The Sex Of Physician And Reproductive Healthcare Uptake By Adolescents In Delta State Nigeria

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ABSTRACT

This study investigates relationship between adolescents' reproductive health uptake and their preference for the sex of their physicians in Delta State Nigeria. The question the study answered was if the sex of the physician is relevant in adolescents' reproductive health uptake in Delta State. The research combined quantitative and quality methods such as questionnaire, focus group discussions and interviews to provide the needed answers to the question raised. The result from the study showed that there is a relationship between the sex of adolescents' patients in reproductive health and the sex of the physicians providing the services. The study concludes that adolescents be given a choice of who their physicians should be since it is their rights to be so allowed and a way of improving access and use of adolescent reproductive health services.

Key words: Adolescents, Delta State, Reproductive healthcare, Sex of Physician, Nigeria

1. INTRODUCTION

One of the important ingredients in the health seeking behaviour of adolescents in the field of medicine is that the services must be provided in the atmosphere of confidentiality [1, 2, 3, 4, 5]. Hock-Long et al. [4] in their study identified confidentiality of consent for care and service environment as two types of structural factors which affect access to sexual and reproductive health services for adolescents. Ralpha and Brindis [6] and Ford, Millstein, Halpern-Felsher and Irwin [7] in their discussions of barriers to accessing reproductive healthcare reiterated the significance of confidentiality in ensuring adolescents' willingness to access health services, disclose sensitive health information, and return for necessary follow-up care. According to them, confidentiality protections are particularly important for reproductive and other sensitive healthcare, as adolescents are likely to forgo needed care in the absence of these protections. One important area where confidentiality is needed during adolescent treatment is in the sex of the physician –whether they are male or female [6]

Gender plays a role in reproductive health (RH) access and utilisation. Human Rights Law gives legitimacy to claims to be treated equally irrespective of gender without discriminations [8,9].Physicians who are the service provider are major determinants of the willingness of adolescents to either use a particular service or not depending on their sex [10]. Important attributes of the physicians which make their services acceptable or rejected by adolescents include: their negative attitude [5,6,11,12]; their adherence to confidentiality in their practices[4], how serious they take their services with their patients[12]; providers competence and effectiveness[6,11,13] and the physicians sex –whether they are males or females [6, 7]. Hence, the tolerance level of patients have to be treated by the opposite sex in reproductive healthcare provision is an essential factor of whether the services will be used or not [6].According to Ralpha and Brindis [6], if services are provided by the opposite, the health users may forgo such services.

The relationship between the sex of physicians and reproductive healthcare usage has been studied [6, 8, 14, 15, 16, 17]. Hall et al.[16] concluded in their study that female physicians were more likely to meet a standard appropriateness for breast examinations and pap smears than were male staff physicians, whereas female residents were less likely than male residents to treat and follow up urinary tract infection in children appropriately. Lurie et al.[10] and Fennema et al.(18) reported in their separate studies that many patients had preference for physicians of the same sex especially among females patients in clinical situations requiring rectal and genital examinations. In two other studies by Kelly [19] and Blake [20], more women insisted on being treated by female physicians. Women patients equally reported greater satisfaction when treated by female physician than male [21]. The work by Kalo [22] on utilisation of adolescent reproductive health services by young people in Vanuatu finds out that practitioner gender poses a barrier for female patients who were apprehensive about being examined by a male physician on one hand and male patients who were not comfortable being examined by a female provider. Furthermore, other studies [23, 24,25] observed that some male physicians felt less confident providing pelvic examinations and contraceptive counseling. In Nigeria, a related gender based issue has to do with the treatment of STIs. Fatusi et al.[26], had shown that Nigerian adolescents who experienced STIs symptoms, delayed care seeking and treatment if they are to be treated by the opposite sex.

Sherman [17] believed that though modern medicine claims to be gender neutral, many patients as well as physicians are not. According to him, although girls are frequently given a choice of gender for gyneacological care, this is offered to boys much less for intimate examinations. He further observed that, the widespread presence and success of women's clinics who offer general care suggest that a significant percentage of women prefer same gender care for all their needs. Furthermore, he opined that though most men would prefer being attended to by male physicians as well as male assistances during urological treatments; the refusal of some health facilities employing male assistants had led to embarrassing situation where female assistants aid male urologists in such procedures even against their wish. The resultant imparts, in his view, is that some male patients avoid doing such treatment all together. He further argued that, institutions are partially blind when it comes to hiring staff as gender is a protected federal class and equal employment laws need to be followed. Yet legal exemptions for issues of bodily privacy are routine (bonafide occupational qualifications). According to Sherman [17], unlike the case with racial preferences, it is legal to grant patients their gender preferences when intimate exposure is required; however, hospitals try to avoid this issue because of greater staffing needs and increased costs. In conclusion, Sherman [17] admittedly conceded that though the issue of physicians sex preference is not the biggest problem we face in terms of access to medical care, it has remained a factor that is poorly recognised and largely unstudied. This study investigates if the sex of the physicians matter in adolescents' uptake of reproductive healthcare in Delta State, Nigeria.

2. METHODS

2.1 PRELIMINARY/RECONNAISSANCE SURVEY AND DELIMITATION OF THE STUDY AREA

Reconnaissance visits were paid to the surveyed Local Government Areas (LGAs). The LGAs are; Burutu and Bomadi – Delta South Senatorial District, Ughelli North and Udu –Delta Central Senatorial District and Ika South and Ukwuani – Delta North Senatorial District). These were followed by contacts setting, acquisition of necessary clearance and authorisation from the Ministry of Basic Education, Delta State, which is the body responsible for Secondary Education. Another aim of the contact setting was to make appointments for data collection. Apart from visits to stakeholders in the Ministry of Basic Education, the Ministry of health as well as Local governments' authorities were visited. This phase started with obtaining of further clearance and permission from the Ministry of health and the Coordinator of Primary Health Centre at the Local Government Areas. Permission was sought to interview some key personnel in the health sector as well as some selected health facilities in the LGAs of the study and the collection of information and list of health facilities in the LGAs from the Ministry.

2.2 RESEARCH DESIGN AND POPULATION

The survey design was adopted for this study due to the nature of the study. The data needed were primary data using questionnaires, in-depth interviews and focus group discussions (FGDs). Adolescents in schools were the focus of this study. This was in recognition of the fact that adolescents spend most of their time in schools and undergo adolescence development and transition during their school life. It is also in schools that adolescents have close interaction with their peers who may influence their sexual health behaviour. The schools are thus critical in shaping reproductive and sexual behaviour of adolescents, and in providing reproductive health information and services that can help them meet their reproductive and other health concerns [27]. The study population included: adolescents in public secondary schools in Delta State, health providers from selected health facilities and senior officers and persons representing government departments. The total population of students in these schools is 218,562 [28]. The reason for the selection of students in secondary schools as participants for this study is based on the fact that the students are likely to have the age range of 10 – 20 as defined as adolescents for the purpose of this study.

2.3 SAMPLE/SAMPLING TECHNIQUES

In this study, combinations of sampling techniques were used at different stages. In the first stage, the cluster sampling technique was used in selecting the Local Government Areas (LGAs) and the schools in the LGAs where this research was carried out. The use of cluster sampling was due to concentration of youth in the selected LGAs and schools with similar attributes [29]. Before the selection of LGAs, Delta State was demarcated into three parts based on existing senatorial districts. Two LGAs were selected from each senatorial district; making a total number of six LGAs. In each LGA, two secondary schools were selected purposively

which included a school in an urban area and one school from a rural location; bringing the total schools where the study was carried out to 12 from a pool of 452 secondary schools [28]. The sample size was 1500 students and this was equally drawn from the twelve schools with each having 125 respondents respectively. The use of equal protocol of 125 students from each class was based on the fact that equal sample of students were sampled from each class for equal representation of students in each school. The sample size of 1500 was drawn using the Rule of Thumb which states that; for large populations (over 150,000), small sampling ratios (1 percent) are possible and sample of about 1500 can be very accurate [30] In the second stage, the stratified sampling technique was used in order to ensure equal opportunity of participation of students (males and females). The study used systematic random sampling to select respondents from each school -125 secondary students comprising 63 male and 62 females, since the population of males was higher in most classes. Six focus group discussions (three for males and three for females) were held in the three senatorial districts with 12 students each (6 males and 6 females) from each senatorial district to complement data from survey. In all, two FGDs were held per Senatorial District with one for males and the other for females.

Purposive sampling technique was used to select health providers (12 in all) and key informants (6 key informants). The aim was to get a sample capable of providing rich information [31] based on the providers and key informants practical experience with adolescents, and their familiarity with reproductive health issues. Their selection was based on their long services in reproductive matters and their potential to provide data on the range of reproductive health services offered in Delta State as well as the LGAs, and those that were offered to adolescents.

2.4 SOURCES OF DATA/DATA REQUIRED FOR THE STUDY

The data for this study were collected through field survey by the researcher with means of questionnaires to elicit information such as age, educational level of parents, ethnic group, income level of parents, use of RH, and adolescents' physicians' sex preference among others in the selected schools. Additionally, focus group sessions were held with groups of adolescents to complement information from questionnaires. Also, key health personnel were also interviewed to give their views on adolescents' sex preference of physicians for their reproductive healthcare in Delta State. Ten well trained Field assistants administered the questionnaires as well as carried out focus group discussions and interviews.

2.5 DATA ANALYSIS

The Statistical Products and Service Solutions (SPSS) by IBM, version 21 was used for data analysis in this study – analyzing 1465 filled questionnaires – with 35 questionnaires declared invalid. First the analysis involved the use of descriptive statistics such as Frequency tables, percentages to elucidate respondents' demographic characteristics. Cross tabulation was used to analyse adolescents' perception of whether they will use adolescents' reproductive health services if provided by opposite sex. Chi-Square was used to establish that

the relationships in cross tabulations were not just superficial, but truly significant. N6 software was used to analyse qualitative data after transcription and coded by themes relevant to the study.

2.6 ETHICAL CONSIDERATIONS

As a study that dealt with minors and in line with the Centre for Population and Environmental Development standards, some ethical guidelines were followed. Necessary authorisations and clearance before commencement of the study was obtained from relevance authorities. Although parental or guardian consent was required in the course of undertaking this research with minors, this was not possible because the target of this study was the in-school adolescents. The researchers considered the Ministry of Basic Education as well as the school authorities as the guardians and obtained informal verbal consent from the adolescents before the commencement of the survey and interviews [27]. The researchers also informed the target group in detail about the study purpose and were made to be aware that participation was voluntary, and that they will be free to decline or end the interviews at any time if they have compelling reasons to do so. The target groups were also informed that the survey will be confidential and that the interviews would be held with confidentiality, and that it would not be used for any other purpose other than for academic purposes. The interviews took place in situations that enhanced confidentiality and which was comfortable for the researcher and adolescents [27, 32]. This enhanced participant's sensitivity and co-operation [33].

3. RESULTS

As indicated in Table 1, the respondents were found almost in equal proportion in Junior Secondary School (49.7%) and Senior Secondary School (50.3%).Their sex were 51.3% and 48.7% for male and female respectively with most of their ages falling within 15-17 years (37.4%) and 12-14 years (36.2%) respectively. These ages were followed by those with 9-11(21.5%) and pocket of them (4.9%) in the age range of 18-20 years. Most of the respondents were Christians who are either Protestants (42%) or Pentecostal (40.6%) with Catholic membership accounting for 15.4%. The respondents were almost equally divided among Ijaw (28.5%), Urhobo (28.3) and Igbo (28.1%) by their ethnic dispositions. Educationally, most of the parents of the respondents had either secondary (32.9%) or primary (32%) education as their highest level of education. However, a good proportion of the parents had no schooling (25.8%). The highest level of income of these parents could be found in the income range of 31,000 Naira – 40,000 with the proportion of 38%, followed by 10,000 Naira or less (28.7%). Those within 11,000 to 20,000 Naira and 21,000 to 30,000 Naira income ranges had 15.1% and 12.7% respectively. Both the locations of the respondents' schools and residents were almost equally found in rural communities as well as urban centres. As for school location, the proportion was 49.6% and 50.4 respectively for rural and urban, while it was 49.6% and 47.3% respectively for rural and urban communities for residents of respondents.

Table 1: Socio-demographic and economic characteristics of the sampled population (1465)

Characteristics	Frequency	Percent
Classes of Students		
Junior Sec. Students	731	49.7
Senior Sec. Students	734	50.3
Sex		
Male	752	51.3
Female	713	48.7
Age		
9-11	315	21.5
12-14	530	36.2
15-17	548	37.4
18-20	72	4.9
Religion Affiliation		
Catholic	226	15.4
Protestant	616	42
Pentecostal	595	40.6
Others	28	1.9
Ethnicity		
Urhobo	430	28.3
Itsekiri	19	1.3
Isoko	118	8.6
Ijaw	418	28.5
Igbo	411	28.1
Others	69	5.2
Fathers' Highest Level of Education		
No schooling	371	25.3
Primary	460	31.4
Secondary	494	33.7
Tertiary	140	9.6
Mothers' Highest Level of Education		
No schooling	386	26.3
Primary	477	32.6
Secondary	469	32.0
Tertiary	133	9.1
Fathers' Income		
10,000 or less	421	28.7
11,000 – 20,000	205	14.0
21,000 – 30,000	179	12.2
31,000 – 40,000	59	4.0

41,000 and above	91	6.2
I don't know	510	34.8
Mothers' Income		
10,000 or less	420	28.7
11,000 – 20,000	238	16.2
21,000 – 30,000	192	13.1
31,000 – 40,000	51	3.5
41,000 and above	81	5.5
I don't know	483	33.0
Location of Schools		
Rural	726	49.6
Urban	739	50.4
Location Residence		
Rural	727	49.6
Urban	693	47.3
No response	45	3.1

Table 2 summarised the findings on the basis of those males that female attended to in the studied LGAs. From the table, it is evident that overwhelming proportions (92.3%) of respondents were not comfortable with female staff providing the services to them in the studied Local Government Areas. Four Local Government Areas of Udu, Ughelli North, Ika South and Ukwuani have respondents well over 90% while Burutu and Bomadi LGAs respondents got to over 80% for those who were of the opinion that they were not comfortable with female providing adolescents' reproductive health service (ARHS) to them. Only 7.7% of respondent agreed that they were comfortable with the services provided by female. In the senatorial districts, Delta Central led in the group of males who were not comfortable with females providing ARHS to them with 96.8% without marked difference from Delta North with 93.8%. Delta South Senatorial District had 86% in the category of males who disliked services provided by female. Ecologically, the upland areas had a greater proportion of respondents (95.3%) who are males but dislike female services than in the wetland area (86%). The excerpt from interview and focus group discussion also supported the data above:

"In my year as a medical practitioner, though we are not concerned with sex of our patients, most time especially among young boys, it is usual to find them resisting being attended to especially when it comes to opening their private parts" **--A female physician giving her experience with treatment of boys who required reproductive healthcare in an interview**

"I don't think it is fair to allow women physicians to treat boys especially when the physicians are very young. Some of them are not comfortable doing it and end up making silly mistakes. Men should treat men and women should face women" **-- An extract from an FGD**

"It is an abomination to just allow women to see the nakedness of boys in the name of medical treatment. Most time we have no choice but medicine must remember the pride of human beings whether they are male or female. We need privacy when we are well. Why must treatment violate this?" **--An extract from an FGD**

Table 2: Comfort Level of males with female physicians as providers of ARHS by LGAs, senatorial districts and by ecological zones

LGAs	Comfort Levels of Males with females in the Provision of PRHS				Total	
	Comfortable with Female Service Providers		Not Comfortable with Female Services Providers			
	N	%	N	%	N	%
Bomadi	21	17.2	101	82.8	122	100
Burutu	13	10.7	109	89.3	122	100
Udu	4	3.2	120	96.8	124	100
Ughelli .North	4	3.1	123	96.9	127	100
Ika South	7	5.5	121	94.6	128	100
Ukwuani	9	7.0	120	93.0	129	100
Total	58	7.7	694	92.3	752	100
Senatorial Districts						
Delta South	34	13.9	210	86.0	244	100
Delta Central	8	3.2	243	96.8	251	100
Delta North	16	6.2	241	93.8	257	100
Ecological Zones						
Upland	24	4.7	484	95.3	508	100
Wetland	34	13.9	210	86.0	244	100

P Value= .000

Like their male counterparts discussed in Table 2, Table 3 present summary of responses of the views that females respondents who once received ARHS from males. From the table, the average proportion for the studied LGAs was 98.9%. In the individual LGAs that took part in the survey, an extremely very high proportion of over 97% were of the opinion that they were not comfortable with male providing the services. Again, though the differences in the respondents' responses in term of their proportions in the individual LGAs were very small, Ughelli North recorded 100% while Udu and Ika South each recorded 99.2% each. The other three LGAs in the survey recorded 99.1%, 98.4% and 97.5% in Ukwuani, Bomadi and Burutu LGAs respectively. In the senatorial districts, Delta Central recorded, 99.6%, Delta North had 99.1% while Delta South had 9.9% of female who dislike being attended to by male physicians. The Ecological Zones witnessed a higher proportion of female who dislike male physician as providers of ARHS in the upland areas with 99.4% to wetland LGAs with 97.9%. The chi square test indicates a significance relationship between the sex of patients and sex of the physician with a 'p' value of .000. The result from the interviews and focus group discussion equally supported the fact that females preferred to be attended by females as found below:

"It is a natural thing for women to desire to be attended to by women physicians because of privacy. For example, I know my daughter will forgo any treatment if a man should be the one who will attend to her in a hospital". **--A female physician giving her experience with treatments of boys who required reproductive healthcare in an interview.**

"Men use their eyes to undress you even with your clothes on, not to talk of being naked before them. I know most times hospitals don't give us choice but it is very important that whether male or female, we should be given the right of choice to choose who should attend to us. This is very important in routine examination such as breast examination. How can a man be effective in this scenario –holding tight to firm well pointed breasts of a beautiful lady. Physicians are fresh and blood. We should save them the temptation and equally

respect the privacy of ladies. I know many of us will not go for such intimate examination if a man should be the one to do it". **--An extract from an FGD.**

Table 3: Comfort Level of females with male physicians as provider of ARHS by LGs, senatorial districts and by ecological zones

LGAs	Comfort Levels of Females with Males in the Provision of ARHS				Total	
	Comfortable with male Service Providers		Not Comfortable with male Services Providers			
	N	%	N	%	N	%
Bomadi	2	1.6	120	98.4	122	100
Burutu	3	2.5	118	97.5	121	100
Udu	1	.8	117	99.2	118	100
Ughelli .North	0	0.0	117	100.0	117	100
Ika South	1	.8	117	99.2	118	100
Ukwuani	1	.9	116	99.1	117	100
Total	8	1.1	705	98.9	713	100
Senatorial Districts						
Delta South	5	2.1	238	97.9	243	100
Delta Central	1	.4	234	99.6	235	100
Delta North	2	.9	233	99.1	235	100
Ecological Zones						
Upland	3	.6	467	99.4	470	100
Wetland	5	2.1	238	97.9	243	100

P Value= .000

In Table 4, it was evident that both sexes of male and female when combine did not want to be attended to by physicians of opposite sex as the average of both sexes who were not comfortable being attended by physicians of opposite sex for the studied area is 95.6%. However slight variations were evident in the individual local government areas. For example, the greatest dislikes for physicians of opposite sex attending to opposite sex were found in Ughelli North and Udu LGAs respectively with 98.4% and 98%. These were followed by 96.9%, 96%, 93.4% and 90.6% in Ika South, Ukwuani, Burutu and Bomadi LGAs respectively. The proportion was 98%, 96% and 92% in Delta Central, Delta North and Delta South respective. In the ecological zones, more respondents of both sexes were not comfortable being attended to by physicians of opposite sex in upland (97.3%) than in the wetland with 92%. The chi square test indicate a significant relationship between the sex of patients and sex of the physician with a 'p' value of .000.

Table 4: Comfort Level of both sexes with physicians of opposite sex as provider of ARHS by LGs, senatorial districts and by ecological zones

LGAs	Comfort Level of both sexes with physicians of opposite sex providing APRHS				Total	
	Comfortable with Service Providers for both sexes		Not comfortable with Service Providers for both sexes			
	N	%	N	%	N	%
Bomadi	23	9.4	221	90.6	244	100
Burutu	16	6.6	227	93.4	243	100
Udu	5	2	237	98	242	100

Ughelli .North	4	1.6	240	98.4	244	100
Ika South	8	3	238	96.9	246	100
Ukwuani	10	4	236	96	246	100
Total	66	4.4	1399	95.6	1465	100
Senatorial Districts						
Delta South	39	8	448	92	487	100
Delta Central	9	1.8	477	98	486	100
Delta North	18	4	474	96	492	100
Ecological Zones						
Upland	27	2.7	951	97.3	978	100
Wetland	39	8	448	92	487	100

P Value= .000

5. DISCUSSION

This study investigates if the sex of the physician matters in adolescents' uptake of reproductive healthcare in Delta State, Nigeria. Our study demonstrates that there is a relationship between the sex of physicians and adolescents (being they male or female) willingness in the uptake of reproductive healthcare as the Chi-Square test of relationship indicated. In this study, a very high proportion of males (92.3%) were against female attending to them, therefore, the fact that female attended to them was to overlook the place of their confidentiality – signifying that most of such males may not be willing to use the services simply because they were offered by female and thereby negating the factor of access and utilisation of such ARHS. Therefore, confidentiality provided by making males attend to male is essential if services must be access by them by avoiding the effects of what the studies by Ralpha and Brindis [6] and Ford et al.[7], that if there is no confidentiality, adolescents might not be willing to disclose sensitive sexual and reproductive health information to providers. Just like their male counterpart, it is clear that a higher proportion of females' respondents (98.9%) abhorred receiving ARHS from male physicians and there is a significant relationship between the sex of female adolescents' patients and the sex of the physician for reproductive healthcare. From Table 3, it is evident that the confidentiality of services in most of the healthcare providing outlets were our respondents in this study obtained services, had not taken confidentiality a priority since a vast majority of opposite sex still provided the services even though the beneficiaries are against such arrangement. This may have obstructed some would be users of ARHS from doing so, thereby limiting access to the services and their utilisation in line with the studies by Ralpha and Brindis [6] and Ford et al. [7] that, if there is no confidentiality, adolescents might not be willing to disclose sensitive sexual and reproductive health information to providers.

Comparatively, though both male as well as female abhorred being attended to by the opposite sex, in this study, there were more female (98.9%) than male (92.3%) in the studied area who abhorred this. In the senatorial districts, compared to males who did not like female physicians' services in Table 2, more females dislike services that are provided by male physicians. For example, in Delta South in the case of males that hated females services it was 86% compared to 97.9% of females who dislike males services in the same senatorial

district. In Delta Central, males who hated female services had the proportion of 96.8% compared to 99.6% of females who hated males services in the same senatorial area and lastly in Delta North, males who dislike females services stood at 93.8% compared to 99.1% of females who hated males in the same senatorial district. Overall for females who hated male physicians attending to them in the senatorial district, Delta Central had the highest proportion of 99.6%, followed by 99.1% of Delta North and 97.9% for Delta South. There are more female upland (99.4%) compared to male (95.3%) and more female in wetland (97.9) compared to 86% in the ecological zones. The findings from this study also agreed with other studies such as those by Lurie et al.[10] and Fennema et al.(18), Kelly [19], Blake [20] and Comstock et al [21] that reported that many patients had preference for physicians of the same sex.

6. CONCLUSION

Though the confidentiality which comes from the same sex providing adolescents reproductive health service to adolescent patients by physicians of the same sex is essential, this study revealed that, this was not being practice by service providers of the adolescents from the studied area. The research results overwhelmingly emphasised that whether male or female, it is the desires of the respondents that they be attended to by physicians of the same sex to ensure confidentiality since most of them were not comfortable being attended to by physician of the same sex. With the renewed expectations by governments in Delta State, Nigeria and indeed the World to deal with issues of adolescents reproductive health such as STIs including HIV/AIDS, this research calls for the relevant authority in Delta State and Nigeria that the adolescents patients should be given the right of choice to choose physicians of their choice to attend to their reproductive health needs since this will promote a higher desire to access and use reproductive services since confidentiality will be ensured through this system of freedom of choosing their physicians.

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