ORIGINAL RESEARCH ARTICLE

The effect of sexuality on the quality of life of elderly people in Morocco

DOI: 10.29063/ajrh2023/v27i8.8

Hicham Mejdouli[1], Abdellatif Baali[1], Nadia Ouzennou[2] and Hakima Amor[1]*

Laboratory of Pharmacology, Neurobiology, Anthropobiology, Environment and Behaviour, Semlalia Faculty of Sciences, Cadi Ayyad University, Marrakech, Morocco[1]; Higher Institute of Nursing and Health Techniques of Marrakech, Ministry of Health and Social Protection, Morocco[2]

***For Correspondence:** Email: *hicham.mejdouli@ced.uca.*ma; Phone: +212 665 61 64 21

Abstract

In Morocco, the sexuality of the elderly is still a taboo subject, and sexual health is very much marginalised in the care system. The aim of this study was to investigate the relationship between sexuality and the quality of life of elderly people in Morocco. A cross-sectional survey using a structured questionnaire aimed at a sample of 354 people aged 65 and over attending health centres in the province of Essaouira was conducted between 2021 and 2022. The French version of the Leipad scale was used to assess quality of life and sexual functioning. Our results showed that sexual functioning is a major determinant of quality of life in the elderly. Participants' Leipad scores ranged from 9.7 to 93.5, with an average of 29.4 (σ =11.2). The highest score indicating an alteration in quality of life was recorded for sexual functioning (83.9±19). We need to think about an integrated strategy, involving all those involved in gerontological and social action, to promote the sexual health of older Moroccans so that they can "age in good health". *(Afr J Reprod Health 2023; 27 [8]: 76-82).*

Keywords: Sexuality, quality of life, elderly, Morocco

Résumé

Au Maroc, la sexualité de la personne âgée reste un sujet encore tabou et la santé sexuelle est très marginalisée dans le système soins. L'objectif de ce travail était d'étudier la relation entre la sexualité et la qualité de vie des personnes âgées au Maroc. Une enquête transversale via un questionnaire structuré destiné à un échantillon de 354 personnes âgées de 65 ans et plus fréquentant les centres de santé de la province d'Essaouira a été menée entre 2021 et 2022. La version française de l'échelle Leipad a été utilisée pour évaluer la qualité de vie et le fonctionnement sexuel. Nos résultats ont montré que le fonctionnement sexuel est un déterminant majeur de la qualité de vie des personnes âgées. Le score du test Leipad des participants variait de 9,7 à 93,5 ; la moyenne est de 29,4 (=11,2). Le plus haut score traduisant une altération de la qualité de vie était noté pour la dimension fonctionnement sexuel (83,9±19). Il est nécessaire de penser à une stratégie intégrée, impliquant tous les acteurs de l'action gérontologique et sociale, pour promouvoir la santé sexuelle des aînés marocains afin de leur permettre de « vieillir en bonne santé ». *(Afr J Reprod Health 2023; 27 [8]: 76-82).*

Mots-clés: Sexualité, qualité de vie, personnes âgées, Maroc

Introduction

Thanks to the improvement in the life expectancy of its population and the significant reduction in fertility, Morocco is undergoing a demographic transition characterised by an increase in the number of elderly people. By 2022, almost 4.3 million people will be aged 60 and over, representing 11.7% of the total population, compared with just 2.4 million in 2004 and 8% of the total population. According to demographic projections by the Haut-commissariat au Plan, by 2030 the number of people aged 60 and over will have risen to six million, representing 15.4% of the population, an increase of 42% compared with 2022[1]. The increase in life expectancy is accompanied by an increase in the risk of polypathologies and a deterioration in quality of life[2].

Despite beliefs that it disappears with age, sexuality is an important area of interest for older people and its effect on their quality of life is well established[3]. Sexuality is a "central aspect of the human being throughout life, encompassing sex, gender identities and related roles, sexual orientation, eroticism, pleasure, intimacy and

reproduction. Sexuality is experienced and expressed in the form of thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Sexuality therefore encompasses many dimensions, but not every person necessarily feels or experiences every one of them. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors"[4]. Sex life is also considered to be one of the main factors influencing quality of life[5]. The presence of sexual dysfunction directly affects quality of life[6]. Yet many older people experience their sexual health problems in isolation, rather than seeking competent help[7].

The problem is more acute in environments where discussion of sexuality is taboo[8]. In addition to the various age-related problems, older people may suffer from a sense of social marginalisation due to stigmatisation and deprivation of privacy and sexuality[9]. Although there are many studies on the elderly, the relationship between sexuality and quality of life remains partly unexplored by Moroccan researchers specialising in this field. In Morocco, where 64.4% of the elderly have at least one chronic disease, geriatric care is virtually non-existent, there are few medico-social establishments and the Ministry of Health and Social Protection has no strategy for the care of the elderly[8].

In this context, the aim of this study is to investigate the effect of sexuality on the quality of life of the elderly in Morocco, as well as other associated factors in order to propose to decision-makers actions that will help to improve the quality of life of Moroccan seniors and enable them to "age in good health".

Methods

Between 2021 and 2022, we conducted a cross-sectional survey of 354 subjects aged 65 and over. In the absence of an exhaustive list of elderly people in the province of Essaouira, the site of our study (Marrakech-Safi region, Morocco), study participants were selected at random during their visits to the province's health centres. The sample size was calculated using Fisher's formula. Data were collected via a questionnaire that was administered to the participants, in compliance with the required ethical considerations (favourable opinion of the ethics committee, oral consent, anonymity and confidentiality). The variables included in our study were age, gender, place of residence (urban-rural), marital status, level of education, lifestyle (solitary-family), occupation, medical coverage, financial conditions and health status (morbidity and subjective physical health). Quality of life was assessed using the Leipad test[10], a multidimensional instrument consisting of 31 items categorised into seven dimensions: physical function, self-care, depression and anxiety, cognitive functioning, social functioning, sexual functioning (SF) and life satisfaction. Each dimension comprises 2 to 6 items. Each item is rated on a 4-point Likert scale, ranging from 0 (best quality of life) to 3 (worst quality of life). The total score is established by adding the scores of the different items in the different dimensions of the scale. The score is then converted to a linear scale from 0 to 100.

The data collected was entered and statistically processed using SPSS PC 21 (IBM Statistical Package for the Social Sciences). Qualitative variables were described by their number and percentage, and quantitative variables by their mean and standard deviation. Comparisons between groups were made using Chi2 tests for qualitative variables and Student's t tests and ANOVA for quantitative variables. The linear regression model was used to explore the associations between the dependent variable and the independent variables. For the linear regression model, the dependent variable used was the sexual function score of the elderly, and the independent variables were, in addition to the total score of the Leipad test, the socio-demographic and health variables retained in our study. The significance level was set at 5%.

Results

Socio-demographic and socio-sanitary characteristics

The socio-demographic and socio-health characteristics of the subjects studied are given in table 1. Our sample included a total of 354 people aged 65 and over living at home, 197 of whom were men (55.6%) and 157 women (44.4%). The subjects' ages ranged from 65 to 95, with an

Table 1: Socio-demographic and socio-sanitary characteristics of the subjects studied and sexual functioning scores from the Leipad test

Characteristics		**n**	**%**	**Average SF score**	**Test t or F**
Genre	Men	197	55.6	78 ± 19.3	7.01 ***
	Women	157	44,4	91.4 ± 15.7	
Age groups	65-74 ans	241	68.1	82.2 ± 19.6	4.7**
	75-84 ans	79	22.3	85,9 ± 17.9	
	>=85 ans	34	9.6	92.2 ± 14.4	
Place of residence	Urban	164	46.3	86.6 ± 18.2	2.4*
	Rural	190	53.7	81.6 ± 19.5	
Marital status	Married	214	60.5	75.3 ± 18.7	12.7***
	Unmarried	140	39.5	97.1 ± 9.9	
Literacy	Yes	70	19.8	82.8 ± 20.8	0.5 ns
	No	284	80.2	84.2 ± 18.6	
Socio-professional activity	No profession	121	34.2	91,5 ± 15.9	15.5***
	Retirees	155	43.8	79.9 ± 19.2	
	Assets	78	22.0	80.3 ± 20.1	
Financial difficulties	Yes	174	49.2	87.8 ± 17.5	3.8**
	No	180	50.8	80.2 ± 19.7	
Homeowner	Yes	310	87.6	82.5 ± 19.4	3.6***
	No	44	12.4	93.6 ± 13.1	
Cohabitation	Solitaire	36	10.2	97.2 ± 8.5	4.5***
	With the family	318	89.8	82.4 ± 19.3	
Morbidity	Yes	204	57.6	85.2 ± 18.8	1.5 ns
	No	150	42.4	82.2 ± 19.2	
Subjective health	Good	243	68.6	80.5 ± 19.4	5.3***
	Wrong	111	31.4	91.6 ± 16.2	
Medical cover	Yes	269	76	83.8 ± 19.3	0.3 ns
	No	85	24	84.5 ± 18.5	

*ns: not significant; *p<0.05; **p<0.01; ***p<0.001*

average of 72.8 years (standard deviation=6.9 years). The 65-74 age group was the most represented (68.1%), followed by 75-84 (22.3%) and 85 and over (9.6%). As for marital status, 60.5% of participants were living with a partner at the time of the survey, 7.6% were single, 1.4% were divorced and 30.5% were widowed. Most (92.4%) of the subjects interviewed had children, 74.3% of whom had at least one child living with them. More than half (53.7%) lived in rural areas and 46.3% in urban areas. At the time of the survey, 87.6% of participants owned their own home, and most (89.8%) lived with their family. In terms of level of education, 80.2% were illiterate, 10.7% had primary education and 9.1% secondary education or more. With regard to socio-professional activities, 22.0% of participants were working at the time of the survey, 43.8% were retired, while 34.2% had never had a socio-professional activity. Among the retired, only 19.5% reported receiving a retirement pension. At the time of the survey, 76.8% of respondents said they were receiving financial assistance from family members (sons, daughters, relatives). Although this proportion is significant, almost half (49.2%) of the subjects were suffering from financial difficulties. In terms of health status, 57.6% of respondents said they were suffering from at least one chronic disease at the time of the survey, including 20.1% and 2.8% with 2 and 3 or more diseases respectively. Hypertension and diabetes were the chronic conditions most frequently reported by respondents, with proportions of 37.6% and 29.6% respectively. All of these chronic conditions were medically diagnosed. In addition, 68.6% of participants said they felt in good health, including 2.5% in very good health, and 31.4% in poor health, including 3.1% in very poor health. Lastly, 76.0% of those surveyed had basic medical cover, including 53.7% under the RAMED (Régime d'Assistance Médicale aux Economiques Démunis) scheme, which provides health insurance for people living in poverty and vulnerability in Morocco.

Sexuality and quality of life

Participants' Leipad scores ranged from 9.7 to 93.5, with a mean of 29.4 (σ =11.2). Cronbach's alpha

value was 0.90. The highest score indicating an alteration in quality of life was noted for the SF dimension (83.9±19). In fact, 57.1% of the participants were not sexually active (item 25 of the Leipad test) and 57.3% stated that they were not interested in sex at the time of the survey (item 24 of the Leipad test). To study the effect of sexual functioning on the quality of life of the group studied, we used a simple linear regression model. The dependent variable was the "total score on the Leipad test", while the explanatory variable was the "sexual functioning score on the Leipad test". The results of this analysis show that the participants' quality of life was closely linked to their sexual quality of life (t= 24.42; p<0.001).

The results of the relationship between the mean scores for the sexual functioning dimension of the Leipad test and the socio-demographic and socio-health characteristics of the subjects studied are also presented in Table 1. These results show that sexual quality of life appears to be related, in order of importance, to socio-professional activity, gender, marital status, subjective health, age, cohabitation, financial difficulties, home ownership and place of residence. The highest average scores, reflecting poor quality of sexual life, were recorded by people who had not engaged in any professional activity, women, unmarried people, those who reported poor health, older people, people living alone, people with financial difficulties, people who did not own their own home, and people living in urban areas.

Table 2: Multiple linear regression model of the score for the sexual functioning dimension of the Leipad test and the socio-demographic and socio-health characteristics of the group studied

	A	t
Genre	5.4	2.3*
Age groups	1.5	1.6
Marital status nial	15.8	7.5***
Place of residence	-1.3	0.7
Literacy	3.1	1.4
Socio-professional activity	0.6	0.4
Homeowner	1.6	0.6
Cohabitation	-6.08	2.1*
Financial difficulties	-4.8	2.8**
Morbidity	-1.8	1.1
Subjective health	5.7	2 .9**
Medical cover	2.5	0.2

**p<0.05 ; **p<0.01 ; ***p<0.001*

In order to measure the weight of each of these characteristics on the dependent variable 'score for the sexual functioning dimension', we used the multiple linear regression model (Table 2). In order of importance, the sexual quality of life of the group studied was statistically associated with marital status, subjective health, the existence of financial difficulties, gender and lifestyle (cohabitation). Unmarried people, those reporting poor health, those with financial difficulties, women and those living alone had a relatively poorer quality of sexual life.

Discussion

The study included 354 people aged 65 and over. Men were more represented in our sample, at 55.6%. The average age of the subjects surveyed was 72.8 years, with a predominance of the 65-74 age group (68.1%). The majority of participants lived in rural areas (53.7%). More than half of our sample (60.5%) were married at the time of the survey and 30.5% were widowed, with a higher proportion of widowed women (46.5% compared with 8.6% of men), while the proportion of married men was much higher than that of women (80.6% compared with 44.8% respectively). In our sample, 89.8% of the people studied lived with their family, 75.6% of whom lived with a large family (children, grandchildren, brothers, etc.). This proportion is relatively close to that recorded nationally in 2015[11], which was 96%.

In terms of health, self-assessment is a key indicator of the general health of individuals, in terms of both physical and mental health[12], with 68.6% of the elderly people studied declaring themselves to be in good health. This proportion clearly exceeds the values (between 44.5% and 55.6%) reported by previous studies conducted in different regions of Morocco[13,14] and corroborates that of a study conducted in the province of Essaouira, the location of our study (75.5%)[15]. This positive self-assessment of health could be explained by the constitutionalisation of the right of access to healthcare in Morocco in 2011 and the introduction of RAMED medical cover in 2012. As for chronic illnesses, 57.6% of participants said they had at least one diagnosed chronic illness, with women more affected than men (60.9% versus 50.2%). The 2018 National Survey on Population

and Family Health revealed an increase in the proportion of chronic diseases as age increases from the age of 60. According to the same source, 64.4% of Moroccans aged 60 and over suffer from at least one chronic disease, including 20% of diabetics and 34% of hypertensives[16]. Our results also showed that these two diseases were the most common among the elderly in our sample, with prevalence rates of 29.6% and 37.6% respectively. Comorbidity was found in 22.9% of our sample, which corroborates the results of the ENPA national survey of elderly people (15.4% of people aged 60 and over have 2 diseases, 7.1% have 3 diseases and 5.5% have 4 or more diseases)[17].

Medical cover, for its part, is an important determinant of the population's access to care and the reduction of health costs, and is also a factor affecting the use of health services by the elderly. The results of our study showed that 76% of elderly people had basic medical cover, 53.7% of whom were covered by RAMED. This proportion is almost identical to that reported by the Ministry of Health and Social Protection, which indicated that 52% of people aged 60 and over are covered by this social security system[16].

The mean score of the Leipad test calculated was 29.4 (0= best quality of life; 100= worst quality of life), qualifying the quality of life of the people surveyed as satisfactory. As in several previous studies, sexual functioning was most implicated in poor quality of life in our study, with a score of 83.9 (the scores for the other dimensions ranged from 14.4 to 40.5). The SF score of the Leipad test calculated was 67.7 in France[18] and 98 in Tunisia[2].

In addition to the factors that are supposed to have an influence on the sex life of the elderly, such as reproductive ageing, the menopause, hormonal deficiency, chronic illnesses and their treatments (hypertension, diabetes) and psychosocial factors[19], sexuality is still a taboo subject in the Moroccan cultural context[8].

According to the World Health Organisation, sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors[4]. In our study, there was a clear association between the SF score and the socio-demographic and health characteristics of the group studied. Our results indicate that the sexual functioning of women appears to be more impaired than that of men. The mean SF scores were 78 in men and 91.4 in women. This could be explained mainly by age-related physiological changes in women in general and the marital status of our sample in particular. Of the 140 unmarried participants in our sample, 70.7% were women. The proportion of widowed women was higher (46.5% compared with 8.6% of men), while the proportion of married men was much higher than that of women (80.6% compared with 44.8% respectively). It should be noted that in Morocco, men are more likely to remarry after the death of their wife than women[8]. Furthermore, sexuality is culturally more centred on men; women are more conservative and passive in terms of sexuality in the Moroccan context.

Several previous studies[8,21,22] have indicated the negative impact of advanced age on quality of life in general and sexual quality of life in particular. Our study showed that the mean SF score of the Leipad test in our sample rose from 82.2 for the 65-74 age group to 92.2 for the 85 and over age group, reflecting a deterioration in SF with advancing age.

Our results also showed that people living in rural areas had a better average SF score than those living in urban areas. This could be explained by the urban lifestyle affecting psychological well-being. Psychological disorders have been indicated as a major determinant of sexuality in elderly subjects[23,24].

Employment with a stable and sufficient income has a positive influence on an individual's quality of life by enabling them to meet their daily needs and also facilitates access to social and health services[8], and enables older people to maintain their self-esteem[25]. Following the example of several previous studies[26-28], our results showed that participants with no professional activities and those who reported financial difficulties had higher mean scores on the SF, thus reflecting a deterioration in the sexual dimension of quality of life.

In Morocco, owning a home is a priority for the elderly, who spend a larger proportion of their income on it[29]. Indeed, the home in which elderly people live seems to represent a protective shell for them[22]. This variable influences the sexuality of our sample. Subjects who did not own their own home had a higher mean MSDS score (93.6) than those who did (82.5). In addition,

loneliness has a negative impact on quality of life30 and the absence of a spouse has a negative impact on the sex life of elderly people[27]. Our study revealed an association between this variable and SF. People living alone, without a spouse or family, had an average SF score in the Leipad test close to 100 (97.2), indicating a worse quality of life in this respect.

Several studies have highlighted the effect of deteriorating health on quality of life[2,31]. Self-rated health is a good indicator of an individual's physical and mental well-being[32]. In our sample, subjective health status had an effect on sexual functioning. Older people who felt in good health had a lower mean score on the SF dimension (80.5±19.4) (reflecting a better quality of life) than those who felt in poor health (91.6±16.2).

Conclusion

Sexuality is still a taboo subject in Morocco. This study has shown that sexual functioning is a major determinant of the quality of life of the elderly in Morocco. It is therefore important to think about an integrated strategy, involving all those involved in gerontological and social action, to promote the sexual health of elderly Moroccans and enable them to 'age in good health'. It is also important to speed up the process of generalising social protection, which has just been launched in Morocco, to strengthen the care system with medico-social establishments to care for the elderly and to integrate sexual health into public health programmes.

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