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How do Nigerian Gynaecologist in a Tertiary Health Facility Manage Infertile Patients for Sexual Dysfunction?

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Abstract

This study was conducted to evaluate the approaches gynaecologists in Osun East Senatorial district; South west Nigeria uses to screen and manage their infertile women for sexual dysfunction. Forty gynaecologists and their resident doctors managing infertile women at Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife, Nigeria, were interviewed (June -December 2020) using an in-depth-interview guide and semi-structured questionnaires. All the forty doctors assessed the sexual functioning of infertile patients. The Assessment was usually done at the first time of seeing the patient and at other times when patients start a discussion about it or when a patient's complaints are directly related to it. Ways of eliciting sexual concerns were by asking on the frequency of sexual intercourse per week, about ejaculatory intercourse, sexual satisfaction, and dyspareunia. None of them used any standardized assessment tools to screen infertile women. Most are not aware of any standardized tools for sexual functions assessment because they had no training in sexual dysfunction in both undergraduate and postgraduate training as it was not in their curricula. While they welcome the introduction of the tools in training and in the case file of patients, they believed that routine screening using these tools would increase the waiting time and would be an added burden on the doctors. This study showed that gynaecologists and residents are poorly equipped to address sexual problems and sexual dysfunction among infertile women. It is imperative that the curricula of medical training be updated to include assessing sexual functioning tools for better care.

***Keywords**: Female sexual dysfunction, Nigerian gynaecologist, Management.*

Introduction

Sexual dysfunction among infertile women is an emerging area of study in Nigeria. Despite the availability of studies on sexual dysfunction among infertile women in developed countries [1,2,3], studies among Nigerian infertile women are few [4,5]. Infertility is a pandemic in Nigeria, with some studies showing some of the highest incidences in the hospital settings in Sub-Saharan Africa [6,7]. This being the case calls for an investigation into the sexual problems encountered by the infertile female population [7]. The culture of silence in sexuality-related issues due to adverse socio-cultural and religious practices in Africa means that many infertile women may be suffering in silence with nobody to voice out their frustration. The societal discrimination, divorce threats and general abuses, and domestic violence suffered by these women is likely to affect their sexual response. Hence, there is a clarion call for investigation into the extent of sexual dysfunction suffered by infertile women, identify modifiable risk factors to develop

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appropriate culturally sensitive and acceptable modalities of treating these women [5, 6].

A growing number of healthcare practitioners deal with sexual dysfunction in many patients with chronic illnesses. Infertile women are a cohort of people largely managed by gynaecologist either at public or private health care facilities. The gynaecologist is in a vantage position to help infertile women with sexual dysfunction since they are, by training, the best qualified to handle intricate sexuality problems. The quality of information given to these women and the manner in which it would be delivered is very critical in helping them cope with their sexual difficulty. This is particularly delicate because the central issue surrounding infertility revolves around sexuality and having a satisfying sexual life. Unfortunately, there is no published study from Nigeria on the extent to which gynaecologist screen infertile women for sexual dysfunction. It is important to fill this extant knowledge gap since Nigeria has no official protocol or national guideline for the management of sexual dysfunction. Even in developed countries, studies on gynaecologist approach in management of female sexual dysfunction are few [1, 8, 9, 10].

This study was conducted to evaluate the approaches gynaecologists in Osun East Senatorial district, Southwest Nigeria, uses to screen and manage their infertile women for sexual dysfunction. This is very important in view of the increasing evidence that sexual dysfunction may be a pertinent problem among infertile Nigerian women.

Materials and Methods

This is part of a larger study on prevalence, predictors. Pattern and management of female sexual dysfunction between infertile and fertile women in Osun East Senatorial District, Southwest, Nigeria being a PhD research thesis for the Award of PhD by the Texila America University/ the University of Central Nicaragua. This study was approved by the Ethics and Research Committee (ERC) of the Obafemi Awolowo University Teaching Hospitals Complex Ile-Ife, Nigeria (Protocol No: ERC/2019/12/14) and by Health Research Ethics Committee, Institute of Public Health, Obafemi Awolowo University, Ile-Ife, Nigeria (Protocol No: IHUOAU/12/1389) and it was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki. Verbal informed consent was obtained from all the doctors before inclusion in this part of study.

This is a mix- method study incorporating quantitative aspects and qualitative aspects using an in-depth interview guide. In the quantitative aspect, a self-administered questionnaire was developed to investigate the screening practices employed by health workers (doctors) in assessing sexual dysfunction among infertile patients and strategies used in managing their patients' sexual issues. The questionnaires included sociodemographic characteristics of the doctors including age, marital status, religion, job description, years of experience. The second aspect explored the assessment of sexual functioning, when the assessment was usually done, frequency of assessment, ways of eliciting sexual functions, usual feeling with sexuality discussion with patients, the third section include their knowledge and use of standardized tools for assessment of sexual functioning of patients. The last section explored the treatment given to patients with sexual dysfunction.

In the qualitative aspect, an in-depth interview guide was used in gathering data about the experience in teaching undergraduate and postgraduate students on the topic of female sexual dysfunction. Information on their own training in female sexual dysfunction and the use of standardized sexual functioning tools in the routine teaching and services in the teaching hospital were also explored. The responses were triangulated with the results of the quantitative data. Data gathered from the questionnaires were appropriately sorted,

coded, and entered into the computer system using Statistical Package for Social Sciences (SPSS) version 22 and STATA 12.

Results

Table 1 showed the demographic characteristics of the forty participants. The Majority (85%) were males, the mean age is 40.95 years. Forty percent were aged 18-39 years, thirty percent were aged 40-49 years, and twenty-five percent were aged 50 and above. Fifty-five percent were married, while forty-five percent were single. Ninety percent were Christians. Professional cadre include Registrar (35 percent); Senior Registrar (32.5 percent) and Consultant (32.5 percent). Their years of experience include 3 years and below (20 percent), 4 to 5 years (45 percent), more than 6years (35 percent). Table 2 showed the screening practice for sexual dysfunction in patients by health care providers for patients. All forty doctors assess the sexual functioning of infertile patients. The Assessment was usually done at the first time of seeing the patient in all the patients. However, among five doctors the assessment also occurs when patients start discussing it or when a patient's complaint is directly related to it. Ways of eliciting sexual concerns among the clients include asking about on the frequency of sexual intercourse per week, asking about ejaculatory intercourse, asking about how satisfying the sexual intercourse has been and enquiring about sexual dyspareunia. They are all comfortable discussing sexuality issues.

Table 3 showed respondent's experience with the use of standardized tools in assessing sexual functions. Reasons for none use of standardized tools include among others include no tools available in the case file (100%), no training and skills in the use of standardized assessment tools (75%), not incorporated in the undergraduate and postgraduate training curriculum, not aware of any standardized tool, inadequate time (62.5%), patients' embarrassment (42.5%), it is a private matter (35%), lack of privacy and / or confidentiality (25%) and cultural limitations (10%). Table 4 showed the experience of treatment of female sexual dysfunction. Twenty (50%) of the doctors had treated a patient for female sexual dysfunction. Management strategies include behavioural modification (30%), psychotherapy (25%), treatment of other systemic illnesses (10%), and sex therapy (5%).

Discussion

The objective of this study was to evaluate how gynaecologist address the sexual problems of their infertile patients. This study clearly showed that sexual history taking by Nigerian gynaecologists during outpatient consultation of infertile women was grossly inadequate, unstructured and not systematic. There is no data in Nigeria or even in Africa in this area to the best of our knowledge. Studies investigating the specific content of the physician's sexual history taking or how physicians assess patients' sexual function worldwide are few. Studies on the influence of physician characteristics such as gender, age, race, sexual orientation, location of medical education, and type of practice on sexual history taking revealed contradicting findings [11, 12]. While some studies show female physicians are significantly more likely to discuss sexual activity with clients [12], others reported no significant association between gender and sexual history taking or screening for sexual dysfunction [11]. While a previous study showed, younger physicians are more likely to take sexual histories [13]. Another study found no significant association between physician age and asking about sexual activity [12] or screening patients for sexual dysfunction [11].

Our findings showed that the doctors were purely interested in asking about the frequency of sexual intercourse per week, presence of ejaculatory intercourse, satisfaction with sexual activity and about presence or absence of dyspareunia as they were taught during their undergraduate and postgraduate medical

training. There are also no differences in between consultants and residents in terms of age, duration of practice, gender in their pattern of assessment of female sexual dysfunction. Given that sexuality is a key section of women's physical and psychological health [14] and that the gynaecologist by the depth and specialization across specialties are better positioned to deal with sexual dysfunction, all efforts should be made to inculcate sexual assessment functioning in their training and the gynaecologist knowledge and competence base should be regularly updated. Improvements in medical training and further training courses are essential to improve the outpatient care of women with female sexual dysfunction [8].

The findings in this study contrast with that from Switzerland where up to 7.9% of gynaecologists ask about sexuality issues [1]. A higher prevalence of 40 % gynaecologist reported routinely exploring sexual problems at routine gynaecology unit [14]. In our study, the only domain of sexual function commonly inquired of by the gynaecologist is the presence or absence of dyspareunia. The common complaint of dyspareunia has been explained by the observation that patients prefer a somatic approach in which pain is an appropriate symptom to talk about with a physician [1]. Other symptoms such as lack of desire or arousal difficulties are considered to be too intimate or not ideal or appropriate to mention in a gynaecological consultation. As expected, all the doctors are comfortable discussing sexuality matters.

It is surprising that none of the doctors routinely use standardized sexual functioning assessment tools. The reasons given for non-use of these tools include, among others: no tools available in the case file (100%), no training and skills in the use of standardized assessment tools (75%), not incorporated in the undergraduate and postgraduate training curriculum, not aware of any standardized tool, inadequate time (62.5%), patients embarrassment (42.5%), it being assumed to be a private matter (35%), lack of privacy and/or confidentiality (25%) and cultural limitations (10%). The above reasons had also been reported by others [9], and it clearly showed that Nigerian doctors are poorly equipped to address sexuality health problems. Yet, the gynaecologists by their training are supposed to be expert in addressing the conditions of the female genital tract across the female life course [2, 14]. They are well-positioned among all other doctors to address sexuality issues with female patients and especially infertile women. Findings from in-depth interviews among all cadres of doctors showed that the poor assessment of sexual functions by the doctors is deep rooted in non-inclusion of these tools in the training curricula at undergraduate and postgraduate level of education.

The opinion of these doctors was sampled on the feasibility and desirability of including the assessment tools for sexual dysfunction in the patient's case file. While some supported it, some voiced out that it will be more time-consuming and increase waiting time for the patients which may discourage clinic attendance. It has been observed that the daily work lead in obstetrics and gynaecology does not permit time to develop a special focus on communication because the priority lies on medical or surgical interventions, Still, the fact remains that the patient gynaecologist communication is characterized by specific intimate topic with a high emotional impact and the gynaecologist must respond to these emotions and personal beliefs and values of their patients [15]. Not taking a detailed relevant, and focused sexual history from patients highlights many missed opportunities for counselling and treatment of sexual dysfunction. This is a clarion call for the inclusion of up-to-date guidelines on sexuality education, assessing sexual functions in all women in the curriculum of undergraduates, and postgraduate medical training [14].

Despite the obvious deficiencies revealed from the responses on in-depth interview, fifty

percent of the doctors stated that they had previously treated a patient with sexual dysfunction. Treatment modalities rendered included behavioural modifications, psychotherapy, treatment of other systemic illnesses, and sex therapy. However, how relevant and effective these treatments are need further evaluation.

Any discussion of sexuality in a gynaecology clinic is typically limited, mainly because of a lack of models or protocols available to guide the discussion of the topic. It has thus been suggested that the use of protocols may facilitate the discussion of sexual issues in gynecological settings. It has the potential to provide an effective approach to the complex aspects of sexual dysfunction in women. This study showed that patient's discussion of sexuality with doctors in Nigeria is limited because of several factors, which also had been confirmed by previous studies in other countries [2, 10, 16, 17, 18, 19, 20]. In a related study among German gynaecologists [8], it was reported that the gynaecologists did not regularly take a complete sexual history of their patients. They were mainly concerned with recognizing female sexual dysfunction and encouraging their patients to undergo treatment.

Conclusion

This study showed that consultants and residents in Obstetrics and Gynaecology department are poorly equipped to address sexual problems and sexual dysfunction among infertile women. It is imperative that the curricula of medical training be updated to include assessment of sexual functioning tools. In the interim it is suggested that models should be provided to guide a doctor in the discussion of sexual dysfunction.

Table 1. Socio-demographic Characteristics of Participants (N=40)

Variable	Frequency	Percentage
Sex		
Male	34	85
Female	6	15
Age(years)		
28-39	18	45
40-49	12	30
≥50	10	25
Marital status		
Single	18	45
Married	22	55
Religious		
Christianity	36	90
Islam	4	10
Professional Cadre		
Registrar	14	35.0
Senior registrar	13	32-5
Consultant	13	32.5
Years of experience		
3 and below	8	20.0
4-5	18	45.0
>6	14	35.0

Table 2. Screening Practice for Sexual Dysfunction in Patients by Health Care Providers for Patients

Screening Practices	Frequency	Percentage
Assessment of Sexual functioning n=40		
Yes	40	40.0
No	0	0.0
When assessment is usually done*		
First time of seeing the patient	40	100.0
When patient starts discussion about it	5	5.0
When patient's complaints are directly related to it	5	5.0
Ways of eliciting sexual concerns in patients*		
By asking about frequency of sexual intercourse per week	40	100.0
By asking about ejaculatory intercourse	40	100.0
By asking about how satisfying sexual activity has been	40	100.0
By asking about dyspareunia	40	100.0
Usual feeling with sexuality discussion with patients n=40		
Comfortable	40	100.0
Embarrassed	-	-
Uncomfortable	-	-

*Some gave multiple responses

Table 3. Use of Standardized Assessment Tools for Assessment of Sexual Dysfunction among Health Care Providers

Variable	Frequency	Percentage
Ever Use of Standardized Tools in assessing Sexual Functions		
Yes	0	0.0
No	40	100.0
Reasons for non-use of the standardized tools*		
No tool available in the case file	40	100.0
No training and skills in the use of standardized assessment tools	30	75.0
Not incorporated in undergraduate and postgraduate training curriculum	30	75.0
Not aware of any standardized tool	25	62.5
Inadequate time	25	62.5
Patient's embarrassment	17	42.5
It is a private matter	14	35.0
Lack of privacy and/or confidentiality	10	25.0
Cultural limitation	4	10.0

*Some gave multiple responses

Table 4. Treatment of Female Sexual Dysfunction

Variable	Frequency	Percentage
Treatment experience		
Ever treated FSD	20	50.0
Never treated FSD	20	50.0
Management strategy*		
Behavioural modification	12	30.0
Psychotherapy	10	25.0
Treat other systemic illnesses	8	20.0
Sex therapy	2	5.0

*Some gave multiple response

In-Depth Interview for Doctors

Consultants

An in-Depth Interview was Conducted on Consultants Gynaecoloigsts in the Institutions. Here were the Except:

Participants 1. A 54 – year old Consultants

It is when you brought up this topic that I just remembered that I have never taught students on this topic. As much as I could remember I was not taught this topic in my undergraduate and postgraduate residency period. I could only recollect faintly that I occasionally hear about such tools along the line once in a while at conference presentation or while reading some journals. I have never really read it or studied it in details.

Asked why he is not using it while Assessing Patients. Here is his Response

You cannot use what you are not knowledgeable about. More so the tools are not incorporated in patients case files. It will be difficult to enquire of such information routinely if the questionnaire is not readily available.

Asked about the Willingness to use the Tools if Incorporated into Patient's Case File. Here is his Response

I believe I will use it, but this means more time will be spent attending to one client and there are many patients waiting to be attended to. The patients would start complaining about longer waiting time and this may discourage them from accessing care in the teaching hospital.

Asked about Suggestions to enable the Incorporation of Female Sexual Functioning Tools into Routine Infertility Clinics. This is an Elaborate Suggestion given by a Senior Colleague

I understand there are many tools developed to assess female sexual functioning. It will be desirable to incorporate them in the undergraduate and postgraduate medical school curricula. This would make it easy for doctors to be versed in the knowledge and use of them. In addition, a uniform tool should be agreed upon and a protocol developed for the hospital use. This protocol should then be submitted to medical records to be incorporated into the case not.

Another Consultant -a 43-year-old Consultant made Further Suggestions

Incorporating the tools routinely into all gynaecology case files may not be economical. A separate multidisciplinary unit to handle patients with sexual dysfunction should be created Time has come when gynaecology department will take the issue of sub-specialization serious. It will be difficult to incorporate such with all gynaecology patients having other complaints such as uterovaginal prolapse, genital fistula, uterine fibroids,

gynaecology oncology cases, pelvic inflammatory diseases, endometriosis etc. The clinic would be boring and stressful not only to the doctors and nurses but also to the patients. I suggest that a separate infertility unit should be developed and devoted to all aspects of infertility. By so doing they will have enough time to go into details on sexual functioning. We should not forget that sexuality is a multidisciplinary issue which involve the gynaecologist, the psychologist, sex therapist, social workers, and specially trained nurses.

Senior Registrars

A Senior Registrar I have this to say

We were not taught about sexual dysfunction in our undergraduate and postgraduate education. I cannot mention any screening tools for sexual function screening. This study just aroused my interest to browse and study management of sexual dysfunction. It will be good if the tool is incorporated into our infertility case file but this means more time to spend with patients during the clinics.

A Female Senior Registrar I have this to say:

I don't have any knowledge of definition and classification of sexual dysfunction. I know that men and women can have sexual difficulties but to I have not studied it in an organized topic as sexual dysfunction. I always ask questions about presence or absence of pain or satisfaction about sexual intercourse but I don't know it as component of sexual dysfunction. It will be good if that can be introduced in our training curriculum.

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Conflict of Interest

The authors declare no conflict of interests. This work is purely done and published from the PhD research thesis.

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