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## Female sexual function and urinary incontinence

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### Citation

Bekker, M. D. (2011, March 31). *Female sexual function and urinary incontinence*. Retrieved from <https://hdl.handle.net/1887/16684>

Version: Corrected Publisher's Version

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Downloaded from: <https://hdl.handle.net/1887/16684>

**Note:** To cite this publication please use the final published version (if applicable).

# Chapter 7

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## **How do continence nurses address sexual function and a history of sexual abuse in daily practice?**

(J Sex Med 2010;7:1464-1468)

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## Introduction

Sexual function (SF) involves a complex interaction of emotions, body image and intact physical responses. Urinary incontinence may have a negative impact on various aspects of SF. In females, several studies have demonstrated a strong association between pelvic floor disorders, lower urinary tract symptoms, overactive bladder with or without urinary incontinence, and sexual dysfunction (1-7). In fact, sexual dysfunction is a common, underestimated, and untreated complaint in women with urologic disorders while treatments such as pelvic floor rehabilitation for urinary incontinence may improve SF (8;9). Furthermore, besides the possible negative impact of vaginal/pelvic surgery on SF, incontinence following vulvar, cervical, or surveillance for bladder cancer has a negative impact on female SF (10-13).

In males, urinary incontinence following prostate surgery is a problem with regard to SF. The incidence of incontinence varies from one percent after transurethral resection to twenty-five percent after radical prostatectomy (14). However, overall, erectile dysfunction and premature ejaculation are the most common problems in males (15-17).

In general, males and females who seek urological care will be at relatively high risk of having problems with SF. In our view, care providers should be properly aware of possible co-existing sexual problems.

Several authors have reported a correlation between urinary tract symptoms and a history of sexual abuse (SA) in adults (18-23). This correlation meets several criteria suggesting a causal relationship (21). In treating patients with urinary symptoms, care providers should also consider the possible involvement of SA. In practice, questions about SF and possible SA in the past are not part of routine history taking, even though clinicians believe knowledge about any incidence of SF or SA may contribute to the success of their treatments (24-26).

Currently, an increasing number of Dutch hospitals have assigned nurse practitioners and physician assistants with various levels of competence and experience to take over certain aspects of patient care. Within their areas of competency, and with appropriate training and supervision, they can provide medical care similar in quality to that of physicians. In the Netherlands, many urologists work closely with certified and registered continence nurses. They have advanced knowledge and skills regarding bladder dysfunction, incontinence, bladder catheterization, patient education and preventive care. These nurses play an important role in helping patients to understand and manage their urinary incontinence and to improve their quality of life.

Currently, such nurses use a patient-centered model and do not focus primarily on illness management (cure). Within such a model, nursing practice should also involve the assessment of sexual health issues (27-29). Research has confirmed the importance of nurses considering the monitoring and managing of common post-operative effects such as erectile dysfunction in men after prostatectomy (30;31).

Since continence nurses are involved in assessing sexual problems, respondents were asked about their perception of sexuality. The purpose of this survey was to investigate whether Dutch continence nurses address patients' SF and SA, to delineate perceived barriers to performing this assessment and to document current attitudes towards these issues.

## Methods

At the Astra Tech Congress for Continence Nursing (The Hague, the Netherlands, November 13<sup>th</sup>, 2009), all participating nurses were asked to complete a 19-item questionnaire. This questionnaire (appendix) was designed by the urologist/sexologist at our clinic (H.W.E). It addressed SF-related practices at outpatient clinic visits, attitudes, beliefs and overall impressions of male and female sexual functioning (SF), including sexual abuse (SA).

Demographic data included type of practice, patient population, gender and age. The survey was accompanied by a cover letter explaining the objectives of the study. All data were collected anonymously.

The Medical Ethics Committee was consulted before starting this study to verify whether ethical approval was necessary. As the study did not concern any information recorded by the investigator in such a manner that subjects can be identified, directly or through identifiers linked to the subjects, and it did not involve any compromise of the study participants' integrity, the Committee declared that no formal ethical approval was needed. Furthermore, they waived the requirement to obtain a signed consent form for all subjects.

## Statistical analysis

We analyzed the data using SPSS release 17 (SPSS Inc., Chicago, IL, USA). Comparisons between proportions were made using the chi-square test. Continuous variables were compared using the student's *t*-test. *P*-values < 0.05 were considered statistically significant.

## Results

At the annual congress, all 190 attending nurses were asked to participate in this study. A total of 93 nurses completed the questionnaire (response rate 48.9%). All surveys returned were complete, i.e. more than 80% of all applicable questions were answered. The majority of the nurses surveyed (85.9%) worked in a district general hospital, 5.4% in a university hospital and the remaining 8.7% in rehabilitation centers. Their mean age was 47 years, with a standard deviation of 8. In line with the male/female ratio in Dutch continence nursing, there were more female (96.7%) than male (3.3%) respondents. For more than half the respondents (57.3%), the male/female ratio within their patient populations was evenly divided.

### Female sexual function

One of the primary goals of our survey was to assess whether Dutch continence nurses address patients' SF as part of history taking. Of the respondents, 11.8% never asked female patients about SF; 37.6% asked only rarely; 44.1% asked often and 6.5% always asked about SF (Table 1). Nearly half the respondents who screened rarely or not at all (n=46) stated they had insufficient knowledge about SF to ask appropriately about this issue (47.8%). A minority (n=8) differentiated possible questions about SF based on the patient's age and the type of surgery they had undergone.

**Table 1** Asking about female sexual function

|   |      |       |
|---|------|-------|
| How frequently do you ask your female patients about sexual function?           | n=93 |       |
| Never   | 11   | 11.8% |
| Rarely  | 35   | 37.6% |
| Often   | 41   | 44.1% |
| Always  | 6    | 6.5%  |
| Reasons not to ask (or to ask rarely) about sexual function:                    | n=46 |       |
| I have insufficient knowledge about how to ask adequately about sexual function | 22   | 47.8% |
| I assume the urologist has asked about it                                       | 18   | 39.1% |
| I find the subject difficult to bring up  | 13   | 28.3% |
| If there is a problem, I have insufficient knowledge of therapeutic options     | 8    | 17.4% |
| I do not have enough time   | 5    | 10.9% |
| I know the urologist asks about it  | 1    | 2.2%  |
| Other, namely   | 8    | 17.4% |
| How do you ask about sexual function?   | n=47 |       |
| I ask 1 or 2 questions about:   |      |       |
| Incontinence during sexual activity   | 44   | 93.6% |
| Sexual activity   | 29   | 61.7% |
| Dyspareunia   | 28   | 59.6% |
| Incontinence during orgasm  | 6    | 12.8% |
| Libido  | 5    | 10.6% |
| Arousal/lubrication   | 5    | 10.6% |
| Orgasm  | 1    | 2.1%  |
| I ask other questions, namely..   | 2    | 4.2%  |

The 47 respondents who asked their female patients often or always about SF focused their questions on incontinence during sexual activity (93.6 %), sexual activity itself (61.7 %) and dyspareunia (59.6 %). Two respondents explained that they asked their patients open-ended questions to explore whether they were willing to discuss sexual issues.

### Male sexual function

Of the respondents, 13.2% never asked their male patients about SF, 46.2% only rarely, 36.3% often and 4.3% always (Table 2). Of the nurses who never or only rarely asked patients about SF (nearly 50% of the total), the majority either assumed the urologist had already done so (48.1%) or felt they had insufficient knowledge of how to ask appropriately about SF (38.9%). Of the 14

**Table 2** Asking about male sexual function

| How frequently do you ask your male patients about sexual function?             | n=91<br>(2 missing) |       |
|---|---------------------|-------|
| Never   | 12                  | 13.2% |
| Rarely  | 42                  | 46.2% |
| Often   | 33                  | 36.3% |
| Always  | 4                   | 4.3%  |
| Reasons not to ask (or to ask rarely) about sexual function:                    | n=54                |       |
| I assume the urologist has asked about it                                       | 26                  | 48.1% |
| I have insufficient knowledge about how to ask adequately about sexual function | 21                  | 38.9% |
| I find the subject difficult to bring up  | 13                  | 24.1% |
| If there is a problem, I have insufficient knowledge of therapeutic options     | 6                   | 11.1% |
| I do not have enough time   | 4                   | 7.4%  |
| Other   | 14                  | 25.9% |
| How do you ask about sexual function?   | n=37                |       |
| I ask 1 or 2 questions about:   |                     |       |
| Erectile dysfunction  | 32                  | 86.5% |
| Sexual activity   | 25                  | 67.6% |
| Ejaculation   | 13                  | 35.1% |
| Incontinence during sexual activity   | 17                  | 45.9% |
| Libido  | 7                   | 18.9% |
| Incontinence during orgasm  | 5                   | 13.5% |

respondents who responded 'other', 6 stated that they were confident the urologist had already addressed SF. Others reported that in their daily practice asking about SF depended on specific patient characteristics such as age and the type of surgery the patient had undergone.

The 37 respondents who often or always asked about male SF focused on erectile dysfunction (86.5%), sexual activity itself (67.6%) and incontinence during sexual activity (45.9%).

### Sexual Abuse

Of the respondents, 28% never asked their patients about SA, 49.5% asked only rarely, 19.4% stated that they asked 'often' and 3.2% 'always'. The arguments given by the 72 respondents as to why they never asked or asked only rarely are summarized in Table 6 with "insufficient knowledge about how to appropriately ask about SA" being mentioned most frequently (41.7%). Other respondents (22.2%) indicated that specific nonverbal signals from the patients (e.g., poor eye contact, fidgeting, soft voice, or reluctance to speak about the topic) prompted them to ask about SA (Table 3).

### Attitudes/beliefs

Screening for sexual dysfunction was considered to be 'quite important' to 'very important' by the majority of nurses (65.2% and 31.5%). Not all respondents indicated that they believed screening for a history of SA to be important; 11.1% regarded screening for SA as 'somewhat important' and one respondent did not find it important at all. Education on sexual issues was considered to be 'quite important' to 'very important' by the majority of nurses (45.2% and 53.8%).

These opinions on SF and SA were given in the context of asking about sexuality and abuse (Table 4). Although asking about SF in general was stated to be (34 'quite' and 8 'very') important, these 42 nurses did not ask or only rarely asked about female SF. ( $p=0.04$ ) The same

**Table 3** Asking about a history of sexual abuse

| How frequently do you ask your patients about sexual abuse?                               | n=93 |       |
|---|------|-------|
| Never   | 26   | 28%   |
| Rarely  | 46   | 49.5% |
| Often   | 18   | 19.4% |
| Always  | 3    | 3.2%  |
| Reasons not to ask (or to ask rarely) about a history of sexual abuse:                    | n=72 |       |
| I have insufficient knowledge about how to ask adequately about a history of sexual abuse | 30   | 41.7% |
| I find the subject difficult to bring up  | 16   | 22.2% |
| I assume the urologist has asked about it   | 14   | 19.4% |
| If there is a problem, I have insufficient knowledge of therapeutic options               | 8    | 11.1% |
| I do not think it is important in a urological practice                                   | 6    | 8.3%  |
| I do not have enough time   | 4    | 5.6%  |
| Other   | 16   | 22.2% |

**Table 4** Asking about and opinion on sexual function and sexual abuse

| How important is it to screen patients for sexual dysfunction?<br>(n=92, 1 missing)        |        |                |                 |                    |               |       | P Value |
|--|--------|----------------|-----------------|--------------------|---------------|-------|---------|
|  |        | Very important | Quite important | Somewhat important | Not important | Total |         |
| How frequently do you ask your <b>female</b> patients about sexual function?               | Never  |                |                 |                    |               |       | 0.040*  |
|  | Rarely | 8              | 34              | 3                  | 0             | 45    |         |
|  | Often  | 21             | 26              | 0                  | 0             | 47    |         |
|  | Always |                |                 |                    |               |       |         |
|  | Total  | 29             | 60              | 3                  | 0             | 92    |         |
| How important is it to screen patients about sexual dysfunction?<br>(n=90, 3 missing)      |        |                |                 |                    |               |       | P Value |
|  |        | Very important | Quite important | Somewhat important | Not important | Total |         |
| How frequently do you ask your <b>male</b> patients about sexual function?                 | Never  |                |                 |                    |               |       | 0.042*  |
|  | Rarely | 10             | 40              | 3                  | 0             | 53    |         |
|  | Often  | 18             | 19              | 0                  | 0             | 37    |         |
|  | Always |                |                 |                    |               |       |         |
|  | Total  | 28             | 59              | 3                  | 0             | 90    |         |
| How important is it to screen patients for a history of sexual abuse?<br>(n=90, 3 missing) |        |                |                 |                    |               |       | P Value |
|  |        | Very important | Quite important | Somewhat important | Not important | Total |         |
| How frequently do you ask your patients about sexual abuse?                                | Never  |                |                 |                    |               |       | 0.006   |
|  | Rarely | 16             | 42              | 10                 | 1             | 69    |         |
|  | Often  | 14             | 7               | 0                  | 0             | 21    |         |
|  | Always |                |                 |                    |               |       |         |
|  | Total  | 30             | 49              | 10                 | 1             | 90    |         |

\* Statistically significant, chi square test

**Table 5** Age of respondents and reasons not to ask.

| Reasons not to ask about <b>female</b> sexual function:                            |       | Age (years) |      |       | P value |
|--|-------|-------------|------|-------|---------|
|  |       | < = 40      | > 40 | Total |         |
| <i>I find it difficult to bring up</i>   | Yes   | 8           | 6    | 14    | 0.003*  |
|  | No    | 13          | 65   | 78    |         |
|  | Total | 21          | 71   | 92    |         |
| <i>If there is a problem, I have insufficient knowledge of therapeutic options</i> | Yes   | 7           | 2    | 9     | 0.000*  |
|  | No    | 14          | 69   | 83    |         |
|  | Total | 21          | 71   | 92    |         |
| Reasons not to ask about <b>male</b> sexual function:                              |       | Age (years) |      |       | P value |
|  |       | < = 40      | > 40 | Total |         |
| <i>I find it difficult to bring up</i>   | Yes   | 8           | 5    | 13    | 0.001*  |
|  | No    | 13          | 66   | 79    |         |
|  | Total | 21          | 71   | 92    |         |
| <i>If there is a problem, I have insufficient knowledge of therapeutic options</i> | Yes   | 4           | 2    | 6     | 0.023*  |
|  | No    | 17          | 69   | 86    |         |
|  | Total | 21          | 71   | 92    |         |

\* Statistically significant, chi square test

applied for male SF; 50 nurses either did not ask at all or asked only rarely about male SF, even though they stated that it was important to ask about this issue (40 'quite important' and 10 'very important'). ( $p=0.042$ ) Fifty-eight nurses asked only rarely or never asked at all about SA, although they considered it important (42 'quite important' and 16 'very important'). ( $p=0.006$ )

Compared to their older and probably more experienced colleagues, nurses younger than 40 years of age experienced more difficulties in raising the subject of both male and female SF ( $p=0.001$  and  $p=0.003$  respectively). Furthermore, they more often indicated having insufficient knowledge about therapeutic options for both male and female sexual problems ( $p=0.023$  and  $p=0.000$  respectively) (Table 5).

## Discussion

The present study evaluates the beliefs, attitudes and practices of Dutch urological continence nurses towards SF and SA in their patient populations. Although they acknowledge the importance of SF, about half the continence nurses do not ask about this issue. Important barriers are insufficient knowledge both about how to address sexual problems and about possible therapeutic options. Furthermore, continence nurses often assumed that other health care providers are responsible for addressing sexual issues, a premise that has been confirmed in previous studies (32-35).

Physicians, including urologists, do not consistently ask about sexual function and admitted not being sufficiently competent in dealing with either male or female sexual dysfunction (24;36-38). This may indicate that a urological patient is given no opportunity to openly discuss

possible sexual problems. It is, therefore, important that urologists and attending nurses agree on who is responsible for addressing sexual health. Only 6 of the 93 respondents indicated that this was properly discussed within their practices. This miscommunication between different health care providers on who is responsible for discussing sexual issues has been detected in previous studies (10;39). Furthermore, evaluation from a patient's point of view showed that most patients thought discussing sexual concerns with nurses was appropriate, and all subjects thought that physicians should discuss sexual concerns with clients (40;41). Physicians and nurses have to be on the same page in addressing sexual functioning in urological clinics, particularly when sexual dysfunction is a known side effect of the treatment/surgery being undertaken by the patient (male or female).

Most nurses asked their female patients about urinary incontinence during sexual activity (93.6%), whereas others asked about sexual activity in general (61.7%) and dyspareunia (59.6%). Male patients were asked about erectile dysfunction (86.5%), as this condition is known to be prevalent among elderly men. Although we used a non-validated questionnaire with dichotomic answers, we still have insufficient information about the extent to which nurses include emotional factors and discuss the psychological distress of sexual problems and/or the impact on the patient's sexual life, intimate relationships, and/or overall quality of life.

This study has a number of limitations. The first of these is the use of a non-validated questionnaire. First, the study used a survey questionnaire for which content validity and reliability were not previously established. Hence, the reliability of the results must be interpreted in light of this limitation. Unfortunately, validated instruments that evaluate nurses' practices and beliefs do not exist. However, the questionnaire used in this study was able to achieve the objectives of the study. Future research should be performed using validated instruments to confirm the results of this survey. As in all questionnaire studies, there is the risk of a bias in reporting, as the respondents may overestimate the frequency of asking about SF and SA. We attempted to reduce this potential bias by making the survey anonymous. Furthermore, no account was taken of socio-cultural factors relating to either the patients or the nurses. These factors can also play an important role in the assessment of sexual problems.

The response rate of 48.9% can be explained by the active recruitment at the Continence Nursing congress. Nearly all Dutch continence nurses attended this congress, so the sample can probably be considered representative for the total population of nurses educated in and certified for continence nursing. However, this does not apply to nurses in general.

The results demonstrate that demographic characteristics may influence nurses' willingness to ask about SF. Younger nurses more often experienced difficulties in bringing up sexual problems, and attributed this in part to their lack of knowledge about therapeutic possibilities. Both young and older nurses have received the same educational program, so age may be related to length of clinical experience within urological care or general life experiences. Another factor might be fear of stereotyping. Research among nurses has revealed that nurses' reluctance to ask about sexual issues is partially influenced by the public image of young nurses being seen as a sex object (28).

Although SF and SA are thought to be important issues about which to ask, urological nurses do not ask about it or ask about it only rarely. This is contradictory and may, as such, be due to the lack of awareness, education and training. Nurses may want to ask about SF but do not know how. Some intrinsic and extrinsic factors may explain the discrepancy between not asking about sexual function and yet finding it important. A study among Greek nurses highlights some intrinsic factors such as gender and age differences between nurse and patient (35). Both nurse and patient may be uncomfortable with starting a discussion on sexuality because of these differences. Other intrinsic factors are personality characteristics and familiarity between nurse and patient. Work load, lack of time and privacy are other possible extrinsic factors mentioned by the nurses as influencing whether or not sexual issues are raised. Apart from these factors, lack of knowledge was recognized and the need was stressed for education in both (patho)physiological issues and communication skills (35).

Currently, sexual health care is included in the training program of Dutch continence nurses. After two lectures on urinary incontinence and SF, another two hours are spent on learning how to talk about sex. Apparently this education program is insufficient. Some nurses may interpret sexuality rather narrowly as related to sex and sexual relations and may, therefore, not be aware of the wider considerations that need to be made in relation to the general and sexual quality of life when caring for people suffering from urological diseases. Continence nurses, in particular, who are responsible for the management of medical aids and appliances for urinary complaints (i.e. pads/catheters), should also be aware of the fact that these aids can have a negative impact on individuals' sexual and emotional well-being. In addition, the education program should recognize the nurses' personal reasons for their reluctance to talk about sexuality. Nurses should be encouraged to examine their own attitudes, to gain insight into their own behavior and to develop skills that will enable them to learn to avoid potential pitfalls. Furthermore, they should be informed that questionnaires, such as the PeIFs and the Golombok Rust Inventory for Sexual Satisfaction, have been proven to be effective tools in detecting sexual problems and a history of SA (42-45). The use of these structured tools can be helpful in arriving at an assessment, especially for those who have specific difficulties with asking about sexual difficulties and abuse.

## Conclusion

In urological care, the issues of sexual function and sexual abuse are important, but they are often difficult to discuss, and apparently many Dutch incontinence nurses consider themselves unable to talk about these issues, or feel uncomfortable doing so. However, it is important for urological patients to have an adviser who has enough time and knowledge to listen to them, and who understands their feelings and worries about sexual function. Accordingly, continence nurses should be able to understand and deal with patients' concerns, give them information

and, if necessary, refer them to a qualified sex therapist for further support, advice and treatment. In addition, more extensive education on sexual care should be implemented in the training program of continence nurses.

**Acknowledgements**

This study was initiated by the Pelvic Floor & Sexuality Research Group Leiden. We wish to thank Astratech Benelux BV, for supporting this study by providing their annual congress as a research setting.

## Appendix

### I. Female sexual function

1. How often do you ask your female patients about sexual function?  
Never  -> continue with question 2  
Rarely  -> continue with question 2  
Often  -> continue with question 3  
Always  -> continue with question 3
2. You ask your female patients never or rarely about sexual function. What are your reasons for not asking? (Multiple answers possible)  
I do not think it is important in a urological practice   
I do not have enough time   
I find the subject difficult to bring up   
I assume the urologist has asked about it   
I have insufficient knowledge about how to ask appropriately about sexual function   
If there is a problem, I have insufficient knowledge of therapeutic options   
I know the urologist asks about it   
Other, \_\_\_\_\_
3. You ask your female patients often or always about sexual function. How do you ask about sexual function? (Multiple answers possible) I ask 1 or 2 questions about;  
Sexual activity   
Incontinence during sexual activity   
Incontinence during orgasm   
Dyspareunia   
Libido   
Arousal/lubrication   
Orgasm   
I ask other questions, namely, \_\_\_\_\_
4. What percentage of your female patients do you believe experience sexual dysfunction? (Please give a percentage) \_\_\_\_\_%

### II. Male sexual function

5. How often do you ask your male patients about sexual function?  
Never  -> continue with question 6  
Rarely  -> continue with question 6  
Often  -> continue with question 7  
Always  -> continue with question 7

6. You ask your male patients never or rarely about sexual function. What are your reasons for not asking? (Multiple answers possible)
- I do not think it is important in a urological practice
- I do not have enough time
- I find the subject difficult to bring up
- I assume the urologist has asked about it
- I have insufficient knowledge about how to ask appropriately about sexual function
- If there is a problem, I have insufficient knowledge of therapeutic options
- I know the urologist asks about it
- Other, \_\_\_\_\_
7. You ask your male patients often or always about sexual function. How do you ask about sexual function? (Multiple answers possible) I ask 1 or 2 questions about;
- Sexual activity
- Incontinence during sexual activity
- Incontinence during orgasm
- Erectile dysfunction
- Libido
- Ejaculation
- I ask other questions, namely, \_\_\_\_\_
8. What percentage of your male patients do you believe experience sexual dysfunction? (Please give a percentage) \_\_\_\_\_%

### III. Sexual abuse:

9. How often do you ask your patients about a history of sexual abuse?
- Never  -> continue with question 6
- Rarely  -> continue with question 6
- Often  -> continue with question 7
- Always  -> continue with question 7
10. You ask your patients never or rarely about a history of sexual abuse. What are your reasons for not asking? (Multiple answers possible)
- I do not think it is important in a urological practice
- I do not have enough time
- I find the subject difficult to bring up
- I assume the urologist has asked about it
- I have insufficient knowledge about how to ask appropriately about sexual function
- If there is a problem, I have insufficient knowledge of therapeutic options
- I know the urologist asks about it
- Other, \_\_\_\_\_

11. You ask your patients often or always about a history of sexual abuse. What are your reasons for not asking:

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**IV. Opinion**

12. How important is it to screen patients for sexual dysfunction?

Not important

Somewhat important

Quite important

Very important

13. How important is it to screen patients for a history of sexual abuse?

Not important

Somewhat important

Quite important

Very important

14. How important is it for you to be educated on sexological issues?

Not important

Somewhat important

Quite important

Very important

**V. Demographics**

15. What is your age? \_\_\_\_\_ Years

16. What is your gender? Male

Female

17. Where do you work? Academic hospital

District general hospital

Rehabilitation institution

18. Your patient population consists of \_\_\_\_\_% men

\_\_\_\_\_ % women

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