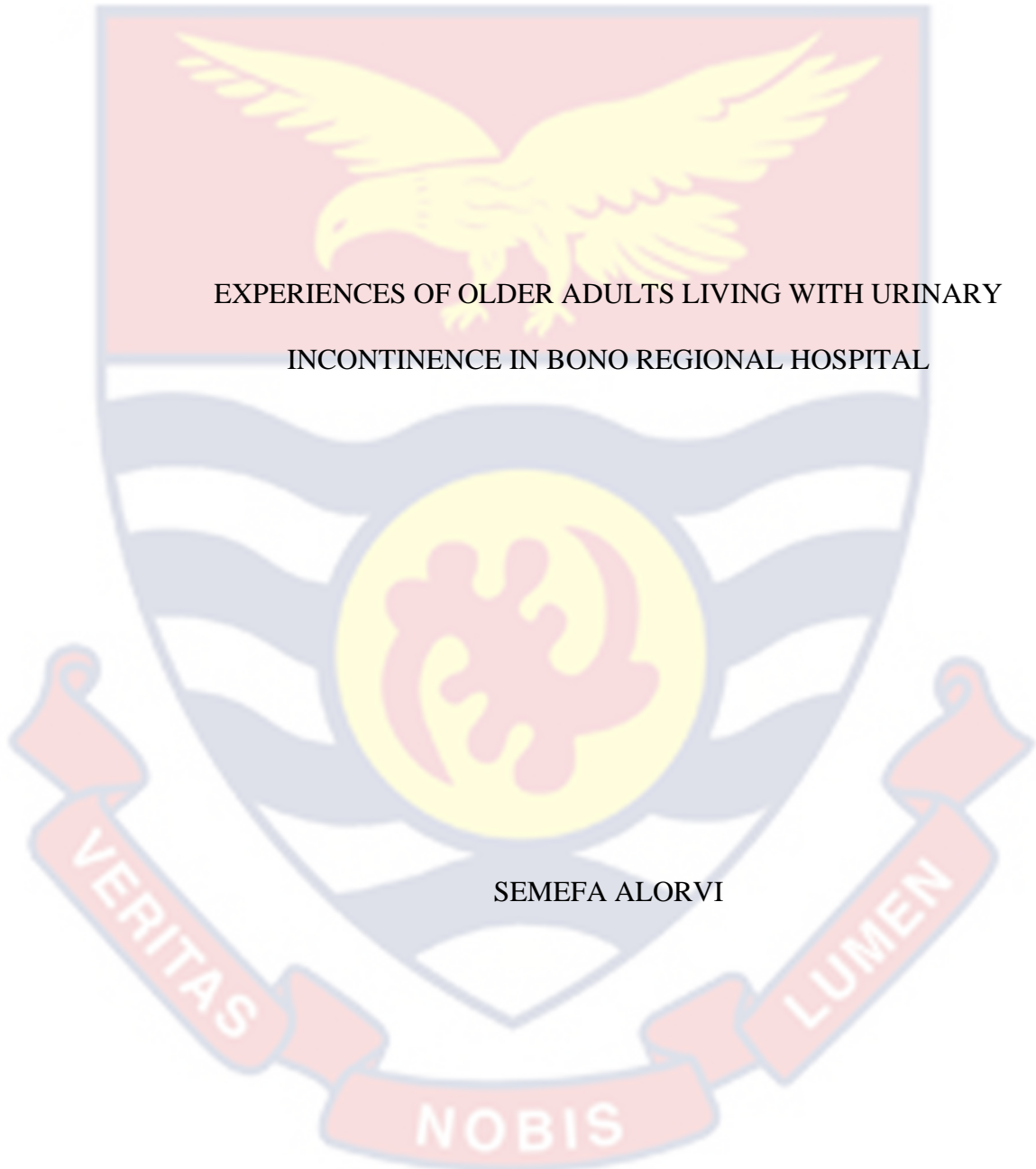


UNIVERSITY OF CAPE COAST



EXPERIENCES OF OLDER ADULTS LIVING WITH URINARY
INCONTINENCE IN BONO REGIONAL HOSPITAL

SEMEFA ALORVI

2023

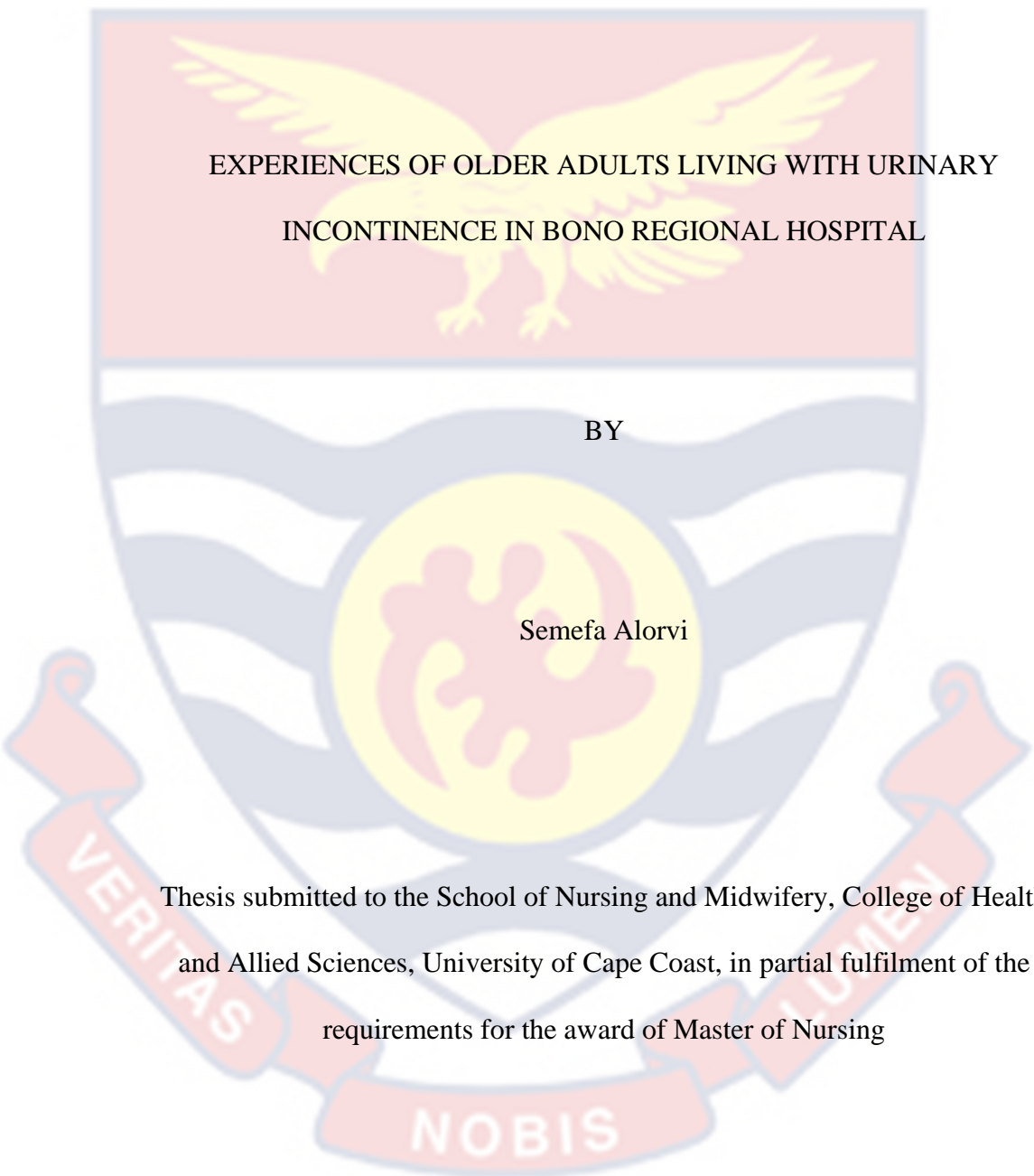


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EXPERIENCES OF OLDER ADULTS LIVING WITH URINARY
INCONTINENCE IN BONO REGIONAL HOSPITAL

BY

Semefa Alorvi

Thesis submitted to the School of Nursing and Midwifery, College of Health
and Allied Sciences, University of Cape Coast, in partial fulfilment of the
requirements for the award of Master of Nursing

November, 2023

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented in whole or part for another degree in this University or anywhere.

Candidate's signature..... Date:

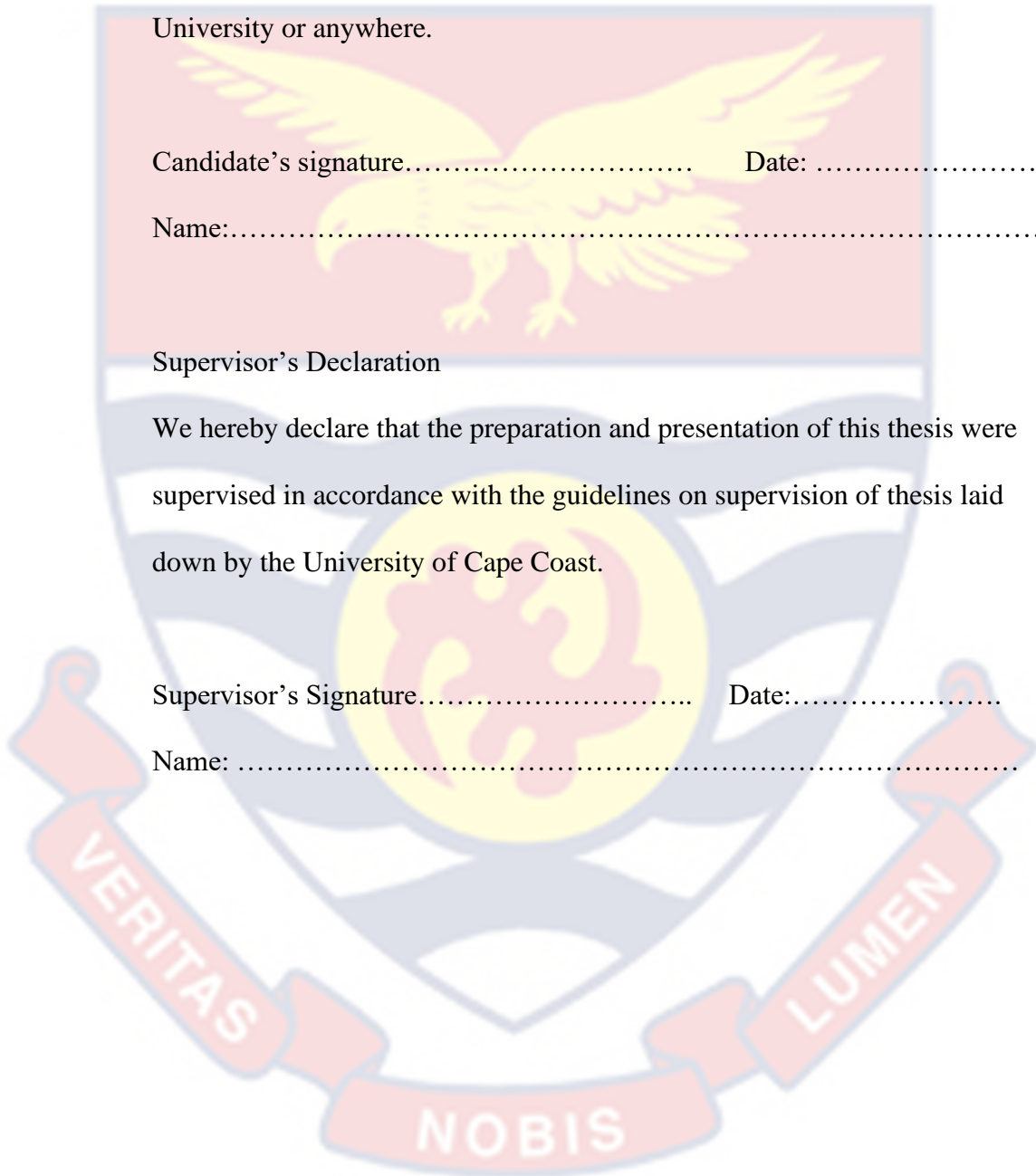
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Supervisor's Declaration

We hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

Background: Urinary incontinence (UI) poses detrimental impacts on several domains of health. Nonetheless, there is paucity of empirical evidence on the experiences of older adults living with UI in Ghana. This study explored the experiences of older adults living with UI in the Bono Regional Hospital.

Methods: A descriptive qualitative study was conducted among seven purposively sampled adults aged 60 years and above who reported to the Urology Clinic of the Bono Regional Hospital. In-depth interview was conducted among the participants using a semi-structured interview guide. Braun and Clarke's approach for thematic analysis was employed for data analysis.

Results: Data analysis revealed that UI negatively impacts the physical, psychological and social domains of life of older adults living with UI. Physical impacts of UI included general body discomfort and appearance, disturbed sleep pattern, dehydration and nutritional impairment, and impaired sexual function. Sense of worry, agony, and anxiety, and suicidal ideation, were the psychological impacts of UI experienced by the participants. Also, they experienced social impacts of UI such as impaired interpersonal interaction, limitations on traveling, and limitations on attending professional and social gathering. Nonetheless, participants coped with UI through self-encouragement and assurance, good personal hygiene, and lifestyle modification.

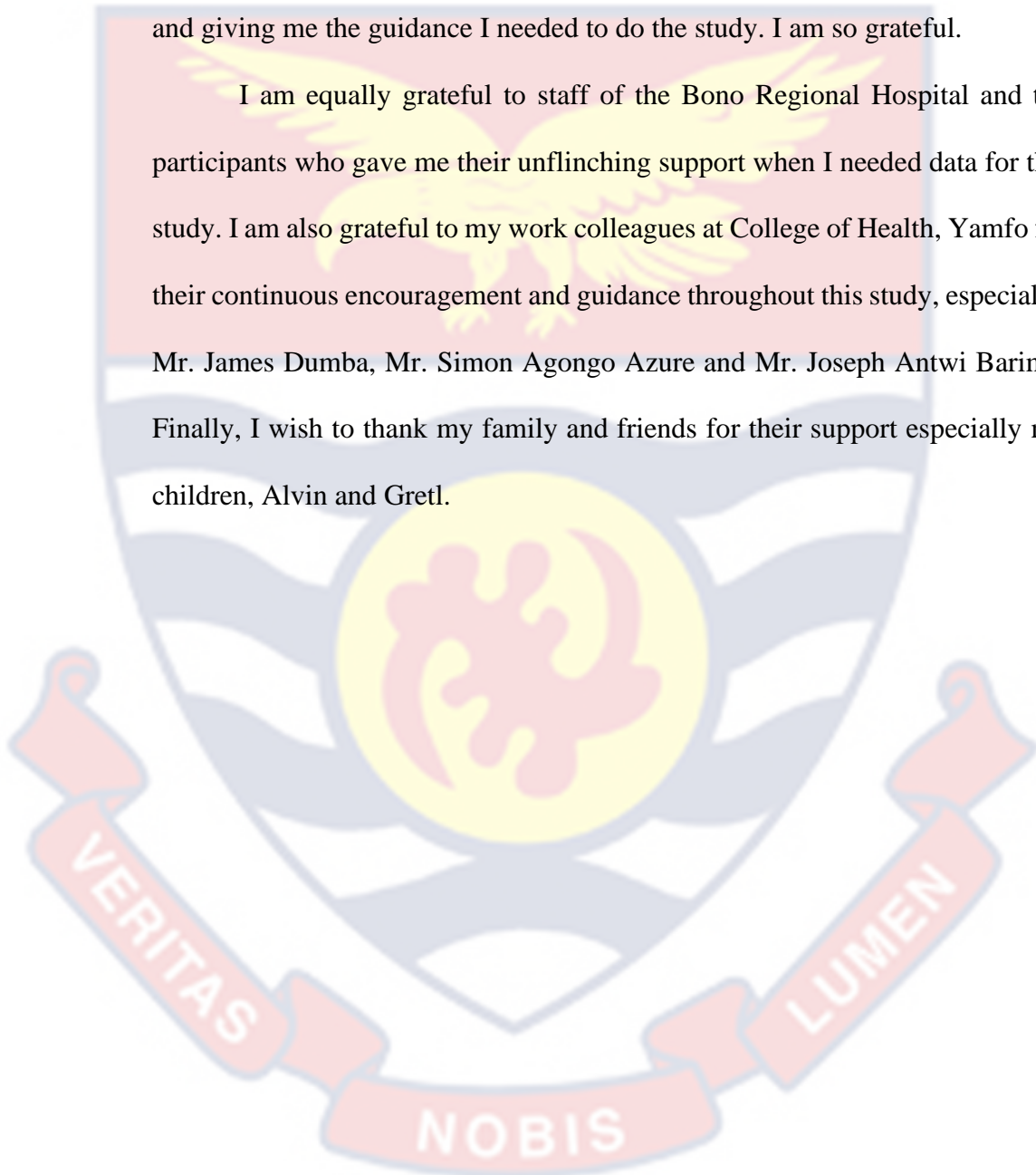
Conclusions: This study revealed several physical, psychological, and social impacts of UI on the wellbeing of older adults. There is the need to provide older adults with the necessary physical, psychosocial, and spiritual support to help them develop effective coping strategies to manage urinary incontinence.

Keywords: **Keywords:** Experiences, Urinary incontinence, Older adults, Bono Regional Hospital, Ghana

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DEDICATION

To my husband, Norbert Akonu Gyapong.



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LIST OF ACRONYMS

WHO – World Health Organization

UI - Urinary Incontinence

ICD – International Classification of Diseases

ICS – international Continence Society

CDC- Centre for Disease Control and Prevention



CHAPTER ONE

INTRODUCTION

Background of the Study

Urinary incontinence (UI) presents as a distressing public health problem that affects people globally. As a major public health concern, UI predominantly affects the geriatric population (Aoki et al., 2017; National Institute of Aging, 2017; Sheng et al., 2017). Globally, the prevalence of UI as reported in population-based studies ranges from 9.9% to 36.1% (World Health Organization [WHO], 2017). Several epidemiologic studies estimate the prevalence of UI to be between 25%–45% in females and 5%–35% in males (Grant & Currie, 2020; Shaw & Wagg, 2021), and this is twice as high in older adults (Davis et al., 2020; Milsom & Gyhagen, 2019; Shaw & Wagg, 2021; WHO, 2017). A systematic review found the pooled prevalence of UI to be 21% in Sub-Saharan African among women aged 15-100years (Ackah, et al., 2022). Varying prevalence estimates reported in literature may be due to difference in definitions of UI, population demographics, study designs, and study durations.

The etiology of UI among the elderly population is multifactorial. However, increasing age, and the age-specific physiological changes occurring in the lower urinary tract system have been increasingly stressed as a major risk factor among other notable factors such as obesity, chronic respiratory disorders, surgical complications, multigravidity and multiparity (Aly et al., 2020; Biswas et al., 2017; Corrado et al., 2020). More than 40% women aged 70 years and above are victims of UI (Milsom & Gyhagen, 2019). The high prevalence of UI among the geriatric population forms part of the widespread misperception that UI is an expected part of aging. Nonetheless, the

International Classification of Diseases (ICD) classifies UI as a disease (WHO, 2023).

Moreover, UI impacts on many aspects of the lives of victims, with resultant detrimental consequences on their quality of life (Biswas et al., 2017).

For a typical aged patient suffering from UI, significant impairment of various components of their quality of life is eminent (Biswas et al., 2017; Corrado et al., 2020; Fan, Huang, & Yu, 2015; Ghafouri et al., 2014). Quality of life is the individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (Gibbons, Skevington & WHO Quality of Life[WHOQOL] Group, 2018). It comprises four main domains as physical, social, psychological and environmental.

Despite the well-documented evidences on the burden of UI on the quality of life of those living with UI, the extent of funding required to propel research activities, and treatment of UI in Ghana is greatly encumbered by the unawareness by the public and some health professionals that UI is a disease (Aikins et al., 2016; Apt, 2012; Dovie, 2019; Frost et al., 2015; Tikkinen, et al., 2012). Thus, there is need for public health activities to increase awareness about UI, and researches that will seek to broaden understanding about UI and its dynamic trends within the Ghanaian context. This study is timely to describe the experiences of older adults living with UI who are being cared for in the Urology Clinic in Bono Regional Hospital.

Problem Statement

In Ghana, a prevalence rate of 12% has been reported for UI (Ofori et al., 2020). It is noteworthy that the presence of UI exposes individuals to a

number of detrimental social, emotional, and psychological consequences, and poses a great threat on the quality of life of older adults (Javanmardifard et al., 2022; Sensoy et al., 2013). In Ghana, there has been limited studies on urinary incontinence (Danso et al., 2007; Ofori et al., 2020) but those studies were not specifically related to older adults although they form the majority of the population living with the condition. This situation could result in a negative toll on the attainment of Sustainable Development Goal (SDG) 3, which aims to ensure healthy lives and promote well-being for people of all ages. These consequences therefore call for rigorous studies to be conducted on the subject. However, there is not yet a published study in Ghana which explores the experiences of older adults in relation to the physical, psychological and social domains of life.

There is also limited attention in most healthcare settings in Ghana regarding UI (Agarwal et al., 2014; Ofori et al., 2020). Particularly, the Bono Regional Hospital which serves as a major referral center in the region provides care to people with UI through its Urology Clinic amidst the scarcity and resource-limited state. However, among the wide range of medical care provided to older adults living with UI, psychosocial support and integration of social support into existing services for older adults with UI is missing. Thus, there is a considerable need for studies on the subject of UI and its impact on the domains of quality of life among older adults within the Ghanaian context, particularly in the Bono Regional Hospital, in order to pioneer the conduct of similar or related studies. Hence, this research will form a baseline data for other works within the same scope. Also, findings of the study will aid in filling the dearth in literature by exploring the experiences of older adults regarding UI

and their coping strategies in the management of UI in Bono Regional Hospital in Ghana.

Purpose of the Study

The study sought to describe the impact of UI on the physical, psychological, and social wellbeing of older adults living with UI in the Bono Regional Hospital.

Specific Objectives

The study was guided by the following specific objectives to;

1. describe how UI affects the physically life of older adults.
2. describe the psychological effects of UI on older adults.
3. understand how UI impacts on the social life of older adults.
4. understand the coping strategies adopted by older adults living with UI.

Research questions

1. How does UI affect the physical of older adults?
2. How does UI affect the psychological wellbeing of older adults?
3. How does UI impact the social life of older adults?
4. What coping strategies do older adults adopt in managing UI?

Significance of the Study

Findings generated from the study will assist in describing the physical, psychological and social burdens of UI among the gerontological population within the Ghanaian context. This in turn provides relevant information for effective coping strategies for better management of the patients' physical, psychological and social impact of UI. Further, the results of the study will inform policies which are geared towards ensuring healthy lives and promoting well-being for people of all ages as stipulated by the Sustainable Development

Goal (SDG) 3. Again, findings from the study will be extended to other hospitals and quasi facilities with similar patient populations with UI. The findings of this study will also contribute to existing literature on UI and its impact on various domains of the quality of life of older adults in Ghana and worldwide, and further provide an avenue for further research using mixed methods to obtain a holistic view of the concept of UI.

Delimitations

The scope of the study is delimited to older adults 60 years and above with established diagnosis of UI and are seeking urology care in the Bono Regional Hospital. Also, the variables explored in this study were delimited to the physical, psychological and social domains of health.

Limitations

Given the qualitative nature of the study, interviews were conducted through a mix of face-to-face and telephone approach. The use of telephone interview approach has the tendency to mask some non-verbal cues the researcher could have picked in a face-to-face interview and thereby miss the rich experiences these non-verbal communications could add to this research. Nonetheless, the researcher applied precautions such as active listening, debriefing, and visual aid such as video call to ensure that non-verbal cues were captured to improve methodological rigor of credibility and transferability.

Given the general misperceptions about UI within the Ghanaian context and the stigma attached to older adults living with UI, the researcher faced minimal hesitance regarding participants' willingness to partake in the study which affected the sample size. That notwithstanding, the researcher assured

participants of ethical concerns such as confidentiality, anonymity, and privacy among others prior to their participation.

Definition of Terms

For purposes of this study, the following terms shall be operationalized as defined below;

1. Older adults: individuals who have attained the age of 60 years and above
2. Urinary incontinence: leakage of urine in any form.

Organization of the Study

This study is organized in five chapters. The first chapter deals with the background to the study, the statement of the problem, purpose of the study, research objectives, significance of the study, delimitations, limitations, definition of terms and organization of the study. Chapter two focuses on the review of related literature. Chapter three focuses on methodology which describes the research design, the population sample and sampling techniques, a description of the Bono Regional hospital and older adult participants recruited for the study, data collection instruments, validity and reliability of the instrument, pilot testing, data collection procedures and methods of the analysis. Chapter four describes the results and discusses it. Summary of findings, conclusions and recommendations, form the chapter five of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

A literature review is a piece of academic writing which illustrates knowledge and understanding of the literature on a specific topic put in a context (Institute for Academic Development, 2022). It seeks to present a critical evaluation of content covering existing research on a chosen topic. Literature search began with the use of keywords such as “urinary”, “incontinence”, “older”, “adult”, “leakage” as single search term or in combination using Boolean search tools terms such as, “AND”, “OR” and “NOT”. Searches were generated from databases such as CINAHL, PubMed, Google scholar, Embase among others. Literatures were obtained from journals, periodicals, medical, nursing and other health-related books. Website documents from renowned institutions such as the World Health Organization (WHO) were also consulted. The literature review was organised in three forms; conceptual review, theoretical review, and empirical review.

Conceptual Review

Overview of urinary incontinence

Urinary incontinence (UI) is a condition in which a person is unable to control the release of urine from the bladder, which results in the unintentional leakage of urine (WHO, 2017). UI ranges in severity from occasional leaks to a complete inability to control urination. Research has shown that urinary incontinence is a silent condition that makes women feel uncomfortable talking to others or seeking medical attention (Seshan, 2016). According to Seshan and Muliira (2015), the prevalence of UI varies from 20% to 68% around the world.

Despite the high prevalence of UI, people living with UI are mostly hesitant to make their conditions known until symptoms become severe (Vasavada et al., 2021). Extant literatures have reported the association between increasing age and the risk of UI (Tran & Puckett, 2022; Grant & Currie, 2020; Shaw & Wagg, 2021) and this risk is twice as high in older adults (Davis et al., 2020; WHO, 2017). There are several types of UI, including stress incontinence, urge incontinence, overflow incontinence, functional incontinence, and mixed incontinence (Tran & Puckett, 2022). Each type has its own specific causes and symptoms.

According to WHO (2017), stress incontinence is the most common type and occurs when pressure on the bladder, such as coughing or sneezing, causes urine to leak out. Urge incontinence, also known as overactive bladder, is characterized by a sudden and intense urge to urinate, which can result in leakage if a person cannot get to a restroom in time. Overflow incontinence occurs when the bladder is unable to empty completely, leading to frequent dribbling or leaking. Functional incontinence is a type that occurs when a person has difficulty reaching the restroom due to physical or cognitive limitations. Finally, mixed incontinence is a combination of two or more types of urinary incontinence (WHO, 2017).

UI impacts significantly on a person's quality of life, leading to embarrassment, social isolation, and decreased activity levels (Elenskaia et al., 2011). In spite of all the challenges associated with UI, most people do not seek medical help. Hospital visits on account of UI represents only an underrepresented population of those living with UI (Minassian et al., 2013; Minassian et al., 2012). However, there are a variety of treatments available,

including lifestyle changes, pelvic floor exercises, medications, and surgery, which can improve symptoms and help people manage the condition

Overview of the domains of quality of life

Quality of life is the individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (Gibbons et al., 2018). It comprises four main domains as physical (which describes an individuals' perception about their physical state), psychological (which describes an individuals' perception about their affective and cognitive state), social (which describes an individuals' perception about their interpersonal relationships and the social roles in their life) and environmental (which describes the individual's perception about their environment) (Gibbons et al., 2018).

There is empirical evidence that individuals living with chronic health conditions, have their health-related quality of life mostly impacted (John Hopkins Arthritis Centre, 2023; de Wit & Hajos 2013). Health-related quality of life spans the physical, social and psychological domains of the conventional WHO quality of life domains. Given the chronicity of UI, various life activities of people living with UI are negatively impact. This negative impact expands to consequently affect key domains such as the physical, psychological and social domains of health (Urology Care Foundation, 2023). For a typical elderly patient suffering from UI, significant impairment of various components of their quality of life is eminent (Biswas et al., 2017; Corrado et al., 2020; Fan, Huang, & Yu, 2015; Ghafouri et al., 2014). Thus, this study operationalized the three domains of quality of life (physical, psychological and social) to understand the

experiences impact of UI of older adults living with UI in Ghana with regards their overall wellbeing.

Empirical Review

Physical Health Impact of Urinary Incontinence

Urinary incontinence can significantly impact physical health by causing skin irritation, muscle strain, an increased risk of falls, dehydration due to reduced fluid intake, impaired sleep, urinary tract infections, mobility loss, sexual health issues, hygiene challenges, and even pressure ulcers in severe cases (Biswas et al., 2017; Corrado et al., 2020). It is important to review literature in this area in order to contextualize the study.

In a systematic review and meta-analysis on the correlates of UI, Batmani et al. (2021) found that physical consequences such as pressure sores, sleep disturbances and decreased sleep quality, urinary tract infections, falls and fractures to be associated with UI. Further to that, UI was associated with other physical characteristics such as age, obesity, diabetes, hypertension and smoking.

In Nigeria, Ugare et al. (2014) conducted a cross-sectional in which they found some physical challenges associated with living with UI. They found that UI was characterised by urine retention and was only relieved by the use of catheter. Also, UI was the main cause of complications such as pyuria (18.2%), pericatheter sepsis (17.5%), and haemorrhage which mostly occurred during the change of catheter (16.8%). Mainly, compromised physical comfort was mostly associated with UI among the study participants.

In a cross-sectional study, Corrado et al., (2020) examined the impact of UI on the quality of life of 28 patients living with UI in the Metropolitan City

of Naples, Italy. Participants were interviewed using a multidimensional questionnaire. Findings from the study revealed that, UI was associated with physical challenges in the area of participants' occupation ($p = 0.044$), and was complicated by comorbidities ($p = 0.038$), obesity ($p = 0.008$), and the use of diuretics ($p = 0.007$).

Further, Kwak et al. (2015) characterised the physical impacts of UI, in their study where they found that participants who had UI also experienced challenges regarding self-care, pain and physical discomfort, and mobility. Also, odour resulting from UI and inability to change clothing frequently were major physical challenges of UI which consequently affects quality of life.

Woodward (2014) explained that the force of friction and shear that occurs when the skin comes into contact with clothing increases the risk of skin break down, manifesting as pressure sores especially among people living with UI. Given this sequence of impact, the physical impact of UI is eminent through pressure sores and physical damages to the skin.

Psychological Health Impacts of Urinary Incontinence

Urinary incontinence has significant psychological impacts on affected individuals. There is evidence that, UI often leads to emotional distress, low self-esteem, social isolation, depression, anxiety, and strained relationships. It can also affect sexual function, disrupt sleep, and lead to avoidance behaviors that impact daily life (Kessler et al., 2022; Stickley et al., 2017). A review of these psychological impacts are important to situate this study within the appropriate theoretical context.

In a prospective population-based cohort study, Kessler et al., (2022) investigated the effect of UI on negative self-perception of health and

depression in elderly adults. They recruited 1,593 elderly adults among whom interviews were conducted at baseline, 2008, 2016 and 2017. The findings revealed that elderly adults with UI at the baseline study had a 4.0 and 3.4 risk of developing negative self-perception of health and depressive symptoms, respectively, after nine years of follow-up, compared to those without UI. The results show a greater probability of mental problems among elderly adults with UI.

Similarly, Stickley et al. (2017) in their study, investigated the effects of UI on mental health and loneliness among community-dwelling older adults in Ireland. They analyzed data of 6903 community-dwelling adults aged 50 years or above in the first wave of The Irish Longitudinal Study on Ageing (TILDA) in 2009–2011. Findings revealed that UI and its frequency and severity were significantly associated with series of mental health problems, particularly, depression, and loneliness. Thus, stronger link has been established between UI and markers of psychological wellbeing.

In another longitudinal study, Bogner et al. (2002), examined the relationship between UI and psychological distress in community-dwelling older adults. They hypothesized that persons with UI associated with condition-specific functional loss would be most likely to report psychological distress. Findings from the study revealed that persons with UI were more likely to experience psychological distress compared to those without UI. Persons with condition-specific functional loss secondary to UI were substantially more likely to have psychological distress than were persons without UI. However, after controlling for age, gender, ethnicity, and chronic medical conditions, the association between condition-specific functional loss secondary to UI and

psychological distress remained statistically significant. Generally, findings from the study uphold the evidence that condition-specific functional impairment mediates the relationship between a chronic medical condition and psychological distress.

In another study, Avery and Stocks (2016), examined the associations between UI and depression and psychological factors through the review of population-based studies. From their review, they found that there is a significant relationship between UI and psychological disorders such as depression, anxiety among others.

Findings from the study by Wang et al. (2014) revealed the significant association between UI and the experience of stigma among women living with UI. Although stigma may not be psychological in nature, it poses several psychological impacts on the individual. Thus, based on their findings, it is important to consider pragmatic approaches to reduce stigma associated with living with UI in order to improve health seeking among people living with UI.

Social health impacts of urinary incontinence

Urinary incontinence, the involuntary loss of urine, has significant social health impacts on affected individuals. This condition can lead to social isolation as individuals withdraw from activities due to fear and embarrassment. Reviewing literature on this topic is relevant to inform further understanding.

Using qualitative approach, Javanmardifard et al. (2022), explored the psychosocial experiences of older women in the management of UI. The study employed a semi-structured interview guide to collect in-depth data from 22 older women living with UI through purposive sampling. Data analysis was done using a conventional content analysis approach. It was found that older

people with UI had various psychosocial experiences while living with and managing this disease. These experiences were characterised into four main themes namely, “problem incompatibility with the disease,” “mental impasse,” “facing social restrictions,” and “concealment and social escapism.” The findings imply that paying attention to these psychosocial experiences while supporting and taking care of these patients can positively impact their psychosocial health and quality of life.

In another study, Fultz and Herzog (2001) examined the social and emotional impacts of UI on people aged 40 years and above who were living with UI. It was found that, those who were younger, male, less educated, lower in social desirability, in poorer health, or losing greater quantities of urine were more likely to report psychosocial distress, although these correlates were not consistently significant. Compared with continent respondents, significantly higher percentages of incontinent respondents reported feeling depressed, lonely, or sad. In the multivariate models, incontinence retained an independent association with loneliness, but not with sadness or depression. Even though the direct psychosocial impact of urine loss may be minor in many cases, UI is associated with a constellation of physical and behavioral factors that can impose a social and emotional burden. This suggests that UI cannot be adequately evaluated or treated without consideration of the patient's overall quality of life.

Adaptive mechanisms for urinary incontinence

Living with UI can be a stressful event for most people. Nonetheless, several people adopt some useful strategies in managing and living with UI so as to reduce the negative consequences of the condition on their overall quality

of life. It is important to include such coping or adaptive mechanisms in this review in order to expand knowledge on the concept.

In Iran, a qualitative study was conducted by Javanmardifard et al. (2022) to explore the experiences of older women regarding how they coped and managed UI. Following data collection through the use of face-to-face unstructured in-depth interviews with 22 purposively sampled older women living with UI, a conventional content analysis approach was applied. Findings revealed that four main categories of “resilience” with three subcategories, “change in lifestyle” with six subcategories, “attempt for treatment of the condition” with three subcategories, and “receiving support” with two subcategories. Generally, the study found that older women suffering from UI were resilient against the condition, had changed their lifestyles to manage the condition, and sought treatment. In addition, receiving support from the family and the society played a significant role in the follow-up and management of the condition.

In a study, Mohamed et al. (2020) examined the coping strategies adopted by menopausal women in managing UI. Findings revealed that both negative and positive coping mechanisms were utilised by the participants. Nonetheless, only half (50%) of the participants utilised any form of coping mechanisms, while others did not utilise any form of coping mechanisms.

In a cross-sectional study, Aydin et al. (2022), examined the coping strategies for UI among a sample of 320 older adults. It was found that the frequency of use of coping mechanisms for UI was associated with illiteracy level, being single, having chronic disease, advanced age, being a woman, having UI during activities, having a wet diapers or underwear, sharing the

issues with relatives, not consult a doctor because they are afraid of being examined.

In the study by O'Neil and Gilmour (2003), management strategies for UI were identified. It was found that management by family physicians (without the need for specialist referral) includes lifestyle modification, pelvic floor muscle strengthening, bladder retraining, and pharmacotherapy with muscarinic receptor antagonists. Findings further reveal that patients with pelvic organ prolapse might require specialist referral for consideration of pessaries or surgery, but family physicians can provide follow-up care. Women with more complex problems, such as severe prolapse or failed continence surgery, require referral.

Summary of the review

This chapter presents a review of the literatures in relation to the thematic areas of the study. The review was structured in such a way that both conceptual and empirical reviews were presented. Findings reveal that, as a very important geriatric syndrome that affects older adults globally, UI has far reached consequences for individuals who suffer it. UI impacts negatively on various domains of health such as physical, social and psychological wellbeing of the individual. Generally, there is paucity of empirical evidence regarding the topic of UI and its impact among people living with it within the Ghanaian context. Previous studies focused on prevalence of UI without further efforts to describe the psychosocial and physical burdens of this condition. Given the increasing age expectancy, and transitions in demographic characteristics, it is important to develop pragmatic evidence-based approaches to reduce the burden of chronic diseases on the gerontological population. This study

therefore sought to fill the empirical gap by describing the experiences of older adults regarding how UI impacts on their physical, psychological and social wellbeing in the Bono Regional Hospital.



CHAPTER THREE

RESEARCH METHODS

Introduction

The study sought to describe the impact of UI on the physical, psychological, and social wellbeing of older adults living with UI in the Bono Regional Hospital. This section describes the methods that were employed in ensuring that the objectives of the study were well achieved. Emphasis was placed on specific areas such as the research design, study area, population, sampling procedure, data collection instrument, data analysis and ethical considerations.

Research Design

A qualitative descriptive research design was employed in this study in order to describe the subjective experiences of the participants (Green & Thorogood, 2014). Grove et al. (2015) describes a qualitative research design as a systematic, interactive, and subjective approach that is used to describe and to give meaning to life experiences. Given the lack of empirical paucity regarding the impact of UI on the physical, psychological and social domains of health within the context of Ghana, this approach was employed to derive accurate picture of how the situation is and to draw meaningful insights. Although several other designs could have been used, the qualitative descriptive design was considered for the study because of its advantage of allowing detail-oriented data to be collected (Brandon, 2018). This means, respondents get the opportunity to describe their individual experiences related to how UI has affected the quality of their lives in an in-depth manner and thereby aiding the researcher to draw out a vivid description about this phenomenon.

Study Area

The study was conducted within a clinical setting at the Bono Regional Hospital. The Bono Regional Hospital is located in the western side of Sunyani, the administrative capital of the Bono Region of Ghana. It lies on Latitude 7.34598° or $7^{\circ} 20' 46''$ north and Longitude -2.31443° or $2^{\circ} 18' 52''$ west and is bounded on the north by New Dormaa township, Sunyani Central Business area on the south, Penkwase on the east and Odumase on the west. The hospital is the largest secondary-level hospital (by patient attendance and specialist care) in Sunyani and the Bono Region. Serving as a major referral centre, the hospital receives cases from health facilities in the Bono and other surrounding regions. (Nketia et al., 2022). It has twenty-six (26) units or departments with a total bed capacity of 350 and offers 24hour Accident and Emergency services as well as general and specialists services including running a Urological clinic which saw a total of 2,482 cases of urinary related conditions in the year 2022 out of which twelve (12) were urinary incontinence. The justifications for choosing this facility are that, it being a major referral centre it sees a lot of urinary related cases and it runs a urological clinic where patients with UI, including older adults may attend. Also, no previous study has been conducted among aged patients with UI to describe how the condition impacts on various domains of their health. Therefore, a study in this hospital will serve the purpose of being a pioneer for the conduct of similar studies.

Population

A research population is typically a sizable group of people or things that serve as the main subject of a scientific inquiry. Research is conducted with the population's welfare in mind. However, because population sizes are so

large, it is frequently impractical and expensive for researchers to test every member of the population. Researchers use sampling techniques because of this. The term "research population" also refers to a clearly defined group of people or things that are known to share common traits. Typically, every person or object within a population shares some sort of unifying quality. The study population comprises older adults aged 60 years and above living with UI and are seeking care at the urological unit.

Inclusion and exclusion criteria

Inclusion criteria involves the features that potential research participants must possess in order to be part in the study (Nikolopoulou, 2022). For this study, older adults aged 60 years and above, diagnosed with UI, and have reported to the Urological Clinic of the Bono Regional Hospital within the study period were enrolled. Participants who consented to partake in the study were recruited.

Nonetheless, exclusion criteria “comprise characteristics used to identify potential research participants who should not be included in a study” (Nikolopoulou, 2022). Participants who had been diagnosed with any mental disorders were excluded from the study in order for their mental disorders not to compromise the responses. Also, those with severe medical conditions requiring hospitalization were excluded.

Sampling procedure

A purposive sampling approach was used to select respondents for this study. Purposive sampling is a type of non-random sampling method (Banerjee & Chaudhury, 2010) which recruits participants for a study based on their particular knowledge of a phenomenon for the purpose of sharing that

knowledge (Streubert, & Carpenter, 2011). This sampling procedure is widely used in qualitative research it enables the researcher obtain rich information because the participants have directly experienced the phenomenon.

For a qualitative study, the rule-of-thumbs for the determination of sample size is the point of saturation. A total of 7 participants were interviewed at which point data saturation was reached. The sample was generated based on the Urology clinic register of older adults aged 60 years and above. Data was collected in four (4) months i.e. from July to October, 2022. Although the eligible participants were eleven (11) in number by then, only nine (9) consented to partake in the study, however, data saturation was achieved by the time the 7th participant was interviewed.

Data collection instrument

The researcher utilized a semi-structured interview guide in gathering rich information from participants in line with the study objectives and information collected on literature review. The semi structured interview guide is an ideal instrument for this study because although carefully constructed questions are asked, it allows enough flexibility to enable new questions to pop up based on the responses of the interviewee. The interview guide was structured in five (5) sections. Section A comprised the socio-demographic characteristics of the participants or background information such as; age, sex, educational level, ethnicity number of years living with urinary incontinence and presence of any other medical condition aside urinary incontinence. Section B, C and D bordered on a set of questions aimed at eliciting responses from participants about the impact of urinary incontinence on their physical, psychological and social health respectively (WHO, 1996) while Section E

contained questions about their coping mechanisms in adapting to urinary incontinence. The items in the interview guide were guided by the three domains (physical, psychological and social domains) of health and thorough literature review.

Following the development of items in the interview guide, pre-testing was done at the St. John of God Hospital, Duayaw Nkwanta using two (2) older adults who were aged 62 and 65 years respectively. These two participants were living with UI and shared similar characteristics in terms of age and other clinical features with the main study sample hence their recruitment for pretesting. It was ensured that, responses from the pretesting were not added to the main study. The pretesting helped to correct any ambiguities in the interview and ensure that it was clear. After pretesting, the follow up question “If you are unable to sleep well or take enough water, etc., how does that affect your health” was added to clarify the first probe in section B which reads “Has urinary incontinence impacted on your activities of daily living such as sleep, intake of fluids, foods and medication?”

Data collection procedures

The researcher collaborated with the Unit In-charge and staff of the Urological Clinic where older adults routinely visited for consultations and reviews. This collaboration was geared towards generating a list of all eligible participants from the registry and making announcements of the study so that those who were interested would prepare to give their consent for participation in their next urological visit. Of the eleven (11) participants listed and approached, only nine (9) consented to partake in the study but a total of seven (7) had been interviewed by the point of saturation. Their verbal consent was

sought in their next visit and they were made to indicate the time and venue convenient for them for their interviews.

On the scheduled dates of the data collection for each participant, their informed consent was re-established after the purpose of the study was explained to them again so that those who may have changed their mind not to take part in the study could withdraw without any hindrance. Each participant was given an assurance of confidentiality. When this was done, they were provided with a written informed consent which were well explained by the researcher. Participants were then granted great autonomy to read thoroughly the consent form where they could decide to sign or thumbprint before any interview could commence. This autonomous activity lasted between 5-10 minutes or even less depending on the pace of the participant.

A semi-structured interview guide was used to collect data. The interview guide consisted of five sections, that is, A to E. During a one-on one interview lasting averagely between twelve to twenty-five (12-30) minutes, the interviews were conducted in either English or Twi as per the convenience of the study participants. The Twi is a much more universal language in the Akan speaking areas and the Bono region is no exception, as the Twi language far more dominant as compared to Bono. There will therefore not be any significant translation losses. In addition, Bono is not yet a documented language so it will be impossible to write a translation into Bono). Re-establishing consent from participants and the subsequent interviews were done on different schedules and at different venues as were convenient for each of them. Therefore, the researcher returned to the urological clinic or venue that the participant indicated to continue the one-on-one interviews depending on the scheduling

and venue arrangements done with the participants. It was reiterated to each participant that they had the opportunity to back out from the interview if for any reason they did not want to continue at any point in time. They could also choose not to respond to a question if they did not want to.

The interviews were conducted by the researcher with the aid of a voice recorder. A research assistant was engaged to write down the interview and put down notes in order that significant cues would not be missed. These were kept in a folder of field notes to aid transcription. Three (3) interviews were conducted within the hospital setting, two (2) conducted at participants' homes and two (2) were done through phone calls since physical presence was not possible.

In recent times telephone interviews have become accepted in qualitative research as a number of researchers have concluded that respondents are willing to engage in telephone conversations and produce high quality data (Drabble, Trocki, Salcedo, Walker, & Korcha, 2016; Saura & Balsas, 2014; Vogl, 2013). As and when participants felt exhausted or distressed during the interview sessions, they were made to take a break for some minutes before the interview continued.

Data analysis

Data obtained from the qualitative study was transcribed verbatim from audio forms to written. Interviews conducted in Twi were then translated into the English language before the analysis began. According to Green and Thorogood (2014), thematic analysis is well-suited for qualitative descriptive study. The analysis was guided by the Braun & Clarke (2006) approach to thematic analysis. This method of analysis consists of a six-phased step-by-step

guide, namely, familiarizing yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes and producing a final report. Following the six steps, the researcher first played each interview audio several times to familiarize its content before transcribing them into written forms. Also, field notes were also read to know some important cues that were picked while interviewing each participant. Prior to the commencement of the analysis, two interviews which were conducted in Twi were transcribed in Twi before transcribing back to English. The researcher read the written transcripts thoroughly several times and highlighted codes shared on the phenomenon by respondents. The codes generated were revised for homogeneity to form smaller themes, which were later revised into sub-themes. The emerging sub-themes were further categorized and revised into larger overarching themes that reflect the experiences and viewpoints of the participants. The data was reviewed several more times for congruence with the identified themes. Finally, a supervisor with much knowledge into data analysis was consulted to review the data to ensure that due diligence had been done by the researcher. The developed themes were then made concrete for the final analysis report.

The analysis followed a deductive approach, driven by the three domains of quality of life (physical, psychological and social) and an objective on adaptive mechanisms. Thus, the analysis followed a top-down or structured approach, where the researcher developed a clear idea of what is being looked for in the data based on the existing domains of the quality of life. Thus, codes or categories that align with their domains of the study were considered for the analysis.

Ethical considerations

Ethical approval was sought from the Institutional Review Board of the University of Cape Coast (IRB-UCC) with identification number UCCIRB/CHAS/2021/246. A request letter written by the researcher in addition to a copy of clearance from IRB- UCC was served to management and Ethical Review Board of Bono Regional Hospital and laid down ethical processes in the facility duly followed. Some ethical issues which were followed included informed consent, autonomy and confidentiality. To obtain informed consent from participants, the researcher provided each participant with adequate information about the study, how the results will be used, assurance of confidentiality and anonymity. They then appended their signature or thumbprint as proof of their consent to the study. Confidentiality was maintained by ensuring that hard copies of transcribed interviews, audiotapes, field notes were locked safely in a cabinet where no one but only the researcher had access. Anonymity of participants was also ensured by using number codes instead of participants' names. Participants were admonished that should they want to back out of the study at any point in time, they had the right to do so. The data from this study was used for only academic purposes. Participants were also not being named in any report ensuing from this study. Sources of ideas and information for this study were be duly cited and referenced to avoid plagiarism.

Rigor of the Study

The goal of rigor in qualitative research is to ensure that the research design, method, and conclusions are explicit, public, replicable, open to critique, and free of bias (Leung, 2015) Criteria used in ensuring rigor included

credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018).

Credibility

This research was qualitative research and utilized interview as a means of data collection. This approach gave the participants a good opportunity to express themselves and give details of their experiences or knowledge on the topic of interest. The researcher spent 12-30 minutes for each interview with the participants and this helped the researcher to gain detailed information, observe verbal and non-verbal behaviours and make proper interpretation from them. The transcribed data was reviewed by the researcher twice and a supervisor with much knowledge looked into the data analysis. Written documents from the interview were reviewed several times before making conclusions in order to ensure that conclusions drawn from the respondents' data reflect their original views (Korstjens & Moser, 2018).

Transferability

Transferability means describing not only the behaviour and experiences, but their context as well, so that the behaviour and experiences become meaningful to an outsider (Korstjens & Moser, 2018). Transferability refers to the extent to which the findings of a qualitative study conducted in one context can be applied or transferred to another, similar context. To ensure transferability in this study, it was ensured that the specific context or setting of the study was described in terms of location, participants, time frame, and any unique characteristics that may influence the findings. Also, details of the study methodology were described in order to improve reader understanding and reproducibility. During the analytical phase, it was ensured that direct quotes of

the participants were incorporated in the findings to illustrate key points or themes, hence allowing readers to connect with the voices of the participants and understand the context better.

Dependability

Dependability refers to the stability of the data over time and over the conditions of the study (Polit & Beck, 2014). Selection of the participants for the research was maintained throughout the study with the purposive sampling techniques as discussed earlier. Conditions and environment for conducting the research was maintained for each interview. The gathered data was discussed with a supervisor of much knowledge in order to come out with better deductions and confirmations.

Confirmability

Confirmability is the neutrality or the degree to which the findings are consistent and could be repeated (Connelly, 2016). The research recordings were transcribed verbatim. After that, it was listened to and compared with the written documents line by line to ensure accuracy which could promote repeatability and also confirm that findings are not a figment of the researcher's own imagination but purely drawn from respondents' data.

Plan for Dissemination of Research Findings

A dissemination plan is a plan for disseminating research findings or products to those who will use the information in practice (CDC, 2015). Very critical to quality reporting of qualitative research results are clarity, organization, completeness, accuracy, and conciseness in communicating the results to the reader of the research manuscript (Johnson, Adkins, & Chauvin, 2020). Data was stored in electronic formats on a computer. The findings of the

study will be disseminated to the School of Nursing and Midwifery, UCC, the Sam Jonah Library, UCC and research department of the Bono Regional Hospital. Email of researcher was given to study respondents upon request so copies of research findings will be made available to participants through emails upon request. Further to that, the study findings will be converted into a publishable manuscript and submitted to a peer-reviewed journal for publication to help disseminate the findings to the scientific community.



CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

The first section of this chapter presents the findings of the study in relation to the impacts of urinary incontinence on the quality of life of older adult clients who visited the Bono Regional Hospital during the study period. The background information of the participants was presented first. Then, guided by the Braun & Clarke (2006) approach to thematic analysis, themes and sub-themes were presented and supported by selected verbatim quotes to illustrate content of the interviews. Findings were presented for a total of 7 participants which was the sample size obtained at the point of data saturation.

Table 1: Background Information of the Participants

Pseudonyms	Age	Sex	Religion	Ethnicity	Educational level	Length of time living with UI	Co-morbidities
P1	60	Male	Christianity	Ewe	Tertiary	3 years	Hypertension
P2	61	Male	Christianity	Dagaaba	Tertiary	6 months	None
P3	67	Female	Christianity	Fante	Tertiary	5 years	None
P4	68	Male	Christianity	Ashanti	Middle school	3 years	None
P5	68	Female	Muslim	Ga	Tertiary	9 years	Hypertension
P6	62	Female	Christianity	Bono	Tertiary	3 years	Hypertension
P7	64	Female	Christianity	Fante	Middle school	3 years	Hypertension

Table 1 presents the background information of the participants who were interviewed, a total of 7 participants, comprising 4 females and 3 males,

whose ages ranged from 60 to 68 years were interviewed. All participants are Christians except one who was a Muslim. The participants belonged to diverse ethnic groups which include: Ewe, Fante, Ga, Dagaaba, Ashanti and Bono. Except for one participant who lived with urinary incontinence for a minimum of 3 months, others lived with it for up to 3 or more years. Four participants had hypertension as a co-morbidity, while 3 had no co-morbidities.

Organization of Themes and Sub-themes

From the thematic analysis, four (4) major themes and twelve (12) sub-themes emerged as summarized in table 2. These themes were in tandem with the four study objectives, and were supported with verbatim quotes to further expand and convey the ideas in each sub-theme.

Table 2: Summary of themes and sub-themes from transcribed data

Themes	Sub-themes
Physical health impacts of urinary incontinence	i. General body discomfort and appearance ii. Disturbed sleep pattern iii. Dehydration and nutritional impairment iv. Impaired sexual function
Psychological health impacts of urinary incontinence	i. Sense of worry, agony and anxiety ii. Suicidal ideation
Social health impacts of urinary incontinence	i. Impaired interpersonal interaction ii. Limitations on traveling iii. Limitations on attending professional and social gathering.

Adaptive mechanisms for urinary incontinence	i. Self- encouragement and assurance
	ii. Personal hygiene
	iii. Lifestyle modification

Source: Field data, 2023

Theme 1: Effects of Urinary Incontinence on Physical Health

This theme explored participants' experiences of urinary incontinence and how it impacted their physical health. These impacts were expressed and discussed under four themes: general body discomfort and appearance; disturbed sleep pattern; dehydration and nutritional impairment; and impaired sexual function.

Sub –theme one: General body discomfort and appearance

Participants described how urinary incontinence imposed some discomforts on them and altered their physical appearance. The feeling of bodily pains was one of the eminent reasons for their generalized body discomfort. One of the male participants had this to say about the discomfort he experienced from pain in his manhood as a result of urinary incontinence:

... I have discomforts too. I feel pain in my manhood (Penis)... I don't feel comfortable in my manhood. -P2

Fatigue was another reason for the experience of generalized body discomfort among three of the participants who shared their experiences:

Yes! I feel fatigued from constantly getting up to go to the washroom and plenty washing (chuckling). – P2

... I wake up with headaches in the morning, my BP goes up and I feel tired so I have to be in bed for a while... - P5

I feel tired. I feel tired so even in the day, sometimes, I have to lie down small when I wake up. - P7

In addition to the feelings of discomfort, participants described that they had disturbed body image due to some alterations in their dressing and its associated body odor. Due to the constant wearing of pads, diapers, and the wetness that comes with wearing some of these auxiliary underpants, some participants said they felt so uncomfortable. Four participants shared their experiences this way:

...It affects everything! Your dressing, you can't even dress. Hmmm...because, any dress you put on will get wet.

– **P1**

When it started, I had body odor because I did not know what to do.... Now I am in my menopausal ages but I still use sanitary pad and diapers [because of urinary incontinence]. - P3

Hmmm... I always had to be wearing pad or liner. It is so uncomfortable. I don't like it at all. I need fresh air. - P6

Ehenn! If the urine is dropping in my pants, I will surely smell and sometimes I feel it Even if I put something in my pant like pad, I still smell because it is urine... I feel it!

– **P7**

Sub-theme two: disturbed sleep pattern

Disturbance in the sleep pattern of participants was a major issue of concern to them as far as the physical impact of urinary incontinence was concerned. Most of them associated this interrupted sleep to the frequency at which they had to wake up to urinate in the night. Most of them shared this experience this way:

Sometimes, it gives [me] sleepless night... - P1

At night times, when I wake up to urinate, the urine would leak while I have come back to bed ... and after that I am unable to really sleep again. -P2

Hmmm... when I sleep too, I have to wake up and be 'wee weeing', because I don't want to soil the bed or soil the pant.

I do this always so I don't sleep much. - P7

Sub-theme three: Dehydration and Nutritional impairment

For the fear of soiling their beds and overloading themselves with fluids which may precipitate their urinary incontinence, most of the participants resorted to low intake of water. Thus, they tend to be thirsty and hungry although they would have wished to drink enough water or taken sufficient food. Some of them recounted this experience:

Due to this urinary incontinence], I do not drink a lot of water because I fear there will be more urine. Even if I am eating and there is soup, I am not able to take in much soup. – P3

I have not been eating well as it used to be. – P4

Naturally, I am someone who likes taking a lot of water but because of this issue, I have tried to adjust to not taking so much.... Once I step out for any reason, then I put a limit on that [water intake] and I end up becoming thirsty most of the time. – P5

I have been careful what I take in especially fluids.... I have been someone who liked to drink a lot of water before I started experiencing this so me not being able to drink

enough water is something that makes me feel very thirsty.... I feel like I am a bit dehydrated. - P6

Sub-theme four: Impaired sexual function

Participants recounted how urinary incontinence posed negative impacts on their sexual function mostly resulting to low sexual activities. Most of the participants complained of low sexual libido which they ascribed to the frequent leakage of urine. One female participant with urinary incontinence recount how her husband had to engage in extramarital sexual affairs due to her inability to satisfy her husband's sexual needs. Their concerns regarding sexuality have been described below:

...Because of what I am going through, I do not want to try it [sex] at all.... I don't want to take any risk again. No! as for that [sex] I don't do it. -P1

My sex drive has honestly gone down. It doesn't normally come to mind. My mind is on something else. – P2

That [sex] is another big problem for me. I have not been active. In the beginning, my husband did not understand me, he even cheated on me with other women, and I still think he is doing it.... My husband sees it like he is living with a baby. There got to a time he wasn't coming closer to me. But, what can I do about it? - P3

After an intercourse, the next day, the frequency of the incontinence increases but after some few days if nothing happens again, it will come but not as frequent like immediately when I have had an intercourse. -P5

Theme 2: Psychological Health Impacts of Urinary Incontinence

Participants experienced arrays of psychological distresses as a result of urinary incontinence. *These impacts were described in two main sub-themes as: sense of worry, agony and anxiety; and suicidal ideation.*

Sub-theme one: Sense of worry, agony and anxiety

Most of the participants expressed intense worry about the current state they found themselves in. Their worry springs from the realization that, their current conditions may have no positive outcomes even after treatment. Some of them also expressed their worry over the embarrassments they had to suffer as a result of living with urinary incontinence. Some of them described their worries as below:

... as a human being [like me] you will be thinking and worrying about certain things [like this]; [although] people say you shouldn't get thinking or worried, you will certainly think about it. – P1

Hmmm! I won't lie to you. I haven't been myself in a while. I am really worried whether this situation will get better and how soon. -P2

If you look at a grown-up woman like me, with all that I have achieved in life [yet] suffering from this strange disease, you should know it is disturbing me and.... So, I think about it a lot... - P3

One of the participants recounted the sense of agony she had to go through considering how traumatizing it was to consider living with urinary incontinence for the rest of her life. She had this to say:

...I am imperfect now. I am really agonized. There is a saying that life begins at forty. Now that I am supposed to rest after my retirement and enjoy life, look at what this strange disease is doing to me. – P3

Due to the long-term worrying experienced by some of them, anxiety becomes inevitable. This sense of anxiety was severe for one of the participants, while the other got over it because she believed she had to acquaint and purpose her mind to live with urinary incontinence for as long as possible. They had this to say:

Hmmm! This has been very stressful. [I] step out very anxious all the time. This has been mentally draining because, [I] have to be anxious [because] I may wet my dress. – P6

Recently, I had that anxiety and all that but now there has been little improvement that kind of gives me a possible outlook on what to think, so I don't feel seriously anxious. –

P5

Sub-theme 2: Suicidal ideation

The thought of living with urinary incontinence and its associated embarrassments was a reason for ideating suicide, as described by one of the participants. Although others see urinary incontinence as a major issue of psychological concern, suicide ideation was not an option for them, except for one participant who had this to say:

In the beginning [of this urinary incontinence], I did not wish to live again because when I look at myself as a grown-up woman with urine dripping from me, I felt

like killing myself. I would have taken my life had it not been a divine intervention. – P3

Theme 3: Social health impacts of urinary incontinence

Urinary incontinence had some unbearable impacts on the social health of the participants. Participants described how various domains of their social life were affected. These impacts have been characterized into three main sub-themes as: impaired interpersonal interaction; limitations on traveling; and limitations on attending professional and social gathering.

Sub-theme one: Impaired interpersonal interaction

Participants recount the impact of urinary incontinence on their ability to maintain lasting and meaningful relationships with people within their social networks. Thus, they limited their interactions with people so as to save themselves from embarrassments. Some participants shared their predicaments below:

You cannot mingle [with people] like you used to. No! no! no! Even, sometimes, my colleagues will like to pay me visit but when they come, I will tell my wife to tell them I am outside the room.... You will feel uncomfortable so it is better to keep them away from yourself. – P1

.... It limited my social life in a way and how I relate to people outside my home. -P5

.... I don't get close to people. Maybe if I am talking to the person, I will have to keep some distance so that if there is any odor, the person will not [perceive the smell]. So, I

don't want them to know ...I keep a distance or when I keep long at a place, I don't mingle too much... – P7

Sub-theme two: Limitations on traveling

Due to urinary incontinence, some of the participants do not consider the decision to travel anywhere. Even for the few who travel, long journey is not a considerable option for them. Thus, instead of embarking on journeys either for events or some other reasons, it becomes difficult for them, especially, to convey in public transport. They had this to say concerning their situation of traveling:

.... If it is a journey that will require that I spend the night outside my home, it disturbs me. I always have to get a private place to lodge. – P3

.... I try to make time for some of those engagements but traveling to other areas and staying for a couple of days, I try to avoid it if I can. - P5

.... if I am in a public transport, I mostly would sit behind the driver [in order] that I could beg him to stop for me to urinate. [Even with that] you may feel shy [since you might be the only begging for him to stop for you to urinate]. – P

7

Sub-theme three: Limitations on attending professional and social gathering

All participants had major concerns with attending social gatherings due to their urinary incontinence. They perceived that they may be embarrassed while attending these gathering in case, they soil themselves with urine. Some others

believe people may be aware of their condition which may draw wrong perceptions about them. They shared their predicaments as below:

When there is a convention at church, I am not able to partake because I fear that if I go and sleep there, people will see my condition. [similarly], when there is a funeral in my hometown and I have to attend, I will always go and look for a private place to lodge [to avoid embarrassment]. – P3

These days I do not really want to be in the crowd for long because, though I sometime wear pad, it becomes full [soiled with urine] and so I have to quickly leave ... so I don't stay in social gathering for a long time. – P6

One participant also expressed her inability to go to work again due this condition:

*For some time now, almost 3 months, I don't ... go to work, you know it is not easy. As for work, I cannot go! As for that one, I can't go!
– P1*

Theme 4: Adaptive mechanisms for urinary incontinence

Almost all participants adopted positive coping mechanisms for urinary continence. They believed living with this condition for the rest of their lives will require of them to adopt useful adaptive skills that will sustain them until they get any potential remedies or their successful end of life. These adaptive mechanisms have been characterized into three themes: self-encouragement and assurance; personal hygiene; and lifestyle modification.

Sub-theme one: Self-encouragement and assurance

Some of the participants express their hope that things will get better. This expression of hope was in regards to their trust in God and expectations for a better future devoid of their current predicament. They had this to say:

... I am just looking at God to heal me. That is my hope. ...I just hope that one day they would find a cure [for my urinary incontinence]. – P1

Lastly, I put my trust in God that one day I will be healed. – P3

Sub-theme two: Personal hygiene

Almost all the participants were identified with their ability to maintain self-hygiene as an adaptive mechanism for urinary incontinence. Personal hygienic practices such as regular washing of clothes, change of soiled clothes, use of pads, diapers and panty liners among others have been well-tolerated by the participants as adaptive mechanisms for urinary incontinence. Some of these practices were described below:

I also wash my under-wears often to prevent odor... - P2

What helps me now is the use of diapers and the sanitary pad.... So, I change my diapers from time to time. -P3

Oh! for now, it's the panty liners that help me. But when I know I will keep long out of the home I use sanitary pad.-

P5

... I would put pad in my pant ... so, panty liners and pad

– P7

Sub-theme 3: Lifestyle modification

Participants shared some helpful modifications they made to their lives in order to survive the stress of living with urinary incontinence. Some of them

restrained themselves from traveling for long hours, reducing their intake of excessive water, whilst others engaged in some forms of pelvic muscle strengthening exercises to help them live with urinary incontinence. This was how some of them described these lifestyle modifications:

I try to make time for some engagements but traveling to other areas and let's say, staying for a couple of days, I try to avoid it if I can, because of the stress of ensuring that I have toilet facilities close by. – P5

...I cut down on water... -P5

There is also some exercise they have been teaching me at the hospital. ... [Kegels] ... so I do it small by small. - P5

... You see, she was teaching me about some exercise... Kegel!

... I have started not long but I am praying that it will help me. - P7

Four major themes, and twelve subthemes emerged for the analysis. Issues ranging from physical, social, as well psychological factors accounting for urinary incontinence were narrated by participants, and have been duly analysed for further discussion.

Discussions

This section is dedicated to the detail discussions of the results from the analysis. Below is the outline of the order of the discussions.

1. Physical Health Impact of Urinary Incontinence
2. Psychological Health Impacts of Urinary Incontinence
3. Social health impacts of urinary incontinence
4. Adaptive mechanisms for urinary incontinence

Effects of Urinary Incontinence on Physical Health

The objective seeks to describe the experiences of participants regarding how UI impacts their physical health. This objective was achieved through a qualitative analysis which revealed that the physical health associated with urinary incontinence included general body discomfort and appearance, disturbed sleep pattern, dehydration and nutritional impairment, and impaired sexual health function. This means the physical health of the adult who participated in the study was negatively affected by UI. The finding is in line with extant literature (Corrado et al., 2020), which found UI to have impacted negatively on physical wellbeing of participants. The study mainly focused on evaluating the impact of urinary incontinence on quality of life among residents of the Metropolitan City of Naples, Italy, using a newly designed multidimensional questionnaire. The study discovered that overflow urinary incontinence was associated with a greater deterioration in the aspirational and occupational domain. Symptom severity was worse in those who had comorbidities, who had a high body mass index or who used diuretics. The results suggested that there is a significant impairment of quality of life in patients who have only primary education and who follow a pelvic floor rehabilitation program.

Interestingly, participants expressed concern about sleep disturbance as a major issue they experienced due to UI. Similar observations were made in a previous study where quality of sleep was greatly influenced by UI (Winkelman et al., 2018). This finding can be explained by the fact that older persons who are affected frequently wake up at night due to the need to urinate or an unintentional leak, which causes fragmented and insufficient sleep.

Additionally, the worry and stress associated with the possibility of accidents at night can make sleep problems worse, which feeds a vicious cycle of poor sleep quality.

Additionally, for the fear of experiencing severe symptoms of UI, most older adults are not able to drink sufficient water and some hydrated foods. Thus, this alteration in hydration and nutritional status negatively impacts on the physical wellbeing of the participants. Similar findings were reported by Willis-Gray et al. (2018). This implies that, people living with UI will have to balance their intake of water vice-a-vice their urge for urination as well as have a well-informed schedule on the time of the day to take in enough water and when to reduce water intake in order to have a balanced hydration status.

The finding has several implications on the adult populations; urinary incontinence can lead to skin irritation and infections due to the constant moisture and exposure to urine; increase the risk of developing UTIs, which can cause pain, discomfort, and fever. Urinary incontinence can increase the risk of falls and fractures, particularly in older adults who may have other mobility issues. The physical health impacts of urinary incontinence can significantly affect an individual's quality of life, leading to functional impairment and reduced independence. Treatment options such as pelvic floor exercises, medications, and surgical interventions may be effective in managing urinary incontinence and improving physical and psychological well-being.

Psychological Health Impacts of Urinary Incontinence

The study revealed that the psychological health impact of urinary incontinence were sense of worry, agony and anxiety as well as suicidal ideation. This means adults who participated in the study had a severe

psychological issue with urinary incontinence. Some to the extent of considering suicide. The finding corroborates Bogner et al. (2002), who worked on urinary incontinence and psychological distress in community-dwelling older adults. Their study aimed at examining the relationship between urinary incontinence (UI) and psychological distress in older adults. They hypothesized that persons with UI associated with condition-specific functional loss would be most likely to report psychological distress. Persons aged 50 and older (n = 781) were interviewed between 1993 and 1996 for whom complete data were available. The study found that persons with UI were more likely to experience psychological distress. Persons with condition-specific functional loss secondary to UI were substantially more likely to have psychological distress as measured by the GHQ than were persons without UI. In multivariate models that controlled for potentially influential characteristics such as age, gender, ethnicity, and chronic medical conditions the association between condition-specific functional loss secondary to UI and psychological distress remained statistically significant. Among people with UI, persons with persistently elevated GHQ scores were much more likely to report condition-specific functional impairment from UI.

Stickley, Santini, and Koyanagi (2017), posited that UI was associated with worse health among older adults. Little is known however, about its relation with loneliness or the role of mental health in this association. The study discovered that although frequency of UI and activity limitations due to UI were both significantly associated with loneliness prior to adjustment for mental disorders, neither association remained significant after adjustment for both depression and anxiety. The study further drew the attention to the fact that UI

is associated with higher odds for loneliness among older community-dwelling adults but this association is largely explained by comorbid mental health problems, in particular, depression.

Urinary incontinence is a common problem among older adults, and it can have a range of psychological implications that can significantly impact their quality of life. Older adults with urinary incontinence may become socially isolated due to fear of embarrassment or the need to constantly be near a bathroom. This can lead to feelings of loneliness and depression. The fear of having an accident or being unable to control one's bladder can lead to anxiety and panic attacks. This can further exacerbate the problem of urinary incontinence. It's important for older adults with urinary incontinence to seek treatment and support to address both the physical and psychological aspects of their condition.

Social health impacts of urinary incontinence

Another interesting finding that emerged from the study was that impaired interpersonal interaction, limitations on traveling, limitations on attending professional and social gathering were the social health impacts of urinary incontinence as posited by the participants. This means adults who participated in the study felt their social life was curtailed by urinary incontinence.

Fultz and Herzog (2001), explored self-reported social and emotional impact of urinary incontinence. The study identified incontinent respondents at risk for psychosocial distress and to understand the relationship between urinary incontinence (UI) and other determinants of social and emotional status. Incontinent respondents self-reported the extent to which urine loss restricted

social activities or affected their feelings about themselves. All respondents were asked whether they felt depressed, lonely, or sad. Covariates included sex, age, race, education, social desirability, health status, frequency of urine loss, quantity of loss, and urgency. The study discovered that participants who were losing greater quantities of urine were more likely to report psychosocial distress, although these correlates were not consistently significant. The study further reported that participants were feeling depressed, lonely, or sad.

Javanmardifard et al. (2022), investigated psychosocial experiences of older women in the management of urinary incontinence. Their study aimed to determine the psychosocial experiences of older women in the management of urinary incontinence. The results indicated that the older people with urinary incontinence had various psychosocial experiences while living with and managing this disease. Accordingly, the participated had problem incompatibility with the disease, mental impasse, facing social restrictions, and concealment and social escapism. Facing social restrictions corroborates the findings of this current study where participants had limitations to social programmes and gathering.

Implications of social health impact of urinary incontinence among older adults can be drawn from the findings. It includes the following but not limited to causing embarrassment, shame, and social isolation, leading to reduced quality of life for older adults. This can result in decreased participation in social activities, leading to feelings of loneliness and depression. Urinary incontinence can be stigmatized, and older adults who suffer from it may feel embarrassed or ashamed to discuss their condition with others. This can lead to a reluctance to seek help or to use incontinence products, leading to further

social isolation and reduced quality of life. Urinary incontinence can also have an impact on caregivers who may be responsible for providing assistance to older adults with the condition. Caregivers may also experience social isolation and may be unable to participate in social activities due to the demands of providing care. The cost of incontinence products, medical appointments, and treatments can add up quickly, leading to financial strain and reduced ability to participate in social activities. The social health impact of urinary incontinence among older adults can be significant and should be taken seriously. It is important to provide education, resources, and support to older adults and their caregivers to help them manage this condition and maintain their social health and well-being.

Adaptive mechanisms for urinary incontinence

The finding of the study showed that self-encouragement and assurance, personal hygiene, and lifestyle modification served as the adaptive mechanisms for urinary incontinence. Anyone experiencing such a condition would have to develop a coping strategy to avert or minimise the impact as outlined by the participants in this current study. Some use medications and non-medications strategies in managing urinary incontinence. Several studies have been done in this regard.

Mohamed, Helmy, and Hafez (2020), research coping strategies with stress urinary incontinence among menopausal women. The purpose of their study was to identify coping strategies among menopausal women with urinary stress incontinence. The results of the study showed that half of the participants seldomly used any coping strategies, The self-reliant coping strategy was the most used one while the emotive coping strategy was the least used one. The

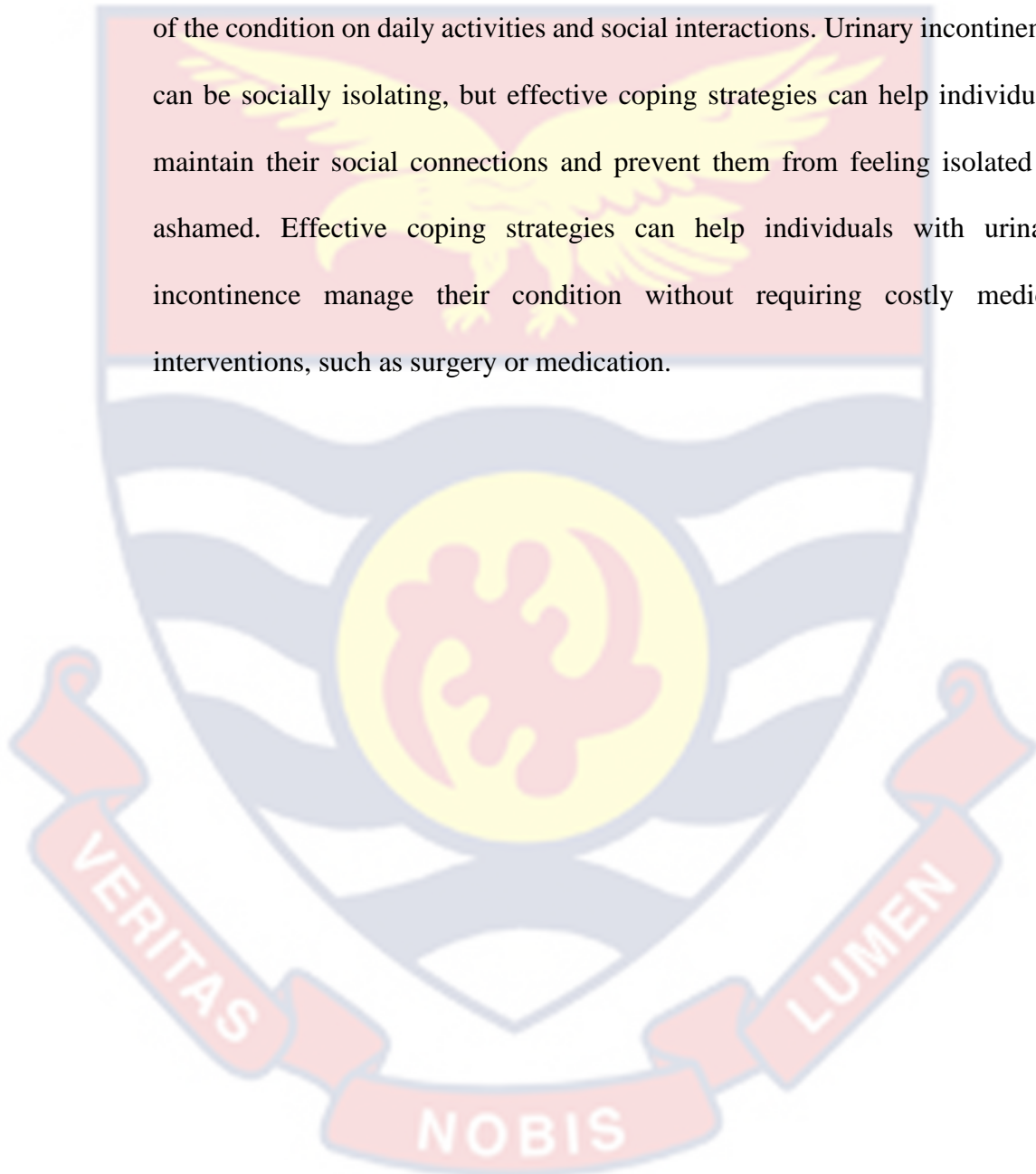
researchers posited that women use problem-based coping strategies (Evasive and confronting) in an attempt to positively cope with health problems.

Aydin Avci, Öz Yildirim, Yildirim, and Bulgak (2022), non-medication coping strategies for urinary incontinence in older adults: factors associated with frequency of use. The aim of this study was to determine the frequency of the use of non-medication coping strategies for urinary incontinence in older adults. The results of the study discovered that older adults who were illiterate, who were single, who had a chronic disease, who were at an advanced age, who were women, who described having urinary incontinence during activities, who always experienced leaking urine, whose diapers or underwear got wet, who shared these issues with their relatives, and who did not consult a doctor because they were afraid of being examined were all found to have a higher frequency of use of coping strategies for urinary incontinence.

Javanmardifard, et al., (2022), work on experiences of urinary incontinence management in older women. The present study aimed to determine older women's experiences in urinary incontinence management. In their research, the data were collected through face-to-face unstructured in-depth interviews with 22 older women suffering from urinary incontinence selected via purposeful sampling. The study found that in addition to receiving support from the family, the society played a significant role in the follow-up and management of the condition. They were of the view that their findings can help healthcare team members focus on urinary incontinence, design care programs for older women with this condition, and improve their quality of life.

Urinary incontinence can be a challenging condition for adults to manage, and coping strategies can play an important role in helping them

maintain their quality of life. The specific implications of coping strategies for managing urinary incontinence can vary depending on the strategies used and the individual's situation. Coping strategies that are effective in managing urinary incontinence can lead to improved quality of life by reducing the impact of the condition on daily activities and social interactions. Urinary incontinence can be socially isolating, but effective coping strategies can help individuals maintain their social connections and prevent them from feeling isolated or ashamed. Effective coping strategies can help individuals with urinary incontinence manage their condition without requiring costly medical interventions, such as surgery or medication.



CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter presents a summary of the study's process as well as the key findings that emerged from the study. The chapter also has the conclusions and recommendations that were made based on the findings of the study. Areas suggested for further research are also presented.

Summary

The focus of the study was to describe the experience of older adult patients living with UI in the Bono Regional Hospital. It sought to inquire how UI affects physical, psychological and social health of older adult patients and adaptive measures older adults employ while living with urinary incontinence. A qualitative descriptive research design was employed in this study in order to explore the the experiences of the older adults on urinary incontinence. The population which consisted of older adults sixty (60) years and above were selected from Bono Regional Hospital for the study. Purposive sampling technique was employed to select participants for the study. Self-developed semi-structured interview schedule was used in collecting data from the Urological Department of the Bono Regional Hospital. The interviewed data were transcribed, coded and analysed thematically using the Braun and Clarke approach. Findings were discussed in relation to the research questions.

Key findings

1. The study discovered that physical health impacts associated with urinary incontinence included general body discomfort and appearance, disturbed sleep pattern, dehydration and nutritional impairment and impaired sexual function.
2. The study revealed that psychological health impacts of urinary incontinence were sense of worry, agony and anxiety as well as suicidal ideation.
3. The finding of the study showed that impaired interpersonal interaction, limitations on traveling, limitations on attending professional and social gathering were the social health impacts of urinary incontinence.
4. The findings of the study portrayed that self-encouragement and assurance, personal hygiene, lifestyle modification served as the adaptive mechanisms for urinary incontinence.

Conclusions

Generally, older adults living with UI had negative experiences regarding their condition. These experiences impacted on their physical, psychological and social health. Nonetheless, participants were able to adopt mechanisms such as self-encouragement and assurance, good personal hygiene, and lifestyle modification to effectively cope with their condition.

Recommendations

1. Caregivers should encourage individuals to maintain good hygiene and dryness by changing their incontinence products regularly. Using skin protectants and moisturizers can also help prevent skin breakdown and improve the appearance of the skin. Healthcare practitioners should address any underlying medical conditions that may be contributing to nocturia (nighttime urination), such as diabetes or heart failure. Caregivers can help

individuals manage their fluid intake in the evening and implement a toileting schedule to minimize nighttime bathroom trips. Caregivers can encourage regular fluid intake and offer nutritious snacks and meals.

2. Healthcare practitioners and caregivers need to acknowledge and validate the individual's feelings of worry, agony, and anxiety. They should listen actively and empathetically to their concerns, and provide reassurance that urinary incontinence is a common condition that can be managed.
3. Open communication between individuals with urinary incontinence and their family and friends can help reduce social isolation and feelings of stigma. Healthcare practitioners and caregivers can encourage individuals to discuss their condition with their loved ones and provide information on how to talk about urinary incontinence in a respectful and supportive manner.
4. Healthcare practitioners, caregivers, and family members should educate individuals with urinary incontinence on their condition, provide access to resources such as incontinence products and support groups, and encourage them to take an active role in their treatment plan. Healthcare practitioners, caregivers, and family members should suggest modifying the home environment, such as installing grab bars or handrails, to make it easier for individuals to manage their condition independently.

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Appendices

University of Cape Coast
College of Health and Allied Sciences
School of Nursing and Midwifery
Cape Coast.
1st July, 2021.

The Chairman,
Institutional Review Board
University of Cape Coast
Cape Coast.

Dear Sir,

APPLICATION FOR ETHICAL CLEARANCE FOR RESEARCH

SEMEFA ALORVI (SN/MNS/19/0008)

I wish to apply for ethical clearance to enable me conduct research on the topic "Quality of Life of Aged Patients with Urinary Incontinence in Bono Regional Hospital".

The research is to enable me write thesis as part of my requirements for the master of Nursing Programme. Kindly find attached all relevant documents for this purpose.

Yours faithfully,



Semefa Alorvi.

NOBIS



UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH



Telephone: 233-033-209 7282
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Email: adulthealth.nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DAH/T/2/Vol.1/25

Your Ref:

1st July, 2021

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast

Dear Sir,

REQUEST FOR ETHICAL CLEARANCE: MS. SEMEFA ALORVI

I am the supervisor of the above named Master of Nursing student of the School of Nursing and Midwifery, University of Cape Coast with registration number: **SN/MNS/19/0008**.

She intends to conduct a study on the topic: **"QUALITY OF LIFE OF AGED PATIENTS WITH URINARY INCONTINENCE"**. The aim of the study is to explore the quality of life among aged patients with urinary incontinence at the Bono Regional Hospital.

We would be grateful if you could accord her the necessary assistance.

Thank you,

Yours faithfully,

Dr. Irene Kerkoi Aboh
Supervisor

NOBIS



UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF ADULT HEALTH



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UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DAH/I/2/Vol.1/24

Your Ref:

1st July, 2021

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast

Dear Sir,

REQUEST FOR ETHICAL CLEARANCE: MS. SEMEFA ALORVI

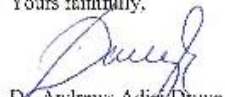
Ms. Semeffa Alorvi is a Master of Nursing student at the School of Nursing and Midwifery, University of Cape Coast with registration number: SN/MNS/19/0008.

She intends to conduct a study on the topic: **"QUALITY OF LIFE OF AGED PATIENTS WITH URINARY INCONTINENCE AT BONO REGIONAL HOSPITAL"**.

We would be grateful if you could review her topic for ethical clearance.

Thank you.

Yours faithfully,


Dr. Andrews Adjei Druye
Ag. Head

NOBIS

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 055093143 / 0550878309
E-MAIL: irba@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/1325
YOUR REF:
OMB NO: 0998-0279
IORG #: IORG0009096

12TH APRIL, 2022

Ms. Semefa Alorvi
Department of Adult Health Nursing
University of Cape Coast

Dear Ms. Alorvi,

ETHICAL CLEARANCE – ID (UCCIRB/CHAS/2021/246)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted Provisional Approval for the implementation of your research **Quality of Life Age Patients with Urinary Incontinence in Bono Regional Hospital**. This approval is valid from 12th April, 2022 to 11th March, 2023. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

A handwritten signature in blue ink, appearing to read 'S. Owusu'.

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST



College of Health
P.O. Box, 23
Yamfo – Sunyani.

27th June, 2022.

The Administrator
Bono Regional Hospital
Sunyani.



Dear Sir,

REQUEST TO CONDUCT RESEARCH AT BONO REGIONAL HOSPITAL

I write to humbly request to conduct research at the Bono Regional Hospital's Urological Clinic.

I am a Master of Nursing student at the University of Cape Coast (UCC) undertaking a research on the Topic on the topic **Quality of Life of Agod Patients Living with Urinary Incontinence in Bono Regional Hospital.**

With your permission, I would like to begin the data collection process from Thursday, 28th June, 2022 and will continue until point of saturation is reached.

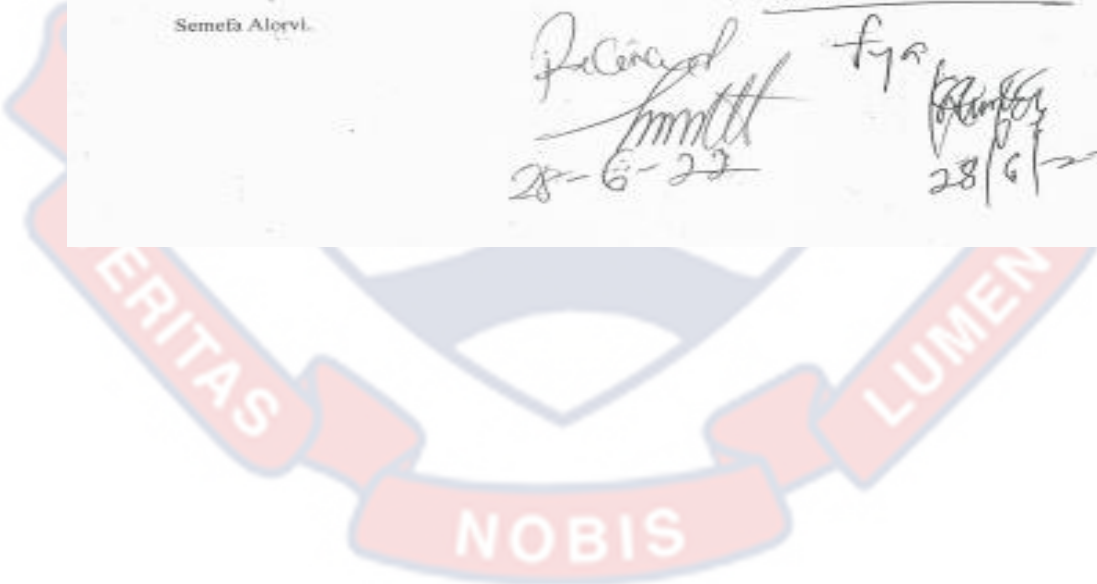
I count on your kind approval. Kindly find attached ethical clearance for this research from the Institutional Review Board (IRB- UCC).

Yours Faithfully,

Semeifa Alorvi

Semeifa Alorvi.

Research Unit
Received for
28-6-22
28/6/22



INTERVIEW GUIDE FOR AGED PATIENTS WITH URINARY INCONTINENCE

Dear interviewee, I am a final year Masters student of University of Cape Coast, and I humbly invite you to take part in a study that determines the impact of urinary incontinence on your quality of life. Your responses will be valuable to for academic purposes. Be informed that participation is voluntary and you have the right to withdraw at any point of the interview. I will require of you to fill in the items in section A. This interaction will last for 15-30minutes during which I will keep a voice record of your responses for future retrieval. However, every information provided by you will be kept confidential. Thanks for your co-operation.

Time interview commenced:

Time interview ended:

Date:

Section A: Background Information

1. Number Code:

2. Age (in years):
.....

3. Sex: a. Male []

b. Female []

3. Religion: a. Christian []

b. Islam []

c. Traditionalist []

d. Others (please specify):

.....

4. Ethnicity: a. Akan []

b. Bono []

c. Fante []

d. Others (Please specify)

.....

5. Education level: a. No formal education []

b. Primary []

c. Junior High School []

d. Senior High School []

e. Tertiary []

5. Number of years you were living with urinary incontinence:

.....

6. Other medical diagnosis asides urinary incontinence (Please specify):

a.....

b.....

c.....

Section B: Impact of Urinary Incontinence on Physical Health

Can you share with me how urinary incontinence has impacted your physical health?

Probes:

- Has urinary incontinence impacted on your activities of daily living such as sleep, intake of fluids, foods and medication?
- Does it impact on your dressing, mobility, body odour, fatigue and discomfort?
- How about your sexual life?
- If you are unable to sleep well or take enough water, etc., how does that affect your health?

Section C: Impact of Urinary Incontinence on Psychological Health

Can you explain to me how urinary incontinence has impacted on your psychological wellbeing?

Probes:

- What are your thoughts about your self-image and appearance?
- Share with me some of your negative feelings about yourself.
- Do you sometimes feel anxious, depressed and filled-up with suicidal thoughts? Tell me more about that.

Section D: Impact of Urinary Incontinence on Social Health

Tell me how urinary incontinence has impacted your social life.

Probes:

- How has urinary incontinence impacted your interpersonal relationship with others?
- How has it affected your attendance to social gathering (e.g., church, funeral, wedding, market etc.)?
- How about embarking on a journey with people?

Section E: Adaptive measures by the aged while Living with Urinary Incontinence

What mechanisms have you put in place to help you adapt to urinary incontinence?

Probes:

- What changes have you made in your daily life to help you adapt to the situation?
 - Dressing
 - Drinking
 - Socialising, etc.



1

NSEMMISSA A EFA AYAREFOO A WOTUMI DWONSO GU WON HO MPOFIRIM HO.

Mest: dee tɔrebeyi nsemmissa yi ano se, meye Osuani a merept abodin krataa Masters wo Cape Coast suapon no mu, nti ommoa me wo nhwewwema a mereye yi ho. Saa nhwewwema yi fa wan a wotumi dwonso gu won ho bent a wantee se dwonso de won no hu, me nsunsuansoo a ewo wo won daa daa asetena ne won anigyeet so. Anoyie a wobema no bema nhwewwema ne adesaa no atumi aka so yie. Kae hama se, emye ohye so na wode rebeyiyi esem yi ano, na mmom, bent biara a wopt no wotumi gyae nsem yi ano yi. Ebo bebia ama me pii se wobeyiyi nsemmissa a ewo ofa 'A' a odi kan no mu. Saa nkemma twetwe yi beko so beye simma adasaa ne aduanan ntam, na saa bent no nso, mekye wo kasa no aga ahoma so sodee daakye bi yerehwewe adi dwuma a yebehama.

Kae hama nso se, anoyie biara a wode bema no rempae abonten. Meda wo ase se wagye me nsem yi ato mu.

Bent a nsemmissa no hyiz aset:

Bent a nsemmissa no aite:

Eda:

Ofa a odi kan 'A': Nsem a efa woara wo ho

1. Asontyede: a ewo wo krataa no so (Number Code):
2. Mfet a wadi:
3. W'abasa a. Obaa ()
b. Obarima ()
3. Osom a wowa nsa: a. Kristoni ()
b. Kramoni ()
c. Obosonsomni ()
d. Osom fofoe (twent osom kora):

LANGUAGES GENERAL STUDIES DEPT
P. D. BOA
UENR SUHYANI

2

4. Abusuakoo a wofiri nsa: a. Asanteni ()
b. Bononi ()
c. Mfanteni ()
d. haabi foforo (twent baabi a wofiri)
5. Baabi a wasua nrewoana aduru: a. Wonko sukuu da ()
b. Primary ()
c. J.S.S ()
d. S. H. S ()
e. Suapon ()
5. Mfet dodoo sen ni na wodwonsɔ mpofirim?:
6. Woyi saa dwonsɔ yadeɛ yi firi ho a yadeɛ foforo bent na ewo ho? (ho yadeɛ no din):
a.
b.
c.

Ofa a eto so nmiensa 'B': Nsunsuansoo a mpofirim dwonso yadeɛ yi wo wo wo daa daa asetena ne w'anigyeet so.

1. Nsunsuansoo bent na mpofirim dwonso yadeɛ yi anya wo w'ahooden so?
Nsemmissa:
 - Saa mpofirim dwonso yadeɛ yi ha wo dan daa dwumadie te se tuma, nsunom, adidie ne aduro nom ho anaa?
 - Enya nsunsuansoo wo wo ntaadehye ne wo nanteɛ ho anaa? Ena paapon ba wo ho, taa wo bent anaa steeteɛ wo?
 - Mpa mu agodie nso te sen?
2. Saa mpofirim dwonso yadeɛ yi de adwɛndwene ne kodanma abeto wo so anaa?

3

Nsemmissa:

- Sen na wodwene fa sodee nnipa si hama wo fa ho?
 - Edem na wodwene se emye ade papa wo wo ho?
 - Eya a wodi yaw, w'ani nnye anaa adwene bi tumi ba wo tiri mu se kodi wo ho awu? Ka biribi kakra fa ho.
3. Ka nsunsuansoo a mpofirim dwonso yadeɛ yi de abeɛ wo wo wo ne nnipa ntam asetena mu.
Nsemmissa:
 - Nsunsuansoo bent na mpofirim dwonso yadeɛ yi wo wo wo ne afoforo nkutahodie ho?
 - Mpofirim dwonso yadeɛ yi ma wotumi ko baabi a nnipa atwa ahyia anaa (baabi te se; asore, ayie, ayeforo, edwa mu, ne dee akaka ho)?
Wotumi nso se nnipa afoforo ho mu tu kwan anaa?