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## UNFORSEEN HEALTH PROBLEM IN FEMALE SEASONAL AGRICULTURAL WORKERS: URINARY INCONTINENCE

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### Abstract

*Female seasonal agricultural workers constitute a risk group in terms of urinary incontinence because such workers have trouble in accessing and using health care services due to their working conditions and their low socio-economic levels. The study was carried out to determine the prevalence of urinary incontinence and factors affecting these and treatment received in female seasonal agricultural workers. In this cross-sectional study in which 300 women were reached. 56.0% of the women have urinary incontinence. The risk of having urinary incontinence is increased 3.5 times by being married, 6.7 times by having a chronic cough, 2.9 times by having a cystocele. Only 26.2% of the women had sought help from a healthcare organization with complaints of urinary incontinence. According to the study there was urinary incontinence in more than half of the women, but it was determined that the women made little effort to receive treatment for their urinary incontinence. It is recommended that women should be*

*educated in topics like UI statistics, risk factors and the prevention and treatment of UI, and that those who have incontinence should be guided to receive treatment.*

### **Keywords**

Seasonal agricultural worker, Woman, Urinary incontinence, Risk factors.

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## **1. Introduction**

Urinary incontinence (UI), which is seen relatively often among women – a reason why it is sometimes accepted as normal – is defined by the International Continence Society (ICS) as an involuntary leakage of urine that can be demonstrated objectively and which causes social and hygiene problems (Abrams at al., 2002). In studies that have been carried out, it has been shown that the prevalence of UI varies between 15% and 52% worldwide and that more than 200 million people experience UI problems (Irwin at al., 2006; Yip & Cardozo, 2007; Ge, Lu, Zhang & Li, 2010). In studies that have been carried out in Turkey it has also been indicated that the prevalence of UI varies from 20.5%-68.8% in women in the age range 15 to 70 and over (Biri at al., 2006; Filiz, Uludağ, Çınar, Gorpelioglu & Topsever, 2006; Koçak, Okyay, Dundar, Erol & Beser, 2005).

UI causes problems to 15-30% of women in their social, psychological, physical and sexual lives and it prevents women from socialising with other people. Furthermore, UI causes problems to women in terms of constant urine leakage and anxiety about smelling bad, feeling themselves inadequate and dirty, decrease in self-esteem, disruption to body image and similar issues (Minassian, Drutz & Al-Badr, 2003). However, it is also known that women do not search for help because of the thought that UI is a natural outcome of aging and of giving birth, because they feel ashamed and embarrassed, do not know where to ask for help, do not trust in treatment and are afraid (Shaw, Brittain, Tansey & Williams, 2008). It is indicated that there are many factors that cause UI. Some of these include: being female, being of an advanced age, being overweight, smoking, having had too many pregnancies and parities, the delivery method used, interventions, a difficult labor, macrosomia at delivery, menopause, chronic diseases, usage of some drugs, chronic cough, chronic constipation, hard working conditions, gynaecological problems and surgical interventions for these problems, and urinary system infections (Biri at al., 2006; Filiz at al., 2006; Hannestad, Lie, Rortveit & Hunskar, 2004; Haslam & Laycock, 2008).

When the risk factors are taken into consideration, female seasonal agricultural workers(SAW) constitute a risk group in terms of UI because such workers have trouble in accessing and using health care services due to their working conditions and their low socio-economic levels (Kutlu & Koruk, 2014). As a matter of fact, in studies that were done with agricultural workers it has been shown that in female SAW, the following problems are seen more: undernutrition, inadequate genital hygiene, adolescent pregnancy, high reproductive rate, no/late or inadequate prenatal care, miscarriage and stillbirth because of agricultural factors, and reproductive health problems (İnakcı, Şimşek, Koruk & Tekin Koruk, 2009; Koruk & Şimşek, 2010). It is important to determine the level of health problems such as UI which negatively affect the quality of life of disadvantaged groups such as SAW in order to regulate the delivery of health care.

This study was carried out to determine the prevalence of UI and factors affecting these and treatment received in female SAW.

## **2. Materials And Method**

### **2.1 Study Area**

Şanlıurfa province, where this study was carried out, is located in the Southeast Anatolia region of Turkey. The State Planning Organization has ranked it as 73<sup>rd</sup> of 81 cities in terms of its socio-economic development ranking, which includes education, health and social indicators (Republic of Turkey Ministry of Development, 2011). However, with the “South-east Anatolia Project”, the economy in the south-east has improved in recent years. The Atatürk Dam was built (1983–1992), the Urfa irrigation channels were constructed and water was provided to arid and semi-arid lands, leading to agricultural development. Although the capacity of agriculture has increased, the region is still poor in terms of industrial production. Maternal and child health and family planning services have been given a priority status in this region. The education level is also extremely low in the region (47.7% of women and 28.2% of men are illiterate). In this area, families are characterized by lower parental education, larger household sizes, higher numbers of children and greater poverty (Turkey Demographic and Health Survey, 2013). Thus, in the study area, residents have low education levels, the local community mostly comprises unemployed people and there is also a high proportion of SAW (Kutlu & Koruk, 2014).

### **2.2 Study Population**

As far as the socio-demographic characteristics of the SAW were concerned, 58.0% were female, 72.0% were married. 60.0% were uneducated (23.8% for males, 86.2% for females), the mean age was  $34.7 \pm 9.8$  years and the mean number of people living in the household was  $8.0 \pm 3.3$ . 90.0% of the SAW's earned below the minimum wage (311 USD), the time they had worked in the fields was  $9.4 \pm 8.9$  months within the year (Kutlu & Koruk, 2014).

The total number of SAW families is estimated as 124,630, constituting 25% of Şanlıurfa's urban population. Some SAW families work annually for a single employer during the harvest season and return home at the end of the season. Others "follow the crops", moving a few times per season between 23 different cities to perform specialized work such as hoeing beets or harvesting cotton (Koruk, Şimsek, Tekin Koruk, Gürses & Doni, 2010).

### **2.3 Setting and Sample**

This cross-sectional survey was conducted from February to March 2015 in Şanlıurfa. The target population of the study was married women aged between 15 and 49 who were working as SAW.

The sample selection was made using the World Health Organization (WHO)/EPI 30-cluster survey sampling technique. The 30 cluster sample was developed by the WHO in 1978. The 30 cluster survey is a modified two-stage cluster sampling method (World Health Organization, 1991). In this study in the first stage, 30 districts were selected as clusters with probability proportionate to the size of the population from the district list. After this, 30 streets were determined from the list of streets in the each district through a simple random sampling as the starting point, In the second stage, samplig was started with third household and continued with neighbouring housholds on the right side of the street until 10 individuals were reached. A total of 300 women were reached in 30 clusters, including 10 women in each cluster. Although the sampling unit is the individual subject, the sampling is conducted on the household level. In every household, only one female SAW in the age range 15 to 49 was interviewed. When there was more than one woman in the household in the age range 15 to 49, one woman was selected by utilizing the Kish Selection Grid (Kish, 1949). Pregnant women were excluded from the research.

The written permission of the Ethics Committee of Harran University and the verbal permission of the participants were granted for the research.

### **2.4 Data Collection**

The research data was collected via a Data Collection Form. The Data Collection Form consisted of 42 questions. 11 questions on this form are about women's characteristics, 13 questions are about their fertility, 11 questions are about the risk factors increasing UI, three questions are about types of UI and 4 questions are about the individual practices used by women for their UI, the situations in which women received treatment, types of treatment and reasons for not receiving any treatment.

The data was collected according to the statements of the women participating in the research. Weight and height measurements were taken after the data form was filled.

The non-Turkish speaking women participating in the research were interviewed with the assistance of translators.

The dependent variable in the research is UI; independent variables are socio-demographic features, fertility, factors that facilitate UI, practices used for UI and treatment situations.

## **2.5 Definitions**

The term "seasonal agricultural worker" means an individual who is employed in agricultural employment of a seasonal or other temporary nature.

UI was determined by asking the participants if they had experienced a UI problem within the last month.

Participants complaining of UI due to phenomena such as increased intra-abdominal pressure when coughing, laughing, sneezing, straining, yawning or lifting a heavy object were considered to have "stress incontinence". Those participants who passed urine when they could not reach the toilet and who afterwards felt the need to use the toilet again were considered to have "urge incontinence". Those having both stress and urge incontinence were considered to have "mixed incontinence" (Haylen et al., 2010).

## **2.6 Data Analysis**

The data collected from the research was evaluated by utilizing the Statistical Package for Social Sciences (SPSS) for Windows 16.0 computer program. In evaluating the data, percentage, average, standard deviation from the descriptive statistics and chi square and Mann-Whitney U test from the univariate analysis were utilized. The effect of independent variables on UI was evaluated with Logistic Regression Analysis Backward Stepwise (Conditional) Method. The data which was acquired is in the 95% confidence interval interpreted 0.05 significance level.

### 3. Findings

The average of age of the female SAW was  $29.2 \pm 9.7$ ; the average body-mass index (BMI) was  $25.0 \pm 5.3 \text{ kg/m}^2$ . 54.8% of the women were underweight, overweight or obese. 73.3% of the women were married, 53.0% were illiterate and 71.7% had not finished primary education. 68.0% could not speak Turkish which is the official language. 49.0% of the women evaluated their economic condition as poor. The period women spent working as agricultural workers was  $15.3 \pm 9.7$  years, their time spent working in an agricultural field per day was  $12.1 \pm 2.1$  hours. Furthermore, 82.7% of them stayed in tents and sheds on the agricultural sites.

It was determined that the average number of pregnancies for the female SAW was  $5.3 \pm 3.2$ , the number of miscarriages was  $1.6 \pm 1.0$ , the number of abortions was  $1.5 \pm 0.8$ , the number of normal deliveries was  $4.4 \pm 1.0$ , the number of C-sections was  $1.8 \pm 1.0$ , number of deliveries in the agricultural sites was  $3.1 \pm 2.7$ , the number of deliveries at home was  $4.0 \pm 2.6$ , the number of deliveries at the hospital was  $2.8 \pm 1.7$ . The average age of the women at first labor was  $20.7 \pm 3.6$  and the average age of the women at last labor was  $29.0 \pm 6.5$ . Furthermore, 33.0% of the women had histories of difficult deliveries, 19.3% had macrocosmic deliveries, and 35.7% had an episiotomy at delivery. 7.3% of the women had entered the menopause and the average period without menstruation after menopause was  $3.2 \pm 1.9$  years.

It was determined that 56.0% of the female SAW had UI. Out of all the women who had UI, 21.7% of the women had stress incontinence, 7.0% had urge incontinence and 27.3% had mixed incontinence (see Table1).

**Table 1:** Urinary incontinence in women and distribution related to its type

Urinary Incontinence and Type	Number	%
No Incontinence	132	44.0
Stress	65	21.7
Urge	21	7.0
Mixed	82	27.3
<b>Total</b>	<b>300</b>	<b>100.0</b>

When the risk factors increasing UI in the female SAW were analyzed it was determined that 49.3% of the women had chronic diseases, 33.3% were continuous drug-users, 13.7% were cigarette smokers smoking approximately  $7.6 \pm 5.8$  cigarettes a day, 32.0% had chronic coughs, 37.3% had constipation, 63.7% had had one or more urinary infections in the past year and they

had had a urinary infection approximately  $2.9 \pm 1.7$  times in the past year. Furthermore, 15.3% of the women had uterine prolapse, 44.0% had a cystocele, 24.0% had complaints of hemorrhoids, 4.3% had pelvic organ prolapse operation and 1.7% had undergone a hysterectomy operation.

It was determined that married female SAW (64.1%), illiterate workers (59.7%), the ones speaking mostly Kurdish at home (56.9%), the ones with poor economic conditions (61.2%), and the ones staying in tents and sheds while working as agricultural workers (56.9%) had more instances of UI than others ( $p < 0.05$ ). Again, it was determined that with increasing age (the median age of the women with UI was 28.0, the median age of the women without UI was 25.0), with increasing body-mass index (the median BMI of the women with UI was 25.5, the median BMI of the women without UI was 23.4) and period of labor as an agricultural worker (the median period of labor of those who had UI was 15.5, the median period of labor of those who did not have UI was 11.5) the rate of incidence of UI was increasing ( $p < 0.05$ ). The effects of the following variables over UI are not shown: mostly using the Kurdish language at home, economic conditions, the location of the accommodation while working as an agricultural worker and the daily working hours in the agricultural sites ( $p > 0.05$ ).

There was more UI in the female SAW who had had miscarriages (70.8%), who had had abortions (64.8%), who had had difficult deliveries (71.7%), who had had macrosomic deliveries (69.0%), who had had an episiotomy at the delivery (62.6%), who did not have regular menstruation (78.0%) and who had entered the menopause (86.4%) ( $p < 0.05$ ). The effects of the following variables over UI are not shown: having an abortion and having an episiotomy at the delivery ( $p > 0.05$ ).

Furthermore, it was determined that there was no meaningful relationship between the workers who had UI and numbers of pregnancies, miscarriages, abortions, normal deliveries, C-sections, deliveries at the agricultural sites, deliveries at home, deliveries in hospital, age at first labor, age at last labor, and the period without menstruation after entering the menopause ( $p > 0.05$ ).

It was determined that women with chronic diseases (62.8%), continuous drug-users (62.0%), cigarette smokers (65.9%), those with chronic coughs (83.3%), those who had constipation (71.4%), who had had urinary infections in the past year (65.4%), who had uterine prolapse (71.7%), cystocele (74.2%) and hemorrhoids (69.4%), who had had a pelvic organ prolapse operation (61.5%) and had undergone hysterectomy (80.0%) had more UI than others

( $p < 0.05$ ). The effects of the following variables over UI are not shown: continuous drug-use, smoking, abdominal prolapse ( $p > 0.05$ ).

Furthermore, it was determined that there was also no meaningful relationship between the female SAW who had UI and the amount of daily smoking, or the number having a urinary infection in the past year ( $p > 0.05$ ).

The Logistic Regression Analysis Model (Backward Stepwise (Conditional)) is formed in the study with the following variables which create statistically meaningful differences in the univariate analysis. These variables are: marital status (categorical variable), educational status (categorical variable), age (continuous variable), BMI (continuous variable), the period spent working as a female SAW (continuous variable), miscarriage (categorical variable), difficult delivery (categorical variable), macrosomic delivery (categorical variable), regular menstruation (categorical variable), entering menopause (categorical variable), chronic disease (categorical variable), chronic cough (categorical variable), constipation (categorical variable), having had a urinary infection in the past year (categorical variable), uterine prolapse (categorical variable), cystocele (categorical variable), hemorrhoids (categorical variable). With the Logistic Regression Analysis it was determined that the risk of having UI was increased 3.5 times by being married, 6.7 times by coughing complaints and 2.9 times by having a cystocele (see Table 3. 2)

**Table 2:** *The logistic regression model of risk factors related to urinary incontinence*

Risk Factors	B	P	OR	95% CI
Marital Status (connubiality)	1.263	<0.001	3.537	1.88-6.65
Complaints of Cough (existent)	1.904	<0.001	6.714	3.48-12.94
Cystocele (existent)	1.072	<0.001	2.921	1.69-5.03
<b>Constant</b>	<b>-1.651</b>	<b>&lt;0.001</b>	<b>0.192</b>	

26.2% of the female seasonal agricultural workers who had UI went to a healthcare organization as a result of their UI and the place most visited was the public hospital (68.2%). Furthermore, it was determined that 38.7% of the women used a pad/diaper because of their UI, while 47.0% of the women had their own individual practices. Among these individual practices, changing their underwear frequently and wearing cotton underwear (82.2%) was highest ranked (see Table 3).



**Table 3:** Distribution of the practices of women for urinary incontinence

Practices	Number	%
<b>Visit to a Healthcare Organization</b>		
Yes	44	26.2
No	124	73.8
<b>Healthcare Organization Visited*</b>		
Public hospital	30	68.2
Private hospital	8	18.2
Private practice	5	11.4
Community clinic/Family physician	1	2.2
<b>Using Pad/Diaper</b>		
Yes	65	38.7
No	103	61.3
<b>Individual Practices Carried Out</b>		
Yes	79	47.0
No	89	53.0
<b>Individual Practices**</b>		
Changing underwear frequently and using cotton underwear	65	82.2
Not lifting heavy weights	5	6.3
Making hot application	4	5.1
Reduce salt and liquid foods	3	3.8
Using herbal medication	1	1.3
Not delaying in going to the toilet	1	1.3
<b>Total</b>	<b>168</b>	<b>100.0</b>

\*The number of those who answered the applied healthcare organization question is 44.

\*\*The number of those who answered the individual practices question is 79.

21.4% of the female seasonal agricultural workers with UI stated that they had received treatment for UI. All of the female seasonal agricultural workers who received treatment for UI had received medical treatment alone. 50.0% of the female seasonal agricultural workers who had not received any treatment for UI stated that they had not received any treatment because

they accepted UI as a normal situation and 28.8% of the women workers who had not received any treatment stated that they had not received any treatment because of feelings of shame, fear and not trusting healthcare personnel (see Table 4).

**Table 4:** *Distribution of treatment received*

<b>Treatment Received</b>	<b>Number</b>	<b>%</b>
Yes*	36	21.4
No	132	78.6
<b>Reasons For Not Receiving Any Treatment</b>		
Accepting UI as normal	66	50.0
Shame, fear, no trust in healthcare personnel	38	28.8
Economic situation and having no health insurance	15	11.4
Not having the opportunity		
Negative attitude of spouse	12	9.1
	1	0.7
<b>Total</b>	<b>168</b>	<b>100.0</b>

#### 4. Discussion

The average of age of female SAW is  $29.2 \pm 9.7$ . When other studies that were done with the women agricultural workers are also evaluated it was seen that the average age varies from 27.0 to 35.6, and that the women who are employed in the agricultural sector are young adults. (Koruk & Şimşek, 2010; Gözükara, Koruk & Kara, 2015; Gözükara, Ersin & Şimşek, 2015).

The level of illiteracy among the female SAW is 8.5 times greater than the average in Turkey which is 6.2% (TÜİK Education Statistics, 2013). In their study of agricultural workers, Kutlu and Koruk also state that 86.2% of the female SAW had not been able to finish their primary education. In the same study it is stated that women are employed more than men in the agricultural sector and a significant number of these women were not able to/did not continue their education, especially because they did not have equal opportunities in their education as a result of their gender (Kutlu & Koruk, 2014). Although the official language in the country is Turkish, the fact that there are workers who do not speak any Turkish but only speak Arabic or Kurdish supports the above mentioned situation. In the studies that were done it is stated that the agricultural workers' problems in language and communication are one of obstacles preventing

them accessing health care services (Arcury & Quandt, 2007; Anthony, Williams & Avery, 2008). The female SAW are in a disadvantageous position in accessing health care services both because of their lower level of education and because of communication problems originating from the language they use. For this reason, health care services should be designed to correspond to the users' language and culture. The economic condition of approximately half of the female SAW was poor. The ILO (International Labour Organization) states that 60% of SAW across the world live below the poverty line (International Labour Organization, 2004). In other studies it is also stated that agricultural laborer families are one of the poorest groups in their communities (Nygaard & Heit, 2004, Kutlu & Koruk, 2014).

In this study, the fact that more than half of the female SAW were in the underweight, overweight and obese group indicates that there are significant nutrition problems. It is indicated that these negative consequences are because of the difficult working conditions, inadequate living conditions, economic problems and the pressure of saving money (Şimşek, 2012).

The females workers work approximately 12 hours a day in hard conditions, have to live in bad and inadequate living conditions such as tents and sheds and these conditions last for many years in which they continue to be agricultural workers. In one study it is stated that in an agricultural area 4 out of every 5 families live in one-roomed tents, 52.7% of them also use their tents as bathrooms, 48.4% of them do not have electricity, and 32.9% of them have limited access to healthy drinking and domestic water (Şimşek, 2012). These poor shelter and hygiene conditions increase the women's risk workers of developing a urinary system infection. As a matter of fact, female SAW stated that they had had an average of 2.9 urinary infections in the past year. In female SAW the numbers of pregnancy, parity, miscarriage and abortion are higher than the average in Turkey (Turkey Demographic and Health Survey, 2013). In addition, many of them have poor obstetric histories because the many negative factors in their lives, such as workers poverty, a lower level of education and difficult living and working conditions prevent them from searching for and accessing health care services. As a matter of fact, in research in which Koruk and Hamidanoğlu evaluated the primary care health services in Şanlıurfa they also stated that being a SAW negatively affects the accessibility of primary healthcare by a factor of two times (Koruk & Hamidanoğlu, 2013). In addition it is stated that adverse pregnancy and delivery outcomes can occur in female SAW in relation to the influence of physical (heavy

lifting, long periods of physical activity), chemical (pesticides etc.) and biological risks (Arcury & Quandt, 2007; International Labour Organization, 2004).

The prevalence of UI in the female SAW was determined as quite high with a level of 56.0%. In the female workers with UI, mixed incontinence (27.3%) was observed the most, followed by stress incontinence (21.7%) and urge incontinence (7.0%). In many studies mixed UI is similarly most frequently observed, and is followed by stress and urge incontinence (Espino at al., 2003; Gözükarar at al., 2015; Filiz at al., 2006). There are a lot of risk factors for UI in female SAW. These include a poor obstetric history, marriage at an early age and adolescent pregnancy/delivery, a high rate of reproduction, inadequate and hard working and living conditions, a long time spent working in jobs requiring physical strength and heavy lifting and inadequate genital hygiene. It is thus not that surprising that the female SAW have such a high level of UI.

In Turkey sex life and reproduction generally starts with marriage. In female SAW marriage and accordingly the first pregnancy can occur as low as the age of 13. This situation is an important factor in the increase of pregnancy and reproductive rate. This study has shown that being married is a factor that increases the probability of UI by 3.5 times. In the studie that have been carried out it has been determined that in married women there is a greater prevalence of UI (Kök, Şenel & Akyüz, 2006; Hsieha at al., 2008).

In this study it was determined that having a chronic cough is another important factor that increases UI by 6.7 times. Chronic cough increases the bladder pressure, causes a weakness in the urethral sphincter mechanism and contributes to the generation of incontinence (Fine, Antonini & Appell, 2004). Cough complaints are seen more especially in smokers, in people who have obstructive lung disease, and in those who frequently have respiratory tract infections. It is stated that the risk of having UI is multiplied 2-3 times in people who have chronic obstructive lung disease (Hannestad et. al., 2003). The fact that the female SAW had histories of chronic disease, cigarette smoking and chronic cough supports this finding.

In the study it was determined that having cystocele was a factor that increased UI by 2.9 times. Cystocele is an important factor that demonstrates the weakness of the pelvic floor muscles. Therefore, the pelvic floor muscle weakness increases the UI (Gomel, Munro & Rowe, 1995). In addition to frequent pregnancies and delivery, working for long periods in jobs

requiring physical strength and involving heavy lifting activities, as in agricultural labor, are also influential in the weakening of pelvic floor muscles.

It was determined that 73.8% of the female SAW did not go to healthcare organizations because of their UI complaints. Similarly to this research, other studies have also stated that between 69.4% and 90.0% of women neglected to apply to a healthcare organization (Kök at al., 2006; Öztürk, Toprak & Basa, 2012). Only one fifth of the female SAW with UI received treatment. In other studies that were carried out it was shown that the number of women receiving treatment for UI is low and the rate of women receiving no treatment ranges between 72.4% and 85.8%. Although negatively influencing the quality of life, UI can be neglected, since it is accepted as a disease that does not directly threaten life and most of the time considered as normal. Female SAW, especially when they are working in agricultural fields, can further neglect health needs they do not think are urgent. Two of the fundamental reasons here are that they are far away from urban areas and it is hard for them to access health care services. At such times the SAW generally try to treat themselves (Şimşek, 2012).

It was determined that 38.7% of the female workers with UI used a pad/diaper. Again, similarly to this research, it can be seen in other research that one woman in two uses a pad/diaper for UI (Kök at al., 2006; Demir & Kızılkaya Beji, 2015; Saleh, Bener, Khenyab, Al-Mansori & Al Muraikhi, 2005). Notwithstanding that the usage of a pad is an important indicator showing the severity of UI, it is thought-provoking that there are a great deal of women not looking for any treatment to a problem which is ruining their quality of life and who accept this situation as normal.

Instead of receiving professional medical care for UI, approximately half of the female SAW with UI were using individual practices such as changing their underwear frequently, using cotton underwear, not lifting heavy weights, making hot application, avoiding salt and liquids. However, they stated that they had difficulties in carrying out these practices while in the agricultural fields.

## **5. Conclusion And Recommendations**

It was determined that approximately more than half of the female SAW had UI but that the effort they put into seeking treatments for UI was low. In line with these findings, it is recommended that working and living conditions which increase the risk of UI among female

workers should be improved, that women should be educated in topics like UI statistics, risk factors and the prevention and treatment of UI, and that those who have incontinence should be guided to receive treatment.

In the future study the researcher may research health seeking behaviour about IU. Also some study may be done to raise awareness and this studies effectiveness may be tested.

The important limitation in the study was communication problems. We met with the problem about language those who speak the language other than the official language, Turkish. We used translator to solve this problem.

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