

Urinary incontinence in Moroccan and Turkish women: a qualitative study on impact and preferences for treatment

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ABSTRACT

Aim

To gain insight into the impact of urinary incontinence on the daily lives of Moroccan and Turkish women and their preferences for treatment.

Design of study

A qualitative analysis of data from semi-structured in depth interviews with 30 Moroccan and Turkish migrant women with urinary incontinence.

Setting

Six general practices with large numbers of immigrant families in four cities in the Netherlands.

Method

Semi-structured in depth interviews were conducted with Moroccan and Turkish migrant women, who presented with complaints of urinary incontinence in six general practices with large numbers of immigrant families on the practice list in four different cities in the Netherlands.

Results

All the women adhered closely to bodily cleanliness and considered incontinence to be dirty. As Muslims, they were obliged to perform ritual prayers preceded by ablution five times per day and the urinary incontinence breached their status of ritual purity. Therefore, they had to wash more often and experienced this as a heavy burden. In a number of the women, shame formed a reason why they could not talk to anybody about the incontinence, not even with the doctor. One-third of the women felt that their GP had not taken them seriously. Knowledge about anatomy, physiology and available treatments was mostly lacking. In addition, the women did not understand the aim of the exercises from the physiotherapist. The majority of women gave preference to help from a female doctor.

Conclusion

Urinary incontinence in Moroccan and Turkish migrant women formed a considerable problem in their daily following of the Islam faith. Shame on the part of the patient and miscommunication at the doctor's surgery led to inadequate care.

Keywords

Islam; migrants; patient preference; quality of life; urinary incontinence; women.

INTRODUCTION

Urinary incontinence is a common problem in women: daily involuntary urine loss occurs in 7% of women younger than 65 years and the percentage increases with age to 14% in elderly women who are still living independently at home.¹ Incontinence can lead to decreased physical and psychological well-being and to social problems. The experienced emotional consequences and physical limitations vary between people,² with not all patients seeking help.^{3,4}

The population of older Muslim immigrants is growing in the Netherlands, as in other European countries. In the Netherlands the largest groups are Turkish and Moroccan immigrants.⁵ Very few Muslim women consult their GP because of incontinence.⁶⁻⁸ Ageing of the population of immigrants can be expected to lead to more cases of urinary incontinence. Their perception of incontinence, the consequences on their daily lives and their expectations about medical help have not been studied previously. From studies on Muslim women and migrants in general, we can surmise that they will be more ashamed of incontinence, suffer different consequences in their daily lives and have to overcome more barriers to seek and accept help than indigenous western European women.⁶⁻⁸

Insight into the perceptions and care needs of these women is necessary for adequate and tailored

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Submitted: 9 March 2006; **Editor's response:** 25 May 2006;
final acceptance: 30 June 2006.

©British Journal of General Practice 2006; 56: 945-949.

How this fits in

Urinary incontinence is a common problem in women, with a serious impact on daily life. Only few Muslim women consult their GP because of incontinence. To date no knowledge is available about the reasons for not seeking help and we have no insight into the perceptions and care needs of these women. This study reveals that urinary incontinence has a huge impact on their daily lives as it breaches their status of ritual purity. Half of the women were deeply ashamed, and this was the reason why they did not visit the doctor. Shame on the part of the patient and miscommunication at the doctor's surgery led to inadequate care. The women did not understand the aim of the exercises from the physiotherapist. The majority of women gave preference to help from a female doctor.

medical care.⁹ Therefore, we addressed the following questions:

- how do Moroccan and Turkish migrant women perceive urinary incontinence?
- what consequences does it have on their daily lives? and;
- what are their wishes regarding treatment?

METHOD

A qualitative approach was taken to answer these questions because the topic is poorly understood and the research is perception-oriented.¹⁰ Semi-structured in depth interviews were conducted with Moroccan and Turkish migrant women who presented with complaints of urinary incontinence, until no new information was imparted and thus theoretical saturation had been reached. To comply with the criterion of achieving the widest possible variation in study population that is a requirement of such a qualitative approach, women were recruited in different ways.^{11,12} At six general practices with large numbers of immigrant families on the practice lists in four different cities in the Netherlands, the GP approached Moroccan and Turkish women who were either known to have incontinence or had asked for a prescription for incontinence materials. In addition, patients were recruited by one female physiotherapist who specialised in pelvic floor muscle exercise therapy and by two female Moroccan care consultants. All the eligible women were sent a letter in Dutch and/or Arabic with information about the study. The interviews took between 45 and 60 minutes and were held at the patient's home or at their doctor's surgery.

A trained Muslim female researcher conducted all the interviews, audiotaped the conversations and transcribed them verbatim. If necessary, a female family member or translator was present. The interviewer followed an interview guide that contained the following themes: perception of the incontinence, psychosocial consequences and

influence on intimate relations, experience with and expectations about treatment. This interview guide was formulated on the basis of the literature and the outcomes of a discussion with a panel of experts in the field of urinary incontinence and cultural diversity. Background data were gathered on country of origin, religion, education, profession and parity. The severity of the incontinence was evaluated by means of the PRAFAB score (Protection, Amount, Frequency, Adjustment, Body image).¹¹

The PRAFAB score includes questions on the involuntary loss of urine frequency, the amount of urine that is lost each time, the use of incontinence material, the limitations of activities of daily living and the effect on self-image. The following categories were distinguished as: mild (1–7 points); moderate (8–13 points) and severe (14–20 points). Interview data were all analysed independently by two researchers to isolate the most important themes (investigator triangulation).^{11–12} Citations were selected that supported the major themes derived from the interviews.

RESULTS

The study population ($n = 30$) comprised 13 Moroccan women and 17 Turkish women with a mean age of 45 years (standard deviation = [SD]: 9.0) (Table 1). There were no striking differences between the Moroccan and Turkish women. The majority ($n = 23$) did not have a profession and had received a low level of education. Mean duration of living in the Netherlands was 24 years (SD = 7.0). Incontinence was chiefly moderate ($n = 10$) to severe ($n = 16$) according to the PRAFAB scores. All the patients were Muslim.

Consequences on daily life

Devout Muslims have to perform ablutions (Wudhu) before each of the ritual prayer sessions prescribed at five set times each day (as-Salaat). The majority of the study group ($n = 25$) reported that in the past, they had been able to complete several of the prayer sessions with one and the same ritual purification, whereas now, they had to repeat it every time. The ablution is no longer considered to be valid after passing urine, vaginal discharge, faeces or flatus from the genital organs or anus. Consequently, the incontinence was affecting their worship of the Islam faith:

'I can't go to the mosque and pray straight away any more. I can't guarantee that after ablution I will retain the state of purity. Having to wash myself 5 to 7 times a day is really starting to get me down. Sometimes I can't pray because there is nowhere I can wash.' (Moroccan, 27 years.)

'Before praying your body and underwear need to be really clean. So how can I do that when I'm staying with other people? That I find really difficult.' (Moroccan, 39 years.)

'I am ashamed to go to the toilet at their house, because there are men sitting in the room opposite.' (Turkish, 55 years.)

The women in this study ($n = 30$) all adhered closely to bodily cleanliness. They therefore found incontinence dirty and extremely bothersome. Whenever they lost urine, they washed themselves as soon as they could. To cope with such an event, these women always had a supply of absorbent pads and clean underwear with them:

'I am getting really fed up with having to wash myself and change my clothes all the time, these are the biggest problems. I am having trouble keeping it up, although I want to have everything really clean.' (Turkish, 33 years.)

More than half ($n = 18$) of the women had spoken to their husband or a family member about the incontinence. Shame was the most important reason to hide it from their husband.

Six women answered 'yes' to the question whether the incontinence negatively influenced intimate relations with their husband. One woman who was divorced did not want to remarry because of the incontinence:

'A man wants a healthy wife who also wants sex.' (Moroccan, 39 years.)

Some women did not feel shame because they explicitly stated that their condition was created by Allah:

'It has nothing to do with shame. Some things we receive from Allah, and I am not going to feel ashamed about them.' (Moroccan, 38 years.)

Expectations about treatment

Slightly more than half of the women in this study ($n = 17$) had consulted their GP because of urinary incontinence. Five women visited a doctor in their country of origin for this problem.

The women who had not sought help were not aware that their GP could do anything for them. Some felt ashamed towards a male GP or did not dare to bring up the subject, or considered the incontinence to be a normal situation at their age.

Most of the women ($n = 23$) gave preference to a female doctor:

Table 1. Characteristics of the study population ($n = 30$).

Age in years	
25–40	11
41–50	11
50–65	8
Country of origin	
Morocco	13
Turkey	17
Translator	
None	14
Family member	8
Translator	8
Marital status	
Unmarried	1
Married	22
Divorced	6
Widow	1
Education	
None	2
Low	14
Intermediate	5
High	5
Parity	
0–1	3
2–4	21
5–9	6

'In Islam, a woman must always choose a female physician.' (Moroccan, 36 years.)

In this study population, the nine women who had been referred to a physiotherapist had stopped going: they did not understand the reason for the exercises, they were unable to do the exercises regularly, or they soon gave up because they did not notice any effect:

'I thought, do I have to do sport here? Ridiculous! Will it help? How am I supposed to contract and relax my pelvic floor muscles?' (Turkish, 33 years.)

One-third of the women felt their GP had not taken them seriously; they wanted not only to talk about the problem, but also to be examined and referred for further tests when treatment was unsuccessful. They believed Allah had sent them this condition and they owed it to Him to seek the best possible treatment. Only if it became evident that there was no solution available, then they had to accept the incontinence:

'For all things you receive from Allah, just say "Al-hamdu li-Llah." You must try everything: going to the GP, taking your medication. When at last you can't get better then you have to

accept it; that is qadr, predestinated.
(Moroccan, 48 years.)

Although most of the women said that they had understood the explanation given by their GP (16 women had needed a translator for this), a number of women indicated clearly that they had been troubled by language problems.

All the women lacked basic knowledge and understanding of the function of the bladder and genital organs. It also appeared that they were unaware of the favourable effects and the aim of exercise therapy.

DISCUSSION

Summary of main findings and comparison with existing literature

The first major finding in this study is that the urinary incontinence strongly interfered with the ritual purity prescribed for the daily prayer sessions. Muslims have to perform ablutions after urine loss prior to each of the five daily prayer sessions. The women found that having to wash so many times was a heavy burden. These religious restrictions as a result of urine loss in Muslim patients have been mentioned in a small study previously.¹³ In addition, they have to maintain their bodily cleanliness away from the men's eyes, because they wish to hide the incontinence. According to three of the four large Islamic Schools of Jurisprudence (Shafi'i, Hanafi and Maliki), a prayer is not valid without prior ablution. For medical reasons, Muslims do not have to follow all the prescriptions in some situations, such as Ramadan for example. Therefore, it was felt that it would not be inconceivable to also excuse (Ma'zur) women with urinary incontinence.

About half of the women did not talk to anyone about the incontinence, not even with their husband, because they were ashamed. This confirmed the taboo surrounding incontinence and the large role of shame in the sex differences in Muslim cultures.¹³

The dissatisfaction with the GP can partly be explained because the women desired an active role from the GP to refer them if the complaints persist. It was also shown in this study that many Muslims, believe that illness comes from Allah, but that in principle, Allah also has a cure for every illness. This can lead them into a continuous search for healing of their complaints.^{14,15} Women from ethnic-minority groups report problems in their relationship with the GP also because of different beliefs about health and health care. Good relationships between GP and patients are necessary for mutual understanding.^{14,16}

The majority of Muslim women prefer, for religious reasons, a female doctor,^{6,7,13} not only — as is the case with Western European women — for complaints in the genital region.¹⁷

Patients with urinary incontinence can benefit from exercise therapy as long as they persevere with the exercises.^{18,19} The Moroccan and Turkish women did not resist this form of treatment, but it failed because of miscommunication and lack of understanding

Strengths and limitations of the study

This study has a number of limitations. The study population comprised women who had chiefly been selected by their GP or a physiotherapist and they all wanted to talk about their problem. This led to over-representation of women who felt less ashamed and were able to seek help more easily. Over half of the women made use of a translator. This might have led to socially acceptable answers and obstacles when talking about intimate relations. A study conducted in Qatar using written questionnaires showed that as many as 47% of the Muslim women with incontinence indicated that the problem was having a negative effect on the relationship with their husband.⁷

A strong point in this study is that it included such a large and otherwise difficult to trace group of patients who were willing to participate and did not object to being audiotaped.

Implications for future research and clinical practice

This study contributes more insight into the complaint of incontinence in Moroccan and Turkish migrant women. Firstly, urinary incontinence had considerable consequences for them regarding the important status of ritual purity and also on their daily worship of the Islam faith.

Muslim organisations may wish to investigate the possibility of excusing these women from ablutions before every prayer session. Shame played a large role in remaining silent.

Knowledge about the anatomy and physiology of their bodies and information about treatment options for urinary incontinence were generally lacking. The majority of women wanted help from their, preferably female, GP.

Funding body

Not applicable

Ethics committee

Not applicable

Competing interests

The authors have stated that there are none

Acknowledgments

We thank L den Koning, medical student, for her help with conducting the interviews.

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