Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester

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Background. Urinary incontinence is a significant health problem with potentially serious physical, psychological and social consequences. The true prevalence is difficult to ascertain, especially in hard to reach groups such as ethnic minority populations and research in this area is lacking. The UK has an increasingly diverse population, and ascertaining the needs for continence care among ethnic minority groups is crucial.

Objectives. This study aimed to explore views and experiences of incontinence and perceptions of care among South Asian Indian women in Leicester, UK.

Methods. A qualitative focus group study involving four focus groups, each of six women, was undertaken. Focus groups were conducted in the participants’ chosen language and facilitated by a bilingual moderator. Groups were tape-recorded, transcribed and analysed in a systematic and iterative way based on the constant comparative method.

Results. Women commonly normalized symptoms of urinary incontinence, attributing them to the ageing process or consequences of childbirth. Help-seeking behaviour was hindered not only by feelings of embarrassment in discussing sensitive problems, especially with male health professionals, but also the perceived embarrassment felt by doctors. Women reported a lack of available information in culturally sensitive media. Talk-based media were more highly valued than text-based media. Generational differences in help-seeking behaviour were apparent.

Conclusions. This exploratory study provides valuable understanding of the continence needs of South Asian Indian women. Common needs were identified, as were important generational differences. Suggestions offered by women for the existing service improvement seemed relatively modest in terms of resources required.

Keywords. Access, culturally competent, ethnicity, qualitative, urinary incontinence.

Introduction

Urinary incontinence is a significant health problem with potentially serious physical, psychological and social consequences. It is a common condition among adult women, with prevalence estimates ranging from 14% to 71% among Caucasians. However, little data exist on the prevalence or impact of urinary incontinence in hard to reach groups such as the elderly, institutionalized and ethnic minorities. Research from the US suggests significant differences in adjusted risk of incontinence among women of different ethnicities. However, it is not clear how these results translate to the UK where the majority ethnic groupings are quite different.

Simple and effective treatments for urinary incontinence are available in primary care, but research has shown that many people who have incontinence do not seek services. For instance, even among those with severe symptoms, only about one-third accessed health services for their problem.
Modern National Health Science (NHS) policy includes a goal of creating services that meet the individual needs of all patients. In common with many countries, the UK has an increasingly diverse population including a comparatively large and growing black and minority ethnic (BME) population. In the 2001 census, the BME population was 7.9% (4.6 million), having risen from a figure of 5.5% in 1991 to 4.2% in 1981. The South Asian group accounts for about half of this population (2 million people) and several UK cities have significant South Asian populations, including Birmingham and Leicester.

In Leicester, although the urogynaecology unit provides services to an inner city population comprising a 35% minority ethnic population, recent audit data showed that the local South Asian Indian community was under-represented with only 15% of clinic attendees in 2004–2005 designating themselves of that ethnic group. This finding led us to question whether the continence needs of South Asian women may vary from Caucasian women. As part of a larger research programme, we developed this qualitative study to explore the views and experiences of women in the South Asian Indian community in Leicester about urinary incontinence and their perceptions of available care.

Methods

Study population

Leicester is a multi-cultural city of 280 000 people, the largest city in the East Midlands region of the UK and the 10th largest in the country. The 2001 census described 63.9% of the population as white. Nearly 65 000 inhabitants were of South Asian origin, originating from India, Pakistan and Bangladesh, frequently having migrated via the east African countries Kenya, Uganda and Tanzania. The biggest minority population (25.7%) was described in the census as Indian. The target population for this study were women of South Indian Asian origin who attended community groups in predominantly South Indian Asian areas of the city.

Focus groups

Focus groups are an appropriate choice of method when seeking to explore women's views and experiences of incontinence and continence services. Focus groups are also particularly well suited for use in areas previously under-researched and have been successfully used with ethnic minority community groups in other health-related research. Our focus groups were organized through pre-existing women's groups at South Asian Community Centres (voluntary or charity-funded organizations), gurdwaras (religious meeting place for Sikhs) and Hindu temples within Leicester. Public information sessions were given at each venue by one of the authors (AD), and at the end of these, women were asked whether they would be willing to participate in a focus group discussion. All women were invited to participate and their continence status was neither sought nor known.

Advice was sought from the local research ethics committee (LREC) about whether formal ethical approval was required. At the time the study commenced, the role of the LREC was to assess research involving NHS patients and staff, or other research taking place in the NHS premises. Thus, we were told that formal approval was not necessary for this community-based study, and that assessment was outside the remit of the LREC. Furthermore, at that time our institution did not have a system for formal review of studies falling outside the remit of the LREC.

However, we decided to conduct the study to the same standard with which we have conducted other focus group-based studies which have been approved by an LREC, in order to protect the rights of the participants as much as possible. By the nature of focus group studies, participants give consent by participating and are free to withdraw from the discussion, or indeed the entire group, at any time. Focus groups were arranged at a location convenient to the women, usually at the religious centre or at the home of one of the participants. Each focus group included six women. Most older women spoke only their native language of Hindi, Gujarati and Punjabi. Many of the younger, second-generation Indian women were bi- or multi-lingual. Care was taken to recruit women of similar age and linguistic ability in the same focus group to encourage discussion. The discussions were conducted in the participants' chosen language and facilitated by a bilingual moderator (AD). This encouraged the non-English speaking women to discuss issues in their own language in a comfortable environment. Before starting the focus group, all participants were given information about the purpose of the study and verbal consent was obtained. Women were informed that they could withdraw consent at any time during the discussions, by either choosing not to participate or by leaving the discussion. Participants were also reassured that any quotations used in publications would be anonymized, using name aliases. Women were also asked for their explicit verbal consent to audio-record the focus groups discussions and were informed that the tapes would be destroyed once translation and transcription was complete. This information was tape-recorded at the beginning of each focus group discussion. Participating women also agreed among themselves to keep details of the focus group discussion confidential to allow people to speak freely.

The development of the focus group schedule was informed by the main research questions, review of the literature and discussions within the research
team. The schedule had broad questions which the moderator used to guide the discussion. The schedule was used flexibly and the emphasis was on gaining the perspectives of the women themselves (Table 1).

The main areas explored in the focus groups were as follows:

- awareness of incontinence;
- quality of life issues;
- seeking help for urinary incontinence;
- awareness of treatment options; and
- suggestions for better service provision for women from ethnic minorities.

Women were not asked to disclose whether or not they had experienced symptoms of urinary incontinence. All focus groups were tape-recorded and transcribed verbatim into English. Name aliases were used on all transcripts. Any colloquial words and phrases that could not be translated verbatim were replaced with an English phrase carrying the same meaning.

Analysis
A systematic and iterative method of analysis based on the constant comparative method was used. The data were read and re-read. Initially, ‘open codes’ were applied to the data representing the significance of sections of text. Initially, this was done independently by two researchers (AD and EP) and then discussed together. Open codes were then grouped into organizing categories or overarching themes. The coding was partly influenced by the research questions but more particularly by ideas arising during data collection and analysis. Quotations are provided as illustration of the themes, each identified by focus group number.

Results
Four focus groups were held. After the first focus group, it became clear that generational differences may be important in formulating views and experiences of incontinence and therefore two focus groups were held with women aged 30–60 years (Groups 1 and 3) and two with women aged 60–85 years (Groups 2 and 4) (Table 2). The focus groups worked well and in all groups women discussed the issues around incontinence and continence care freely. The following overarching categories were identified from the analysis:

1. normalization/management of symptoms;
2. help seeking/access to health care; and
3. suggestions for improved service.

Each category is discussed below. Some categories contain subsidiary themes within them and these are identified by subheadings.

Normalization/management of symptoms
Overall, women felt that urinary symptoms such as leakage, frequency and nocturia were a normal part of the ageing process, and so not considered to be serious symptoms of a disease state. So, they were unlikely to regard these symptoms as something to be concerned about:

I don't think that was a problem, just like Seema was saying, that I thought it was part of getting old and not really a problem. (Focus Group 1)

Because symptoms were considered to be a part of the ageing process, they tended to be normalized. All of the women who took part in the discussions had a very accepting attitude towards these changes, with the overall feeling that little or nothing could be done:

I used to think that going to the toilet many times was OK. Maybe I have drunk too much or because it's cold. (Focus Group 1)

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<tr>
<th>Table 1 Schedule of focus group discussion</th>
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<td>Schedule of content of focus group discussion (exact content and order varied according to participants' responses). Prompts such as 'why?', 'in what way?' and 'can you say a bit more about...?' were used to explore initial responses in more depth. Questions asked by facilitator:</td>
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<td>1. Have you heard about anyone having urinary incontinence?</td>
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<td>2. How did you or they (relatives or friends who suffer from urinary incontinence) cope with it?</td>
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<td>3. Why do you think incontinence occurs?</td>
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<td>4. Do you know of any treatment available for incontinence?</td>
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<td>5. Would you be willing to try alternative therapies?</td>
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<td>6. Who would you like to see if you developed this condition and why?</td>
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<td>7. Why do you think most women don’t seek help for this problem?</td>
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<td>8. How do you think we can increase awareness within the community about incontinence?</td>
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<td>9. How do you think we can improve the services provided in the NHS for managing women with incontinence?</td>
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<td>10. If any of the participant answered that they or a family or friend suffered from incontinence, they would be asked if they would be willing to share the experience with the group, including issues around access to care, treatment and how satisfied they were with the received care.</td>
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<th>Table 2 Characteristics of focus groups and participants</th>
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<td>Focus group</td>
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The problem is that there is more than one problem, like heart and diabetes, so there are many problems and this may not be so important. When we get older diseases engulf us, so there is little we can do. (Focus Group 2)

Most of the women had formed explanations for the cause of their condition:

Part of the reason is that muscles have gone weak, and we feel there is no cure for weakness, it has to happen so it will, we are old, nothing can be done. (Focus Group 4)

Some women recalled that they had suffered with these symptoms for years so that it had become a part of their daily lives and they had developed management strategies to incorporate these symptoms in their everyday life:

I used to avoid going out, my husband is so sweet, first thing he would do is try and find out where the toilets were, and we would sit near to the toilet, as I could just not control it. (Focus Group 1)

I cut down drinking during the day because of my job as a visiting officer I didn't want to use the customer’s toilets. I would have a cup of tea in the morning and then not drink anything for the next 5–6 hours. But it made my bladder condition worse. (Focus Group 1)

It was apparent that in spite of the difference in the ages of the women from the focus groups and that the younger women were bilingual with good understanding of both written and spoken English, all the women had heard or read little about the subject of continence:

We say that we are educated but you don’t realise and I didn’t realise how big a problem this is and that something can be done about it … I’ve lived in this country all my life, I was educated here and I didn’t think that this was a problem, so I never saw a doctor about it. (Focus Group 3)

Help seeking/access to health care

Five women in the groups had sought help for their incontinence symptoms, but the majority felt that the symptoms were not that important to prompt a consultation with the GP (or family doctor), even if they were seeing their GP for other symptoms:

I never thought it was a problem to go see the GP (Focus Group 2)

I thought it was a small problem and it would go away, maybe I drank too much water, never thought it was such a big problem with so many people affected. You don’t go to see your GP for small problems. (Focus Group 2)

The women in the older age focus group put their urinary symptoms down to side effects of the medications that they were on (e.g. diuretics for hypertension):

I take tablets for hypertension and cholesterol, so during the day I go every hour but during the night am OK, only get up once, I drink plenty because I have kidney problems as well. (Focus Group 4)

Interaction with health care professionals. Although many women had not sought medical help, the women who had approached their GP felt that they had not received any valuable advice to manage the condition, with some saying that the GP had reinforced their belief that nothing could be done:

The doctor said that because you have so many children your womb has dropped and said you’re getting old, it will get better, didn’t give me any medication. (Focus Group 2)

He said I was going through the menopause and this was normal, he made me feel like ‘what are you complaining about, woman, just get on with it’. (Focus Group 3)

Embarrassment. Women across all the focus groups commonly reported feeling embarrassed when going to see their GP for personal reasons such as incontinence. The reasons given for this were mainly the gender of the GP and the sensitive nature of the problem:

I’m embarrassed to see the doctor, I have a male GP, but if I tell him he will refer me to the female GP, but I don’t want that because they will examine me and I don’t want that. (Focus Group 4)

Embarrassment. Women across all the focus groups commonly reported feeling embarrassed when going to see their GP for personal reasons such as incontinence. The reasons given for this were mainly the gender of the GP and the sensitive nature of the problem:

I think I make him (GP) uncomfortable, he realises it’s embarrassing and he tries to make it easier, he doesn’t look at me either when he talks about the problem. (Focus Group 4)

In discussing their interactions with their GP, several women felt that the GP was embarrassed to address continence issues:

My GP was more embarrassed than I was, probably because he is an elderly male GP and I felt I couldn’t talk to him openly about the problems I had. (Focus Group 1)

Characteristics of health professionals. During the focus group discussions, we tried to explore further whether women had a preference for the gender of the medical professionals they saw and whether this made a difference in their health-seeking behaviour. In all focus groups, there was an expressed preference
to be seen by a female doctor, for ease of discussing sensitive subjects:

With a lady doctor it’s different, you can be a bit more open than with a male doctor. (Focus Group 4)

I think having a female makes it easier to talk about your personal problems especially those down below, because it’s embarrassing. (Focus Group 1)

In addition, there was strong opinion that women would prefer to see an allied health professional (i.e. continence nurses, district nurses, practice nurses, physiotherapists and health care visitors) rather than the GP. This was partly because of an assumption that allied health professionals would be female:

I have a practice nurse and when we make an appointment they say ‘whom do you want to see?’ and I say ‘the nurse, I don’t want to talk to the doctor’. (Focus Group 3)

Nurses are females and they have more time. (Focus Group 4)

Especially for older women, nurses who visit at home would be better, because then we don’t have to leave the house, problems with transport and waiting in the GP surgery. (Focus Group 2)

Women also suggested that having GPs from similar ethnic backgrounds would be preferable, because they would have a better understanding of cultural issues affecting them, besides being able to communicate in the patients’ own language:

The other thing I’ve noticed is that Asian people tend to go to Asian doctors. They think that there will be no language or cultural issues. (Focus Group 2)

Like when we were young my parents changed to a muslim GP, because somebody said that when you die they do this and they do that and if you have a muslim doctor then he understands the procedures and my mum and dad thought ‘excellent, let’s change to a muslim doctor’. (Focus Group 2)

Treatment options. A majority of the women in the younger focus groups had heard of pelvic floor exercises, but many of them felt that these were only to be done after having a baby. They expressed dissatisfaction at the way they had been taught pelvic floor exercises, highlighting that no one had actually told them the significance of performing these exercises or their long-term benefits:

They told me to do pelvic floor exercises when you have a baby, they don’t exactly say it’s for your bladder, they just said ‘you have had a baby and it will help with your muscles’, it was not said ‘if you don’t do this you will have bladder problems later’. (Focus Group 3)

The problem is not knowing if I am doing the right pelvic exercises. (Focus Group 1)

No one emphasised it, what you could end up suffering if you didn’t do them (pelvic floor exercises). All they say is ‘just do it to strengthen your muscles’, not that you could end up in nappies, that would be frightening. (Focus Group 3)

In contrast, most of the older women had not heard of pelvic floor exercises. When asked if they had been taught these after childbirth, they said that they had delivered their babies in countries other than the UK, where it was not a routine post-natal practice.

Complementary therapy. During the discussions, women also talked about their experiences of alternative therapies. On the whole, the younger age group women were more likely to consider alternative therapies, including herbal medication. The older women tended to prefer to use medication as prescribed by their doctor. Concurrent use of both Western and traditional approaches was considered to be contradictory by the majority of the women:

I would take the hospital’s medicine; my son is a doctor you see. (Focus Group 4)

I would take the doctor’s medicine or herbal medicine, I wouldn’t mix and match. I don’t think it would help, sometimes I would take herbal medicines if the problem was small. (Focus Group 4)

Use of interpreter services. When asked about the importance and use of interpreter services, members of all four focus groups preferred to use family members rather than the interpreting services offered by the GP surgery or the hospital:

I wouldn’t feel comfortable, again it would be a complete stranger and you end up talking to two people who you don’t know. The interpreter may go home and talk about it and they come from the same community. (Focus Group 2)

A friend of mine’s an interpreter and she went to a GP surgery because she was asked to sit in on an appointment and the lady who she had to translate for lived two doors down the road from her, and they know each other, can you imagine how difficult it must have been for that lady to sit with someone who lives down the road and talk about such a personal issue? That is why I wouldn’t be comfortable with an interpreter, I would just demonstrate, even if I didn’t speak the language. (Focus Group 3)
Only one of the 24 women who took part would have preferred an interpreter, because of fear of family members finding out about her condition.

Suggestions for improving services

*Increasing awareness.* In the UK, several charitable organizations such as the Continence Foundation have run campaigns to increase continence awareness within communities. Unfortunately, it did not seem that any of the women from the focus groups had heard of these, nor had they received any leaflets on the subject.

I haven’t seen that many articles but to be honest I haven’t really been that interested in this. (Focus Group 2)

At the end of each focus group, we asked the women to suggest ways of increasing awareness within the community and improving existing services. Their responses were analysed and are reported under the following themes: professionals, opportunistic screening and publicity.

**Professionals.** The women felt that health professionals should use a more direct approach in addressing the problem. They felt that if they were directly asked they were more likely to discuss their problem:

If they ask you are happy to answer back, rather than you tell them. (Focus Group 2)

There was the feeling that if urinary symptoms were asked about by health professionals then they must be of some significance, and so women would be more likely to talk about their condition:

If the nurse asks you then it’s like it’s recognised, it’s not just something you have, it’s an issue, that’s why she has brought it up and because it affects so many women. (Focus Group 3)

**Publicity.** Women in all four focus groups felt that talk-based awareness campaigns were more likely to be successful than written ones. It was interesting to learn from these women that a large majority of these monolingual speakers are not literate and are unable to read the printed material, even in their native languages:

Asian community is a lot of word of mouth. (Focus Group 1)

My mother in law can’t read, I have to translate it for her. Talks are the way forward. (Focus Group 1)

We also noted that the younger generation of women were unable to read their ethnic languages:

English would be good so that my daughter can read it, she can’t read Gujarati. (Focus Group 4)

Women felt that to overcome the taboo of talking about incontinence, others who have the problem should be encouraged to come forward and share their experience:

If you have champions within the community it has to be someone who has been through it. (Focus Group 3)

Women felt that small group discussions, rather than large groups with health care professionals, would be more valuable than printed leaflets to enable them to gain a better understanding of the nature of the problem and available solutions:

Small community centres that these elder women go to and give them talks, in a small group they are more likely to be receptive, not 100%, but if they know a little bit about it they will talk, better than you giving a talk in a large group. (Focus Group 1)

I don’t think leaflets help, we hardly ever read. We bring them and then throw them out, sometimes we don’t understand them. (Focus Group 2)

Like the leaflet explains how to do pelvic floor exercises, but how do you know that you are doing them right. (Focus Group 3)

Most women participating in our focus groups subscribed to media channels catering specifically to ethnic minorities (e.g. SABRAS radio, BBC Asian network and MATV) and they felt that these were very strong media to disseminate awareness within the community by having programs in local languages addressing this problem:

BBC radio is good; once a week they have a health program … that will be good. (Focus Group 1)

Program on TV, in a casual manner, like two women near a temple, make a joke about it and then how it was sorted. So then people will know there is treatment. (Focus Group 3)

**Discussion**

Understanding the reasons why women do or do not seek treatment for incontinence is hampered by the ethnic homogeneity of the existing data (primarily white Caucasian) and the lack of comparative data from ethnic minority populations. Most previous work suffers from selection bias, studying patients recruited from within the health service environment. We have explored continence needs and attitudes to health care access among South Asian Indian women in the community.

We confirmed the existing knowledge about the sensitive nature of the problem and demonstrated that
typical coping mechanisms used by these women were similar to a Caucasian sample.\textsuperscript{16} The participating women considered their symptoms to be an inevitable consequence of ageing and childbirth, and normalized their symptoms, resulting in the adoption of management strategies to minimize the impact of the incontinence upon their lifestyle.\textsuperscript{17} A consequence of this was that most women had not considered attending the GP to discuss an issue which they thought was unavoidable, or a side effect of other treatments. Women also held the belief that no treatments were available, a finding similar to that reported by others, among women of Caucasian origin.\textsuperscript{18} Adult Asians are known to attend general practices more frequently compared with European patients.\textsuperscript{19} Assuming this to be true for the women in our study who had attended the GP for other medical conditions, they still did not feel that incontinence was an ‘important’ enough symptom to discuss with the GP.

It is of significance that women identified considerable difficulties in discussing continence issues with their GP. Some women felt that their GP dismissed their concerns and was not aware, or not prepared, to consider definitive treatment for the condition. A lack of consultation and management skills in continence care has been identified by others.\textsuperscript{20,21} Eriksen et al.\textsuperscript{22} found that >50% of cases of incontinence were inadequately managed. Swanson et al.\textsuperscript{23} showed that only 34.6% of family physicians felt very comfortable dealing with urinary incontinence.

The women in our study did report that their GPs appeared to be embarrassed to discuss continence with them, and most of the women were registered with practices staffed mostly by male doctors. Embarrassment among patients is known to be an issue for continence care,\textsuperscript{24} but we are not aware of other work which has explicitly identified perceived embarrassment among health professionals as a barrier to effective care delivery. Although we did not interview the GPs, it is possible that social stigmata among the South Asian population contribute to the difficulty which they may have in discussing continence care with their patients. The preferences of the women we studied were for female doctors or nurses to discuss their problems with, which suggest that these gender issues are also playing a significant role. There was also a preference for a doctor or nurse from the same ethnic group, which suggests that cultural issues and taboos were important to the women.

The issue of interpreter services is frequently discussed in relation to ethnic minority groups, and translating and interpreting services are now considered to be a pre-requisite for a comprehensive service in a multi-ethnic area.\textsuperscript{25} A systematic review of the impact of medical interpreter services on the quality of health care\textsuperscript{26} found that optimal communication, highest patient satisfaction, better outcomes and the fewest errors of potential clinical consequence occur when ethnic minority patients had access to trained professional interpreters or bilingual health care providers. Additionally, the quality of care for ethnic minority patients was often inferior when untrained, ad hoc interpreters (including family members, friends, medical and non-medical staff and strangers) were used.

However, our study has revealed some interesting insights based upon the women’s preferences which would not have been identified in the systematic review. The majority of women preferred to attend with a bilingual family member to translate, rather than to make use of hospital provided translators, which appeared to be a consequence of the close-knit communities in which these women tended to live. They were keen to avoid situations where they may encounter a social contact in a medical setting and reveal sensitive or personal information in that situation. In contrast, patients from Chinese and Vietnamese Asian backgrounds preferred using professional interpreters rather than family members, and preferred gender-concordant translators,\textsuperscript{27} which suggest that there may be culture-specific differences and that generalization is unwise.

Our focus groups provided an opportunity to compare attitudes and opinions between women of different ages, who were either immigrants (the older women) or second-generation Asians born in the UK (the younger women). We found no difference in the level of awareness about the prevalence of continence problems, available treatments or in the women’s tendency to accept and normalize their symptoms. Both age groups identified embarrassment in themselves and in their GPs, and both preferred female and non-medical health care input. Younger women did, however, seem to have greater knowledge about pelvic floor exercises and were more likely to consider complementary therapies.

In contrast to Caucasian populations who find written leaflets helpful,\textsuperscript{28} our women thought that conventional leaflets would not make an impact in increasing awareness within their community and were much more enthusiastic about talk-based media in the form of short advertisements and educational talks on the local (culturally relevant) media and small group discussions. Ideally, these discussions would involve a member of their own community who had experience of the condition and its treatment.\textsuperscript{29}

Understanding the philosophy of a different culture and integrating this understanding into the provision of clinical care is challenging and complex. It is important to realize the effects which culture, religion and family background have on patients. A deeper understanding of these effects will inform the development of a service which would cater to the needs of a specific population. We have gained valuable understanding of the continence needs of South Asian women and have received suggestions from our focus groups on
appropriate ways to develop a service that will provide not only cultural sensitive care but also be a focal point for improving awareness of incontinence within the community. This study involved a self-selecting sample of women and it is not clear how widely the findings are generalizable. However, it has laid the groundwork for further research towards gaining a better understanding of urinary incontinence in an ethnic community and educating ourselves as the health care providers about implementing culturally sensitive care.

Declaration

Funding: University Hospitals of Leicester NHS Trust and University of Leicester.

Ethical approval: As described in the text, we sought the opinion of our local research ethics committee about approval for this study. At the time, the role of the NHS LREC was to assess research taking place in the NHS premises or research studying NHS patients or staff. This study was therefore declared outside the remit of the LREC. In order to ensure participant confidentiality and to protect the rights of participants as much as possible, we conducted the study in an identical fashion to other focus group work we have done where the LREC had previously given an opinion. It is the nature of focus group studies that individuals are able to withdraw consent at any time by physically ceasing to participate or by removing themselves from the group. We believe that we have conducted this study according to the principles of the Helsinki Declaration.

Conflicts of interests: AD and EP have no interests to disclose. DT currently sits on the advisory board of clinical studies funded by Eli Lilly and Co., and Johnson & Johnson Medical. Consultancy payments for these studies have been managed by the University of Leicester Research and Business Office and used to support his research programme. He is also the principal investigator on three investigator-initiated studies that are funded by research grants from Johnson & Johnson Medical, Astellas Pharma and UCB Pharma. In 2006, he has received grants-in-aid towards attendance at International Scientific meetings from American Medical Systems, Astellas, Pfizer, UCB Pharma and Janssen Cilag. CJM has provided surgical training in the use of the Tension-free Vaginal Tape (TVT) and Transobturator Vaginal Tape (TVT-O) devices, and the Apogee and Perigee mesh systems for prolapse surgery during sessions organized by Johnson and Johnson Medical and American Medical Systems. He has received honoraria for speaking at symposia at International meetings.

References


