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Professional Education in Sexology in Sub-Saharan Africa: A Continental Survey

Part of the "Special Issue on Professional Education in Clinical Sexology"

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ABSTRACT

Background: Sexology as a clinical and professional discipline remains underdeveloped in Sub-Saharan Africa, where formal education is limited and fragmented. Existing training typically focuses on HIV/AIDS and reproductive health, with little attention to broader sexual health issues such as dysfunction, diversity, and psychosexual wellbeing. This neglect is likely to contribute to persistent unmet needs and stigma surrounding sexual health care across the region. This paper examines Sub-Saharan Africa as part of a wider study on professional education and training in sexology.

Methods: This mixed-methods study combined quantitative and qualitative approaches to examine current education in sexology. The Global Survey on Professional Education in Clinical Sexology (GLOPES) was distributed via professional networks in 11 Sub-Saharan African countries, yielding 28 responses. Additionally, seven semi-structured interviews were conducted with clinicians and educators in Clinical Sexology, to provide exploratory insights into training gaps, barriers and opportunities. Quantitative data described existing curricula, accreditation processes, and institutional structures, while qualitative analysis identified thematic challenges and innovations.

Results: A total of 28 responses were received from 11 Sub-Saharan African countries. The majority of responses were from South Africa, contributing nearly half of all responses, 14 (48%). Botswana, Kenya, Nigeria, and the DRC each contributed two responses, while Gabon, Guinea, Liberia, Malawi, Mozambique, and Zimbabwe each contributed one. Findings revealed deficits in curriculum standardization, accreditation pathways, and postgraduate opportunities. Educational content is often dispersed across gynecology, psychiatry, and urology, lacking a cohesive framework. Interviews highlighted stigma, political and religious sensitivities, limited institutional ownership, and resource constraints alongside examples of emerging regional initiatives.

Discussion: Participants emphasized the need for expanded, standardized, and culturally appropriate sexology education in Sub-Saharan Africa. Priorities include curriculum development, accreditation mechanisms, faculty training, and policy engagement to strengthen professional recognition. Regional collaboration and innovative delivery models may help address current gaps and resource limitations. Sustainable education frameworks are essential to improving sexual health in Sub-Saharan Africa.

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Sexology education; accreditation; sub-saharan africa; sexology; sexual health

Background

Across Sub-Saharan Africa (SSA), numerous challenges affect health outcomes, including limited access to quality healthcare services and capacity gaps among providers. These challenges extend into the realm of sexual health, which remains a critical but under-resourced aspect of public health across the sub-continent (World Health

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Organization Regional Office for Africa, 2022). While significant attention has been given to sexual and reproductive health in the context of infectious diseases, particularly HIV/AIDS, (Porst & Reisman, 2018) the broader field of sexology, encompassing sexual medicine, psychosexual well-being, and sexual diversity remain nascent in terms of both clinical training and academic development (Achen et al., 2023; Ajayi et al., 2021).

For the purposes of this study, Sub-Saharan Africa (SSA) is defined in accordance with United Nations and World Health Organization regional classifications, encompassing countries located wholly or predominantly south of the Sahara Desert. Under this classification, the region comprises 47 countries. This framing is widely used in global health and medical education research, reflecting shared structural challenges in health-system capacity, workforce development, and training infrastructure, while acknowledging substantial internal heterogeneity. The present study received responses from 11 of these countries, reflecting uneven institutional engagement and methodological constraints related to survey dissemination.

The decision to focus analytically on Sub-Saharan Africa was further informed by recent organizational developments within the World Association for Sexual Health (WAS). During the period of data collection, WAS formally established a new regional federation, the Eastern Mediterranean Federation for Sexual Health (EMFeSH) which incorporates several countries in North Africa that were previously included within broader African reporting structures. In line with this revised regional framework, and consistent with the organization of the present special issue, findings are reported here for Sub-Saharan Africa as a distinct analytical region. A companion paper in this special issue addresses professional education in sexology in the Middle East and North Africa (MENA). While this regional focus supports coherence and comparability across PES reports, the authors recognize the diversity of sociocultural contexts, healthcare systems, and educational infrastructures within Sub-Saharan Africa, as well as the uneven country representation in the present dataset. Findings should therefore be interpreted as illustrative rather than representative.

This paper adopts the term sexology to describe the scientific and interdisciplinary study of human sexuality, encompassing medical, psychological, sociocultural, and educational dimensions (Haeberle & Gindorf, 1993). In contrast, sexual medicine refers to the clinical subspecialty concerned with the diagnosis, treatment, and prevention of sexual dysfunctions and other medically related aspects of sexuality, including reproductive, hormonal, and psychosexual health (Porst & Reisman, 2018). Sexual health, as described in the World Health Organization's working definition, refers to a state of physical, emotional, mental, and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction, or infirmity (World Health Organization, 2006). These terms are used contextually throughout this paper, reflecting the ways in which sexual health and sexual medicine are commonly framed within existing clinical and educational structures in many Sub-Saharan African contexts. However, this study adopts the broader globally accepted term sexology to emphasize interdisciplinary educational initiatives that include psychology, nursing, social work, and public health (Coleman & Ford, 2024). Given that the term "sexology" may not yet be widely familiar or institutionally adopted in many Sub-Saharan African settings, the more adaptable and widely used concept of sexual health will also be employed throughout this paper where appropriate (World Health Organization Regional Office for Africa, 2022).

While discussions of sexology in Sub-Saharan Africa can provide valuable insights, generalizing about healthcare across the region is inherently problematic due to wide variations in socioeconomic conditions, healthcare systems, and cultural contexts. Formal approaches to sexual health education have tended to prioritize biomedical and public-health concerns, with less systematic attention to psychosocial and relational dimensions of sexuality. Regional discussions should therefore balance sensitivity to local diversity while still identifying common structural constraints, including the influence of externally imposed or homogenizing frameworks (Abimbola, 2019; World Health Organization, 2010).

Sub-Saharan Africa bears the highest global burden of sexually transmitted infections (STIs), including HIV, syphilis, gonorrhea, and chlamydia (World Health Organization, 2022). The persistence of these infections is compounded by inadequate sexual health education, limited healthcare access, and pervasive stigma (UNAIDS, 2021; World Health Organization, 2022). Among key populations, including men who have sex with men (MSM) and female sex workers, HIV prevalence remains high with structural and social barriers limiting uptake of preventive interventions like pre-exposure prophylaxis (PrEP) (World Health Organization, 2022).

Gender disparities significantly shape sexual and reproductive health outcomes, with women and girls facing disproportionate risks due to entrenched socio-cultural norms, early marriage, female genital mutilation and restricted reproductive autonomy (Muluneh et al., 2021; World Health Organization, 2014). Young women aged 15–24 represent one of the most vulnerable demographics for both STIs and unintended pregnancies (Bolarinwa & Boikhutso, 2021). Sexual violence as reported by intimate partners is widespread in Sub-Saharan Africa, with survivors facing physical, psychological, and social consequences, including unwanted pregnancies, sexually transmitted infections, and stigma (Apatinga et al., 2021; Ikwara et al., 2025; Ssewanyana et al., 2019; World Health Organization, 2013).

The sexual health landscape in Sub-Saharan Africa is also shaped by evolving demographic change and rapid urbanization. Adolescent sexual behavior, characterized by early sexual initiation and inconsistent condom use, elevates the risk of STIs and unintended pregnancies, necessitating comprehensive sexuality education and youth-friendly services. Emerging technologies and accelerated cultural changes in sexual behaviors, intimacy, and relationship configurations present both challenges and opportunities (Koebe et al., 2024).

Male sexual dysfunction, though less frequently studied, (Campbell & Stein, 2014) represents another critical dimension of sexual health, with conditions such as erectile dysfunction increasingly linked to non-communicable diseases like diabetes and hypertension as well as socio-cultural factors influencing masculinity and healthcare-seeking behaviors (Amidu et al., 2010; Nyalile et al., 2020).

Professional Education in Sexology in Sub-Saharan Africa: The Evolution of Clinical and Interdisciplinary Pathways

The development of sexology training as a recognized professional specialty in Sub-Saharan Africa has often been described as slow and uneven, shaped by global health crises (Nachega et al., 2023), socio-cultural beliefs, infrastructural limitations and the geopolitical complexities of the continent. The HIV/AIDS epidemic, for example, redirected healthcare funding and policy focus toward infectious disease management, often at the expense of broader sexual health concerns (Nachega et al., 2023; World Health Organization, 2022). Furthermore, structural and socio-cultural barriers, including restrictive norms around sexuality and entrenched practices such as female genital mutilation, continue to limit research, education, and clinical services (Muluneh et al., 2021) The geopolitical instability in many Sub-Saharan African nations has further hindered the advancement of sexual medicine, with conflict zones such as the Democratic Republic of Congo experiencing widespread sexual violence, overwhelming local healthcare infrastructures (The Wall Street Journal, 2024).

Historically, sexual health concerns in Sub-Saharan Africa have been subsumed under infectious and reproductive health education, with a dominant focus on infectious diseases such as STIs and HIV/AIDS. Consequently, clinical training, research, and curricula have largely overlooked the broader spectrum of sexual disorders, resulting in clinical gaps and limited patient care (Giami & Pacey, 2006; Pretorius et al., 2022). Unlike high-income countries where sexual medicine is incorporated into postgraduate education, progress in Sub-Saharan Africa has relied primarily on individual clinicians and private-sector initiatives, with many professionals seeking training abroad through institutions like the International Society for Sexual Medicine (ISSM) School.

Despite these challenges, signs of progress have begun to emerge, particularly in recognizing how specific sexual health related problems affect overall sexual wellbeing. Notable initiatives include the integration of sexual medicine into undergraduate curricula at Stellenbosch University, South Africa (Van Deventer et al., 2023), the establishment of a Fellowship in Sexual Medicine at Amref International University, Kenya (Amref International University, 2024), and the launch of a postgraduate Diploma in Sexual Health through the College of Medicine of South Africa (Colleges of Medicine of South Africa, 2024). Additionally, innovative educational programmes have been introduced to support multidisciplinary oncology care providers, recognizing the intersection of oncology and sexual health (Wittmann et al., 2024).

This paper presents findings from the Global Survey on Professional Education in Sexology (GLOPES), conducted by the WAS Professional Education in Sexology (PES) Committee (2021–2025). The survey examines the global state of clinical sexology education and is supplemented here by qualitative interviews with Sub-Saharan African experts in sexology.

Our analysis focuses on Sub-Saharan Africa, mapping current educational frameworks, identifying training gaps, and proposing contextually relevant strategies for strengthening professional capacity in sexology.

Methodology

This study reports on the Sub-Saharan African component of the Global Professional Education and Training in Clinical Sexology (GLOPES) survey, a global exploratory mapping exercise developed by the Professional Education in Sexology (PES) Committee of the World Association for Sexual Health (WAS). The GLOPES survey was designed to describe the landscape of professional education and training in sexology internationally, rather than to function as a formal inferential survey. As part of this special issue, regional analyses were undertaken by contributing author teams, each responsible for interpreting findings within their respective geographic contexts.

In addition to secondary analysis of GLOPES survey data relevant to Sub-Saharan Africa, the authors conducted a supplementary qualitative inquiry to explore contextual factors, perceived gaps, and future directions in sexology education within the region. This qualitative component was developed following preliminary review of the GLOPES findings and was intended to deepen interpretation of the survey results rather than to provide comprehensive or representative accounts.

Quantitative Methodology

The Global Professional Education and Training in Clinical Sexology (GLOPES) survey was conducted in collaboration with the PES Committee of the World Association for Sexual Health (WAS) and the University of Agder, Norway. The questionnaire was co-developed by PES Committee members, including contributors who were professionally active in Sub-Saharan Africa at the time of survey development, providing advisory input on cultural and contextual relevance.

The survey was disseminated globally through multiple channels. The WAS Media Committee and PES Committee facilitated broad distribution, while PES members working within Sub-Saharan African professional networks actively circulated the survey within the region. Circulation occurred through pre-identified professional networks and professional groups, and recipients were encouraged to share the questionnaire within their own networks to maximize reach and engagement. Survey responses were collected anonymously.

Qualitative Methodology

While the GLOPES survey provided an overview of existing educational structures and training activities, the qualitative component was included to explore complementary contextual experiences and perspectives that could not be captured through quantitative data alone.

A semi-structured interview guide was developed by the lead author, informed by preliminary analysis of the GLOPES survey findings and contextual background review. The guide was

intentionally narrow and exploratory in scope. Core thematic domains included perceived challenges, barriers, opportunities, and future directions in undergraduate and postgraduate training in sexual medicine and sexology. Participants were invited to reflect on both national and regional contexts.

Study Population and Sampling

The qualitative component targeted individuals with expert knowledge or experience in sexual medicine or sexual-health service provision. Purposive sampling was used to identify key informants based on eligibility criteria that included clinical, educational, or leadership involvement in sexual medicine or sexology, with professional engagement in Sub-Saharan Africa.

A peer-referral approach was used to broaden participation, whereby initial participants were invited to suggest additional contacts within their professional networks. While this facilitated access to senior expertise in a small and emergent field, it may have favored individuals already engaged with sexology-related initiatives. A total of seven key informants were interviewed. Participants represented multiple Sub-Saharan African countries and professional backgrounds. The limited number of interviews reflects both the emergent nature of formalized sexology training in the region and the exploratory purpose of the qualitative component.

Data Collection

Data were collected between October 2024 and December 2024 through semi-structured key informant interviews, conducted in a one-on-one format. The interviews followed a predesigned interview guide to ensure consistency while allowing for flexibility to explore deeper insights. The interview covered key themes, including:

- Undergraduate education in sexology
- Postgraduate education in sexology
- Challenges and opportunities in training
- Recommendations for future development

Interviews were conducted using different modes based on participant preference, time zone differences, feasibility, and professional commitments:

- One participant was interviewed in person (face-to-face)
- Two participants were interviewed via WhatsApp video calls
- Four participants were interviewed via Zoom

Ethical Considerations

Ethical approval for the Global Survey on Professional Education in Clinical Sexology (GLOPES) was granted through the University of Agder, Norway. The survey targeted healthcare professionals and educators and did not involve patients or vulnerable populations. Participation was voluntary, and no personal identifiers were collected. Survey responses were anonymous and analyzed in aggregate.

The qualitative component of the study involved semi-structured interviews with expert informants. This component was considered minimal risk and was conducted in accordance with accepted ethical principles for qualitative research involving professional expert interviews. Prior to participation, all interviewees received a letter of introduction outlining the purpose and nature of the study. Written and/or verbal informed consent was obtained from all participants before interviews were conducted. Participants were informed that participation was voluntary and that they could decline to answer any questions or withdraw from the study at any time without consequence.

All interviews were audio-recorded with participant consent and supplemented with detailed field notes to ensure accurate documentation. Audio files and transcripts were stored securely in password-protected digital files. A single researcher acted as custodian of the qualitative data, with access restricted to the research team. Identifying information was removed during transcription, and confidentiality was maintained throughout data handling and reporting.

Considerations on Nomenclature

For the purposes of analysis, participants' use of the term's *sexual health*, *sexual medicine*, and *sexology* was interpreted contextually, with attention to the meaning intended rather than strict terminological distinctions, reflecting the fluid and emergent nature of professional discourse in this field within Sub-Saharan Africa.

Data Analysis

Interview transcripts were analyzed using an inductive thematic approach at a semantic level. Initial familiarization and coding were conducted by the authors, with themes refined through iterative review and discussion among the research team. The qualitative findings are presented to illustrate and contextualize patterns identified in the survey data.

Results

Quantitative Results

A total of 28 responses were received from 11 countries in Sub-Saharan Africa. South Africa dominated the dataset, contributing nearly half of the total responses 14 (48%). Each of the following countries recorded two responses; Botswana, Kenya, the DRC and Nigeria. Moreover, Gabon, Guinea, Liberia, Malawi, Mozambique and Zimbabwe, each had one response. Not all respondents completed every item; therefore, denominators vary slightly across tables and are reported accordingly.

Organizational and Academic Structure

Universities (40.7%) are the most common organizations, followed by professional societies (25.9%). Private-sector organizations are less involved (18.5%) (Table 1).

Public and private organizations are equally represented (38.5% and 30.8%, respectively), while NGOs contribute the same as private organizations.

Table 1. Type of programme organization.

Organization type	*N*	(%)
University or College	11	(40.7%)
Sexological / Sexual Health Institute	5	(18.5%)
Sexological / Sexual Health Professional Society or Association	7	(25.9%)
Activist organization	1	(3.7%)
Other	3	(11.1%)
Total	**27**	**(100%)**
Non-responders		1

Table 2. Academic disciplines (more than 1 answer possible).

Profession	*N*	(%)
Medicine	12	(42.9%)
Psychology	8	(28.6%)
Psychotherapy	6	(21.4%)
Nursing	7	(25.0%)
Physiotherapy	4	(14.3%)
Social Work	9	(32.1%)
Pedagogic / Teaching	6	(21.4%)
Sexology	11	(39.5%)
Other	10	(35.7%)

Accreditation Requirements

Less than half of the respondents (42.9%) indicated that completing the training contributes to accreditation in their region. This suggests a limited integration of these programmes into official accreditation pathways. While not accredited, professional continuing education points are awarded to most training (57.1%).

Academic Focus

Medicine (41.4%), psychology (27.6%), sexology (37.9%) and social work (31.0%) dominate as academic disciplines, reflecting a clinical and healthcare-oriented focus. Many respondents who identified as medical, psychological or social work professionals, cross identified as sexologists (respondents were able to make more than 1 choice on this question) (Tables 2 and 3).

The programmes target diverse professionals, with general medical practitioners (69%) and psychiatrists (41.4%) being the most common audiences. Social workers, psychologists and counselors make up a sizeable total together.

Note that the 'Other' category comprised respondents who did not identify as physicians, psychologists, nurses, or counselors but who were nonetheless involved in sexual-health service delivery or research. This included allied health professionals (e.g., pharmacists), community health and NGO workers, undergraduate students

Table 3. Target groups for educational programmes.

Role	*N*	(%)
General medical practitioners	20	(69.0%)
Psychiatrists	12	(41.4%)
Other medical specialties	9	(31.0%)
Psychologists	12	(41.4%)
Psychotherapists/Counselors	9	(31.0%)
Physiotherapists	7	(24.1%)
Nurses	11	(37.9%)
Social Workers	13	(44.8%)
Teachers	7	(24.1%)
Activists	9	(31.0%)
Other	6	(20.7%)

(More than 1 answer possible).

Table 4. Eligibility for admission? (more than 1 answer possible).

Status	N	(%)
Currently enrolled as Undergraduate students	8	(28.6%)
Individuals holding an undergraduate degree	7	(25.0%)
Currently enrolled as graduate students	6	(21.4%)
Individuals holding a graduate degree	8	(28.6%)
Licensed Clinical professionals	15	(53.6%)
Other	5	(17.9%)

Table 5. Academic level of educational programme.

Qualification	*N*	(%)
Bachelor (Undergraduate)	7	(25.9%)
Certificate	3	(11.1%)
Master	4	(14.8%)
PhD	1	(3.7%)
Continuing erofessional education	10	(37.0%)
Short Courses	1	(3.7%)
Not applicable	1	(3.7%)
Total	**27**	**(100.0%)**
Non-Responders	1	

and policy or programme staff engaged in sexual-health programmes.

Admission and Academic Levels

Most programmes are designed for licensed clinical professionals (51.7%) and graduate-level participants (Tables 4, 5, and Abimbola, 2019).

Continuing Professional Education (37%) and certificate programmes (11.1%) dominate the academic offerings, with limited emphasis on formal degrees.

Supervision and Clinical Training

Clinical supervision is required for most programmes (51.9%), but its implementation is inconsistent (e.g., 34.5% rely on faculty, while others allow students to choose supervisors) (Tables 6–8).

Table 6. Is clinical supervision required to complete the programme?

Response	*N*	(%)
Yes	14	(51.9%)
No	13	(48.1%)
Total	**27**	**(100.0%)**
Non-responders	1	

Table 7. How do students in the training programme receive clinical supervision?

Supervision Type	*N*	(%)
Defined faculty or instructor in the programme	10	(34.5%)
Defined external supervisor in the community	2	(6.9%)
Supervisor of the student's own choice	2	(6.9%)
Other	2	(6.9%)
Non-responders	10	

Table 8. What level of clinical training does your programme offer according to the PLISSIT model?

Training	Level	*N*	(%)
Basic	P/LI	8	(42.1%)
Counselling	LI/SS	2	(10.5%)
Sex Therapy	P/LI/SS	4	(21.1%)
Specialist	P/LI/SS/IT	4	(21.1%)
Not relevant		1	(5.3%)
Non-responders		9	

Note: PLISSIT levels—P: Permission; LI: Limited Information; SS: Specific Suggestions; IT: Intensive Therapy.

Clinical training predominantly provides basic skills (27.6%) with some focus on specialist training (13.8%).

Recognition and Certification

Few countries recognize occupational positions labeled "Sexologists" (26.9%) or officially register educational programmes as a recognized profession (32%). Certification (38.5%) is the most common outcome, while formal degrees like Masters (15.4%) or Doctoral (3.8%) are rare (Tables 9–11).

Qualitative Data Analysis

Participation in interviews was through individual referrals.

Participant ID	Country of practice
P1	Kenya
P2	Nigeria
P3	Kenya
P4	South Africa
P5	South Africa
P6	South Africa
P7	South Africa

Table 9. Qualification attained at completion of programme.

Qualification	*N*	(%)
Diploma	4	(15.4%)
Certificate /certification	10	(48.1%)
Bachelor's degree	1	(3.8%)
Master's degree	4	(15.4%)
Doctoral degree	1	(3.8%)
Other	6	(23.1%)
Total	**26**	**(100.0%)**
Non-responders	2	

Table 10. In Your country are there occupational positions labeled as sexologists?

Affiliation	*N*	(%)
No	17	(65.4%)
Yes - In health care or private public institutions	7	(26.9%)
Yes—In Educational public institutions	1	(3.8%)
Other	1	(3.8%)
Total	**26**	**(100.0%)**
Non-responders	2	

Table 11. Does your country recognize clinical sexologists or sexual medicine experts as a profession?

Response	*N*	(%)
Yes	11	(40.7%)
No	16	(59.3%)
Total	**27**	**(100.0%)**
Non-responders		1

Participant Characteristics

Participants included medical doctors, gynecologists, a professor of sexual medicine, and a clinical psychologist

Narrative synthesis of qualitative data analysis

Fragmentation and Lack of Standardization in Undergraduate Sexual Health Education

A key theme in the data is the lack of a structured, standardized approach to sexual health education. Instead of a formalized curriculum, sexual health is dispersed across different specialties, making it difficult for students to acquire comprehensive knowledge. This is commented on in particular at an undergraduate level.

Ad Hoc and Unstructured Teaching

Participants described undergraduate sexual health education as fragmented and inconsistent. Training typically appeared across isolated modules-such as psychiatry, urology, and gynecology, without a unifying structure, and often depending on the availability and enthusiasms of specific lecturers. One participant made note of the ad hoc nature of sexual health lectures, with no core curriculum present in their country.

- *"Well, I would say that at the moment in Nigeria, there's no structured undergraduate education in sexual medicine. So, at best, what we have is particular mention of some form of sexual problems under the related specialties."* (KII 2, Obstetrician & Gynecologist, Nigeria)
- *"You get to learn a little bit about sexual health during the community health, public health rotation. You get to learn a little bit during psychiatry rotation, psychiatry and mental health. You get to learn a little bit during gynecology rotation, and you get to learn a little bit during urology rotation."* (KII 2, Obstetrician & Gynecologist, Nigeria)

One participant was disheartened by the absence of a formal curriculum for sexual medicine noting that what was provided was often rudimentary

- *"And actually, to be honest, and I've done that course, and it was wonderful, but it actually doesn't equip you particularly well. It gives you a certain basis for your knowledge, but it's actually more of an entry degree than it is an exit degree."* (KII 4, Senior Lecturer, Gynecologist & Sexual Medicine Specialist, South Africa)

Integration into Other Medical Fields

One participant emphasized that sexual health is often absorbed into other medical fields, but in a way that lacks depth:

- *"There are different levels to all the different years of study… some in gynecology, some in psychiatry, some in urology. But no one course that ties it all together. You pick up bits and pieces, and if you're lucky, you make the connections yourself."* (KII 7, Andrologist & Clinical Sexologist, South Africa)

Another participant discussing the recent integration of sexual medicine at Stellenbosch University, described the challenges of making sexual health part of core medical education:

- *"We've been trying to get sexual medicine into the mainstream, and at Stellenbosch, we have*

been really fortunate that it is now part of compulsory undergraduate training. But this didn't happen overnight—this took years of convincing, pushing, showing that this is an essential topic, not just an add-on." (KII 5, Gynecologist & Sexual Medicine Specialist, South Africa)

There was further comment on how Sexual health is often de-emphasized as reproductive health, STIs and gender-based violence (GBV) are often given priority.

Limited Recognition and Lack of Ownership

Many participants pointed out that there is no national or regional body taking ownership of sexual health education, and often no entity within universities prepared to take responsibility. One participant lamented the absence of leadership in driving curriculum development, and the lack of inclusion in conference programmes.

- *"No one's come forward to take it forward to say, let's develop a core curriculum. Everyone agrees it's needed, but who will do it? Who will fund it? Who will take responsibility? So, it remains a discussion with no action.*" (KII 7, Andrologist & Clinical Sexologist, South Africa)

Another participant explained how universities resist adopting sexual health as a formal discipline:

- *"Decision-makers at universities don't know what they don't know. They assume sexual health is being covered in other courses, so they don't prioritize it. When we tell them that there's a massive gap, their response is, 'We already have gynecology and psychiatry covering that.' They don't realize that's not enough."* (KII 3, Senior Lecturer & Marriage & Family Therapist, Kenya)

Limitations in Post-graduate education

Limited opportunities and programmes

Opportunities for postgraduate education are very limited and close to non-existent. Many will get their training from overseas educational institutions. One participant commenting on postgraduate education in Sexual Medicine in Nigeria:

- *"At the moment, there's no structured training, postgraduate training for anybody in Nigeria, I would still describe myself as a sexual medicine enthusiast. I have had to train myself both by reading, by learning. Even for the specialties that have a good overlap with sexual medicine, that area of sexual medicine is grossly neglected."* (KII 2, Obstetrician & Gynecologist, Nigeria)
- *"We had one lecture, postgraduate at UCT by … on sexual, and I remember it was on hypersexual desire disorder in four years of training.*" (KII 3, University Lecturer and Marriage & Family Therapist, Kenya)

They also pointed out that sexual medicine is often neglected in related specialties and that many trainers lack experience in this field.

- *"We never ever discussed it in an academic setting. We never spoke to our patients about it, not during our training to become a gynecologist. Colleagues, specialists are just not prepared to join in the conversation."* (KII 4, Senior Lecturer, Gynecologist & Sexual Medicine Specialist, South Africa)

One participant spoke of the historical lack of registered postgraduate qualifications for sexual medicine in South Sub-Saharan Africa. They explain that the Southern African Sexual Health Association (SASHA) made early attempts to establish postgraduate qualifications, but these efforts faced significant blocks and took many years without success.

Paucity of Trainers and Experts

One participant highlighted the lack of experts to train in sexual medicine, noting that most practitioners are not mainstream and lack defined training. There is no generation of trainers helping to pass on that information.

- *"The thing is that if you don't have experts to train in the first place, you see most of the people who practice sexual medicine are not really mainstream. That's not their core business."* (KII 1,

University Professor, Medical Doctor, Sexologist & Journalist, Kenya)

They emphasized the need for structured training and the challenge of defining sexual medicine in Sub-Saharan Africa because of the lack of a structured or defined expert domain, and the dominance of other specialities in dictating the clinical approach to sexology.

- *"And there is no defined training they have gone through. And so, for you to call yourself a sexual medicine practitioner, there needs to be a package of what you've been trained in. And most of the people doing that in Africa don't have a defined package."*(KII 1, University Professor, Medical Doctor, Sexologist & Journalist, Kenya)
- *"So, the challenge is, what is sexual medicine in Africa? When you're saying, I'm a sexual medicine practitioner, what have you studied? It's not well defined because we have not had a structured training.*" (KII 1, University Professor, Medical Doctor, Sexologist & Journalist, Kenya)
- *"The medical model we use is borrowed from psychiatry so you have a clinical psychology where we have people just assessing and doing diagnosis of sexual disorders and providing interventions and treatment from that perspective only."* (KII 3, Senior Lecturer & Marriage and Family Therapist, Kenya)

It was commented that the dominance of the medical model was too restrictive and needed to be opened up, arguing that the term "sexual medicine" may be too restrictive, failing to capture the field's interdisciplinary nature, a term which sexology more accurately describes.

- *"Sexuality cannot—it is interdisciplinary… when you confine it to medicine… I feel so uncomfortable with that because when you talk about sex, there is the issue of sexuality, a lot of it involved in it."* (KII 3, Senior Lecturer and Marriage and Family Therapist, Kenya)

Barriers to the Advancement of Sexual Health Education

Despite increasing recognition of the importance of sexual health, significant cultural, political, and financial barriers persist.

Cultural and Religious Stigma

A participant described the conservative cultural landscape that makes sexual health a taboo topic in Sub-Saharan African contexts, including for professionals themselves, who often don't recognize the importance of Sexual Health. Even for those who do, discussing sexuality can be very awkward bringing with it the taint of promiscuity.

- *"In Africa, sexuality is still shrouded in secrecy. Even among healthcare professionals, people don't want to be associated with teaching or researching sexual health. It's as if working in this field automatically makes you morally questionable."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)
- *"Even among people who are highly professional, they don't think this is an important area. So the whole political, sociocultural system is very stigmatizing. It is not open enough for people to learn sexuality."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)

Participants commented on the disparities in sexual practices and the lack of acceptance of gender diversity in Sub-Saharan Africa.

There is widespread sensitivity when presenting with a sexual problem, and that many people would prefer to see traditional healers rather than medical doctors.

- *"So have somebody walk into the clinic and say, 'I have problems with sexual experience.' It is very rare. Even when people have actual sexual problems, they will come to the hospital and pretend like they have some other problem.*" (KII 2, Obstetrician and Gynecologist, Nigeria)
- *"So, at the moment, people would rather resort to seeking care from traditional healers and all sorts of other preparations that are sold with the promise of cure for sexual problems."*(KII 2, Obstetrician and Gynecologist, Nigeria)
- *"The doctors most of the time work for church clinics, either a Protestant or a Catholic church, and those two actually determine of what they are allowed to do and not to do."* (KII 4, Senior

Lecturer, Gynecologist and Sexual Medicine Specialist, South Africa)

Political and Institutional Resistance

One participant mentioned the difficulty of separating religion and politics, noting that the practice of homosexuality is banned and that religion strongly influences decision-makers and policy-makers. It was commented on that homosexuality is widely considered to be unacceptable and most of Sub-Saharan Africa still practices restrictive abortion laws. A need for designing a sexual health education appropriate to a Sub-Saharan African context was voiced. This threatens the status of sexology as a speciality.

- *"And, you know, the practice of any specialty will require some legal backing that will be politically established. The same way funding for education in sexual medicine is going to require some strong political will."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)
- *"Nobody wants to be seen championing sexual issues. Look at abortion laws, for instance. Most of Africa still practices restrictive abortion laws. Anything related to sex is politically sensitive, so sexual health education doesn't get prioritized."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)

Economic Barriers

One participant pointed out that sexual medicine requires a multidisciplinary approach, making it more expensive to teach. Another participant, noted that it′s also more expensive for patients, and there currently isn't a marketplace for the practice of sexual medicine. The problem of limited resources is a recurring theme.

- *"Training in sexual medicine is expensive because you need multiple trainers—gynecologists, urologists, psychiatrists, psychologists. That kind of programme is costly to maintain. The trainers cannot be one person. It's different, special doctors and professionals. So, paying these people to train a professional is expensive."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)

Participants emphasized that institutions are resource depleted, with commercial funding scarce and insufficient financial resources available to fund sexology training. Similarly individuals have to shoulder a high financial burden if they want to seek overseas training. It was thought that Independent institutions could provide a solution.

- *"We need an institute that's fully funded, so that we're not asking already resource-constrained departments to add programmes with staff they don't have, or to fund positions they don't have the budget for."* (KII 3, Senior Lecturer, Marriage and Family Therapist, Kenya)
- *"Those of us with postgraduate degrees have had to return to private practice to pay off our student debts for those degrees."* (KII 6, Medical Doctor, Sexologist and Global Advocate, South Africa)

Emerging Progress and Innovative Approaches

Despite these challenges, there are promising efforts to expand sexual health education.

Introduction of new education initiatives

One of the participants highlighted the creation of an integrated Undergraduate Sexual medicine course at the university of Stellenbosch. Other participants discussed alternative self-directed modules to make teaching more accessible to fellow professionals.

- *"In 2022, we launched a dedicated course, Positive Sexology. It was a breakthrough moment—finally, a structured curriculum designed for medical students. We are in the final stages of designing our sixth module for third-year students."* (KII 5, Gynecologist and Sexual Medicine Specialist, South Africa)

A further participant highlighted the Amref fellowship programme, offered in partnership with the ISSM, (international society for sexual

medicine. This programme is not purely theoretical but is offered virtually with tutorials and practical experience using a logbook.

Future Directions and Recommendations

Growing Demand for Sexual Medicine Professionals and Structured Training

Participants recognized a significant demand for trained professionals in sexology, driven by the prevalence of sexual health issues and the enthusiasm of those who want to contribute to the speciality.

- *"The greatest opportunities for us will be, at this moment, the need is there. Although the need is not loud, but the need is very strong… 40 to 90 percent of women have female sexual dysfunction."* (KII 2, Obstetrician and Gynecologist, Nigeria)

Many participants recommended and highlighted the needs for structured training programmes, and a distinct speciality. Professionalization in the field, and sensitization of those in allied fields was mentioned. One participant was enthusiastic to dedicate the rest of their career to the speciality.

- *"For me, I think the training of a pool of experts. A training of people who will carry this vision. People who have a well-defined curriculum that they have gone through. Well-defined skills."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)
- *"They can be people who have done undergraduate and then trained in sexual medicine. Or they can be people from related special areas, like urology, gynecology, coming now to specialize further in sexual medicine."* (KII 1, University Professor, Medical Doctor, Sexologist and Journalist, Kenya)

Integrating Sexual Medicine into Education, Healthcare, and Society

A common theme among participants was the need to integrate sexual medicine into both undergraduate training and healthcare services. Participants were in broad agreement in the importance of undergraduate training. One participant felt that these changes would have the potential to reshape societal attitudes toward sex and reducing gender-based violence:

- *"If we can change the paradigm around sex in South Africa … we might just change a little bit of the amount of gender-based violence or interparty violence in the country."* (KII 5, Gynecologist and Sexual Medicine Specialist, South Africa)

Developing Interdisciplinary and Collaborative Approaches

One participant stressed the importance of marketing sexual medicine programmes and structuring them to appeal to professionals in various fields. It was suggested that universities collaborate to develop a standardized undergraduate curriculum, and postgraduate training.

- *"If we as universities put our heads together and say we are working, we as four universities develop a curriculum, like they did for the clinical associates."* (KII 4, Senior Lecturer, Gynecologist and Sexual Medicine Specialist, South Africa)

Strengthening Professional Organizations and Accreditation Standards

One participant highlighted the role of professional organizations in maintaining standards and ensuring ethical practice, highlighting the role of organizations like SASHA, to maintain high standards. Another participant mentioned the need for regional regulatory bodies, and for globally recognized certifications.

- *"Doctors are very, very strong leaders by default, whether they want to be or not." "The media sees you as one, even politicians, whether they are in your circle of friends or your local school—people value your opinion as a doctor."* (KII 6, Medical Doctor, Sexologist, Global Advocate, South Africa)
- *"My vision is for Africa to have regional, respected professional organizations that certify*

sexual health providers. It's about setting clear standards so people can access actual qualifications, not just courses from various organizations." (KII 6, Medical Doctor, Sexologist, Global Advocate, South Africa)

Discussion

This study highlights significant gaps in clinical sexology education across Sub-Saharan Africa, underscoring both quantitative and qualitative deficiencies in training, resources, and professional recognition. The findings indicate an uneven distribution of sexology services and education across the continent, with South Africa more represented than other regions, creating challenges in drawing geographically wider conclusions. This disparity highlights the broader problem of the fragmented and inconsistent provision of sexual health education and services across Sub-Saharan Africa.

Quantitative data show that responses from certain Sub-Saharan African regions remain low, reflecting the absence of a standardized framework for sexology education. The limited representation of countries outside South Africa raises concerns about sampling bias, making it difficult to draw continent-wide conclusions. However, this also signals the vast gaps in sexology services, training, and research in many countries. Qualitative findings reinforce this, as informants emphasized that clinical sexology remains largely informal in many settings, and is generally integrated within other health disciplines, such as gynecology, psychiatry and urology, rather than as a distinct specialty.

Gaps in Undergraduate and Postgraduate Training

The study identifies a notable shortage of integrated and comprehensive sexology programmes at both undergraduate and postgraduate levels. Quantitative findings show that while some universities incorporate sexual health education within broader reproductive health or HIV/AIDS courses, few offer dedicated curricula addressing the full spectrum of sexology; including anatomy, physiology, sexual dysfunction, relationships, and therapeutic practices. As a result, medical students often acquire fragmented knowledge through isolated modules, gaining limited exposure to the interdisciplinary nature of sexual medicine. Many participants described learning about sexual health in disjointed components of other courses, with no unifying structure linking them into a coherent whole.

Participants also indicated that postgraduate education in sexual medicine remains severely limited. Most clinicians who wish to specialize must seek education abroad, primarily through European or North American institutions such as the European School of Sexual Medicine. However, many reported that such training is not easily transferable to Sub-Saharan African contexts due to cultural differences and the lack of local clinical support structures. This reliance on foreign education reinforces inequities and places the responsibility of specialization on individual practitioners rather than institutions. Overall, the absence of systematic training infrastructure means that professional development in sexology often depends on the personal commitment and advocacy of a few motivated individuals rather than established academic pathways.

Challenges in Standardization and Accreditation

This contrasts with the different stages of professionalization present in Europe and other high-income settings, where a gradual transition from fragmented, discipline-based sexuality teaching has given way to recognized sexology training programmes, informed by professional bodies and accreditation frameworks (Amref International University, 2024; Kontula, 2011).

Patterns observed in the current study reinforce the view that Sub-Saharan Africa is at an earlier stage of this trajectory, marked by the absence of standardized curricula and accreditation mechanisms for clinical sexology education. The development of a more unified framework and standardized training programmes could support professional recognition across the region.

Previous attempts by organizations such as SASHA to secure postgraduate recognition have been largely unsuccessful, highlighting the regulatory and institutional obstacles to establishing

sexology as an independent yet collaborative discipline.

Participants described how sexual medicine is frequently subsumed under broader medical and reproductive health programmes, resulting in limited attention to sexual dysfunction, pleasure, and psychosexual well-being. Institutional ownership remains weak, with universities often assuming that existing departments already cover the topic. Consequently, sexology education remains dependent on the enthusiasm of individual lecturers rather than supported by national policy or curricular mandates. This lack of structure reinforces the perception that sexual health is a peripheral rather than essential area of medical education.

Resource Limitations and Institutional Barriers

Participants noted the scarcity of resources, including shortages of textbooks, research journals, faculty development programmes, and clinical training facilities that participants felt continued to limit the growth of sexology education within their institutions. These financial and material pressures were perceived to restrict programme development and accessibility, highlighting the low position of sexology in the hierarchy of medical priorities.

Some participants also noted that political and institutional reluctance to prioritize sexology education compounds these challenges, while religious and cultural sensitivities often make sexuality-related topics politically or socially contentious, discouraging policymakers from publicly endorsing or funding such programmes (Ikwara et al., 2025; World Health Organization, 2006).

Nonetheless, the participants identified the role of private-sector initiatives in filling some of these gaps. Private training institutions, though limited in reach, can provide high-quality education and mentorship to clinicians who can afford them, thereby helping to sustain some continuity in professional development in the field. This suggests that private-public partnerships may offer emergent opportunities.

Sociocultural and Traditional Challenges

Both quantitative and qualitative findings highlight the role of sociocultural, religious, and traditional beliefs in shaping attitudes toward sexual health education. Several participants noted that inherited traditional norms may play a more significant role than formal religion in creating resistance.

The diverse cultural contexts across Sub-Saharan Africa necessitate a tailored approach to sexology education, ensuring that curricula respect local values while providing scientifically sound knowledge. It must be recognized that the traditional healthcare approach may offer culturally acceptable local solutions to sexual problems but Sub-Saharan African traditional healthcare may be poorly researched and may perpetuate some potentially harmful practices. However, many participants noted that sexual medicine is often perceived as conflicting with religious and traditional beliefs, leading to reluctance among healthcare providers and policymakers to engage with the field.

Emerging Progress and Innovations

Despite these challenges, promising developments are emerging. Institutions such as Stellenbosch University have successfully incorporated structured sexual medicine programmes, demonstrating the feasibility of integrating sexology into medical undergraduate education. Similarly, the South African College of Family Physicians is offering South Africa's first postgraduate diploma in Sexual Health and HIV/STI, a development that could significantly increase expertise in clinical sexology, within Southern Africa.

Innovations emerging in East Africa include the AMREF-affiliated fellowship in Sexual Medicine and the clinically focused ISSM/Sexual Medicine Society of North America Sub-Saharan Africa Training Programme in oncosexology. The expansion of digital learning platforms also holds promise for improving access to training, particularly in remote or under-resourced settings, although such approaches continue to rely on coordinated institutional support.

Future Directions and Recommendations

Addressing the systemic challenges emerging from this study were viewed by participants as

requiring a coordinated, sustainable, and multifaceted response. These recommendations are grounded in the study's role as an initial regional mapping of professional education in sexology, drawing together structural survey data and expert experiential insight.

Standardized curricula together with robust accreditation and regulatory frameworks were described as essential to improving quality, coherence, and accountability. These measures were believed to strengthen academic capacity and research culture while lending greater professional recognition to sexology education.

Structured undergraduate and postgraduate programmes were seen as key to cultivating a skilled professional workforce, fostering academic community, and addressing the continent's diverse sexual-health needs. Participants also emphasized the importance of engaging policymakers, religious leaders, and the wider public to help nurture a more supportive cultural and political environment for sexology.

Finally, participants highlighted the value of regional and global networks that promote collaboration and mutual learning, noting that these could elevate the visibility and legitimacy of sexology as a developing field. Together, these strategies point toward a more cohesive and enduring educational ecosystem, one that affirms sexual health as integral to both public health and human rights in Sub-Saharan Africa.

Study Limitations

This study has several limitations that must be considered when interpreting the findings. The quantitative survey may have missed many potential respondents who did not reply, and some of those who did respond may not have provided complete or easily categorizable data. Response rates were low and uneven across the region, partly reflecting differential access to internet connectivity and professional networks. The study is also subject to sampling bias, with responses disproportionately representing South Africa while other Sub-Saharan African countries are underrepresented. This imbalance likely reflects both the relative maturity of South African programmes and the limited visibility of comparable initiatives elsewhere. It therefore limits the ability to make sub-continent-wide generalizations and restricts direct comparisons between South Africa and other regions. The findings should thus be interpreted as illustrative rather than representative.

Additionally, access to professionals involved in sexual medicine was limited, and the survey itself may not have comprehensively captured all relevant perspectives. Recruitment relied on voluntary participation and professional referrals, and intentionally favored respondents already engaged with sexology education, with a particular focus on the challenges and opportunities in the field, thus introducing a particular focus influencing responder bias. The generalizability of the findings is therefore constrained, as they may not fully reflect the diversity of experiences across different Sub-Saharan African regions.

Nevertheless, these limitations mirror the structural challenges identified by participants themselves, namely, the fragmented infrastructure, uneven institutional capacity, and limited documentation of sexology education in the region. Recognizing these constraints helps situate the study's findings as a first step toward a more comprehensive and collaborative mapping of sexology training across Sub-Saharan Africa.

Conclusion

This study reveals structural gaps in sexology care services and professional education across Sub-Saharan Africa, while acknowledging limitations in scope and representativeness. The findings highlight the scarcity of comprehensive programmes, a lack of standardized curricula and accreditation, inadequate resources, and conflicting cultural paradigms. These systemic constraints, coupled with fragmented training programmes and sociocultural challenges, continue to hinder the development of a cohesive discipline in sexology.

Despite these challenges, the study identifies promising developments and opportunities for progress. Emerging initiatives, such as structured academic programmes at Stellenbosch University, a new postgraduate diploma in Sexual Health and HIV/STI medicine in South Africa, and

multidisciplinary training in Kenya demonstrate a growing recognition of the importance of sexual health education.

Advancement will depend on strengthening regional collaboration, creating regulatory and accreditation frameworks, and fostering academic partnerships that ensure quality and sustainability. The outcomes of the study suggest that the development of standardized curricula and faculty-training mechanisms, together with meaningful engagement with policymakers and professional bodies, could support the gradual integration of clinical sexology into both undergraduate and postgraduate medical and allied-health training.

By aligning educational initiatives with identified needs and participant insights, this study offers a foundation for more coordinated efforts to advance sexology education in Sub-Saharan Africa. It represents an initial mapping of current realities and emerging opportunities, a step toward building a regionally responsive and globally connected framework for professional education in clinical sexology.

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Author Contributions

CRediT: **Anthony Smith**: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing; **Tammary Rotich**: Conceptualization, Formal analysis, Investigation, Methodology, Validation, Writing – original draft; **Elizabeth Lucy Nabwile Khisa**: Data curation, Formal analysis, Methodology, Project administration, Software; **Oluwasegun C. Idowu**: Validation; **Prithy Ramlachan**: Conceptualization, Validation, Writing – review & editing.

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