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CLARIFYING VAGINAL ATROPHY’S IMPACT ON SEX AND RELATIONSHIPS (CLOSER) SURVEY IN SOUTH AFRICA

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ABSTRACT

Objective: With a paucity of information from sub-Saharan Africa, the impact of postmenopausal vaginal atrophy on women and male partners in South Africa was investigated.

Methods: Four hundred individuals in South Africa (200 postmenopausal women who had experienced symptoms of vaginal atrophy, and 200 male partners) completed a structured questionnaire.

Results: Sixty-eight percent of women had avoided intimacy because of vaginal discomfort; 62% of men described observing this behavior in their partners. Consequently, 52% of women and 51% of men reported decreased sexual activity – 20% of women and 18% of men believed vaginal discomfort had ‘caused a big problem’. Significantly higher proportions of women than men (p < 0.05) described being ‘put off’ having sex (27% vs. 14%) and feeling emotionally distant from their partners (21% vs. 11%). Twenty-one percent of women who had used local estrogen therapy, reporting benefits including feeling ‘happy’ that their body was ‘working again’ (76%) and increased confidence as sexual partners (71%).

Conclusion: For many postmenopausal women and their partners, symptoms of vaginal atrophy adversely affected sex and relationships, physically and emotionally. Substantial improvements were reported by women who received local estrogen therapy, supporting greater efforts to improve awareness and accessibility of such treatment in South Africa.

INTRODUCTION

Describing recommendations for managing postmenopausal vaginal atrophy, the International Menopause Society (IMS) Writing Group considers that, from a global perspective, research in sub-Saharan Africa should be a priority. The IMS Writing Group highlighted the situation in South Africa, where the prevailing demographics may contribute to a lack of peer-reviewed articles. In 2016, the South African population was estimated at around 56 million individuals, of whom only 8.0% were aged 60 years or above. The estimated prevalence of human immunodeficiency virus (HIV) was 12.7, and life expectancy at birth, in the absence of acquired immunodeficiency syndrome (AIDS), was 62 years. With a paucity of research, there is a dearth of information about postmenopausal sexual welfare in women from South Africa. Consequently, the first study to consider issues pertaining to postmenopausal vaginal atrophy in this country has now been performed, as described in the current paper.

Research involving women from other countries has shown that postmenopausal vaginal atrophy may be under-recognized and under-treated. Reduced postmenopausal estrogen levels underlie its occurrence. Loss of vaginal lubrication and vaginal dryness are often the first reported symptoms, but other symptoms include vaginal discomfort, itching, burning, pain and dyspareunia. Around half of postmenopausal women are affected, although they may be reluctant to seek medical advice – research has shown that almost one-third (32%) of affected women may never have spoken to a health-care provider about the condition, while, in both the United States and the United Kingdom, around 30% experience symptoms for 1 year or more before contacting a physician. Although the symptoms are often progressive, effective therapy is available.

Vaginal atrophy is part of the recently defined ‘genitourinary syndrome of the menopause’ (GSM) – a collection of symptoms, including, but not limited to, genital (dryness, burning and irritation), sexual (lack of lubrication, discomfort or pain, and impaired function), and urinary tract symptoms (urinary urgency, dysuria and infections) associated with aging and reduced sex steroid levels. With action towards a unified approach to reach a consensus on definitions, recognition and management of GSM, the situation for women with vaginal atrophy could improve.

To investigate the situation in South Africa, methodology was adapted from the recently published CLARIFYING VAGINAL ATROPHY’S IMPACT ON SEX AND RELATIONSHIPS (CLOSER)
survey; this aimed to understand the physical and emotional impact of postmenopausal vaginal discomfort by obtaining information from over 4000 women and a similar number of male partners in nine countries across Europe and North America. Vaginal atrophy and its associated symptoms were found to adversely affect sex and relationships (with 55% of women and 61% of men attributing intimacy avoidance to painful sex), although improvements were apparent after use of local estrogen therapy (with 62% of women and 59% of men reporting less painful sex)\textsuperscript{11}. However, many women were unaware of their therapeutic options, and almost 60% had not used local estrogen therapy\textsuperscript{11}. As for women elsewhere, for those in South Africa, understanding the way in which postmenopausal vaginal discomfort affects sex and relationships, and how best to encourage positive dialog about this topic, could enhance outcomes.

Methods

The original CLOSER survey\textsuperscript{11} involved 4100 postmenopausal women and 4100 male partners recruited in the United Kingdom, Denmark, Sweden, Norway, Finland, France, Italy, the United States and Canada, interviewed between December 2011 and February 2012 by the independent market research organization StrategyOne (London, United Kingdom). The current survey involved a total of 400 adults from South Africa (200 postmenopausal women and 200 male partners) interviewed by Edelman Berland (formerly StrategyOne) in August and September 2015.

The study was performed in accordance with the rules and regulations of the Market Research Society; as attitudes and behaviors were surveyed, but no interventions administered, formal medical ethics approval was not sought.

To be eligible for inclusion, the women were required to be aged 55–65 years, be married or co-habiting and to have ceased menstruating for at least 1 year. They should also have experienced vaginal discomfort, defined as the occurrence of any of the following: dryness, itching, burning or soreness of the vagina, bleeding during intercourse, pain during urination or pain in the vagina in connection with touching and/or intercourse. The men were required to be partners of women aged 55–65 years who had ceased menstruating for at least 1 year and experienced vaginal discomfort.

Individuals were recruited via a combination of three methods: free find (interviewers approaching potential participants), referral, and snowballing (female respondents asking their partners to participate in the survey). Recruitment was restricted to metropolitan areas. Demographic information from the South African Audience Research Foundation AMPS (All Media and Products Study) and Statistics South Africa census data was used to ensure that the sample distribution was representative in terms of age, ethnicity, income, etc. of the populations in the regions where the study was performed. For both women and men, the majority of individuals were recruited from Johannesburg (46%), with other respondents from Cape Town (15%), Pretoria (14%), Durban (13%), Port Elizabeth (8%), Bloemfontein (3%) and East London (3%).

There was no direct financial payment, although, in line with standard practice in South Africa, respondents could be entered into a draw to win one of ten department store vouchers for R500.

The survey participants answered a range of questions, as listed in the Supplementary Material (S1: Questions included in the CLOSER survey, see http://dx.doi.org/10.1080/13697137.2017.1262838). The questionnaires included the following topics: symptoms of the menopause and impact on women/relationships; willingness to discuss vaginal discomfort; the effects of vaginal discomfort on women, with particular emphasis on sexual relationships; treatment of vaginal discomfort and its impact on sexual relationships; and sources of information.

Whereas the original CLOSER study was internet-based, given the relatively restricted nature of internet access in South Africa, in the current survey, respondents completed the questionnaires in the presence of experienced researchers who could provide assistance if necessary. In attempts to minimize possible confounding arising from the presence of researchers, these were selected to be close in age to, and the same gender as, the respondents. When women were interviewed before their partners, the men were given the option of completing the questionnaires without assistance, or rescheduling to enable help from a male researcher.

Although South Africa has 11 official languages, the questionnaire was available only in English and included words that did not necessarily have direct equivalents in all languages. However, the individuals completing the questionnaire were enrolled from metropolitan areas, where English is widely spoken and understood. Furthermore, as multilingual researchers were used, if necessary, they could employ other languages to enhance respondents’ understanding of specific aspects of questions (although in no instance did a researcher ask an entire questionnaire in another language).

Respondents were given the choice of answering a pen-and-paper questionnaire or using an electronic version loaded on a tablet device.

Data were summarized descriptively. The overall margin of error was ±6.9% in 95 out of 100 cases. Where appropriate, a non-overlap statistical program was used to evaluate statistically significant differences between groups at the 95% level of confidence. Given the number of questions in the survey, responses to selected questions are described in the current article.

Results

Demographic data

Basic demographic data for the study sample are shown in Table 1.

Symptoms and impact of the menopause

Hot flushes and night sweats affected 86% and 51% of women, respectively. Vaginal dryness affected 50%.
symptoms of vaginal discomfort were reported by the women: vaginal itching (38%), vaginal burning (24%), vaginal pain in connection with touching and/or intercourse (21%), pain during urination (13%), vaginal soreness (12%) and bleeding during intercourse (6%). For 29% of women and 26% of partners, the impact of the menopause was worse than expected.

**Discussing vaginal discomfort**

Eighty percent of women told their partners when they first experienced vaginal discomfort. This was corroborated by 79% of the male interviewees reporting such discussions. More women aged 55–60 than 61–65 years were likely to discuss vaginal discomfort with their partners (80% vs. 63%; \( p < 0.05 \)). Two-thirds of women (67%) and over three-quarters of men (77%) were comfortable discussing vaginal discomfort. Indeed, 90% of men wanted their partners to engage in these conversations.

Conversely, 29% of women were uncomfortable raising the subject with their partners, with 27% feeling that their partners would no longer be attracted to them if they discussed the topic and 24% believing that such dialog would ruin moments of intimacy. More women aged 61–65 than 55–60 years were uncomfortable with these conversations (40% vs. 24%; \( p < 0.05 \)). Notably, across all ages, the proportion of women stating that they were likely to discuss vaginal discomfort with their partners, with doctors, or with pharmacies were 76%, 89% and 58%, respectively. A significantly higher proportion of black African women than white women (64% vs. 42%; \( p < 0.05 \)) were likely to consult pharmacies about symptoms.

**Effects of vaginal discomfort**

Approximately two-thirds of women (68%) had avoided intimacy because of vaginal discomfort, while 62% of men believed they had observed this behavior in their partner (Figure 1a). Among respondents thus affected, the main reasons included concerns relating to sex being less satisfying (reported by 45% of women and 46% of partners), sex being painful (45% of women and 40% of partners), and loss of libido (29% of women and 28% of partners).

In line with an avoidance of intimacy, data from the entire cohort revealed the negative impact of vaginal discomfort on a range of relationship issues (Figure 1a). Half reported decreased sexual activity, and around one-fifth believed vaginal discomfort had ‘caused a big problem’ for their sex lives. Women appeared particularly affected – significantly higher proportions of women than men (\( p < 0.05 \)) reported being ‘put off’ having sex and feeling emotionally distant from their partners.

For many women, vaginal discomfort had a negative impact on their feelings and self-esteem (Figure 1b). Around half believed they had lost their ‘youth’ or were upset that their bodies did not ‘work’ as previously. One-third no longer believed themselves to be sexually attractive. Around one-quarter had lost confidence as sexual partners, felt ‘less of a woman’, or became depressed thinking about their sex lives. One-fifth reported feelings of loneliness as a consequence of the condition.

In keeping with these concerns, a substantial proportion of women (61%) were worried about the long-term effects of vaginal discomfort. This sentiment was expressed by a significantly higher proportion of women with moderate or severe symptoms than those with mild symptoms (67% vs. 53%; \( p < 0.05 \)).

**Treatment and sources of information**

In 40% of women, the symptoms of vaginal discomfort were untreated. Where treatment had been used, this included lubricating gel or cream (26%), vaginal hormone tablets, cream or ring (21%), mineral/vitamin supplements (20%), and hormone replacement therapy (HRT) oral tablets or patches (6%).

Demographic differences in treatment practices were apparent. White women were significantly more likely to have tried some form of treatment than black African women (87% vs. 54%; \( p < 0.05 \)). While current use of vaginal hormone tablets was reported by 12% of the women surveyed, individuals of higher educational status were more likely to be using these (20% vs. 5%; \( p < 0.05 \)).

Although only 21% of the women used vaginal hormone therapy (tablets, cream or ring), the majority stated that it had a positive impact on sexual relationships (Figure 2), including improved sex lives, and couples becoming closer/less isolated from each other. Indeed, 60% of women receiving this treatment claimed to be optimistic about the future of their sex lives. Most also reported more confidence in themselves as sexual partners (71%), perceived themselves as ‘more of a woman’ (64%) and claimed to ‘feel sexually attractive again’ (52%). Many also felt ‘happy’ that their body was ‘working again’ (76%) or ‘rejuvenated’ (48%). Most of the women using vaginal hormone tablets stated that they would recommend these (74%) and reported effective treatment of vaginal discomfort (61%).

The benefits of vaginal hormone therapy were recognized by the partners of women who received treatment (Figure 2), with the majority of these men claiming to ‘look forward to...
having sex’ (90%) and feeling more attracted to their partners (80%).

Forty-eight percent of the women surveyed considered that too little information was available about the symptoms and treatment of vaginal discomfort. When information was sought, women reported consulting health-care providers (87%), printed material (45%), family and friends (26%), and online sources (25%).

**Discussion**

The data from the CLOSER survey in South Africa showed that vaginal atrophy had a negative impact on sex and relationships, both emotionally and physically, for many postmenopausal women and their partners. Intimacy avoidance was common, and many respondents reported less frequent sex. However, this study also revealed substantial improvements following local estrogen therapy in the 21% of the female cohort who received such treatment.

The results from South Africa are generally in line with those obtained when the CLOSER survey was conducted in Europe and North America\(^{11-14}\), which is unsurprising given that vaginal atrophy is a biologically driven, chronic medical condition. However, sociocultural perspectives, including access to health care, may be a consideration in South Africa. This could be reflected in the proportions of women...
receiving local estrogen therapy – 21% in South Africa vs. 41% in the overall CLOSER cohort from Europe and North America\textsuperscript{11}. Health-care access issues in South Africa may be reflected by black African women being more likely to consult pharmacies to obtain information about vaginal atrophy, but less likely than white women to have tried some form of treatment. It is possible that black women may not be able to access physicians as easily as white women and consequently consult alternative sources for information; only physicians and pharmacists were included as health care-related practitioners in the questionnaire (which was originally devised for use in Europe and North America), while in South Africa other practitioners, such as non-allopathic providers, including traditional healers, may also be consulted. Additionally, it should be recognized that treatment recommendations may vary according to the consulted source of information.

Better understanding of the attitudes and behavior of postmenopausal women with regard to symptoms of vulvovaginal atrophy has been advocated, to improve public health policies and target public health campaigns by considering the ways in which the attitudinal and behavioral profiles of affected women have varying representation in different countries\textsuperscript{15}. Country-specific or cultural differences relating to women’s perceptions of sexuality around the menopause\textsuperscript{16} and the impact/perception of vaginal dryness/menopausal symptoms have previously been described\textsuperscript{17,18}, while medical management of the menopause is also likely to reflect local attitudes\textsuperscript{19}.

Encouragingly, the results from South Africa showed most of the interviewees (women and men) to be comfortable talking about vaginal discomfort. Men had a positive attitude towards such conversations, and the vast majority wanted their partners to share their experiences. However, the questionnaire did not solicit any information as to whether male respondents sought treatment for their partners.

When reporting results from the original CLOSER survey, it was considered that the findings may encourage more open communication about vaginal atrophy between couples and their health-care providers\textsuperscript{11}; this would obviously also be beneficial in South Africa. With overcoming the vaginal ‘taboo’ being essential to optimize the heath care of affected individuals\textsuperscript{6}, promoting discussion of vaginal atrophy may enable health-care providers to more effectively support affected women. Indeed, recommendations from the IMS Writing Group consider dialog essential to enable the early detection and appropriate management of the condition\textsuperscript{1}. These recommendations also advocate starting treatment early, before the occurrence of irreversible atrophic changes, and continuing with therapy, to maintain the therapeutic benefits – with all local estrogen preparations being effective, the treatment used will generally be determined by patient preference\textsuperscript{1}. However, in South Africa, therapeutic choice may depend on recommendations women are given from the sources of which they aware and consult (e.g. pharmacist, media information) rather than as a consequence of more widely informed patient preference.

It is appropriate to consider the strengths and weaknesses of the current survey. The study obtained information about postmenopausal vaginal atrophy in South African women. Given the dearth of other available data, research into this subject in sub-Saharan African populations has been considered a priority\textsuperscript{1}, and this is the first study to include consideration of addressing aspects of GSM in a metropolitan cohort of individuals from South Africa. There are currently no data considering HIV and sexual function in postmenopausal

\begin{figure}[h]
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\includegraphics[width=\textwidth]{Figure2.png}
\caption{Figure 2. Benefits on relationships and intimacy reported after vaginal hormone therapy.}
\end{figure}
women from South Africa, and no specific data pertaining to sociocultural perspectives relating to GSM in such populations.

Having obtained demographically representative samples from the metropolitan areas where respondents were recruited, the survey population was likely to have reflected patients presenting to metropolitan clinics in South Africa, with the resulting data informing clinical practice in such situations. However, no data were obtained for rural populations, for whom the situation may differ.

Describing data from a cohort of 702 black South African women, Jaff and colleagues reported that the Stages of Reproductive Aging Workshop +10 (STRAW +10) criteria may be appropriate for staging menopause in resource-limited countries that use self-reported information on bleeding, but, given potential difficulties associated with women’s understanding of terminology, simplification of technical terms may improve accuracy. In the current study, the opportunity to answer questions in the presence of an experienced researcher may have been a strength in terms of broadening the survey population, but, despite efforts to the contrary, a possible weakness for interpreting terminology in languages other than English.

In summary, the results obtained from the CLOSER survey in South Africa are an attempt to address the requirement for additional knowledge about postmenopausal vaginal atrophy in women in sub-Saharan Africa. The reported effects of vaginal discomfort on women and their partners were generally similar to those in Europe and North America, adversely affecting both physical and emotional relationships in many cases. Improvements were apparent following local estrogen therapy. From a South African perspective, while health-care access may be one of the major barriers to receipt of appropriate treatment for women affected by postmenopausal vaginal atrophy, raising awareness, including amongst medical attendants and non-allopathic practitioners, will be a priority to help facilitate this.

Conflict of interest Franco Guidozzi has received honoraria for presentations and/or travel grants from Bayer Healthcare, MSD, Novo Nordisk, GSK and Adcock Ingram. Carol Thomas reports presentation and/or conference travel grants from Bayer Healthcare, Pfizer, MSD, Adcock Ingram and Abbott. Trudy Smith has received research and travel grants from, sat on advisory boards and lectured for, Bayer Healthcare, Eli Lilly, Novo Nordisk, Pfizer, MSD, Adcock Ingram, GSK and Sanofi Aventis. Rossella E. Nappi has a current financial relationship (lecturer, member of advisory boards and/or consultant) with Bayer HealthCare, Endoceutics, Gedeon Richter, MSD, Novo Nordisk, Pfizer, Shionogi and Teva.

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