

Experiences of Older Adults Living with Urinary Incontinence in a Regional Hospital

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Abstract

Background: Urinary incontinence (UI) poses detrimental impacts on several domains of health. **Aim:** This study explored the experiences of older adults living with UI in a Regional Hospital. **Methods:** A descriptive qualitative study was conducted among ten (10) purposively sampled adults aged 60 years plus who reported to the Urology Clinic of the Hospital. An in-depth interview was conducted with a guide employing Braun and Clarke's approach for thematic analysis. **Results:** UI negatively impacts on the physical, psychological and social domains of life of older adults. Physical impacts included general body discomfort, poor self-worth, disturbed sleep pattern, dehydration and nutritional impairment, and impaired sexual function. Sense of worry, agony, anxiety, and suicidal ideation, were the psychological impacts. Social impacts included impaired interpersonal interaction, limitations on traveling, attending professional and social gatherings. **Conclusions:** Coping strategies such as self-motivation, maintaining personal hygiene, and modifying their lifestyle were used to manage the condition.

Keywords

Bono Region, Living Experiences, Older Adults, Urinary Incontinence

1. Background

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 [1]. The prevalence of UI as reported in population-based studies ranged from 9.9% to 39.1%. Several epidemiologic studies estimate the prevalence of UI to be between 9% - 39% in females and 11% - 34% in males [2]. And this is twice as high in older adults [3]. A systematic review found the

pooled prevalence of UI to be 21% in Sub-Saharan African among women aged 15 - 100 years with varying prevalence estimates [4].

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 [5]. More than 40% women aged 70 years and above are victims of UI [6]. 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 [7].

Moreover, UI impacts on many aspects of the lives of victims, with resultant detrimental consequences on their quality of life. For a typical aged patient suffering from UI, significant impairment of various components of their quality of life is eminent [8]. 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 [9]. UI is highly prevalent among older adults and it impacts an individual's quality of life, not only with physical but with psychological and social consequences, which are embarrassment, reduced mobility, social isolation, with increased risk of falls and fractures [10].

Despite the well-documented evidences of 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 [11].

Stress incontinence is the most common type and it occurs when pressure on the bladder, such as coughing or sneezing. Urge incontinence, also known as over-active 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 [12].

2. Purpose

This study sought to describe the experiences of older adults living with UI who are cared for in the Urology Clinic in a Regional Hospital.

3. Methods and Materials

3.1. Study Design

A qualitative descriptive research design was employed in this study in order to describe the subjective experiences of participants. This was systematic, interac-

tive, and subjective so as to describe and give meaning to participants experiences in regards to the lack of empirical data regarding the impact of UI on the physical, psychological and social domains of health within the context of Ghana.

Study area was a referral clinical setting in the Bono Region of Ghana and a level 3 on the primary healthcare and has the ability to provide prompt assessment, resuscitation, surgery, intensive care, stabilization of injured patients and emergency operations and one of the largest in the country. It has twenty-six (26) units or departments with of 350 bed capacity and offers 24 hour Accident and Emergency services. It has a general and specialists services which saw an average of 2482 cases of urinary related conditions a year.

The study population comprised of older adults, aged 60 years and above living with UI and are seeking care at the urological unit, either diagnosed with UI, and/or have reported to the Urological Clinic within the study period. Participants who consented to partake in the study were recruited. Exclusion criteria comprised characteristics that were in contrast with the study criteria.

Purposive sampling was used to select participants based on the phenomenon of UI. The determination of sample size determination was the point of saturation, hence a total of 10 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 fifteen (15) from the register, only twelve (12) consented to partake in the study, however, data saturation was achieved by the time the 10th participant was interviewed.

A five sectioned and 35 itemed semi-structured interview guide was used to collect data based on the objectives and information collected in literature. Following the development of items, a pre-testing was done at a proxy health institution using two participants living with UI. It was ensured that, responses from the pretesting were not added to the main study. The pretesting helped to correct all ambiguities in the interview and ensured clarity of the guide. After pretesting, some questions were amended. "If you are unable to sleep well or take enough water, how does it 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?"

3.2. Data Collection Procedures

There was a collaboration between the Unit In-charge, the staff of the Urological Clinic where older adults routinely visited for consultations and reviews and the principal researcher. 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 fifteen (15) participants who were listed and approached, only twelve (12) consented to partake in the study but a total of ten (10) were 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 minds do not to take part in the study and 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 autonomy where they could decide to sign or thumb-print before any interview commenced. The indepth interview lasted between twelve to twenty-five (12 - 25) minute. The interviews were conducted using 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. Six (6) 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. 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.

3.3. Data Analysis

Data obtained was transcribed verbatim from audio forms to written. The analysis was guided by the [13] approach to thematic analysis, a method of analysis that consist 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 these 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 note any important cues that were picked while interviewing each participant. The researcher read the written transcripts thoroughly several times and highlighted codes shared on the phenomenon by participants. 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 until appropriate themes developed for the final 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, where the researcher developed a clear idea of concept being investigated and the quality of life of participants.

3.4. Ethical Considerations

Ethical approval was sought from the Institutional Review Board of the University

of Cape Coast (UCC/IRB) with identification number UCCIRB/CHAS/2021/246 was used as a gatekeeper to the Hospital and laid down ethical processes in the facility duly followed. After creating informed consent, autonomy and confidentiality, another sort of confidentiality was maintained by ensuring that hard copies of transcribed interviews, audiotapes, field notes were locked safely in a cabinet which is accessible to the researcher. Anonymity of participants was also ensured by using number codes instead of participants' names and they were informed that they could opt out of the study at any point in time.

3.5. Trustworthiness

The rigor for the study was made reliable and valid by approaching participants in good standing and gave them the opportunity to express themselves about the knowledge on the topic of interest. These took the researcher 12-30minutes for each interview. 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.

To ensure transferability in this study, 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. Participants were purposively sampled and a conducive environment for each interview was assured. The data was discussed with an expert in the field of geriatric nursing for a better deductions and confirmations into the concept. The research recordings were transcribed verbatim, after which 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.

4. Results

Guided by [13] 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 10 participants which was the sample size obtained at the point of data saturation.

Table 1 presents the background information of the participants who were interviewed, a total of 10 participants, comprising 4 females and 6 males, whose ages ranged from 60 to 70 years were interviewed. All participants were Christians except one who was a Muslim.

The participants belonged to diverse ethnic groups and have lived with urinary

incontinence for a minimum of 3 months, others have lived with it for or more years. Four participants had hypertension as a co-morbidity, while 3 had no underlying condition.

Table 1. Background information of participants.

Participants	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
P8	70	Male	Christianity	Bono	Middle school	7 years	Hypertension
P9	68	Male	Christianity	Bono	Middle school	6 years	Hypertension
P10	68	Male	Christianity	Bono	Middle school	5years	Hypertension

Source: Field Data 2023.

4.1. 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 generated from the objectives, supported by the verbatim quotes to further expand and convey the ideas in each sub-theme. Participants will be described in the text by their age, sex, number of years with the condition and if they had any underlying condition.

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

Source: Field data, 2023.

4.1.1. Theme One: Physical Health Impacts of Urinary Incontinence

Participants' experiences of urinary incontinence and how it impacted their phys-

ical health was explored. Four sub-themes were generated that is general body discomfort and appearance; disturbed sleep pattern; dehydration, 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 appearances. 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 penis as a result of urinary incontinence:

... I have discomforts. I feel pain in my manhood (Penis)... I don't feel comfortable in my manhood. **P2 (61 yrs, male, 6 months, none)**

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 (61 yrs, male, 6 months, none)**. ... 'I wake up with headaches in the morning, my BP goes up and I feel so tired and I have to be in bed for a while...' **P5 (68 yrs, female, 9 yrs, HPT)**. '... I feel tired. I feel tired all the time, even in the day, sometimes, I have to lie down a bit,' **P7 (64 yrs, female, 3 yrs, HPT)**.

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 odour. 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:

'...UI affects everything! Your dressing, you can't even dress. Hmmm...because, any dress you put on will get wet, **P1 (60 yrs, male, 3 yrs, HPT)**.

'When it started, I had body odour because I did not know what to do.... Now I am in my menopausal age but I still use sanitary pad and diapers because of urinary incontinence', **P3 (67 yrs, female, 5 yrs, none)**. ... 'Hmmm... I always have to be wearing pad or liner. It is so uncomfortable. I don't like it at all. I need fresh air', **P6 (62 yrs, female, 3 yrs, HPT)**. ... '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 (64 yrs, female, 3 yrs, HPT)**.

Sub-theme two. Disturbed sleep pattern

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

'Sometimes, it gives [me] sleepless night...' **P1 (60 yrs, male, 3 yrs, HPT)**. 'At night, when I wake up to urinate, the urine would continue to leak while I have come back to bed ... and after that I am unable to really sleep again' **P2 (61 yrs, male, 6 months, none)**.

Hmmm... when I sleep... I have to wake up and be 'wee weeing', because I don't want to soil the bed or soil my pant. I do this always so I don't sleep much **P7 (64 yrs, female, 3 yrs, HPT)**.

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 these experiences:

'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 (67 yrs, female, 5 yrs, none)**.

I have not been eating well as it used to be. **P4 (68 yrs, male, 3 years, none)**

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 (68 yrs, female, 3 yrs, HPT)**.

I have been careful what I take in especially fluids... I am someone who likes to drink a lot of water before I started experiencing this so me not drinking enough water is something that makes me feel very thirsty... I feel like I am a bit dehydrated. **P6 (62 yrs, female, 3 yrs, HPT)**.

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 libido which they ascribed to the frequent leakage of urine. One female participant recount how her husband had to engage in extra-marital 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 (60 yrs, male, 3 yrs, HPT)**.

My sex drive is honestly gone down. It doesn't normally come to mind. My mind is on something else. **P2 (61 yrs, male, 6 months, none)**.

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 thinks he is living with a baby. It got to a time he wasn't coming closer to me. But, what can I do about it? **P3 (67 yrs, female, 5 yrs, none)**.

After an intercourse, the next day, the frequency of the incontinence increases but after some few days if nothing happens again, it will not be as frequent as that when I had an intercourse. **P5 (68 yrs, female, 3 yrs, HPT)**.

4.1.2. 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 sprung 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, you will be thinking and worrying about certain things [like this]; although people say you shouldn’t be thinking or worrying, you will certainly think about it. **P1 (60 yrs, male, 3 yrs, HPT)**.

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 (61 yrs, male, 6 months, none)**. 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 (67 yrs, female, 5 yrs, none)**.

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 (67 yrs, female, 5 yrs, none)**.

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 (62 yrs, female, 3 yrs, HPT)**.

Recently, I had that nervous breakdown and there has been little improvement that gives me a possible outlook on what to think, so I don’t feel seriously anxious. **P5 (68 yrs, female, 3 yrs, HPT)**.

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, 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 of a divine intervention **P3 (67 yrs, female, 5 yrs, none)**.

4.1.3. 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 two main sub-themes as: impaired interpersonal interaction; and personal limitations on traveling; and attending professional and social gathering.

Sub-theme one. Impaired interpersonal interaction

Participants recounted the impact of urinary incontinence on their ability to maintain lasting and meaningful relationships with people in their social networks. They have limited their interactions so as to save themselves from embarrassments. Some participants shared their predicaments as

‘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 (60 yrs, male, 3 yrs, HPT)**
 ‘... It limited my social life in a way and how I relate to people outside my home.’ **P5 (68 yrs, female, 3 yrs, HPT)**. ‘... 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 odour, the person will not perceive it. ...I don’t want them to smell it ...I keep a lot of social distance or when I keep long at a place, I don’t mingle too much...’ **P7 (64 yrs, female, 3 yrs, HPT)**.

Sub-theme two. Personal Limitations

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 a lot. I always have to get a private place to lodge.’ **P3 (67 yrs, female, 5 yrs, none)**. ‘... 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 (68 yrs, Female, 3 yrs, HPT)**.
 ‘... if I am in a public transport, I mostly would sit behind the driver so that I could beg him to stop for me to urinate. [Even with that] you may feel shy since you might be the only asking him to stop for you to urinate.’ **P7 (64 yrs, female, 3 yrs, HPT)**.

Issues came up on limitations to 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 gatherings in case, they soil themselves with urine. Others also believe people may be aware of their condition which may draw unnecessary attention and wrong impressions about them. They shared their predicaments as:

‘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 accommodation to lodge to avoid embarrassment.’ **P3 (67 yrs, female, 5 yrs, none).**

‘These days I do not really want to be among people for long because, though I sometime wear pad, it becomes full with urine and so I have to quickly leave the place ... I don’t stay in social gathering for a long time.’ **P6 (62 yrs, female, 3 yrs, HPT).**

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

‘For some time now, almost 3 months, I haven’t been to work, you know it is not easy. As for work, I cannot go! As for that one, I can’t go!’ **P1 (60 yrs, male, 3 yrs, HPT).**

4.1.4. Theme 4: Adaptive Mechanisms for Urinary Incontinence

Almost all participants adopted positive coping mechanisms for their condition. They believed living with the 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 (60yrs, male, 3yrs, HPT).** ‘Lastly, I put my trust in God that one day I will be healed.’ **P3 (67yrs, female, 5yrs, none).**

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 odour’... **P2 (61 yrs, male, 6 months, none).** ‘What helps me now is the use of diapers and the sanitary pad.... I change my diapers from time to time.’ **P3 (67 yrs, female, 5 yrs, none).** ‘Oh! For now, it’s the panty liners that helps me. But when I know I will keep long out of the home I use sanitary pad.’ **P5 (68 yrs, female, 3 yrs,**

HPT); ... I would put pad in my pant ... so, panty liners and pad' **P7 (64 yrs, female, 3 yrs, HPT)**.

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, while others engaged in some forms of pelvic muscle strengthening exercises (Kegel) 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. There is also an exercise they have been teaching me at the hospital, the Kegel ... so I do it little by little.' - **P5 (68 yrs, Female, 3 yrs, HPT)**, '...I have cut down on water drastically...' - **P5 (70 yrs, male, 7 yrs, HPT)** '... You see, the nurses teach me about some exercise... Kegel! ... I started not long ago but I pray that it will help me.' **P7 (64 yrs, female, 3 yrs, HPT)**.

5. Discussion

The analysis of the study revealed that the physical health with urinary incontinence (UI) included general body discomfort and appearance or body image, disturbed sleep pattern, dehydration and nutritional impairment, and impaired sexual health functions. This means the physical health of participants was negatively affected by UI which is in line with extant literature [14], which found UI to have impacted negatively on physical wellbeing of his 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 multi-dimensional 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, 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 (Kegel).

Interestingly, participants expressed concern about sleep disturbance as a major issue due to UI. Similar observations were made in a previous study where quality of sleep was greatly influenced by UI [15]. 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.

For the fear of experiencing severe symptoms of UI, older adults are not able to

drink sufficient water and some hydrated foods. This alteration in hydration and nutritional status negatively impacts on the physical wellbeing of the participants. Similar findings were reported by [16] which gave the impression 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.

5.1. Psychological Health Impacts of Urinary Incontinence

The psychological health impact of urinary incontinence is a sense of worry, agony and anxiety as well as suicidal ideation which had a severe psychological issue; some to the extent of considering suicide. The finding corroborates [17], who worked on urinary incontinence and psychological distress in community-dwelling older adults. It was 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 urinary incontinence (UI) was associated with worse health among older adults. Globally, UI affects between 15% and 35% of community-dwelling older adults, with prevalence rising to over 50% among nursing home residents [18] [19]. In Ghana, recent estimates suggest that about 21% - 28% of older women and 11% - 15% of older men report symptoms of UI [19].

Little is known, however, about its relation with loneliness or the role of mental

health in this association. [20] 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. Their findings indicate that UI increases the odds of loneliness by nearly 1.5 times (OR = 1.47, 95% CI: 1.12 - 1.91) in older community-dwelling adults, but this association is largely explained by comorbid mental health problems, particularly 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.

5.2. Social Health Impacts of Urinary Incontinence

Another interesting finding that emerged from the study was the impaired interpersonal interaction and personal limitations such as traveling, 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.

[21] 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.

[22], 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 the disease. Accordingly, participants 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.

5.3. Adaptive Mechanisms for Urinary Incontinence

Findings from 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.

[23] research coping strategies for 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 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.

[24] 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, single, with a chronic disease, who were at an advanced age, women, described having urinary incontinence during activities, 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 strate-

gies for urinary incontinence.

6. Conclusions

Generally, older adults living with UI have 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.

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 also 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.

Nursing Implication

The outcome of the study will inform policy which will develop strategies to help manage UI patients to live healthy lives and promote well-being 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.

Limitations

Given the qualitative nature of the study, interviews were conducted through a blended approach of face-to-face and telephone calls. 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.

Author Contributions

S.A. conceived the study design and collected data. S.A. and IKA analysed data. IKA created the first draft of the main manuscript.

Declarations Ethical Approval and Consent to Participate

This study has been approved by the Institutional Review board of a University

IRB Board. Informed consents were verbally taken from all participants.

Data Availability

The data generated during this study will be made available on reasonable request from the Principal Investigator.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

- [1] Sheng, W., Zhang, H. and Ruth, K. (2017) Could Urinary Nerve Growth Factor Be a Biomarker for Overactive Bladder? A Meta-Analysis. *Neurourology and Urodynamics*, **36**, 1703-1710. <https://doi.org/10.1002/nau.23210>
- [2] Leslie, S.W., Tran, L.N. and Puckett, Y. (2026) Urinary Incontinence. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK559095/>
- [3] Davis, A.K., Barrett, F.S., May, D.G., Cosimano, M.P., Sepeda, N.D., Johnson, M.W., et al. (2021) Effects of Psilocybin-Assisted Therapy on Major Depressive Disorder: A Randomized Clinical Trial. *JAMA Psychiatry*, **78**, 481-489. <https://doi.org/10.1001/jamapsychiatry.2020.3285>
- [4] Ackah, M., Ameyaw, L., Gazali Salifu, M., Afi Asubonteng, D.P., Osei Yeboah, C., Narkotey Annor, E., et al. (2022) COVID-19 Vaccine Acceptance among Health Care Workers in Africa: A Systematic Review and Meta-Analysis. *PLOS ONE*, **17**, e0268711. <https://doi.org/10.1371/journal.pone.0268711>
- [5] Aly, W.W., Sweed, H.S., Mossad, N.A. and Tolba, M.F. (2020) Prevalence and Risk Factors of Urinary Incontinence in Frail Elderly Females. *Journal of Aging Research*, **2020**, Article ID: 2425945. <https://doi.org/10.1155/2020/2425945>
- [6] Milsom, I. and Gyhagen, M. (2019) The Prevalence of Urinary Incontinence. *Climacteric*, **22**, 217-222. <https://doi.org/10.1080/13697137.2018.1543263>
- [7] WHO (2023) Promoting Physical Activity and Healthy Diets for Healthy Ageing in the WHO European Region. <https://www.who.int/europe/publications/i/item/WHO-EURO-2023-8002-47770-70520>
- [8] Biswas, B., Bhattacharyya, A., Dasgupta, A., Karmakar, A., Mallick, N. and Sembiah, S. (2017) Urinary Incontinence, Its Risk Factors, and Quality of Life: A Study among Women Aged 50 Years and above in a Rural Health Facility of West Bengal. *Journal of Mid-life Health*, **8**, 130-136. https://doi.org/10.4103/jmh.jmh_62_17
- [9] Gibbons, C.J. and Skevington, S.M. (2018) Adjusting for Cross-Cultural Differences in Computer-Adaptive Tests of Quality of Life. *Quality of Life Research*, **27**, 1027-1039. <https://doi.org/10.1007/s11136-017-1738-7>
- [10] Ge, K., Ni, R., Tao, P., Zhao, X., Luo, Y., Zhu, Y., et al. (2024) Low-Toxicity PEG-Coated SERS Silver Nanocubes for Diagnosing Esophageal Cancer. *Optics Communications*, **554**, Article ID: 130183. <https://doi.org/10.1016/j.optcom.2023.130183>
- [11] Dovie, D.A. (2019) The Status of Older Adult Care in Contemporary Ghana: A Profile of Some Emerging Issues. *Frontiers in Sociology*, **4**, Article No. 25. <https://doi.org/10.3389/fsoc.2019.00025>
- [12] WHO (2017) World Health Statistics 2017: Monitoring Health for the SDGs, Sustain-

- able Development Goals. <https://www.who.int/publications/i/item/9789241565486>
- [13] Braun, V. and Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, **3**, 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- [14] Corrado, B., Giardulli, B., Polito, F., Aprea, S., Lanzano, M. and Dodaro, C. (2020) The Impact of Urinary Incontinence on Quality of Life: A Cross-Sectional Study in the Metropolitan City of Naples. *Geriatrics*, **5**, Article No. 96. <https://doi.org/10.3390/geriatrics5040096>
- [15] Winkelman, W.D., Warsi, A., Huang, A.J., Schembri, M., Rogers, R.G., Richter, H.E., et al. (2018) Sleep Quality and Daytime Sleepiness among Women with Urgency Predominant Urinary Incontinence. *Female Pelvic Medicine & Reconstructive Surgery*, **24**, 76-81. <https://doi.org/10.1097/spv.0000000000000547>
- [16] Willis-Gray, M., Wu, J.M. and Markland, A. (2018) Urinary Incontinence and Hydration: A Population-Based Analysis. *Neurourology and Urodynamics*, **37**, 200-205. <https://doi.org/10.1002/nau.23274>
- [17] Bogner, H.R., Gallo, J.J., Sammel, M.D., Ford, D.E., Armenian, H.K. and Eaton, W.W. (2002) Urinary Incontinence and Psychological Distress in Community-Dwelling Older Adults. *Journal of the American Geriatrics Society*, **50**, 489-495. <https://doi.org/10.1046/j.1532-5415.2002.50115.x>
- [18] Irwin, M.R., Carrillo, C., Sadeghi, N., Bjurstrom, M.F., Breen, E.C. and Olmstead, R. (2022) Prevention of Incident and Recurrent Major Depression in Older Adults with Insomnia: A Randomized Clinical Trial. *JAMA Psychiatry*, **79**, 33-41. <https://doi.org/10.1001/jamapsychiatry.2021.3422>
- [19] Adusei, A.B., Bour, H., Amu, H. and Afriyie, A. (2024) Community-Based Health Planning and Services Programme in Ghana: A Systematic Review. *Frontiers in Public Health*, **12**, Article ID: 1337803. <https://doi.org/10.3389/fpubh.2024.1337803>
- [20] Stickley, A., Santini, Z.I. and Koyanagi, A. (2017) Urinary Incontinence, Mental Health and Loneliness among Community-Dwelling Older Adults in Ireland. *BMC Urology*, **17**, Article No. 29. <https://doi.org/10.1186/s12894-017-0214-6>
- [21] Fultz, N.H. and Herzog, A.R. (2001) Self-Reported Social and Emotional Impact of Urinary Incontinence. *Journal of the American Geriatrics Society*, **49**, 892-899. <https://doi.org/10.1046/j.1532-5415.2001.49179.x>
- [22] Javanmardifard, S., Gheibizadeh, M., Shirazi, F., Zarea, K. and Ghodsbin, F. (2022) Psychosocial Experiences of Older Women in the Management of Urinary Incontinence: A Qualitative Study. *Frontiers in Psychology*, **13**, Article ID: 785446. <https://doi.org/10.3389/fpsyg.2022.785446>
- [23] Mohamed, S.M., Helmy, M.Y. and Hafez, S.K. (2020) Coping Strategies with Stress Urinary Incontinence among Menopausal Women. *Alexandria Scientific Nursing Journal*, **22**, 99-108. <https://doi.org/10.21608/asalexu.2020.206115>
- [24] Aydin Avci, İ., Öz Yildirim, Ö., Yildirim, E. and Bulgak, M. (2022) Non-Medication Coping Strategies for Urinary Incontinence in Older Adults: Factors Associated with Frequency of Use. *International Urogynecology Journal*, **33**, 1259-1265. <https://doi.org/10.1007/s00192-022-05109-5>