe vera*, *Allium cepa*, *Tragiabrevipes* Pax, *Fluerggea Sp* and *Mondia whitei* significantly treated male dysfunctions like erectile disorder, premature ejaculation, and pain during penetration and short erections. Similarly female herbs including Aloe *vera*, *Fluerggea Sp*. and *Tragiabrevipes* Pax significantly treated dysfunctions like lack of lubrication, lack of sexual arousal, lack of orgasm, atrophic vaginitis and sexual pain (Dyspareunia).

As professional counsellor, the following recommendations were drawn for possible future interventions; It is important that herbalists and health professionals work together and make enquiries from the patients about past or current use of herbal medicines. This may help in educating the patients about the health risks of using herbal medicine and may reduce delays in seeking appropriate care.

Couple communication is paramount in addressing some of the dysfunctions in families. Rather than depending herbs whose pharmacological properties are unknown, couples could use positive communication as a tool of solving sexual problems in households. There is need for collaboration between health professionals with herbal medicine practitioners to identify the common herbal medicines used for treatment of different disease condition, their potential benefits and harm. This would help herbal users in differentiating dangerous herbs from usable ones.

It would be helpful for researchers to study the pharmacological composition of the stimulants used by the respondents. This would help in determining the possible therapeutic and toxicity effect of such drugs. Results from such research research works is important in counseling men and women who use such drugs.

Community leaders, herbalists and the general public need to be sensitized on the need for cultivating very popular herbs to meet the demand future generations. The Ministry of Health should ensure that correct information on use of herbal medicine with conventional medicine is disseminated to general public. This will enable people to make informed choice on use of herbs concomitantly with conventional medicine.

Harvesting of medicinal plants from the wild places such as the forest reserves, national parks in Quen Elizabeth is a point of concern whereby no viable mechanisms have been put in place to propagate them. The plant parts harvested especially those of wild medicines such as roots and stem, pose threat to the future survival of natural reservoirs if domestication strategies are not adopted in the near future. This calls for serious conservation strategies of plant targets in drug development borrowing from the indigenous knowledge of the local people.

Areas for further research

Further studies are needed to establish the effect of the traditional sexual stimulants on men. Further studies are needed on ways in which herbal and modern health care systems could be fully integrated. Studies are also needed on ways traditional medicine can be brought into Uganda's health system and ways to improve regulation and safety standards. Pharmacological study focusing on local commonly used herbal medicines should be done. This should be carried out to identify the exact active compounds of the herbs and to evaluate the effects of these compounds to the children.

Studies into the types of plants and the parts of plants used for medicine should be investigated in the future. The documentation of plants and their therapeutic properties is an area that must be of interest to future researchers.

References

1. Abdullahi H, Tukur J. Sexual stimulants and their effects on women of reproductive age group in Kano, northern Nigeria. Nigerian Journal of Basic and Clinical Sciences. 2013;10:13-16.
2. American Urological Association. Management of Erectile Dysfunction: An Update. <http://www.auanet.org/guidelines/edmgmt. cfm> (accessed 25.07.14) 2014.
3. Arhinful DK. WHO Level II Household Survey to Measure Access to and Use of Medicines in Ghana. WHO Medicines Survey Conducted in GHANA in May/June 2008. Ministry of Health, Ghana.
4. Awodele O, Agbaje EO, Ogunkeye FA, Kolapo AG, Awodele DF. Towards integrating traditional medicine into National Health care Scheme: Assessment of traditional medicine practitioners' disposition in Lagos, Nigeria. Journal of Herbal Medicine. 2011;I:90-94.
5. Berner M, Günzler C. Efficacy of psychosocial Interventions in men and women with sexual dysfunctions: A systematic review of controlled clinical trials. Part 1 - The efficacy of psychosocial interventions for male sexual dysfunction. The Journal of Sexual Medicine. 2012;9(12):3089-3107.
6. Berry MD, Berry PD. Contemporary treatment of sexual dysfunction: Reexamining the biopsychosocial model. The Journal of Sexual Medicine. 2013;10(11):2627-2643.
7. Binik YM, Meana M. The future of sex therapy: specialization or marginalization? Archives of Sexual Behavior. 2009;38(6):1016-1027.
8. Bitzer J, Brandenburg U. Psychotherapeutic interventions for female sexual dysfunction. *Maturitas*, 2009;63(2):160-163.
9. Carpenter D, Janssen E, Graham C, Vorst H, Wicherts J. Women's scores on the sexual inhibition/sexual excitation scales (SIS/SES): Gender similarities and differences. The Journal of Sex Research. 2008;45(1):36-48.
10. Carr A. The effectiveness of family therapy and systemic interventions for adult-focused problems. Journal of Family Therapy. 2009;31:46-74.
11. Choi WS, Song SH, Son H. Epidemiological study of complementary and alternative medicine (CAM) use for the improvement of sexual function in young Korean men: the Korean internet sexuality survey (KISS), part 2. J. Sex. Med. 2012;9:2238-2247.
12. Clewell A, Qureshi I, Endres J, Horvath J, Financsek I, *et al*. Toxicological evaluation of a dietary supplement formulated for male sexual health prior to market release. Regul. Toxicol. Pharmacol. 2010;57:55-61.
13. Cohen PA, Venhuis BJ. Adulterated sexual enhancement supplements more than Mojo. JAMA Int. Med. 2013;173(13):1169-1170.
14. Connor MK, Maserejian NN, De Rogatis L, Meston CM, Gerstenberger EP, Rosen RC. Sexual desire, distress, and

associated factors in premenopausal women: Preliminary findings from the hypoactive sexual desire disorder registry for women. Journal of Sex and Marital Therapy. 2011;37(3):176-189.
15. Dahilig VRA, Salenga RL. Prevalence, perceptions and predictors of complementary and alternative medicine use in selected communities in the Philippines. JAASP. 2012;1(1):16-24.
16. de Tubino Scanavino M. Sexual dysfunctions of HIV-positive men: Associated factors, pathophysiology issues, and clinical management. Advances in Urology, 2011. doi: 10.1155/2011/854792.
17. Department of Health. Proposed changes to NHS availability of erectile dysfunction treatments. Changing prescribing restrictions for sildenafil. London: Department of Health, 2014.
18. Dyer K, das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. Journal of Sexual Medicine. 2013;10:2658-2670.
19. Edwards R. Herbs and Healers of the North: Medicine, Practices and Philosophies in Islamic and Traditional Healing in Northern Ghana. Independent Study Project (ISP) Collection. Paper, 2011, 1250.
20. Fruhauf S, Gerger H, Schmidt HM, Munder T, Barth J. Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis. Archives of Sexual Behavior. 2012;42(6):915-933.
21. Garba ID, Yakasai IA, Magashi MK, Use of Aphrodisiacs amongst women in Kano, northern Nigeria IOSR Journal of Pharmacy. 2013;3:01-04.
22. Giovanni B. Sexual problems and infertility. In G. Cavallini and G. Beretta (Eds.), Clinical management of male infertility (pp. 179-183). London: Springer Link, 2015.
23. Goldbeck-Wood S. Commentary: Female sexual dysfunction is a real but complex problem. British Medical Journal. 2010;341(c5336), 701-701.=
24. Graham CA, Brotto LA, Zucker KJ. Response to Balon and Clayton (2014): Female sexual interest/arousal disorder is a diagnosis more on firm ground than thin air. Archives of Sexual Behavior. 2014;43(7):1231-1234.
25. Günzler C, Berner MM. Efficacy of psychosocial interventions in men and women With sexual dysfunctions—A systematic review of controlled clinical trials. Part 2 - The efficacy of psychosocial interventions for female sexual dysfunction. The Journal of Sexual Medicine. 2012;9(12):3108-3125.
26. Gyasi RM, Tagoe-Darko E, Mensah CM. Use of Traditional Medicine by HIV/AIDS Patients in Kumasi Metropolis, Ghana: A Cross-sectional Survey. American International Journal of Contemporary Research. 2013;3(4).
27. Hall KSK, Graham CA. The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients. Oxford: Routledge, 2012.
28. Hendrickx L, Gijs L, Enzlin P. Distress, sexual dysfunctions, and DSM: dialogue at cross purposes? The Journal of Sexual Medicine. 2013;10(3):630-641.
29. Herbert EB. Press Coverage of Traditional Medical Practice in Nigeria, Journal of Communication. 2012;3(2):75-89.
30. Holst L, Wright D, Nordeng H, Haavik S. Use of herbal preparations during pregnancy: Focus group discussion among expectant mothers attending a hospital antenatal clinic in Norwich, UK. Department Complementary Therapies in Clinical Practice. 2009;15:225-229.
31. Hughes GD, Aboyade OM, Clark BL, Puoane TR. The prevalence of traditional herbal medicine use among hypertensive living in South African communities. BMC Complementary and Alternative Medicine, 13 http://www.biomedcentral.com/1472-6882/13/38.
32. Iancu M. Local Use of Traditional and Modern Medicine: A case study in Babati District, Tanzania. Bachelor's Thesis 15 ECTS submitted to the School of Life Sciences, Södertörn University College, 2011.
33. Kaadaaga Judith, Ononge *et al*. Prevalence and factors associated with use of herbal medicine among women attending an infertility clinic in Uganda, BMC Complementary and Alternative Medicine, 2014. http://www.biomedcentral.com/1472-6882/14/27
34. Kakudidi EK, Bukenya-Ziraba R, Kasenene J. The Medicinal Plants in and around Kibale National Park in Western Uganda. A Norwegian Journal of Botany, LIDIA. 2000;5(4):109-124.
35. Kamatenesi-Mugisha M, Bukenya Ziraba R. Ethnobotanical Survey methods to Monitor and Assess the Sustainable Harvesting of Medicinal Plants in Uganda. In: Maunder M, Clubbe C, Hankamer C, Madeleine G, editors. Plant Conservation in the Tropics. Perspectives and practice. Kew. Great Britain: The Royal Botanical Gardens, 2002.
36. Kamatenesi-Mugisha M. The Socio-Cultural Aspects in Utilisation of Medicinal Plants in Reproductive Health Care in Western Uganda; 8th International Interdisciplinary Congress on women. Gendered Worlds: gains and challenges. Kampala, Uganda, 2002, July 21-26.
37. Kamatenesi-Mugisha M. Medicinal Plants used in Reproductive Health Care in Western Uganda: Documentation, Phytochemical and Bioactivity Evaluation. Kampala, Uganda: Makerere University; 2004. Ph.D. Thesis in Botany, 2004.
38. Kubmarawa D, Akiniyi JA, Okorie DA. Ethnomedicinal survey of the traditional medicine of Lala people of Nigeria, International Journal of Medicinal Plant and Alternative Medicine. 2013;1(3):039-057.
39. Laurent SM, Simons AD. Sexual dysfunction in depression and anxiety: Conceptualizing sexual dysfunction as part of an internalizing dimension. Clinical Psychology Review. 2009;29(7):573-585.
40. Neelesh M, Sanjay J, Bihari G, Savita V. Recent studies on aphrodisiac herbs for the management of male sexual dysfunction, Drug Research. 2011;68(1):03-08.
41. Nolen-Hoeksema, Susan. Abnormal Psychology. 2 Penn Plaza, New York, NY 10121: McGraw-Hill, 2014, 366-367. ISBN 978-1-259-06072-4.
42. Oreagba AI, Oshikoya AK, Amachre M, *et al*. Herbal medicine use among urban residents in Lagos, Nigeria, BMC Complementary and Alternative Medicine, www.biomedcentral.com/1472-6882/11/117
43. Orief YI, *et al*. Use of herbal medicines among pregnant women attending family health centres in Alexandria, Middle East Fertility Society Journal, 2012. http://dx.doi.org/10.1016/j.mefs..02.007.
44. Rayner JA, Willis K, Burgess R. Women's use of complementary and alternative medicine for fertility enhancement: a review of the literature. Journal of Altern Complement Med. 2011;17(8):685-690.

45. Sen S, Chakraborty R, De B. Challenges and opportunities in the advancement of herbal medicine: India's position and role in a global context. Journal of Herbal Medicine. 2011;1:67-75.
46. Shah, *et al*. Evaluation of a multi-herb supplement for erectile dysfunction: a randomized double-blind, placebo-controlled study. BMC Complem. Altern. Med, 2012;12:155.
47. Shin BC, Lee MS, Yang E, Lim H, Ernst E. Maca (L. meyenii) for improving sexual function: a systematic review. BMC Complem. Altern. Med. 2010;10(44):1–6.
48. Skegg K, Nada-Raja S, Dickson N, Paul C. Perceived "out of control" sexual behavior in a cohort of young adults from the Dunedin multidisciplinary health and development study. Archives of Sexual Behavior. 2010;39(4):11.
49. Sohil M, Manish S, Sandip R, Ramkumar D. evaluation of recreational use of aphrodisiac drugs and its consequences, Int J Res Med. 2013;2(1);51-59.
50. Sohil M, Manish S, Sandip R, Ramkumar D. evaluation of recreational use of aphrodisiac drugs and its consequences, Int J Res Med. 2013;2(1);51-59.
51. van Lankveld JJ, Leusink P, van Diest S, Gijs L, Koos Slob A. Internet-based brief sex therapy for heterosexual men with sexual dysfunctions: A randomized controlled pilot trial. Journal of Sexual Medicine. 2009;6:2224-2236.
52. WHO Media Centre. Traditional Medicine. Fact sheet N°134 2008 [http:// www.who.int/mediacentre/factsheets/fs134/en/].
53. Yakubu MT, Akanji MA, Oladiji A. Male sexual dysfunction and methods used in assessing medicinal plants with aphrodisiac potentials. Journal of Ethnopharmacol. 2007;96:11:49-5.