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Sexual Activity Among Women With Genital Fistula In Southern Nigeria

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Abstract
Background: *Genital fistula is a psycho-sexual problem characterized by disruption in sexual relationships due to continuous leakage of urine and/or faeces. We aimed to report sexual activity and associated factors among women with genital fistula in our environment.*
Methodology: *It was a descriptive cross-sectional study carried out in a fistula hospital in Southern Nigeria among sixty women with genital fistula admitted for surgical repair. Informed consent was obtained. Information was obtained using interviewer-administered questionnaires and entered into an electronic database. Data was analysed using descriptive statistics. The mean and standard deviation of numerical variables were obtained. Associations between categorical variables were tested using the Chi square and Fisher Exact tests. The means of numerical variables were compared using the students' T-test. A p-value of less than 0.05 was considered statistically significant.*
Results: *The mean age of the women was 34.4±11.4 years. Of the 60 women studied, 30 (50.0%) were sexually active despite have genital fistula. The reasons for not engaging in sexual activity were embarrassment of incontinence of urine or faeces (18; 60.0%), absence of a sexual partner (8; 26.7%), gynaetresia (3; 10.0%) and old age (1; 3.3%). Out of 8 women who did not have sexual partners, 4 (50%) were single, 3 (37.5%) were widowed and 1 (12.5%) was separated. Prolonged obstructed labour was the commonest aetiology of genital fistula (26; 43.3%). Sexual activity among fistula patients was associated with being married (p=0.030963, x^2 4.655).*
Conclusion: *Half of women with genital fistula are sexually active. Sexual activity is associated with being married. The commonest reason for not engaging in sexual activity is embarrassment from leaking of urine or faeces. Spouses of fistula patients should be reassured that they can have sexual relationship and be encouraged to provide spousal support. Women with sexual dysfunction should benefit from counselling, psychosocial support and long-term treatment.*
Keywords: *Genital Fistula; Obstetric fistula; Sexual Activity; Vesicovaginal Fistula*

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I. Background

Genital fistula is an important sexual and reproductive health problem among women in the low-and middle-income countries.[1,2] Obstetric causes such as prolonged obstructed labour and poorly-performed Caesarean section account for majority of cases in our environment.[2,3] Other less common causes include gynaecological surgeries, trauma, sexual assault, advanced genital malignancies, radiotherapy and congenital malformations.[4-6] Genital fistula is a cause of sexual dysfunction and may result in stigmatization, disruption in sexual relationships and marital disharmony.[7,8] Marital and psychosexual problems have been reported among fistula patients.[8] The reasons include lack of interest in sexual activity, painful sexual intercourse, stigma from continuous leakage of urine or faeces, poor general health, narrowing of the vagina and lack of a sexual partner.[7] Sexual activity is an important aspect of the quality of life of a woman.[9] It is therefore vital to study the sexuality of women with genital fistulas as part of the assessment of their overall well-being and proffer solutions to identified problems. The study was aimed at exploring sexual activity and associated factors among women with genital fistula. The findings will form a basis for advocating spousal support during counselling as well as provide wholistic preoperative and postoperative care to women with genital fistula.

II. Methodology

This was a descriptive cross-sectional study carried out over a period of six months in a fistula hospital in Southern Nigeria. The study population comprised sixty women with genital fistula who were admitted for surgical repair in the hospital. The participants were obtained by consecutive sampling. They were briefed on the purpose of the study and informed consent was obtained from them. Information on sociodemographic characteristics, obstetric characteristics, detailed medical and social history, sexual practices, physical examination, operative findings, management and repair outcomes was obtained using interviewer-administered questionnaires and entered into an electronic database. Data was cleaned and analysed. Descriptive statistics was used. The mean and standard deviation of numerical variables were obtained. Results were presented in form of tables. Associations between categorical variables were tested using the Chi square and Fisher Exact tests. The means of numerical variables were compared using the students' T-test. A p-value of less than 0.05 was considered statistically significant.

III. Results

Sixty women with genital fistula were studied. The ages of the women studied ranged between 15-75 years. The mean age was 34.4±11.4 years. The mean parity was 3.2±2.5. The mean number of children alive was 2.2±2.1. Most (45;75%) of the women with fistula were married. Out of the 48 women who were married before the development of genital fistula, 45 (93.8%) remained married after while 3 (6.2%) were separated following the development of genital fistula. The demographic characteristics of the women are as shown in Table 1. Thirty women (50.0%) engaged in sexual activity despite have genital fistula while 30 (50.0%) were not sexually active. The reasons for not engaging in sexual activity were embarrassment of incontinence of urine or faeces (18; 60.0%), absence of a sexual partner (8; 26.7%), gynaetresia (3; 10.0%) and old age (1; 3.3%). Out of 8 women who did not have sexual partners, 4 (50%) were single, 3 (37.5%) were widowed and 1 (12.5%) was separated. (Table 2). Prolonged obstructed labour was the commonest aetiology of genital fistula among the women studied (26; 43.3%). This was followed by Caesarean section (17; 28.3%). Prolonged obstructed labour and Caesarean section accounted for over 70% of the fistula. Other causes included episiotomy/perineal tear or its repair (7; 11.7%), vaginal hysterectomy (5; 8.3%), abdominal hysterectomy (3; 5.0%), insertion of corrosive herbs into the vagina (1; 1.7%) and congenital malformation (1; 1.7%) (Table 3). Sexual activity among fistula patients was associated with being married. Married women are more likely to engage in sexual activity than those who are single or separated (p=0.030963, x^2 4.655) (Table 4). Being sexually active had no association with age (t=0.1571, df 58, SED 2.970); parity (t=0.6608, df 58, SED 0.656); having living children (p=0.22, x^2 1.491); educational status (p=0.56 x^2 0.343); location/residence (p=0.29 x^2 1.11); type of fistula (p=0.03, x^2 4.655); or aetiology of fistula (p=0.34, x^2 0.90).

Table 1 Demographic characteristics of subjects

Demographic characteristics	Frequency (%)
Age (years)	
<20	3 (5.0)
20-29	17 (28.3)
30-39	27 (45.0)
40-49	7 (11.7)
50-59	3 (5.0)

60&above	3 (5.0)
Parity	
0	3 (5.0)
1	17 (28.3)
2	10 (16.7)
3	8 (13.3)
4	7 (11.7)
5&above	15 (25.0)
No of children alive	
0	15 (25.0)
1	17 (28.3)
2	4 (6.7)
3&above	24 (40.0)
Marital status (before)	
Single	9 (15.0)
Married	48 (80.0)
Separated/Divorced	0 (0.0)
Widowed	3 (5.0)
Marital status (after)	
Single	9 (15.0)
Married	45 (75.0)
Separated/Divorced	3 (5.0)
Widowed	3 (5.0)
Education	
None	6 (10.0)
Primary	10 (16.7)
Secondary	43 (71.7)
Tertiary	1 (1.7)
Residence	
Urban	24 (40.0)
Rural	36 (60.0)

Table 2 Sexual activity among women with genital fistula

Sexual activity	**Frequency (%)**
Sexually active	30 (50.0)
Not sexually active	30 (50.0)
Reasons for not being sexually active	
Embarrassment of incontinence	18 (60.0)
No sexual partner	8 (26.7)
Narrowed vagina (Gynaetresia)	3 (10.0)
Old age	1 (3.3)

Table 3 Aetiology of genital fistula

Aetiology of fistula	**Frequency (%)**
Prolonged obstructed labour	26 (43.3%)
Caesarean section	17 (28.3%)
Episiotomy/Perineal tear	7 (11.7)
Vaginal hysterectomy	5 (8.3)
Abdominal hysterectomy	3 (5.0)
Use of corrosive herbs	1 (1.7)
Congenital	1 (1.7)

Table 4 Association between sexual activity and marital status p=0.030963 x^2 4.655 significant

	Married	Single/Separated	
Sexually active	27	3	30
Not sexually active	18	9	27
	26	17	

IV. Discussion

The study examined sexual activity and associated factors in women with genital fistula. The mean age of the women was 34.4 years. Genital fistula is more prevalent among women of reproductive age in our environment because obstetric factors are responsible for most cases unlike in the developed world where gynaecologic causes account for the majority.[10] In this study, obstetric causes accounted for 83% of the fistulas. Strategies to eliminate genital fistula in low-resource settings should therefore emphasize universal health coverage and provision of emergency obstetric care.[3,11]

Most (75%) of the women with fistula were married. Out of the 48 women who were married before developing fistula, 93.8% remained married. The occurrence of genital fistula did not appear to disrupt the marriages of most of these women. This is important for the psychosocial well-being of these women who require tremendous spousal support for coping. The role of genital fistula in the occurrence of marital disruption is well documented.[8,12,13] Our finding is similar to those of a study in Nigeria that showed that most women with fistula remained married.[14,15] Also, in a study in nine African countries, the authors concluded that most husbands do not abandon their wives who developed obstetric fistula.[16]

Half of the women were sexually active despite living with genital fistula. This shows that a good number of women with fistula can engage in sexual relationships and may reduce stigmatization in the home. A study however showed that most of the women with obstetric fistula had little or no interest in sexual activity.[7] In our study, married women are more likely to engage in sexual activity than those who are single or separated. This finding is not unexpected because majority of the patients remained married following development of genital fistula. Our finding contrasts with that of a Ugandan study that showed that all the women stopped having sex with their husbands.[17]

The commonest reason for not engaging in sexual activity was the embarrassment of leakage of urine or faeces. Other reasons were the absence of a sexual partner, gynaetresia and old age. In other studies, women have reported avoidance of sexual intercourse by their partners due to leakage of urine while some have been abandoned for other women.[17,18] Lack of sexual desire has also been documented as a reason for not having sex.[18] Other women have reported pain and inadequate lubrication as reasons for not engaging in sexual intercourse. Some women reported stigmatization in marriage, separation and divorce due to their inability to fulfil their marital obligations.[18] In a study in Malawi, about half of the women with fistula reported that their husbands were unfaithful and one-third of them used traditional medicine to enhance their sexual function.[19] It is important to understand the experiences of each woman so that identified psychosexual problems can be treated by a multidisciplinary team while planning their surgical repair. Each woman should be offered counselling, psychosocial support and rehabilitation based on their social circumstances, with involvement of the male partner. They should also benefit from long-term treatment for sexual dysfunction after fistula repair.[20] Treatment of sexual dysfunction has been advocated for inclusion into fistula rehabilitation activities.[21]

In conclusion, half of women with genital fistula are sexually active. Sexual activity among fistula patients was associated with being married. The commonest reason for not engaging in sexual activity was the embarrassment from incontinence of urine or faeces. Spouses of fistula patients should be reassured that they can have sexual relationship and be encouraged to spousal support before, during and after the period of care. Women with sexual dysfunction should benefit from counselling, psychosocial support and long-term treatment.

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