URINARY INCONTINENCE IN MUSLIM WOMEN

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This article describes the results of a qualitative study that explores how religion and culture influence Muslim women's decisions to seek healthcare for urinary incontinence.

Urinary incontinence (UI) has a much more devastating effect on the quality of life of Muslim women than on those who are Jewish, Hindu or Christian (Chaliha and Stanton, 1999). For Muslim women, praying is seen as a relationship between the person and God (Naqib al-Misri and Keller, 1994) – leaking urine is a barrier.

Ablution (*wadu*) is a cleansing ritual carried out by every Muslim prior to prayers. The passing of stool, flatus or urine while under ablution necessitates carrying out the ritual again as cleanliness during prayers is required (Naqib al-Misri and Keller, 1994). Prayers (*namaz*), performed five times a day at different intervals, require a Muslim to stand, bend and sit while reciting the verses of the Quran (Islamic Vision, 1989). These actions can cause a leakage for a person who is incontinent. This process of leaking urine and cleansing can have a negative effect on the individual's psychological health, as it brings with it associations of guilt and punishment. Religious beliefs may also create a sense of fatalism, as a person may not feel it is worth seeking treatment as they think their illness is not in their sphere of control but rely on supernatural beliefs and powers (Kelleher et al, 1994).

It is crucial for Muslim women with UI to ask for help to enable them to carry out their daily religious duties (Walsh, 1998). Previous research has found the more severe a leakage, the greater the distress and the more restricted activities become, which is reflected in studies conducted in various ethnic groups (Heit et al, 2006; Samuelsson et al, 1997; Lagro-Janssen et al, 1992; Herzog et al, 1988; Yarnell and Leger, 1979). In these circumstances, people are more likely to consider seeking help (Samuelson et al, 1997; Burgio et al, 1994; Burgio, 1991; Ouslander and Abelson, 1990).

Information gained from an urogynaecologist at a local NHS trust suggested a low percentage of Muslim women accessed services for UI. This may be due to a lack of knowledge about the condition or the sensitive nature of the subject. For example, Wilkinson (2001) found Asian women felt that health professionals were not interested in their problems and did not provide adequate support.

An inability to understand or fully understand spoken English can also make individuals reluctant to seek help (Haggar, 1994; Bhopal, 1986; Anderson, 1985), and communication barriers can play a role in non-compliance to treatment (Tufnell et al, 1994; McAvory and Sayeed, 1989). Relatives are often used as interpreters in consultations – this can lead to personal details that the patient may not be willing to share being disclosed to other family members, or misinterpretation in medical consultations, which can lead to potential clinical mismanagement. It may not be possible to translate clinical and medical terminology accurately to a target language (Wilkinson and Williamson, 1995).

The health-information needs of people from minority ethnic groups differ due to different cultural beliefs and values and their effects of those on healthcare practices (Rashidi and Rajaram, 2000; Ashing-Giwa and Ganz, 1997). An understanding of how cultural and religious beliefs influence and inform women's decisions in relation to UI is required to help health professionals provide a culturally sensitive service, with the ultimate aim of improved patient care.

Aims and methods

The aim of this study was to explore the religious and cultural influences on help-seeking behaviour and decision-making in South Asian Muslim women with UI. A qualitative exploratory design was used to understand values, beliefs, norms and experiences of Muslim women using a semi-structured focus approach. This consisted of broad questions the researcher wished to explore with each participant.

The research was carried out in the northwest of

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England. Potential participants were accessed through English for Speakers of Other Languages classes. The researcher had to be aware of the type of information that should be verbalised, as both sexes attended the sessions. Female group members were all given information packs and were asked to contact the researcher if they requested more information or decided to participate. The issue of communication was a major part in this study. The researcher is from an Asian background, and has the basic ability to speak Urdu. A local translation company translated all written information into Urdu.

All material in the packs was provided in English and Urdu. Manson et al (2003) identified that some people are able to verbalise other languages but sometimes reading that language can be difficult. As such, the researcher decided to explain the study and the consent procedure verbally to each participant. The consent form was signed when the participants understood their role, the role of the researcher and the purpose of the study.

Data was analysed using 'Framework' (Ritchie and Lewis, 2003), which comprises five main stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation.

Findings

All participants were Muslim women aged 21–70 years. They were all parous and suffered from lower tract symptoms. Countries of birth were India (four), England (four) and Pakistan (one). Six participants were Indian Muslim and three were Pakistan Muslim.

As this article is based on the religious and cultural aspects of themes identified in the transcripts, themes that correspond with the two will be discussed. The quotations are taken directly from the transcripts.

General influences on help-seeking and decision-making behaviour

Participants identified childbirth as one of the major causes of UI, followed by old age:

'I have heard old age causes UI but for me giving birth has caused me to leak. I was fine before then.' (Aged 21, England)

They also suggested that poor knowledge of continence services was due to the lack of public awareness. This was a common theme:

'Media has a great influence on people. But there is no awareness about incontinence anywhere really.' (Aged 28, England)

All participants stated they would seek help if they believed their UI had become more of a problem although this would be their interpretation and not anyone else's:

'Not bad [it's not bad] *for me to tell a doctor about, these things happen and now it's a normal routine.'* (Aged 28, England)

Cultural influences on help-seeking and decision-making behaviour

Throughout the interviews, it was apparent that the older participants (35–70 years) did not attach as much importance to cultural influences as the younger participants (21–34 years). Younger participants stated their parents had told them that examination by a male doctor was forbidden and religiously incorrect. However, none of these participants had read this information for themselves but strongly believed their parents' views were in fact religious obligations:

'I don't know if this is written in the book [Quran or Hadith] *but I* [am] *sure it is.'* (Aged 34, England)

Participants were unable to distinguish between cultural or religious behaviours. When questioned, one 34-year-old from England said, 'It must be written in the Quran or Hadith, I just have never read it myself.' However, for the older participants there was a clear distinction:

'It's what people say, there is nothing wrong with going to see a male doctor, it's not religion.' (Aged 70, India)

The older participants identified embarrassment as having a greater influence over their behaviour than religion or culture:

'I would feel embarrassed going to a man doctor, Islam says you should go, if it's going to make you better. It's just embarrassing, telling a man.' (Aged 50, India)

All the participants identified religion and culture as two different influences but as the interviews proceeded, the differences appeared to be blurred:

'Well religion and culture play an equal part, they work together. Without culture I don't think you are following religion correctly.' (Aged 45, India)

Preference for male or female health professionals

When asked whether they would be prepared to disclose their UI to their GP (be they male or female), participants felt it would be a waste of their doctor's time. When given the choice, they stated they would prefer to tell their practice nurse, because they believed the nurse would not be as busy as the GP, although communication would be a problem:

'I would prefer to tell the nurse, they have more time, doctors are always busy but if I can't speak English how would I say it?' (Aged 34, England)

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Older participants stated they had deliberately chosen an Asian GP because of their ability to understand and communicate in Urdu, and the similar cultural backgrounds. Due to their lack of command of English, four participants stated they would inform their GP:

'I would tell my doctor. It would be very embarrassing but at least I would be able to talk to him about it. I can't speak English so how would I tell the nurse?' (Aged 70, India)

Other participants said they would not tell their male GP about their UI under any circumstances, due to the fear of examination. One participant went further, stating:

'I wouldn't tell my doctor because he would want to examine me [pause] *plus I don't think my husband would agree. A Muslim woman should not be examined by a male doctor.'* (Aged 45, India)

Disclosure of UI

Failure to disclose UI to partners and relatives was a common theme, which was mainly due to the embarrassing nature of the subject. Women saw it as a subject area that should not be discussed with their husbands as it was a 'woman's problem' and discussing these issues was culturally wrong. Participants said they would only disclose UI to other female friends or family members. One participant felt she would discuss UI with her husband only if it got any worse. Others said they would never talk about women's problems with a male, including their partner/husband, due to concerns about their reaction:

'He would probably find it awkward. He is quite a strict Muslim and I don't think he would want to talk about it.' (Aged 45, India)

Religious influences on help seeking and decision-making behaviour

The importance of Islam in the lives of participants was emphasised:

'Life, death and health are from Allah. When Allah gives you an illness, you will receive cure from him too. I know Allah will not let me suffer.' (Aged 70, India)

Another participant stated:

'Illnesses are from God and God is the only source that will send you a cure too… you are being tested on every path.' (Aged 37, India)

All participants considered God (Allah) throughout the interviews and Islam was regarded as the most influential and important aspect of their life:

'My religion is not a religion but it is a way of life, this is what Islam means. It teaches me how to live my life.' (Aged 28, England)

Older participants said their religion had never stopped them seeking help:

'As women we should cover up, and not show our privates to anyone. Going to the doctor is a different thing, you are going for help.' (Aged 70, India)

However, the younger participants had a different view:

'My religion states I should not go to a male doctor, for ladies' needs. That is against my religion.' (Aged 34, England)

Participants were asked about Muslim women being examined by a male doctor:

'Muslim women cannot under any circumstances be examined by a male doctor, it is going against what is written in the holy book.' (Aged 34, England)

However, the older participants did not agree with this statement:

'It is not wrong, God has given you health, and illness is also from him [Allah] *what we have to do is go and find treatment, whether it be* [from someone who is] *male or female.'* (Aged 70, India)

Differences appeared to be related to age and country of birth. Younger participants who were British born identified examinations by male doctors as forbidden and were firm in these beliefs, while older participants did not think this was an issue, stating that religion did not restrict seeking help in any way. Older participants who had migrated from India or Pakistan also said in their country they could choose who they saw:

'If I was in my country [India] *I can see man or lady doctor, because we have to pay. Here it is free, so we see whoever we can.'* (Aged 70, India)

Participants were asked about the impact of UI on their religious duties:

'I drink less before I pray, [I also] *go toilet before doing wadu.'* (Aged 70, India)

Leaking urine or having a strong desire to urinate while performing prayers was another issue:

'Praying namaz involves standing, sitting and bending. Sometimes I do get a desire to pass urine. I don't leak or anything I just feel like I want to go.' (Aged 45, India)

Despite the impact on their lives, most women did not consider their UI to be a problem that would cause them to seek professional help.

Discussion and conclusion

Incontinence is gradually becoming an acceptable subject for open discussion (Walker, 1987; Horsfield, 1986; Glew, 1985), but our findings suggest this is not yet occurring in the Muslim population living in the northwest of England.

The inability to communicate directly with health

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professionals can be distressing, especially when approaching sensitive issues such as UI. In this study, family members always accompanied older participants to hospital, which provided a source of communication between professional and patient. However, this may cause additional problems if family members are unaware of some of the medical terms used – they may not be able to provide an accurate channel of communication between professional and patient, leading to potential clinical mismanagement.

UI can lead to social isolation (Breakwell and Walder, 1988). This was an issue in this study, as six out of nine participants either avoided social gatherings, familiarised themselves with the location of the toilets or totally avoided going out. Feelings of anger, guilt and frustration were expressed in the interviews, largely due to the lack of awareness and discussion about incontinence issues. These views have also been echoed in previous research with Caucasian, African, Chinese, Italians, Pakistani and Bangladeshi women of all age groups (Castro-Diaz et al, 2006; Huang et al, 2006; Milsom et al, 2006; Song et al, 2005; Novielli et al, 2003; Sze et al, 2002; Duong and Korn, 2001; Graham and Mallett, 2001; Scott, 1999).

Self-management was always considered prior to medical treatment, examples of this included restricting fluid intake, wearing pads and not attending social gatherings.

The severity of any illness determines whether an individual is likely to seek help or not (Shaw, 1999). Participants all stated they did not believe their symptoms were severe enough for them to seek help, although many wore pads daily. However, when explored further in relation to lower urinary tract symptoms and *namaz*, different views emerged. All participants either leaked urine or felt a strong urge to pass urine, which consequently made them rush prayers. They felt their symptoms caused a barrier between them and Allah – some stated it was a form of punishment and believed a cure was only possible through prayers. It is evident that urinary symptoms can have a devastating impact on well-being (Heit et al, 2006), especially when related to guilt and punishment.

In terms of religion, illness can be viewed as a punishment for the breach of religious codes and morals (Badawi, 1998). Participants in the study all expressed similar thoughts to one 70-year-old from India, who said: 'Good health and illness are both from God, and God is the only source of power that provides you with a cure.' These concur with the findings of Kelleher and Islam (1996).

Religious influences facilitated help-seeking behaviour, for example, some participants believed their religion stated that a woman should seek healthcare from a male doctor if a female doctor was not available. This finding is in line with Naqib al-Misri and Keller's translation of the Hadith (1994), which states that if 'a woman should seek help from a female doctor. If one is not available, she should seek treatment from a male doctor, with the consent and company of a male family member'. This is an example of a religious influence that can potentially restrict access to healthcare for Muslim women, especially if the health issue concerns 'women's needs'.

Muslim customs demand that women should not expose certain bodily parts to anyone except their husbands (Khattab, 2001). This causes many problems for Muslim women who may be reluctant to attend for gynaecological tests. With regard to seeking help, the younger participants believed that their religious teachings stated modesty is required of women by Islam at all times. This was a strong influence and prevented some women from seeking healthcare.

It appears that the influence of culture, especially on the younger participants in the study, was as important as religious beliefs when it came to influencing help-seeking behaviour. For the participants in this study, their religion and culture had a great impact on them as individuals. Religion and culture had a very strong influence on their decisions regarding seeking help.

When women were informed about the possible treatment options for UI, there was a sense of disbelief among the participants. This clearly indicates the low knowledge of 'UI' within this group of women.

Limitations of the study

This study did not consider generalising the findings but was concerned with adding to our understanding of how culture and religion influence Muslim women when accessing services for UI. The sample size was small; this was due to the constraints of conducting a PhD, and women were reluctant to participate. To gain an overall picture the sample size would need to be increased and tested against those Muslim women who have sought help. ■

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