Note: This is Online Appendix 1 of Janse van Vuuren, A.C., Van Rensburg, J.A. & Hanekom, S., 2023, 'Practitioner's knowledge, attitudes, beliefs and practices towards urinary incontinence', *South African Journal of Physiotherapy* 79(1), a1860. https://doi.org/10.4102/sajp.v79i1.1860

Article Addendum

ADDENDUM A: PILOT STUDY

The primary aim of the pilot questionnaire was to assess if the questionnaire was easily understood and interpreted appropriately. A secondary aim was to assess how long it takes to complete the questionnaire.

Private practice GP's and nurses were included. Contact was made via email (Addendum B) to request for practitioners to assist with piloting the questionnaire and answer follow up questions. The email explained that the questionnaire was about practitioner's knowledge, attitudes, beliefs and practices towards UI management, and provided instructions for completing the questionnaires. The primary investigator emailed the questionnaires and further instructions to those HCPs willing to participate. An offer was made to call practitioners and explain the procedure for completing the questionnaire, however no-one requested this. Practitioners were requested to fill in the PHC practitioner questionnaire regarding UI management (Addendum C) and the facility demographics questionnaire (Addendum D). Thereafter, practitioners were requested to fill in a form (Addendum E) regarding the questionnaire. The primary investigator continued to contact practitioners regarding participation, until 10 private practice GPs, and 10 private practice nurses completed the questionnaire.

The mean time to complete the questionnaire was 12 minutes. Suggestions were taken into consideration regarding the flow of questions as well as wording. Elaborations on practitioner's facility setting, type and the district municipality in which they practice was

also included. Further, an Excel spreadsheet was developed to ensure that the correct data could be extracted from the questionnaire. The questionnaire was adapted (Addendum F) and the finalized version was sent to Stellenbosch University's language department for translation. The questionnaire was only translated after piloting as there was insufficient funds available to translate the questionnaire multiple times. This however, poses as a limitation, as the questions may have been interpreted differently in other languages and could have led to misinterpretations. In an attempt to address this, the Afrikaans and isiXhosa versions of the translated questionnaire was reassessed by a Tygerberg hospital doctor specializing in UI, and changes were made accordingly.

ADDENDUM B: PILOT STUDY INVITATION EMAIL

To whom it may concern

RE: Permission to participate in a pilot questionnaire

Research question: **What is the Knowledge, Practice, Attitudes and Beliefs in the Primary Health Care practitioners with regards to Urinary Incontinence Management in the Western Cape**

The above-mentioned study will be using a self-designed questionnaire to collect data regarding the knowledge, attitudes, belief and practice towards the evaluation and management of urinary incontinence.

The primary investigator, Anika Janse van Vuuren will call practitioners willing to volunteer for the pilot questionnaire. The primary investigator will explain the pilot test and the reason behind the study via telephone. The volunteers will be asked to sign informed consent. The pilot will be used to test the questions used, as well as the language it is asked in, to ensure it is appropriate and easy to interpret to the sample population. The pilot will also be used to estimate the length of time it takes to fill in the questionnaire. The primary investigator will ask to what extend questions asked were understood, and how they were interpreted. Based on the feedback received, the questionnaire will be modified as necessary.

The questionnaire will comprise of six sections.

Section A: To be filled out by the facility manager, including questions on facility demographics.

The rest of the questionnaire is to be filled in by primary health care practitioners.

Section B will ask questions regarding the primary health care practitioner's demographics.

Section C-F questions are based on the NICE 2013 guideline (1) and the Incontinence 6th edition (31) as well as what was done in previous studies in different countries of what is expected of initial management with urinary incontinence in women, questions will address knowledge, attitude, beliefs and practice of practitioners.

Section C will ask questions regarding screening for urinary incontinence with all patients.

Section D will ask questions regarding screening and evaluation specific to patients that have come in complaining of urinary incontinence symptoms or have been previously diagnosed with urinary incontinence.

Section E enquires about the management of urinary incontinent patients.

Section F asks about the referral of patients with urinary incontinence.

The questionnaire will be translated into Afrikaans and isiXhosa.

With this information we request permission to send you the pilot questionnaire and follow up questions via email.

Kind Regards

Anika Janse van Vuuren

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0767762810

Stellenbosch University student number 18385389

ADDENDUM C: ORIGINAL PILOT HEALTH CARE PRACTITIONER QUESTIONNAIRE

Knowledge, Attitude, Belief and Practice of the Primary Health Care practitioners regarding Urinary Incontinence – Primary Health Care Practitioner Questionnaire

Background:

Thank you for taking the time to take part in this study!

The aim of this study is to describe current practice regarding management of urinary incontinence at primary health care facilities, and to report on knowledge, practice, attitude and beliefs of primary health care doctors and nurses in the Western Cape primary health care facilities.

Urinary Incontinence has a high prevalence and large financial burden. Data collected from this study will be used to develop an intervention to improve the service delivery of urinary incontinence management at a primary health care level.

Instructions:

Primary health care practitioners in a position to have initial contact with patients, with the appropriate qualifications enabling them to screen, evaluate, manage or refer urinary incontinent patients will be kindly requested to complete this questionnaire.

Please fill in the questions below as honestly as possible.

This questionnaire is not a test to try and catch anyone out, or discriminate based on the findings. If you are unsure of an answer, please do not guess, rather fill in the “I am unsure” box, or skip to the next question.

Please tick only one box per question, unless otherwise specified in the question.

Section B: Participant demographics (To be filled in by Primary health care practitioner)

1. Gender					
Male				Female	
2. Age					
3. Job Qualification					
Doctor (MBChB)	Advanced diploma in Midwifery	Higher certificate Auxillary nursing qualification	Diploma in nursing: staff nurse	Bachelor's degree in nursing and midwifery	Post graduate diploma in nursing/ midwifery/ accoucheur/ Primary care nursing
4. Years in practice					
5. Years practicing at current facility					

END OF THIS SECTION. PLEASE CONTINUE TO SECTION C

Section C: Screening

1. I ask female patients if they have Urinary Incontinence (involuntary urine leakage)	
Yes	No

If you answered Yes, please continue with question 2- 5, please don't fill in question 6-9. If you answered No, please continue with question 6-9 please don't fill in question 2-5.

2. I feel comfortable managing female patients with Urinary Incontinence			
True		False	
3. If you selected False to question 2, please indicate why (Please tick applicable answers)			
I don't fully understand what management consists of			
UI is an awkward topic			
UI does not fall under my scope of practice			
None of the above			
4. It's not necessary to ask elderly female patients about urinary incontinence as it is a normal part of aging that nothing can be done for			
True	False		I am unsure
5. The following factors are risk factors for urinary incontinence: (please mark with X, can select more than one)			
Age		Obesity	
Pregnancy		Urinary tract infection	
Menopause		Functional or cognitive impairment	
Hysterectomy		Smoking	
Diet		Family history	
Diabetes Mellitus		None of the above	

6. I would like to learn more about Urinary Incontinence management		
True		False
7. If you selected False to question 6, please indicate why (Please tick applicable answers)		
I don't have time		
UI does not fall under my scope of practice		
I don't feel comfortable treating female patients with UI		
None of the above		
8. It's not necessary to ask elderly female patients about urinary incontinence as it's a normal part of aging that nothing can be done for		
True	False	I am unsure
9. I don't ask female patients if they have Urinary Incontinence because: (Please tick applicable answers)		
I don't have time		
Female patients have other co morbidities that are more important to be addressed		
UI is an awkward topic to bring up		
I don't feel comfortable managing UI		
I am unsure how to screen for UI		
None of the above		

END OF THIS SECTION. PLEASE CONTINUE TO SECTION D

Section D: UI specific evaluation

If a female patient comes in with a specific complaint/ diagnosis of Urinary Incontinence							
10. I ask female patients to what extent Urinary Incontinence effects their quality of life:							
Yes			No				
11. I ask about urinary tract infection symptoms when female patients report urinary incontinence:							
Yes			No				
12. For Urinary Incontinence symptoms I ask about: (Circle more than one if necessary)							
Urgency	Nocturia	Urine leakage with effort/ exertion/ sneezing/ coughing	Duration of symptoms	Frequency of urinating	Protective behavior (pad use)	Fluid intake daily	I am unsure what to ask
13. Diabetes Mellitus has an effect on urinary incontinence:							
True		False		I am unsure			
14. I initiate bladder diaries when female patients complain of Urinary Incontinence:							
Yes		No					
15. If you answered "NO" to question 14, why do you not initiate bladder diaries							
I am unfamiliar with bladder diaries		I don't have time to initiate bladder diaries		Bladder diaries are not necessary for urinary incontinence evaluation			
None of the above							
16. I conduct a pelvic assessment if Urinary Incontinence is suspected:							
Yes		No		Not applicable to my practice			
17. If you answered "NO" to question 16, why do you not conduct a pelvic assessment							

I am unsure how to conduct a pelvic assessment	I am uncomfortable with pelvic assessments	Pelvic assessments are too time constraining	Pelvic assessments are not necessary for initial evaluation
None of the Above			

END OF THIS SECTION. PLEASE CONTINUE TO SECTION E

Section E: Management

18. I have managed female patients with Urinary Incontinence before.	
Yes	No

If you answered Yes to question 18, please continue with question 19- 25, please don't fill in question 26-28. If you answered No, please continue with question 26-28 please don't fill in question 19-25.

19. Initial Management of Urinary Incontinence can be carried out at a primary health care level	
True	False
20. I feel comfortable managing female patients with urinary incontinence.	
True	False
21. If you selected False to question 20, please indicate why you do not feel comfortable (Please tick applicable answers)	
I don't fully understand what management consists of	
UI is an awkward topic	
It does not fall under my scope of practice	
None of the above	
22. Initial Management of Urinary Incontinence can include (Please tick applicable answers)	
Pelvic floor muscle training	
Medication	
Absorbent products (pads/ diapers)	
Bladder Training Education	
None of the above	
I am unsure	
23. I follow up on female patients after initial management for Urinary Incontinence has been initiated	
Yes	No
24. If you answered NO to question 23, please indicate why you don't follow up (Please tick applicable answers)	

I do not have time	
It is not necessary	
It is the female patient's responsibility to follow up	
None of the above	

25. Failure to adequately manage Urinary Incontinence will have an effect on the female patient's quality of life

True	False	I am unsure

26. Initial Management of Urinary Incontinence can be carried out at a primary health care level	
True	False
27. If I had to manage a female patient with Urinary Incontinence, I would feel comfortable	
True	False
28. If you selected False to question 27, please indicate why (Please tick applicable answers)	
I don't fully understand what management consists of	
UI is an awkward topic	
It does not fall under my scope of practice	
None of the above	

END OF THIS SECTION. PLEASE CONTINUE TO SECTION F

Section F: Referral

29. I am aware of the referral pathway for Urinary Incontinence in my clinic		
Yes	No	We don't have a referral pathway
30. All female patients with Urinary incontinence should be referred to a specialist		
True	False	I am unsure
31. I refer female patients with failed initial management for Urinary Incontinence to: (Please tick applicable answers)		

Urologist		Specialist UI physiotherapist	
Gynecologist		Occupational Therapist	
Urogynecologist		I am unsure who to refer to	
Specialist UI nurse		Urinary Incontinence doesn't need to be referred	
None of the above			

End of Questionnaire.

Thank you for taking the time to complete this questionnaire it is greatly appreciated! The final study will be sent to all primary health care facilities involved in the study. The primary health care facility can then inform all primary health care practitioners regarding the availability of the results.

ADDENDUM D: ORIGINAL PILOT FACILITY DEMOGRAPHICS QUESTIONNAIRE

Knowledge, Attitude, Belief and Practice of the Primary Health Care practitioners regarding Urinary Incontinence – Facility Demographic Questionnaire

Background:

Thank you for taking the time to take part in this study!

The aim of this study is to describe current practice regarding management of urinary incontinence at primary health care facilities, and to report on knowledge, practice, attitude and beliefs of primary health care doctors and nurses in the Western Cape primary health care facilities.

Urinary Incontinence has a high prevalence and large financial burden. Data collected from this study will be used to develop an intervention to improve the service delivery of urinary incontinence management at a primary health care level.

Instructions:

This Facility Demographics questionnaire only needs to be completed by the facility manager.

Section A: Facility demographics: (To be filled in by facility manager)

Facility Name		
Facility Area		
Facility manager contact details (telephone and email address)		
Setting Type: (please tick)	Clinic	
	Community day center	
Is the facility near a secondary/ tertiary referring hospital	Yes	No
Number of nurses at the facility with the following qualifications:		
• **Advanced diploma in Midwifery**		
• **Higher certificate Auxillary nursing qualification**		
• **Diploma in nursing: staff nurse, Bachelors degree in nursing and midwifery**		
• **Post graduate diploma in nursing/ midwifery/ Accoucheur/ Primary care nursing**		
Number of doctors at facility		
Is Urinary Incontinence managed at your facility	Yes	No
Is there a Urinary Incontinence guideline allocated to be used in your facility	Yes	No
If there is a guideline which one is used (Please write name)		
Is there a Urinary Incontinence referral pathway in your facility	Yes	No
Is there currently any Urinary Incontinence education program in your facility for staff/ patients	Staff/ Patients	No
Is there regular general education sessions given in your facility	Yes	No
If yes in what form: (please tick)	Tutorials	
	Reading material	
	Practical demonstrations	

ADDENDUM E: PILOT FEEDBACK QUESTIONNAIRE

1. Did you understand the questionnaire?	
Yes	No
2. If No which part/ section did you not understand?	
3. Did you feel comfortable answering the questions?	
Yes	No
4. If No which part/ section made you uncomfortable?	
5. Was the language/ wording used clear and understandable?	
Yes	No
6. If No which words/ section were not clear/ understood?	
7. Did any of the questions make you feel irritated?	
Yes	No
8. If Yes which questions, and why?	
9. Is the questionnaire too long?	
Yes	No
10. If yes which questions?	
11. Do you think the questionnaire should include any other questions?	
Yes	No
12. If yes please list questions you think should be included?	

Thank you for your time!

ADDENDUM F: FINAL QUESTIONNAIRE AFTER ADAPTATION ENGLISH

Confidential

What is the Knowledge, Practice, Attitudes, and Beliefs of the Primary Health Care practitioners with regards to Urinary Incontinence Management in the Western Cape

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR QUESTIONNAIRES

My name is Anika Janse van Vuuren, and I am a physiotherapy post graduate student at Stellenbosch University. I would like to invite you to take part in a research project which involves the completion of a questionnaire. Your participation is entirely voluntary and you are free to decline to participate or to stop completing the questionnaire at any time, even if you have agreed to take part initially.

This study aims to:
 To explore the current knowledge, attitudes, beliefs and practice behavior of primary health care practitioners towards urinary incontinence evaluation and management in the Western Cape.
 The study will be conducted via a self-developed questionnaire filled in by a primary health care practitioner. I, Anika Janse van Vuuren, the primary investigator will then collect and analyse all the data from the questionnaires.
 All Primary Health care practitioners at Primary Health Care facilities in the Western Cape with the appropriate qualifications will be included in the study
 Some personal questions will include: qualifications, age, as well as years in practice. The questionnaire will consist of: a screening, management, and a referral section regarding urinary incontinence. If you no longer want to answer the questions, you are welcome to stop at any time.

You are being asked to participate because:
 You are working at a primary health care facility, where you will probably be exposed to female patients that may have Urinary Incontinent symptoms, and with your qualifications, you may be able to assist the patients with some degree of care.
If you agree to participate, you will be requested to:
 Answer the questionnaire questions as honestly as possible. Most questions only require you to tick one option, however where specified you will be asked to tick multiple options as appropriate.

The potential benefits of this research are?
 CPD points from the presentation given after questionnaire completion. Information gathered from this study could benefit the final process of developing optimal service delivery at a Primary health care level with regards to urinary incontinence for all patients. This would reduce the economic burden urinary incontinence has in the long term, as well as improving patient's quality of life.
 The final study will be sent to all primary health care settings involved in the study. The PHC facility can then inform all PHC practitioners regarding the availability of the results.

The potential risks involved in participating in this research are:
 No risks have been identified for participation in this study.
 Collected data will have no personal identification of subjects but rather an allocated record/ reference number. Personal identification and the corresponding reference numbers will be stored on a different encryption file. Confidentiality will be maintained throughout this study, with all decisions being made in the subject's best interest.

You can phone the Principal Investigator of this study, Anika Janse van Vuuren, at 0767762810, or alternatively via email at ajvanv45@gmail.com if you have any questions about this study or encounter any problems.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University. The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

You can phone the Health Research Ethics Committee at 021 938 9677/9819 if you have any further concerns about how this study is being conducted, or if you have a complaint.
You can request a copy of this information and a consent form for you to keep safe, from the primary investigator if you would like one.

By filling out this questionnaire you are confirming that you are over 18 years old and have read and understood the above explanation of the study and that you agree to participate. You also understand that your participation in this study is strictly voluntary.

I confirm that I am a primary health care practitioner currently practicing in the Western Cape	◯ Yes ◯ No
I consent to participate in this questionnaire	◯ Yes ◯ No

Facility Demographic Questionnaire

Knowledge, Attitude, Belief and Practice of the Primary Health Care practitioners regarding Urinary Incontinence - Facility Demographic Questionnaire

Background:
Thank you for taking the time to take part in this study!
The aim of this study is to describe current practice regarding management of urinary incontinence at primary health care facilities, and to report on knowledge, practice, attitude and beliefs of primary health care doctors and nurses in the Western Cape primary health care facilities.
Urinary Incontinence has a high prevalence and large financial burden. Data collected from this study will be used to develop an intervention to improve the service delivery of urinary incontinence management at a primary health care level.

Section A:	
Facility Name	_____
Facility Area	_____
District municipality	◯ West Coast ◯ Cape Winelands ◯ Overberg ◯ Garden Route ◯ Central Karoo ◯ Cape town metropole
Facility manager contact details (telephone and email address)	_____
Facility Type	☐ Private ☐ Government
Setting Type:	☐ Clinic ☐ Community day center ☐ Doctors rooms ☐ Other (Please specify)
If other setting type, please specify:	_____
Is the facility near a secondary/ tertiary referring hospital	◯ Yes ◯ No
Number of nurses at the facility with the following qualifications: Advanced diploma in Midwifery	_____
Number of nurses at the facility with the following qualifications: Higher certificate Auxillary nursing qualification	_____
Number of nurses at the facility with the following qualifications: Diploma in nursing: staff nurse, Bachelors degree in nursing and midwifery	_____

Number of nurses at the facility with the following qualifications: Post graduate diploma in nursing/ midwifery/ Accoucheur/ Primary care nursing	_____
Number of doctors at facility	_____
Is Urinary Incontinence managed at your facility	◯ Yes ◯ No
Is there a Urinary Incontinence guideline allocated to be used in your facility	◯ Yes ◯ No
If there is a guideline which one is used (Please write name)	_____
Is there a Urinary Incontinence referral pathway in your facility	◯ Yes ◯ No
Is there currently any Urinary Incontinence education program in your facility for staff/ patients	☐ Staff ☐ Patients ☐ No
Is there regular general education sessions given in your facility?	◯ Yes ◯ No
If yes in what form:	☐ Tutorials ☐ Reading material ☐ Practical Demonstrations ☐ Zoom/ Teams meetings

Primary Health Care practitioner questionnaire

Knowledge, Attitude, Belief and Practice of the Primary Health Care practitioners regarding Urinary Incontinence - Primary Health Care Practitioner Questionnaire

Instructions:
Primary health care practitioners in a position to have initial contact with patients, with the appropriate qualifications enabling them to screen, evaluate, manage or refer urinary incontinent patients will be kindly requested to complete this questionnaire.

Please fill in the questions below as honestly as possible.
This questionnaire is not a test to try and catch anyone out, or discriminate based on the findings. If you are unsure of an answer, please do not guess, rather fill in the "I am unsure" box, or skip to the next question.
Please tick only one box per question, unless otherwise specified in the question.

Section B: Participant demographics (To be filled in by Primary health care practitioner)

1. Gender	◯ Male ◯ Female
2. Age	_____
3. Job Qualification	☐ Doctor (MBChB) ☐ Advanced diploma in Midwifery ☐ Higher certificate Auxillary nursing qualification ☐ Diploma in nursing: staff nurse ☐ Bachelors degree in nursing and midwifery ☐ Post graduate diploma in nursing/ midwifery/ accoucheur/ Primary care nursing
4. Years in practice	_____
5. Years practicing at current facility	_____

Section C: Screening

1. I routinely ask female patients if they have Urinary Incontinence (involuntary urine leakage)	◯ Yes ◯ No
2. If you selected No to question 1, please indicate why you don't ask female patients if they have Urinary Incontinence (Please tick all applicable answers)	☐ I don't have time ☐ Female patients have other co morbidities that are more important to be addressed ☐ UI is an awkward topic to bring up ☐ I don't feel comfortable managing urinary incontinence ☐ I am unsure how to screen for urinary incontinence ☐ None of the above
3. I feel comfortable managing female patients with Urinary Incontinence	◯ Yes ◯ No

4. If you selected No to question 3, please indicate why (Please tick all applicable answers)	☐ I don't fully understand what urinary incontinence management consists of ☐ Urinary incontinence is an awkward topic ☐ Urinary incontinence does not fall under my scope of practice ☐ None of the above
5. It's not necessary to ask elderly female patients about urinary incontinence as it is a normal part of aging that nothing can be done for	◯ True ◯ False ◯ I am unsure
6. The following factors are risk factors for urinary incontinence: (please mark with X, can select more than one)	☐ Age ☐ Pregnancy ☐ Menopause ☐ Hysterectomy ☐ Diet ☐ Diabetes Mellitus ☐ Obesity ☐ Urinary tract infection ☐ Functional or cognitive impairment ☐ Smoking ☐ Family history ☐ None of the above
7. I would like to learn more about Urinary Incontinence management	◯ Yes ◯ No
8. If you selected No to question 7, please indicate why (Please tick applicable answers)	☐ I don't have time ☐ Urinary incontinence does not fall under my scope of practice ☐ I don't feel comfortable treating female patients with urinary incontinence ☐ None of the above

Section D: UI specific evaluation
If a female patient comes in with a specific complaint/ diagnosis of Urinary Incontinence

9. I ask female patients to what extent Urinary Incontinence effects their quality of life:	◯ Yes ◯ No
10. I ask about urinary tract infection symptoms when female patients report urinary incontinence:	◯ Yes ◯ No
11. For Urinary Incontinence symptoms I ask about:	☐ Urgency ☐ Nocturia ☐ Urine leakage with effort/ exertion/ sneezing/ coughing ☐ Duration of symptoms ☐ Frequency of urinating ☐ Protective behavior (pad use) ☐ Fluid intake daily ☐ I am unsure what to ask
12. Diabetes Mellitus has an effect on urinary incontinence:	◯ True ◯ False ◯ I am unsure
13. I initiate bladder diaries when female patients complain of Urinary Incontinence:	◯ Yes ◯ No

14. If you answered "NO" to question 13, why do you not initiate bladder diaries	☐ I am unfamiliar with bladder diaries ☐ I don't have time to initiate bladder diaries ☐ Bladder diaries are not necessary for urinary incontinence evaluation ☐ None of the above
15. I conduct a pelvic assessment if Urinary Incontinence is suspected:	◯ Yes ◯ No
16. If you answered "NO" to question 15, why do you not conduct a pelvic assessment	☐ I am unsure how to conduct a pelvic assessment ☐ I am uncomfortable with pelvic assessments ☐ Pelvic assessments are too time constraining ☐ Pelvic assessments are not necessary for initial evaluation ☐ Not applicable to my practice ☐ I prefer to refer to someone else ☐ None of the Above
Section E: Management	
17. I have managed female patients with Urinary Incontinence before.	◯ Yes ◯ No
18. Initial Management of Urinary Incontinence can be carried out at a primary health care level	◯ True ◯ False
19. Initial Management of Urinary Incontinence can include (Please tick applicable answers)	☐ Pelvic floor muscle training ☐ Medication ☐ Absorbent products (pads/ diapers) ☐ Bladder Training Education ☐ None of the above ☐ I am unsure
20. I follow up on female patients after initial management for Urinary Incontinence has been initiated	◯ Yes ◯ No
21. If you answered NO to question 20, please indicate why you don't follow up (Please tick applicable answers)	☐ I do not have time ☐ It is not necessary ☐ It is the female patient's responsibility to follow up ☐ None of the above
22. Failure to adequately manage Urinary Incontinence will have an effect on the female patient's quality of life	◯ True ◯ False ◯ I am unsure
Section F: Referral	
23. I am aware of the referral pathway for Urinary Incontinence in my clinic	◯ Yes ◯ No ◯ We don't have a referral pathway
24. All female patients with Urinary incontinence should be referred to a specialist	◯ True ◯ False ◯ I am unsure

25. I refer female patients with failed initial management for Urinary Incontinence to: (Please tick applicable answers)	☐ Urologist ☐ Gynecologist ☐ Urogynecologist ☐ Specialist urinary incontinence nurse ☐ Specialist urinary incontinence physiotherapist ☐ Occupational Therapist ☐ I am unsure who to refer to ☐ Urinary Incontinence doesn't need to be referred ☐ None of the above
Please enter your email address if you would like us to contact you regarding the free CPD course, on what initial urinary incontinence management should consist of at a primary health care level.	_____
Please indicate where you received this survey from:	◯ Email ◯ Colleague ◯ Word of mouth ◯ Other (please specify)
If other (Please specify)	_____

End of Questionnaire.
Thank you for taking the time to complete this questionnaire, it is greatly appreciated! The final study will be sent to all primary health care facilities involved in the study. The primary health care facility can then inform all primary health care practitioners regarding the availability of the results.

ADDENDUM G: FINAL QUESTIONNAIRE AFRIKAANS

Wat is die kennis, praktykvoering, houdings, en oortuigings van primêre gesondheidsorgpraktisyns met betrekking tot urinêre inkontinensie behandeling in die Weskaap.

DEELNEMERINLIGTING EN INSTEMMING VORM VIR VRAELYS

TITEL VAN NAVORSINGSPROJEK: Wat is die kennis, praktykvoering, houdings, en oortuigings van primêre gesondheidsorgpraktisyns met betrekking tot urinêre inkontinensie behandeling in die Weskaap.

My naam is Anika Janse van Vuuren. Ek is 'n nagraade fisioterapie student by die Universiteit Stellenbosch. Ek nooi u uit om deel te neem aan 'n navorsingsprojek wat die voltooiing van 'n vraelys behels. U deelname is heeltemal vrywillig en dit staan u vry om te enige tyd te weier om deel te neem of om die vraelys te voltooi, selfs al het u ingestem om aanvanklik deel te neem. Sodra u die voltooide vraelys ingedien het, sal u egter nie meer in staat wees om te ontrek nie. Aangesien die vraelyste anoniem is, en geen antwoorde aan u gekoppe is nie.

Hierdie studie het ten doel om:Die huidige kennis, houdings, oortuigings en praktykvoering van primêre gesondheidsorgpraktisyns ten opsigte van urinêre inkontinensie-evaluering en behandeling in die Wes-Kaap te ondersoek.

Die studie te doen deur middel van 'n self-ontwikkelde vraelys wat deur 'n primêre gesondheidsorpraktisyn ingevul word. Ek, Anika Janse van Vuuren, die primêre ondersoeker, sal dan al die data uit die vraelyste versamel en analiseer.

Primêre gesondheidsorgpraktisyns met die toepaslike kwalifikasies by primêre gesondheids instellings sal in die studie in te sluit word.

Sommige persoonlike vrae in te sluit: soos kwalifikasies, ouderdom, en jare betrokke in praktyk. Die vraelys sal bestaan uit; sifting, behandeling en 'n verwysings praktyke in sake urinêre inkontinensie pasiente. As u nie verder die vrae wil beantwoord nie, is u welkom om te enige tyd die uitnodiging van die hand te wys.

U word gevra om deel te neem omdat:U by 'n primêre gesondheidsorginstelling werk, waar u met moontlike blootsteling is aan vroulike pasiënte met simptome van urinêre inkontinensie. Met u kwalifikasies mag u die pasiënte kan ondersteun met n mate van sorg.

As u instem om deel te neem, sal u versoek word om:So eerlik moontlik die vraelysvrae te beantwoord. Die meeste vrae vereis dat u slegs een opsie merk, maar indien aangedui, sal u gevra word om verkskeie opsies te merk.

Die potensiële voordele van hierdie navorsing is?Voortgesette profesionele ontwikkeling punte word uit die aanbieding gegee na voltooiing van die vraelys. Inligting wat uit hierdie studie versamel word, kan tot voordeel wees van die finale proses om optimale dienslewering op 'n primêre gesondheidsorgvlak te ontwikkel met betrekking tot urinêre inkontinensie vir alle pasiënte. Dit sal die langtermyn ekonomiese las van urinêre inkontinensie verminder, asook die pasiënt se lewensgehalte verbeter.

Die finale studie sal aan alle instellings vir primêre gesondheidsorg wat by die studie betrokke is, gestuur word. Die primêre gesondheidsorg fasiliteit kan dan alle primêre gesondheidsorg praktisyns inlig oor die bevindinge.

Die moontlike risiko's verbonde aan deelname aan hierdie navorsing is:Geen risiko's is geïdentifiseer vir deelname aan hierdie studie.

Versamelde data bevat geen persoonlike identifikasie van die deelnemer nie, maar eerder n toegewysde rekord/ verwysingsnommer. Persoonlike identifikasie en die ooreenstemmende verwysingsnommers sal in 'n ander koderinglêer gestoor word. Vertroulikheid sal gedurende hierdie studie gehandhaaf word, en alle besluite word in die beste belang van die deelnemer geneem.

U kan die hoofondersoeker van hierdie studie, Anika Janse van Vuuren, skakel by 0767762810, of alternatiewelik per e-pos na ajvanv45@gmail.com, as u vrae het oor hierdie studie of probleme ondervind.

Hierdie studie is goedgekeur deur die Etiese Komitee vir Gesondheidsnavorsing aan die Universiteit Stellenbosch. Die studie sal uitgevoer word volgens die etiese riglyne en beginsels van die internasionale verklaring van Helsinki en die Departement van Gesondheidsetiek in gesondheidsnavorsing: beginsels, prosesse en studies (2015).

U kan die Etiese Komitee vir Gesondheidsnavorsing skakel by 021 938 9677/ 9819 as u verdere kommentaar wil lewer.

hierdie studie uitgevoer word, of as u 'n klag het.

U kan 'n afskrif van hierdie inligting en 'n toestemmingsvorm aanvra om veilig te bewaar by u fasiliteitsbestuurder indien u dit wil hê.

Deur hierdie vraelys in te vul, bevestig u dat u ouer as 18 jaar is en dat u die bostaande uiteensetting van die studie gelees en verstaan het en dat u instem om deel te neem. U verstaan ook dat u deelname aan hierdie studie streng vrywillig is.

I confirm that I am a primary health care practitioner currently practicing in the Western Cape	◯ Yes ◯ No
I consent to participate in this questionnaire	◯ Yes ◯ No

Fasiliteit demografie vraelys.

Kennis, houdings, oortuigings en praktyk van primêre gesondheidsorg praktisyns rakende urinêre inkontinensie - Fasiliteit demografie vraelys.

Agtergrond:
Dankie dat u die tyd neem om aan hierdie studie deel te neem!
Die doel van hierdie studie is om die huidige praktyk ten opsigte van urinêre inkontinensie hantering by primêre gesondheidsorg fasiliteite te beskryf, en om verslag te doen oor die kennis, praktyk, houding, en oortuigings van primêre gesondheidsorg dokters en verpleegsters werksaam op primêre vlak in die Weskaapse departement van gesondheid.
Die voorkoms van Urinêre inkontinensie is hoog met n groot finansiële las. Die data wat ingesamel word deur hierdie studie, sal onder andere gebruik word om die dienslewering en hantering van urinêre inkontinensie op primêre gesondheidsorg vlak te verbeter.

Afdeling A: Fasiliteitsdemografie:	
Naam van Fasiliteit	_____
Fasiliteit Area	_____
Distriksmunisipaliteit	◯ Weskus ◯ Kaapse Wynlande ◯ Overberg ◯ Tuinroete ◯ Sentraal-Karoo ◯ Kaapstad metropool
Kontakbesonderhede vir fasiliteitsbestuurder (telefoon en e-pos adres)	_____
Fasiliteitstipe	☐ Privaat ☐ Staat
Soort instelling:	☐ Kliniek ☐ Gemeenskapsdag sentrum ☐ Dokters kamers ☐ Ander (Spesifiseer asseblief)
As ander (Spesifiseer asseblief)	_____
Is die fasiliteit naby 'n sekondêre/ tersiêre verwysende hospital?	◯ Ja ◯ Nee
Aantal verpleegsters by die fasiliteit met die volgende kwalifikasies: Gevorderde diploma in verloskunde	_____
Aantal verpleegsters by die fasiliteit met die volgende kwalifikasies: Hoër sertifikaat in hulpverpleegkunde	_____

Aantal verpleegsters by die fasiliteit met die volgende kwalifikasies: Diploma in verpleegkunde: personeelverpleegster, Graad in verpleegkunde en verloskunde	_____
Aantal verpleegsters by die fasiliteit met die volgende kwalifikasies: Nagraadse diploma in verpleegkunde/ vroedvrou/ vroedmeester/ verpleegkunde in primêre sorg	_____
Aantal dokters by die fasiliteit	_____
Word urinêre inkontinensie behandel in u fasiliteit?	◯ Ja ◯ Nee
Is daar 'n riglyn vir urinêre inkontinensie wat in u fasiliteit gebruik word?	◯ Ja ◯ Nee
As daar 'n riglyn is, watter een word gebruik? (Skryf asseblief die naam)	_____
Is daar 'n verwysingsroete vir urinêre inkontinensie in u fasiliteit?	◯ Ja ◯ Nee
Is daar tans 'n opleidingsprogram vir urinêre inkontinensie in u fasiliteit vir personeel/ pasiënte?	☐ Personeel ☐ Pasiënte ☐ Nee
Word daar gereeld algemene opleidingsessies in die fasiliteit aangebied?	◯ Ja ◯ Nee
Indien wel, in watter vorm:	☐ Tutoriale ☐ Leesstof ☐ Praktiese demonstrasies ☐ Zoom/ Teams vergaderings

Primêre gesondheidsorg praktisyns vraelys.

Kennis, houdings, oortuigings en praktyk van primêre gesondheidsorg praktisyns rakende urinêre inkontinensie - Primêre gesondheidsorg praktisyns vraelys.

Agtergrond:
Dankie dat u die tyd neem om aan hierdie studie deel te neem!
Die doel van hierdie studie is om die huidige praktyk ten opsigte van urinêre inkontinensie hantering by primêre gesondheidsorg fasiliteite te beskryf, en om verslag te doen oor die kennis, praktyk, houding, en oortuigings van primêre gesondheidsorg dokters en verpleegsters werksaam op primêre vlak in die Weskaapse departement van gesondheid.
Die voorkoms van Urinêre inkontinensie is hoog met n groot finansiële las. Die data wat ingesamel word deur hierdie studie, sal onder andere gebruik word om die dienslewering en hantering van urinêre inkontinensie op primêre gesondheidsorg vlak te verbeter.
Instruksies:
Primêre gesondheidsorg praktisyns met toepaslike kwalifikasies om urinêre inkontinente pasiënte te ondersoek, evalueer, bestuur of te verwys, word versoek om hierdie vraelys in te vul.
Vul asseblief die vraelys so eerlik moontlik in.
Hierdie vraelys is nie 'n toets om iemand te probeer uitvang, of om op grond van die bevindinge te diskrimineer nie.
As u onseker is van 'n antwoord, moet asseblief nie raai nie; vul eerder die "Ek is nie seker"- blokkie in of gaan na die volgende vraag.
Merk slegs een blokkie per vraag, tensy anders gespesifiseer word.

Afdeling B: Deelnemer demografie

1. Geslag
- ◯ Manlik
- ◯ Vroulik

2. Ouderdom
_____

3. Beroeps'kwalifikasie
- ☐ Dokter (MBChB)
- ☐ Gevorderde diploma in verloskunde
- ☐ Hoër sertifikaat Hulpverpleegkwalifikasie
- ☐ Diploma in verpleegkunde: personeelverpleegster
- ☐ Graad in verpleegkunde en verloskunde
- ☐ Nagraadse diploma in verpleegkunde/ vroedvrou/ vroedmeester/ verpleegkunde in primêre sorg

4. Jare in praktyk
_____

5. Jare wat u by die huidige fasiliteit praktiseer
_____

Afdeling C: Sifting

1. Ek vra vroulike pasiënte gereeld of hulle urinêre inkontinensie het (Onwillekeurige lek van urine)
- ◯ Ja
- ◯ Nee

2. As u Nee vir vraag 1 gekies het, dui asseblief aan waarom u vroulike pasiënte nie vra of hulle urinêre inkontinensie het nie (merk asseblief alle toepaslike antwoorde).
- ☐ Ek het nie tyd nie
- ☐ Vroulike pasiënte het ander siektes wat belangriker is om aan te spreek
- ☐ Urinêre inkontinensie is 'n ongemaklike onderwerp
- ☐ Ek voel nie gemaklik om urinêre inkontinensie te hanteer nie
- ☐ Ek is nie seker hoe om vir urinêre inkontinensie te sif nie
- ☐ Nie een van bogenoemde nie

3. Ek voel gemaklik om vroulike pasiënte met urinêre inkontinensie te behandel	◯ Ja ◯ Nee
4. As u Nee vir vraag 3 gekies het, dui asseblief aan waarom (merk asseblief alle toepaslike antwoorde)	☐ Ek verstaan nie heeltemal waaruit die bahandeling van urinêre inkontinensie bestaan nie ☐ Urinêre inkontinensie is 'n ongemaklike onderwerp ☐ Urinêre inkontinensie is nie deel van die omvang van my praktyk nie ☐ Nie een van bogenoemde nie
5. Dit is nie nodig om bejaarde vroulike pasiënte oor urinêre inkontinensie te vra nie, want dit is 'n normale deel van veroudering waarvoor niks gedoen kan word nie.	◯ Waar ◯ Onwaar ◯ Ek is onseker
6. Die volgende faktore is risikofaktore vir urinêre inkontinensie: (merk asseblief alle toepaslike antwoorde)	☐ Ouderdom ☐ Swangerskap ☐ Menopouse ☐ Histerektomie ☐ Dieet ☐ Diabetes Mellitus ☐ Vetsug ☐ Urienweginfeksie ☐ Funksionele of kognitiewe inkorting ☐ Rook ☐ Gesinsgeskiedenis ☐ Geen van die bogenoemde nie
7. Ek wil graag meer te wete kom oor die behandeling van urinêre inkontinensie	◯ Ja ◯ Nee
8. As u Nee by vraag 7 gekies het, dui asseblief aan waarom (merk asseblief alle toepaslike antwoorde)	☐ Ek het nie tyd nie ☐ Urinêre inkontinensie is nie deel van die omvang van my praktyk nie ☐ Ek voel nie gemaklik om urinêre inkontinensie te hanteer nie ☐ Nie een van bogenoemde nie
Afdeling D: Spesifieke evaluering van urinêre inkontinensie Waneer 'n vroulike pasiënt met 'n spesifieke klagte/ diagnose van urinêre inkontinensie inkom	
9. Ek vra vroulike pasiënte in watter mate urinêre inkontinensie hul lewensgehalte beïnvloed	◯ Ja ◯ Nee
10. Ek vra na simptome van urienweginfeksies	◯ Ja ◯ Nee
11. Ek vra uit na urinêre inkontinensie simptome: (kies meer as een indien nodig)	☐ Dringendheid ☐ Nokturie ☐ Urine lekkasie met inspanning/ nies/ hoes ☐ Duur van simptome ☐ Frekwensie van urinering ☐ Beskermende gedrag (doek gebruik) ☐ Daagliks vloeistofinname ☐ Ek is nie seker wat om te vra nie
12. Diabetes Mellitus het 'n uitwerking op urinêre inkontinensie:	◯ Waar ◯ Onwaar ◯ Ek is onseker

13. Ek begin blaasdagboeke as vroulike pasiënte kla oor urinêre inkontinensie:	◯ Ja ◯ Nee
14. As u op vraag 13 Nee geantwoord het, waarom begin u nie blaasdagboeke nie?	☐ Ek is nie vertroud met blaasdagboeke nie ☐ Ek het nie tyd om blaasdagboeke te begin nie ☐ Blaasdagboeke is nie nodig vir urinêre inkontinensie evaluering nie ☐ Nie een van die bogenoemde nie
15. Ek doen 'n inwendige vaginale ondersoek as urinêre inkontinensie vermoed word	◯ Ja ◯ Nee
16. As u Nee op vraag 15 geantwoord het, waarom doen u nie n inwendige vaginale ondersoek nie (kies meer as een indien nodig)	☐ Ek is nie seker hoe om 'n inwendige vaginale ondersoek te doen nie ☐ Ek voel ongemaklik met inwendige vaginale ondersoeke ☐ Inwendige vaginale ondersoek is te tydsrowend ☐ Inwendige vaginale ondersoek is nie nodig vir aanvanklike evaluering nie ☐ Is nie deel van die omvang van my praktyk nie ☐ Ek verwys verkieslik na iemand anders toe ☐ Nie een van die bogenoemde nie
Afdeling E: Behandeling van urinêre inkontinensie	
17. Ek het al voorheen vroulike pasiënte met urinêre inkontinensie behandel.	◯ Ja ◯ Nee
18. Aanvanklike hantering van urinêre inkontinensie kan op n primêre gesondheidsorgvlak gedoen word	◯ Waar ◯ Onwaar
19. Aanvanklike bestuur van urinêre inkontinensie behels: (merk asseblief alle toepaslike antwoorde)	☐ Bekken vloer spier oefening ☐ Medikasie ☐ Absorberende produkte (doekies/ doeke) ☐ Blaasopleiding ☐ Nie een van die bogenoemde nie ☐ Ek is onseker
20. Ek volg vroulike pasiënte op nadat die aanvanklike behandeling vir urinêre inkontinensie begin het	◯ Ja ◯ Nee
21. As u Nee op vraag 20 geantwoord het, dui asseblief aan waarom u dit nie opvolg nie (merk asseblief alle toepaslike antwoorde)	☐ Ek het nie tyd nie ☐ Dit is nie nodig nie ☐ Dit is die vroulike pasiënt se verantwoordelikheid om op te volg ☐ Nie een van die bogenoemde nie
22. Indien urinêre inkontinensie nie voldoende hanteer word nie, sal dit 'n uitwerking op die lewensgehalte van die vroulike pasiënt hê	◯ Waar ◯ Onwaar ◯ Ek is onseker
Afdeling F: Verwysing	
23. Ek is bewus van die verwysingsroete vir urinêre inkontinensie in my kliniek	◯ Ja ◯ Nee ◯ Ons het nie 'n verwysingsroete nie

24. Alle vroulike pasiënte met urinêre inkontinensie moet na 'n spesialis verwys word	◯ Waar ◯ Onwaar ◯ Ek is onseker
25. Ek verwys vroulike pasiënte met mislukte aanvanklike behandeling vir urinêre inkontinensie na: (merk asseblief alle toepaslike antwoorde)	☐ Uroloog ☐ Ginekoloog ☐ Uroginekoloog ☐ Spesialis urinêre inkontinensie verpleegster ☐ Spesialis urinêre inkontinensie fisioterapeut ☐ Arbeidsterapeut ☐ Ek is onseker na wie ek moet verwys ☐ Urinêre inkontinensie hoef nie verwys te word nie ☐ Nie een van die bogenoemde nie
Please enter your email address if you would like us to contact you regarding the free CPD course, on what initial urinary incontinence management should consist of at a primary health care level.	_____
Please indicate where you received this survey from:	◯ Email ◯ Colleague ◯ Word of mouth ◯ Other (please specify)
If other (please specify)	_____

Einde van die vraelys.
Dankie dat u die tyd geneem het om hierdie vraelys in te vul, dit word baie waardeer! Die finale resultate van hierdie studie sal aan alle primêre gesondheidsorgfasiliteite wat by die studie betrokke was, gestuur word. Die primêre gesondheidsorginstansie kan dan alle primêre gesondheidsorgpraktisyns inlig oor die beskikbaarheid van die resultate.

ADDENDUM H: FINAL QUESTIONNAIRE ISIXHOSA

Luluphi uLwazi, uQheliselo, Isimo seNgqondo neeNkolelo zamagosa oNyamekelo oluyiNtloko lweZempilo ngokuphathelele uLawulo lokushiywa nguMchamo eNtshona Koloni

IPHETSHANA ELINENKCAZELO YOMTHATHI-NXAXHEBA NEFOMU YEMVUME EYENZELWE AMAXWEBHU EMIBUZO

Isihloko SeProjekti Yophando: Luluphi uLwazi, uQheliselo, Isimo seNgqondo neeNkolelo zamagosa oNyamekelo oluyiNtloko lweZempilo ngokuphathelele uLawulo lokushiywa nguMchamo eNtshona Koloni

Igama lam nguAnika Janse van Vuuren, nongumfundi wezokolulwa kwamalungu kwiYunivesithi yaseStellenbosch. Ndingathanda ukunimema ukuba nithathe inxaxheba kwiprojekthi yophando equka ukuzaliswa koxwebhu lwemibuzo. Ukuthatha kwakho inxaxheba kokokuzithandela ngokupheleleyo yaye ukhululekile ukuba ungala ukuthatha inxaxheba okanye uyeke ukuzalisa uxwebhu lwemibuzo nanini na, kwanokuba ubuvumile ukuthatha inxaxheba ekuqaleni. Noko ke, wakuba ufake uxwebhu lwakho lwemibuzo oluzalisiweyo, akusayi kuphinda ukwazi ukurhoxisa iimpendulo zakho njengoko engachazwa amagama kumaxwebhu emibuzo yaye ngenxa yoko akusayi kubakho ndlela yokukudibanisa neempendulo zakho.

Olu phononongo lunenjongo:Yokuhlola ulwazi olukhoyo, izimo zengqondo, iinkolelo nendlela yoqheliselo lwamagosa onyamekelo oluyintloko lwezempilo ngakuhlolo lokulawulwa kokushiywa ngumchamo eNtshona Koloni.

Uphononongo luya kuqhutywa ngamaxwebhu emibuzo angoozenzele azaliswa ligosa lonyamekelo oluyintloko kwezempilo. Mna, Anika Janse van Vuuren njengomphandi oyintloko ndiya kuthi ndiqokelele ndize ndihlalutye yonke inkcazelo ephuma kula maxwebhu.

Onke amagosa onyamekelo oluyiNtloko lwezeMpilo kumaziko oNyamekelo oluyiNtloko lwezeMpilo aneemfaneleko ezizizo aya kuqukwa kuphononongo.

Eminye imibuzo yobuqu iya kuquka iimfaneleko; ubudala; kwakunye neminyaka yokusebenza. Uxwebhu lwemibuzo luya kuquka ukuhluzwa, ulawulo; kwakunye necandelo lokubhekiselwa ngokuphathelele ukushiywa ngumchamo. Ukuba akusafuni kuphendula imibuzo, uvumelekile ukuba uyeke nanini.

Uyacelwa ukuba uthathe inxaxheba ngenxa yokuba:Usebenza kwiziko lonyamekelo oluyintloko lwezempilo, apho mhlawumbi uya kudibana nezigulana ezingamabhinqa ekusenokwenzeka ukuba zineempawu zokushiywa nguMchamo yaye ngeemfaneleko zakho ungakwazi ukunceda izigulana ngomlinganiselo othile wokunyamekela.

Ukuba uyavuma ukuthatha inxaxheba, uya kucelwa ukuba:Uphendule imibuzo yoxwebhu lwemibuzo ngokunyaniseka kangangoko kunokwenzeka. Uninzi lwemibuzo lufuna ukuba utike nje ukhetho lube lunye, noko ke xa kuchaziwe uya kucelwa ukuba utike ukhetho olungaphezu kolunye njengoko kufanelekile.

Ziziphi iinzuzo ezinokubakho kolu phando?Iingongoma zeCPD kwintetho enikelwa emva kokuba kuzaliswe uxwebhu lwemibuzo. Inkcazelo eqokelelwe kolu phononongo inokuba yinzuzo kwinkqubo yokuqukumbela yokuyila ukunikezelwa kweenkonzo okusemagqabini kumgangatho wonyamekelo lwempilo oluyintloko ngokuphathelele ukushiywa ngumchamo kwazo zonke izigulana. Oku kuya kunciphisa umthwalo wezoqoqosho obangelwa kukushiywa ngumchamo kwixesha elizayo kwakunye nokuphucula umgangatho wobomi wezigulana.

Uphononongo lokugqibela luya kuthunyelwa kuwo onke amaziko onyamekelo lwezempilo oluyintloko abandakanyekileyo kuphononongo. Liya kuthi ke iziko le-PHC lazise onke amagosa e-PHC ngokuphathelele ukufumaneka kweziphumo.

Imingcipheko enokubakho ekuthatheni inxaxheba kuphando yile:Ayikho imingcipheko eye yaphawulwa ekuthatheni inxaxheba kuphononongo.

Inkcazelo eqokelelweyo ayisayi kuba nenkcazelo yobuqu yabalingwa kodwa kunoko iya kuba nengxelo eqokelelweyo/inombolo yereferensi. Ukuchazwa komntu neenombolo zereferensi ezingqamana nako kuya kugcinwa kwifayile ekhowudiweyo eyahlukileyo. Kuya kugcinwa ubumfihlo kulo lonke olu phononongo, zonke izigqibo zisenziwa kucingwa ngomlingwa.

Ungafowunela uMphandi oyiNtloko kolu phononongo, uAnika Janse van Vuuren ku-0767762810, okanye uqhagamshelane naye nge-imeyile ku-ajvanv45@gmail.com ukuba unayo nayiphi na imibuzo ngolu phononongo okanye udibane nazo naziphi na iingxaki.

Olu phononongo luye lwagunyaziswa yiHealth Research Ethics Committee yeYunivesithi yaseStellenbosch. Olu phononongo luya kuqhutywa ngokuvumelana nemiyalelo nemigaqo engqongqo yesiBhengezo seHelsinki sehlabathi, nemilinganiselo yokuZiphatha yeSebe lezeMpilo kuPhando lwezeMpilo: ImiGaqo, iNkqubo namaPhononongo (2015).

Ungafowunela iKomiti yokuZiphatha kuPhando lweZempilo ku-021 938 9677/9819 ukuba kukho izinto ezingakumbi ezikuxhalabisayo ngendlela oluqhutywa ngayo olu phononongo, okanye ukuba unesikhalazo.

Ungacela ikopi yale nkcazelo nefomu yemvume ukuze uyigcine ikhuselekile kumaneja weziko ukuba ungathanda ukuyifumana.

Ngokuzalisa olu xwebhu lwemibuzo uyaqinisekisa ukuba uneminyaka engaphezu kweli-18 ubudala yaye uye wayifunda waza wayiqonda le ngcaciso yophononongo yaye uyavuma ukuthatha inxaxheba. Kanti uyaqonda ukuba ukuthatha inxaxheba kolu phononongo kokokuzithandela ngokungqongqo.

I confirm that I am a primary health care practitioner currently practicing in the Western Cape	◯ Yes ◯ No
I consent to participate in this questionnaire	◯ Yes ◯ No

UXwebhu lweMibuzo ngeeDemografiki zeZiko

Imvelaphi:
Enkosi ngokuthatha eli thuba ube nenxaxheba kolu phononongo!
Injongo yolu phononongo kukuchaza uqheliselo olukhoyo ngokulawulwa kokushiywa ngumchamo kumaziko onakekelo oluyintloko lwezempilo, nokwenza ingxelo ngolwazi, isimo sengqondo neenkolelo zoogqirha namanesi abakumaziko onakekelo oluyintloko lwezempilo eNtshona Koloni
Ukushiywa nguMchamo kugqugqisile yaye kuyabiza kakhulu. Inkcazelo efunyenwe kolu phononongo iya kusetyenziselwa ukuyila indlela yokuphucula ukunikezelwa kwenkonzo yokulawulwa kokushiywa ngumchamo kwizinga lonakekelo oluyintloko lwezempilo.

Inxalenye A:

Igama leZiko

_____

Ummandla weZiko

_____

District municipality

- ◯ West Coast
- ◯ Cape Winelands
- ◯ Overberg
- ◯ Garden Route
- ◯ Central Karoo
- ◯ Cape town metropole

Iinkcukacha zonxibelelwano zemaneja yeziko (ifoni ne-adresi yemeyili)

_____

UHlobo lweZiko

- ☐ Eyobuqu
- ☐ Urhulumente

UHlobo lokuhlela:

- ☐ Iklinikhi
- ☐ Iziko loluntu elivulwa emini
- ☐ Amagumbi oogqirha
- ☐ Okunye (Nceda cacisa)

Okunye (Nceda cacisa):

_____

Ngaba eli ziko likufutshane nesibhedlele esiyintloko/ esiphakamileyo ekuthunyelwa kuso abantu

- ◯ Ewe
- ◯ Hayi

Inani loonesi kweli ziko abanezi mfaneleko zilandelayo: IDiploma ePhambili ekubelekiseni

_____

Inani loonesi kweli ziko abanezi mfaneleko zilandelayo: ISatifiketi esiPhezulu seNesi eNcedisayo

_____

Inani loonesi kweli ziko abanezi mfaneleko zilandelayo: IDiploma yokunesa: istafnesi, Isidanga seBhatshela sokunesa nokubelekisa

_____

Inani loonesi kweli ziko abanezi mfaneleko zilandelayo: Idiploma yasemva kwesidanga yokunesa/ yokubelekisa/ ye-Akhawutsha (yombelekisi oncedisayo)/ Yenesi yonakekelo oluphezulu

_____

Inani loogqirha kwiziko	_____
Ngaba ukuShiywa nguMchamo kuyalawulwa kwiziko lakho	◯ Ewe ◯ Hayi
Ngaba isikhokelo sokuShiywa nguMchamo sikho ukuze sisetyenziswe kwiziko lakho	◯ Ewe ◯ Hayi
Ukuba sikho isikhokelo sisiphi esisetyenziswayo (Nceda ubhale igama)	_____
Ngaba ikho indlela yokuthumela abantu abaShiywa nguMchamo kwiziko lakho	◯ Ewe ◯ Hayi
Ngaba ngoku ikho nayiphi inkqubo yokufundiswa kwabasebenzi/ izigulana ngokushiywa ngumchamo kwiziko lakho	☐ Abasebenzi ☐ Izigulana ☐ Hayi
Ngaba zikho iiseshoni ezenziwa rhoqo neziqhelekileyo kwiziko lakho	◯ Ewe ◯ Hayi
Ukuba uthi ewe zenziwa njani:	☐ Izinto zokufundisa ☐ Izinto zokufunda ☐ Imiboniso eluncedo ☐ Iintlanganiso zika-Zoom/ Ezeqela

UXwebhu lweMibuzo lwamaGosa oNakekelo Oluyintloko lwezeMpilo

ULwazi, iSimo seNgqondo, iNkolelo noQheliselo lwamagosa oNakekelo oluyiNtloko lwezeMpilo lokuShiywa nguMchamo - UXwebhu lweMibuzo lwamaGosa oNakekelo Oluyintloko lwezeMpilo

Imvelaphi:
Enkosi ngokuthatha eli thuba ube nenxaxheba kolu phononongo!
Injongo yolu phononongo kukuchaza uqheliselo olukhoyo ngokulawulwa kokushiywa ngumchamo kumaziko onakekelo oluyintloko lwezempilo, nokwenza ingxelo ngolwazi, isimo sengqondo neenkolelo zoogqirha namanesi abakumaziko onakekelo oluyintloko lwezempilo eNtshona Koloni
Ukushiywa Ngumchamo kugqugqisile yaye kuyabiza kakhulu. Inkcazelo efunyenwe kolu phononongo iya kusetyenziselwa ukuyila indlela yokuphucula ukunikezelwa kwenkonzo yokulawulwa kokushiywa ngumchamo kwizinga lonakekelo oluyintloko lwezempilo.
Imiyalelo:
Amagosa onakekelo oluyintloko lwezempilo akwaziyo ukuba noqhagamshelwano lokuqala nezigulana, aneemfaneleko ezizizo eziwenza akwazi ukuhluza, ukuhlola, ukulawula okanye ukuthumela kwelinye iziko izigulana ezishiywa ngumchamo ziya kucelwa ngesihle ukuba zizalise olu xwebhu lwemibuzo.
Nceda uzalise le mibuzo ingezantsi ngokunyaniseka kangangoko kunokwenzeka.
Olu xwebhu lwemibuzo asilovavanyo lokuzama ukubambisa nabani na, okanye ukucalula ngokusekelwe kwizinto ezifunyanisiweyo. Ukuba akuqinisekanga ngempendulo, nceda ungaqasheli, kunoko zalisa ibhokisi ethi "andiqinisekanga", okanye utsibele kwibhokisi elandelayo.
Nceda utike ibhokisi enye kuphela kumbuzo ngamnye, ngaphandle kokuba kutshiwo embuzweni.

Inxalenye B: Iidemografiki zomthathi-nxaxheba

1. Isini
- ◯ Yindoda
- ◯ Ibhinqa

2. Ubudala
_____

3.Iimfaneleko zoMsebenzi
- ☐ Ngu-Gqirha (MBChB)
- ☐ Idiploma ephambili Ekubele-kiseni
- ☐ Isatifiketi Esiphezulu seNesi eNcedisayo
- ☐ Idiploma yokunesa: istafnesi
- ☐ Isidanga seBhatsh-ela sokunesa nokubele-kisa
- ☐ Idiploma yasemva kwesidanga yokunesa/ ukubelekisa ye-akhawutsha/ Inesi yonakekelo oluphezulu

4. Iminyaka uqhuba umsebenzi
_____

5. Iminyaka uqhuba umsebenzi kweli ziko ukulo ngoku
_____

Inxalenye C: Ukuhluzwa

1. Ndidla ngokuzibuza izigulana ezingamabhinqa enoba ziyaShiywa nguMchamo na (ukuziphumela komchamo)
- ◯ Ewe
- ◯ Hayi

2. Ukuba ukhethe uHayi kumbuzo 1, nceda uchaze ukuba kutheni ungazibuzi izigulana ezingamabhinqa enoba ziyaShiywa na nguMchamo (Nceda utike zonke iimpendulo eziphatheleleyo)
- ☐ Andinalo ixesha
- ☐ Izigulana ezingamabhinqa zinezinye izigulo ezibaluleke kakhulu ezimele zinyangwe
- ☐ Ukushiywa ngumchamo ngumba ekungekho lula ukuwuphakamisa
- ☐ Andiziva ndikhululekile ukulawula ukushiywa ngumchamo
- ☐ Andiqinisekanga ngendlela yokuhluzwa kokushiywa komchamo
- ☐ Akukho nanye kwezi zingentla

3 Ndiziva ndikhululekile ukulawula izigulana ezingamabhinqa eziShiywa nguMchamo	◯ Ewe ◯ Hayi
4. Ukuba uye wakhetha uHayi kumbuzo 3, nceda uchaze isizathu (Nceda utike iimpendulo eziphatheleleyo)	☐ Andiqondi ngokupheleleyo ukuba ukulawulwa ukushiywa ngumchamo kuqulethe ntoni ☐ Ukushiywa ngumchamo ngumba onzima ☐ Ukushiywa ngumchamo akukho phakathi kwezinto endizinyangayo ☐ Akukho nanye kwezi zingentla
5. Akuyomfuneko ukubuza izigulana ezingamabhinqa asele ekhulile ngokushiywa ngumchamo njengoko iyinxalenye eqhelekileyo yokwaluphala ekungasenakwenziwa nto ngayo	◯ Yinyani ◯ Bubuxoki ◯ Andiqinisekanga
6. Ezi nkalo zilandelayo zezomngcipheko ekushiyweni ngumchamo: (nceda uphawule ngo-X, unokukhetha ngaphezu kwenye)	☐ Ubudala ☐ Ukukhulelwa ☐ Ukuyeka ukuya exesheni ☐ Ukukhutshwa kwesibeleko ☐ Indlela yokutya ☐ Isifo seswekile ☐ Ukutyeba kakhulu ☐ Usuleleko lomjelo womchamo ☐ Isiphene sengqondo okanye esokusebenza ☐ Ukutshaya ☐ Imbali yentsapho ☐ Akukho nanye kwezi zingentla
7. Ndingathanda ukufunda ngakumbi ngokulawula ukuShiywa nguMchamo	◯ Yinyani ◯ Bubuxoki
8. Ukuba uye wakhetha ubuBuxoki kumbuzo 7, nceda uchaze isizathu (Nceda utike iimpendulo eziphatheleleyo)	☐ Andinalo ixesha ☐ Ukushiywa ngumchamo akukho phakathi kwezinto endizinyangayo ☐ Ndiziva ndikhululekile ukunyanga izigulana ezingamabhinqa ezishiywa ngumchamo ☐ Akukho nanye kwezi zingentla
Inxalenye D: Uhlolo olukhethekileyo lwe-UI Ukuba isigulana esilibhinqa siza nesikhalazo esikhethekileyo/ ufumaniseko lokuShiywa nguMchamo	
9. Ndibuza izigulana ezingamabhinqa ukuba ukuShiywa nguMchamo kubuchaphazela kangakanani ubomi bazo:	◯ Ewe ◯ Hayi
10. Ndibuza iimpawu zesigulo somjelo womchamo izigulana ezingamabhinqa xa zisithi zishiywa ngumchamo:	◯ Ewe ◯ Hayi
11. Kwiimpawu zokuShiywa nguMchamo ndibuza:	☐ Ungxami-seko ☐ Uku-chama qho ebusuku ☐ Ukwenza umgudu ukuze kuphume umchamo/ uku-zinyanzela/ ukuthimla/ ukukhohlela ☐ Ubude bexesha lokubakho kwee-mpawu ☐ Izihlandlo zoku-chama ☐ Indlela yokuthi-ntela (ukufaka iphedi) ☐ Uku-sela mihla le ☐ Andiqi-nise-kanga ngento emandiyibuze

12. Isifo seswekile sinegalelo ekushiyweni ngumchamo:	◯ Yinyani ◯ Bubuxoki ◯ Andiqinisekanga
13. Ndiye ndiqalise iidayari zesinyi xa izigulana ezingamabhinqa zikhalaza ngokuShiywa nguMchamo:	◯ Ewe ◯ Hayi
14. Ukuba uphendule ngokuthi "HAYI" kumbuzo 13, kutheni ungaziqalisi iidayari zesinyi	☐ Andiqhelananga needayari zesinyi ☐ Andinalo ixesha lokuqalisa iidayari zesinyi ☐ Iidayari zesinyi aziyomfuneko xa kuhlolwa ukushiywa ngumchamo ☐ Akukho nanye kwezi zingentla
15. Ndiqhuba uhlolo lukasikrotyana (pelvis) ukuba kurhaneleka ukuShiywa nguMchamo:	◯ Ewe ◯ Hayi
16. Ukuba uphendule wathi "HAYI" kumbuzo 15, kutheni ungalwenzi uhlolo lukasikrotyana (yenza isangqa kwengaphezu kwenye xa kuyimfuneko)	☐ Andiqinisekanga ngendlela yokwenza uhlolo lukasikrotyana ☐ Andikhululeki ukwenza uhlolo lukasikrotyana ☐ Ukwenza uhlolo lukasikrotyana kuthatha ixesha elininzi ☐ Uhlolo lukasikrotyana aluyomfuneko kuhlolo lokuqala ☐ Alukho phakathi kwezinto endizinyangayo ☐ Ndikhetha ukuthumela komnye umntu ☐ Akukho Nanye Kwezi Zingentla
Inxalenye E: Ulawulo	
17. Ndiye ndakwazi ukulawula izigulana ezingamabhinqa eziShiywa nguMchamo ngaphambili.	◯ Ewe ◯ Hayi
18. UkuLawulwa okokuqala kokuShiywa nguMchamo kunokwenziwa kumgangatho wonakekelo oluyintloko lwezempilo	◯ Yinyani ◯ Bubuxoki
19. UkuLawulwa okokuqala kokuShiywa nguMchamo kunokuquka (Nceda utike iimpendulo eziphatheleleyo)	☐ Ukuqeqesha umgangatho wesihlunu sikasikrotyana ☐ Amayeza ☐ Izinto zokufunxa (iiphedi/amanapkeni) ☐ IMfundo yokuQeqesha iSinyi ☐ Akukho nanye kwezi zingentla ☐ Andiqinisekanga
20. Ndilandelela izigulana ezingamabhinqa emva kokuba ulawulo lokuqala lokuShiywa nguMchamo luqaliwe	◯ Ewe ◯ Hayi
21. Ukuba uye waphendula ngoHayi kumbuzo 20, nceda uchaze isizathu sokuba ungalandeleli (Nceda utike iimpendulo eziphetheleleyo)	☐ Andinalo ixesha ☐ Akuyomfuneko ☐ Yimbopheleleko yesigulana esilibhinqa ukulandelela ☐ Akukho nanye kwezi zingentla
22. Ukusilela ukulawula ukuShiywa nguMchamo ngendlela eyiyo kuya kuba nefuthe kumgangatho wobomi wesigulana esilibhinqa	◯ Yinyani ◯ Bubuxoki ◯ Andiqinisekanga
Inxalenye F: Ukuthunyelwa	

23. Ndiyayazi indlela esetyenziswa kwikliniki yam yokuthumela umntu oShiywa nguMchamo kwelinye iziko	◯ Ewe ◯ Hayi ◯ Asinayo iindlela yokuthumela umntu kwelinye iziko
24. Zonke izigulana ezingamabhinqa eziShiywa nguMchamo zifanele zithunyelwe kwingcali	◯ Yinyani ◯ Bubuxoki ◯ Andiqinisekanga
25. Ndithumela izigulana ezingamabhinqa eziye zasilela kulawulo lokuqala lokuShiywa nguMchamo: (Nceda utike iimpendulo eziphatheleleyo)	☐ Ugqirha wamalungu enzala yotata (urologist) ☐ Ugqirha ojongene nempilo yamabhinqa (igynaenocologist) ☐ Ugqirha wempilo yamalungu okuzala nokushiywa ngumchamo kumabhinqa (iurogynaecologist) ☐ Inesi eyingcali ejongene nokushiywa ngumchamo ☐ Ugqirha oyingcali ejongene nokushiywa ngumchamc ☐ Ugqirha wesi Sigulo ☐ Andiqiniseki ukuba mandizithumele kubani ☐ Akuyomfuneko ukuba umntu athunyelwe kwenye inc xa eshiywa ngumchamo ☐ Akukho nanye kwezi zingentla
Please enter your email address if you would like us to contact you regarding the free CPD course, on what initial urinary incontinence management should consist of at a primary health care level.	_____
Please indicate where you received this survey from:	◯ Email ◯ Colleague ◯ Word of mouth ◯ Other (please specify)
If other (please specify)	_____

Luphelile uXwebhu lweMibuzo
Enkosi ngokuzipha ithuba lokuzalisa olu xwebhu lwemibuzo. Siyixabise kakhulu loo nto! Uphononongo lokugqibela luya kuthunyelwa kuwo onke amaziko onakekelo lwezempilo oluyintloko abandakanyekileyo kuphononongo. Liya kuthi ke iziko lonakekelo oluyintloko lazise onke amagosa onakekelo oluyintloko lwezempilo ngokuphathelele ukufumaneka kweziphumo.

ADDENDUM I: ETHICAL APPROVAL FROM THE HEALTH RESEARCH AND ETHICS COMMITTEE AT STELLENBOSCH UNIVERSITY

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Notice

New Application

15/11/2019

Project ID :11433

HREC Reference No: S19/09/173

Project Title: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Dear Miss Anika Janse Van Vuuren

We refer to your **response to modifications** received on 01/11/2019 03:08. Please be advised that members of **HealthResearch Ethics Committee** reviewed and **approved** your submission via **expedited** review procedures on 15/11/2019.

Please note the following information about your approved research protocol:

Protocol Approval Date: 15 November 2019

Protocol Expiry Date: 14 November 2020

Please remember to use your Project ID 11433 and Ethics Reference Number S19/09/173 on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Departement of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/ProjectView/Index/11433

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Mrs. Melody Shana

Coordinator

HREC1

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Letter
Amendment

16/09/2020

Project ID: 11433

Ethics Reference No: S19/09/173

Project Title: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Dear Miss Anika Janse van Vuuren

We refer to your amendment request and response received 12/08/2020.

The Health Research Ethics Committee (HREC) reviewed and **approved** the amendment as well as the following amended documentation through an expedited review process:

1. Anika Jvv Protocol Version 2 07.08.2020
2. Request To Conduct A Pilot Questionnaire Email_ 20200805
3. Budget_ 20200805.
4. Facility Demographic Questionaire_20200805
5. Participation Information Leaflet And Consent Form For Questionaire_20200805
6. Primary Health Care Practitioner Questionaire_20200805
7. Request To Conduct Main Study Email_ 20200805
8. CPD Talk

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your project ID 11433 and ethics reference number S19/09/173 on any documents or correspondence with the HREC concerning your research protocol.

Yours sincerely,

Mrs. Melody Shana
Coordinator: Health Research Ethics Committee 1

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1)•REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Letter
Amendment

16/11/2020

Project ID: 11433

Ethics Reference No: S19/09/173

Project Title: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Dear Miss Anika Janse Van Vuuren

We refer to your amendment request received 20/10/2020.

The Health Research Ethics Committee (HREC) reviewed and **approved** the following amendment and through an expedited review process:

1. To do additional non-random recruitment to increase the population size
2. To recruit private practice doctors and nurses on a primary health care level via email, and a snow ball sampling method to request permission to participate in the study.
3. The free CPD accredited presentation that will be presented at primary care facilities in the original study procedure, will also be made available via zoom/ teams, to all the health care practitioners who email a questionnaire back to the primary investigator regarding what UI management should consist of at a primary health care level. This date meeting will be communicated to practitioners via email.
4. Addendum document: Request to participate in study email

The following amended documentation was reviewed and **approved**:

1. Protocol Version 3, dated 20/10/2020
2. Email requesting permission to participate in primary study

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your project ID 11433 and ethics reference number S19/09/173 on any documents or correspondence with the HREC concerning your research protocol.

Yours sincerely,

Mrs. Melody Shana
Coordinator: Health Research Ethics Committee 1

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1) REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1) •IRB0005239 (HREC2)

ADDENDUM J: ETHICAL APPROVAL FROM THE WESTERN CAPE DEPARTMENT OF HEALTH

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Natacha Berkowitz
Epidemiologist: City Health

T: 021 400 6864 F: 021 421 4894
E: Natacha.Berkowitz@capetown.gov.za

Ref: 28218 2021-05-11

RE: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Dear Ms Anika Janse van Vuuren

Your research request has been approved as per your protocol. Please refer to the subsequent pages for the approval of any facilities or focus areas requested. Approval comments on any proposed impact on City Health resources are also provided.

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 0866; fax: +27 21 483 6058
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_201911_018
ENQUIRIES: Dr Sabela Petros

Francie Van Zijl Dr
Parow
Cape Town
7505

For attention: Ms Anika Janse van Vuuren, Prof Susan Hanekom

Re: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Facilities

Area	Subdistrict	Facilities		
Area East	Eastern	**Facility name**	**Interaction start date**	**Interaction end date**
		Bluedowns Clinic	2021-05-10	2021-05-31
		Sarepta Clinic	2021-05-10	2021-05-31
Area Central	Klipfontein)	**Facility name**	**Interaction start date**	**Interaction end date**
		Silvertown Clinic	2021-05-10	2021-05-31
Area South	Mitchells Plain	**Facility name**	**Interaction start date**	**Interaction end date**
		Eastridge Clinic	2021-05-10	2021-05-31
Area North	Northern	**Facility name**	**Interaction start date**	**Interaction end date**
		Durbanville Clinic	2021-05-10	2021-05-31
Area South	Southern	**Facility name**	**Interaction start date**	**Interaction end date**
		Parkwood Clinic	2021-05-10	2021-05-31
Area North	Western	**Facility name**	**Interaction start date**	**Interaction end date**
		Albow Gardens Clinic	2021-05-10	2021-05-31
		Spencer Road Clinic	2021-05-10	2021-05-31

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 0866; fax: +27 21 483 6058
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_201911_018
ENQUIRIES: Dr Sabela Petros

Francie Van Zijl Dr
Parow
Cape Town
7505

For attention: Ms Anika Janse van Vuuren, Prof Susan Hanekom

Re: The Knowledge, Practice, Attitudes and Beliefs amongst Primary Health Care practitioners regarding Urinary Incontinence Management in the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact **Sharnolle Lingeveldt (022 487 9264)** to assist you with any further enquiries in accessing the following sites:

Citrusdal Clinic
Darling Clinic
Piketberg Clinic
Saldanha Clinic
Van Rhynsdorp Clinic
Wesbank (Malmesbury) Clinic

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY
DIRECTOR: HEALTH INTELLIGENCE
DATE: 22/06/2021
CC

ADDENDUM K: FREE CONTINUOUS PROFESSIONAL DEVELOPMENT ACTIVITY: "INITIAL UI MANAGEMENT AT A PHC LEVEL" TALK TRANSCRIPT

SLIDE 1

Good day everyone.

Thank you so much for your time and your willingness to participate with our data collection. It is really appreciated and we would just like to say thank you by giving you this free CPD course, on what urinary incontinence management should consist of at the Primary Health care level and what you can do.

SLIDE 2

First off, what is urinary incontinence? It's defined as the complaint of any involuntary urinary leakage. Occurring as a result of a number of abnormalities in the lower urinary tract or due to other illnesses, which tends to cause leaking in different situations.

SLIDE 3

The big question. Can urinary incontinence be managed at a Primary Health care

Level? And the answer is definitely YES!

By who?

In your situations, it will be any of the nurses or doctors who come into first contact with the patient's. Further, the multidisciplinary team consists of urogynaecologist, urologist, specialist nurses, specialist physiotherapists, colorectal surgeons with a subspeciality interests in functional bowel problems for women. And then a member of the elderly care team or an occupational therapist.

SLIDE 4

Urinary incontinence effects women of all ages physically, psychologically and socially, with the prevalence in South Africa being between 27.5% to 35.4%.

The economic burden in 2000 in the USA was 19.5 billion dollars, which is huge. Unfortunately, there is no economic studies done in South Africa yet, however it's expected to be similar.

SLIDE 5

Screening for urinary incontinence is affected by many factors.

Firstly, previous studies done showed that patients don't know that urinary incontinence is a problem, and they therefore don’t seek medical attention for it. A lot of patients think it's just a normal part of aging. They're scared to talk about it, as talking about private things is not part of their culture. There's also a taboo and stigma behind urinary incontinence, so patients don't look for help.

Secondly, healthcare professional’s knowledge, attitudes, beliefs or practices towards Urinary incontinence also has a big effect on screening.

SLIDE 6

Knowledge factors regarding how to manage urinary incontinence, not knowing if it can be managed at a Primary Health care level or any level, and also who is responsible for actually managing urinary incontinence.

SLIDE 7

Attitudes like being uncomfortable with urinary incontinence due to the stigma or the taboo and seeing urinary incontinence as a burden to manage. Also not viewing urinary incontinence as a priority as patients have more important conditions such as hypertension and diabetes, and health care practitioners being too busy or not having enough time to manage urinary incontinence. Lastly viewing it that patient should be the ones initiating urinary incontinence conversations if they have the problem, are attitudes that affect screening for urinary incontinence.

SLIDE 8

Believing that Urinary incontinence is a normal part of age, gender, pregnancy and medical conditions is also limiting or preventing the screening

SLIDE 9

Practices also interfere with screening and management, such as not referring urinary incontinence when unsure of the management, not screening for urinary incontinence daily, managing it with absorbent product's, not following up with patients that have reported to you that they have incontinence. And not managing preventatively or conservatively.

These are all factors that can affect urinary incontinence management on a primary health care level.

SLIDE 10

OK, so before we go into the management some important definitions:

Urinary incontinence can be different types of incontinence.

Firstly, overactive bladder syndrome is urgency with or without urge urinary incontinence. Usually with frequency and Nocturia. Nocturia is incontinence at night. Overactive wet is where urge incontinence is present, whereas in overactive dry incontinence is absent.

Stress urinary incontinence is involuntary urine leakage on effort or exertion So that's where patient’s leak when their coughing, sneezing, jumping or running or any other activities placing stress on the pelvic floor.

SLIDE 11

Urgency urinary incontinence patients are women who are constantly feeling like they need to go to the bathroom even when the bladder is not full. This can be due to detrusor muscle instability. You want to find out if the bladder is overactive due to pelvic floor dysfunction or due to irritants inside the bladder, or infection or due to pressure from constipation or pregnancy.

With urgency being the complaint of a sudden, compelling desire to pass urine, which is difficult to defer.

SLIDE 12

Mixed urinary incontinence is a mix between stress and urge urinary incontinence. Therefore, along with leakage during sneezing and coughing patients also constantly feel like they need to urinate even though the bladder is not full.

SLIDE 13

Alright, so initial management to be aware of, even if you can’t or you don't feel comfortable managing incontinence. This is just what you should be able to do, or advise to at least give the patient.

SLIDE 14

So, the screening process.

This should occur with all patients that you come in contact with in your work environment.

Risk factors for urinary incontinence include age, so more that elderly females (but urinary incontinence is not limited to the elderly), pregnancy, parity, patients that are smoking or if they have a family history of urinary incontinence. Other risk factors include having a poor diet. With diet, things like less fibrous diets increase the likelihood to get constipated. Also, if there is not as much fluid in their diet, dependant on what they're drinking. Further, menopause, hysterectomies, obesity, Lower urinary tract symptoms and functional and cognitive impairment place patients at risk of developing urinary incontinence.

SLIDE 15

Please ask these patients about defecation problems or constipation or when a patient has defecation problems with constipation, please also be aware of urinary incontinence that may be present as it's a predisposition due to the strain contributing to the loss of bladder control and weakness of the pelvic floor. The strain coming from pushing hard trying to get stool out.

This is dependent on patient’s nutrition, their fluid intake and their gut peristalsis (which is dependent on immobility). Certain diseases and medication can also contribute to this.

It’s important to educate these patients on how to sit properly during defecation with their knees higher than their hips, with their feet supported on a box 10 to 15 cm high. Patients should lean slightly forward in this position with a straight back, their abdomen hanging loose, relaxing their elbows on their knees and relaxing the pelvic floor. Patients shouldn’t hold their breath, they should open their mouth and whisper Pah-ha-ha, and keep deep breathing until the urge to push comes, whereafter they can gently push.

If this is not successful, they can lean back and wait a few seconds before resuming to their position and trying again.

It’s important not to strain as it increases the puborectalis muscle pressure making it more difficult to defecate.

SLIDE 16

Surgeries that may place patients at risk for urinary incontinence are low spinal surgeries, radical hysterectomies, low rectal surgeries and complex pelvic surgeries.

SLIDE 17

The medications associated with urinary incontinence are medications for the central nervous system, such as sedatives, hypnotic and smooth muscle relaxant. Autonomic nervous system medication like drugs with antimuscarinic action and medication affecting fluid balance such as diuretics or alcohol as it affects the fluid output.

SLIDE 18

Generally, patients will not share that they have urinary incontinence problems on their own. It's important to ask simple questions such as are you leaking during the day when you cough when you run or during sexual intercourse?

Do you feel the urge to constantly go to the bathroom? How many times a day do you go to the bathroom? When you go, is your bladder full or are you emptying it completely? Or is there only a little bit coming out? And then after you go to the bathroom do you feel that the bladder is empty or not?

Some patients will say no to all of these questions and then after multiple questions or multiple sessions, somewhere in the discussion patients will mention something about pad use and this is normally a good que to ask them. But why are they using pads? And this is normally where they tell you, but they're leaking all day long

SLIDE 19

So, the initial steps.

SLIDE 20

During the general evaluation, you find out about their urinary history, showing where their quality of life is affected.

Ask about their frequency (the normal should be 7-8 times a day and 0-1 times at night), how many times a day are they leaking or wetting themselves? Is it happening at night? Do they have an urgency to go all the time?

Is there constant leakage or not? This would normally indicate a fistula.

Do they have hesitancy or straining to void or is there stopping and starting when their urinating?

And then is there sometimes a sensation of incomplete emptying or, Post micturition dribble where they get up and then it's almost as if a little bit more comes out as they start moving.

SLIDE 21

It's important to categorize urinary incontinence as we mentioned before, as stress mixed or urge urinary incontinence. If it's mixed, you treat the predominant symptoms, so if it's more stress but there's a little bit of urgency, it's treated as stress incontinence, and if there's more urgency than there is stress incontinence you would treat it more as urge incontinence.

Urodynamic testing is not required before initiating conservative management. Please this is also a big area where economic burden comes in. Don’t do it before conservative management has started.

It's important to look at medical history so things that are contributing or exacerbating the incontinence such as mental health, cognitive impairments and disorders of the neurologic system like multiple sclerosis, spinal cord injury or Parkinson's disease, cerebral vascular accident, cauda equina syndrome and pelvic plexus injury. Metabolic system disorders like diabetes are a big one. And then also cardio respiratory system disorders as these patients will be coughing a lot and it puts a lot of strain on their pelvic floor muscles and eventually weakness occurs. Lastly also be aware of Renal system disorders such as lower urinary tract dysfunction that can contribute to urinary incontinence.

SLIDE 22

Obstetrics and gynaecology history is important, so the number and type of deliveries they've had, menstrual history, menopausal status and urovaginal prolapse symptoms.

General assessments about the social and functional impacts that urinary incontinence has and their desire for treatment is big because a lot of people will have the problem but they don't want treatment for it. Education is a big thing there and then patient's expectation for treatment and their motivations.

Consider their social circumstances, so their home environment, their personal relationships, the Occupational History and their lifestyle factors. Where can you make changes? What would you need to consider so on?

It's important to undertake a urine dipstick test for all your urinary incontinence patients to detect the presence of blood, glucose, protein or leucocytes and nitrites. And then you will continue treatment as per the dipstick results.

SLIDE 23

Then bladder diaries, in the initial assessment is so important. So, this is where you would document the cycle of voiding and filling over a minimum of three days. Patients will write down how frequently and how urgently they're going to the bathroom, day and night time urinating or leaking. Patients can measure this by urinating in a cup or a bucket, and then measuring how much they are urinating out (the normal bladder capacity is 400ml in women). Patients also record how much they drink that day and exactly what their drinking. So, was it coffee was it water was it tea? This allows you to investigate if what their consuming may be irritating the bladder, like caffeine, alcohol, acidic drinks, carbonated

drinks, chocolate, dairy and artificial sweeteners? And then how many times are they changing their pad? Which can indicate to you how wet they are during the day and this is normally a good way to also monitor if the treatment is working. It is also important to note medications patients are taking as diabetic medication, diuretics and heart dysfunction medication influences incontinence.

Pad tests are not a routine part of normal evaluation, so please don’t use this as it’s another big economic contribution.

In the initial assessment. Please don't use multi-channel cystometry, ambulatory urodynamics, video urodynamics, Q Tips, Bonney Marshall and fluid bridge tests cystoscopy, imaging like MRI and CT scans or X Ray’s as this is not necessary before conservative treatment has occurred.

SLIDE 24

So, when to refer, the most important objective is our patients should not be getting lost in the system, even if you are uncomfortable managing urinary incontinence or you're unaware of how to manage urinary incontinence. Please just make sure that you address the condition by referring the patient to someone that's capable of treating the condition.

SLIDE 25

So, when to refer to a specialist? So again, this is not always needed. Urinary incontinence can be managed at a Primary Health care level.

But in the cases of haematuria, persistent bladder or urethral pain, and recurrent urinary tract infections you can refer.

Refer woman with urinary incontinence with symptomatic prolapse, that is visible at or below the vaginal introitus to a specialist.

And further indications for consideration for referral is clinically benign pelvic masses, associated faecal incontinence, suspected neurological disease, symptoms of voiding difficulty, suspected urogenital fistulae, so that's the constant leaking that they have, previous continence surgeries, previous pelvic cancer surgeries and previous pelvic radiation therapy.

SLIDE 26

Then, general management.

So, woman presenting with urinary incontinence needs information to help them understand the various types of urinary incontinence, the symptoms that they have, the investigations possible to them, and the treatments that can be recommended.

They should also be given information on where else to go look for support. If they don't want it from you.

The International Continence Society defines conservative treatment as therapies that are usually low cost and managed principally by the person with your urinary incontinence. So, our patients with instruction and supervision from the health care professional. So, it's a very hands off. You are just advising and just being supportive.

SLIDE 27

So, conservative management.

Firstly, lifestyle interventions. You will trial caffeine reduction to overactive bladder patients. Or other bladder irritants, such as citrus or alcohol. This can be replaced by non-caffeinated drinks such as rooibos tea.

You will also advise them on modification of high and low fluid intake. So, if they have low fluid intake, they are more likely to be constipated, more likely to put strain on that pelvic floor and more likely to become incontinent somewhere. If they have high fluid intake, they're constantly running to the bathroom. They might develop urgency, and bladder training is required.

Advice regarding weight loss for BMI over 30 because that's extra strain that’s placed on the pelvic floor.

Then, behavioural training, so bladder training for a minimum of six weeks for mixed an urge incontinence. So that is where they become aware of, “It's not necessary to constantly be going to the bathroom even if there is an urge”, especially if they are not emptying their bladder completely, or if there's not a lot of urine coming out when they urinate.

Training starts with patients only going every half an hour and then they build up to every hour or only after I've really had about 2 cups of water and there's something in my bladder to justify the urge to urinate. This helps to stretch the bladder, and encourages it to hold bigger volumes.

Behavioural training involves quieting patient's urgency by changing the sensory input, such as scrunching their toes or doing calf raises to distract the brain, pelvic floor contractions and abdominal breathing can also calm the bladder down.

It's important for patients to not restrict fluid intake due to fear of leaking as this leads to other problems, and if patients are waking up at night to empty their bladder, educate them to not drink 2 hours before going to bed.

And then combine bladder training with overactive bladder drugs, if bladder training alone is not beneficial for frequency symptoms.

Physical therapy is a very important treatment. Supervised Pelvic floor muscle training for at least three months for stress and mixed urinary incontinence and continue their exercise programs if pelvic floor muscle training is beneficial. This is where you would refer to the physiotherapists.

SLIDE 28

Absorbent products, handheld urinals and toileting aids, should not be considered as treatment for urinary incontinence. Use them only as coping strategies pending definitive treatment or an adjunct to ongoing therapy.

This type of long-term management for urinary incontinence is only after all treatment options have all been explored. Please don't use any intravaginal and intraurethral devices for the routine, management of urinary incontinence in women. And do not advise women to consider such devices other than for occasional use when necessary to prevent leaking, like during physical exercise.

SLIDE 29

Prevention.

Please offer pelvic floor muscle training, so these are your Kegels, to women during pregnancy, to prevent urinary incontinence or to any woman that will come into your practice with any of the previously mentioned risk factors. Please also educate these women on the potential effects that their diet may play in leading to urinary incontinence.

If a woman chooses not to have further treatment for urinary incontinence. Offer her advice about how to manage urinary incontinence on her own and explain to her that if she changes her mind, she can book a review appointment or discuss tests and interventions and reconsider her treatment options.

SLIDE 30

Lastly these are lovely flow diagrams of what treatment should consist of, in what situations that can be accessed via this presentation.

SLIDE 31

It shows what not to do.

SLIDE 32

And then there's another more simplified version.

SLIDE 33

Thank you so much for your time again and have a lovely day.

MANAGING URINARY INCONTINENCE AT A PRIMARY HEALTH CARE LEVEL.

By: Anika Janse van Vuuren

1

WHAT IS UI?

Urinary Incontinence (UI) is defined as 'the complaint of any involuntary urinary leakage'. This may occur as a result of a number of abnormalities of function of the lower urinary tract, or as a result of other illnesses, and these tend to cause leakage in different situations (National Institute for Health and Care Excellence, 2013).

2

CAN UI BE MANAGED AT A PRIMARY HEALTH CARE LEVEL?

YES!

BY Who?

The multidisciplinary team for UI can include:

- Primary health care doctors and nurses
- Urogynaecologist
- Urologist
- Specialist nurse
- Specialist physiotherapist
- Colorectal surgeon (Subspecialist interest in functional bowel problems for women with coexisting bowel problems)
- A member of the elderly care team and/ or occupational therapist

3

BACKGROUND

UI effects women of all ages influencing **PHYSICAL**, **PSYCHOLOGICAL**, and **SOCIAL WELLBEING.**

Prevalence rate in South Africa: 27.5%- 35.4%

Economic burden of UI in USA 2000 = 19.5 billion dollars.

4

FACTORS EFFECTING SCREENING FOR UI:

Patients Help seeking behaviour: Global patient help seeking rate reported: 22.5%

Due to - lack knowledge that UI is a medical condition and not normal, associated feelings of embarrassment and shame

Health care professionals:

- Knowledge
- Attitude
- Belief
- Practices towards UI

5

KNOWLEDGE

- Regarding how to manage UI
- If UI can be managed
- Who is responsible for UI management

6

ATTITUDE

- Being uncomfortable with UI due to stigma/ taboo
- Seeing UI management as a burden
- Not viewing UI management as a priority, as patients have more important conditions to address
- Being to busy/ not enough time
- Patients should be responsible for initiating UI conversations

7

BELIEF

- UI is a normal part of age, gender, pregnancy and medical conditions

8

PRACTICE

- Not referring UI when unsure of management
- Not screening for UI
- Managing UI with Absorbent products
- Not following up on UI patients
- Not managing UI preventatively or conservatively

9

IMPORTANT DEFINITIONS

Overactive bladder (OAB) syndrome

Urgency, with or without urge urinary incontinence, usually with frequency and nocturia. OAB wet is where (urge) incontinence is present and OAB dry is where incontinence is absent (National Institute for Health and Care Excellence, 2013).

Stress urinary incontinence (SUI)

The complaint of involuntary leakage on effort or exertion or on sneezing or coughing (National Institute for Health and Care Excellence, 2013).

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IMPORTANT DEFINITIONS

Urgency urinary incontinence (UUI)

Involuntary urine leakage accompanied by or immediately proceeded by urgency (formally known as urge urinary incontinence) (National Institute for Health and Care Excellence, 2013).

Urgency

The complaint of a sudden compelling desire to pass urine which is difficult to defer. (National Institute for Health and Care Excellence, 2013)

11

IMPORTANT DEFINITIONS

Mixed urinary incontinence (MUI)

Involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing (National Institute for Health and Care Excellence, 2013).

12

INITIAL MANAGEMENT TO BE AWARE OF

Even if you cant/ don't feel comfortable managing UI yourself, and advice to give.

13

SCREENING PROCESS

Should occur with all patients health care practitioners come in to contact with:

1. Risk factors:

- Age
- Pregnancy
- Parity
- Smoking
- Family history
- Diet
- Menopause
- Hysterectomy
- Obesity
- Lower urinary tract symptoms
- Functional or cognitive impairment

14

SCREENING PROCESS

2: Ask about:

- Defecation problems/ constipation = predisposition to UI (strain contributes to loss of bladder control and weakens the pelvic floor)

15

SCREENING PROCESS

3: Surgeries placing patients at risk:

- Low spinal surgery
- Radical hysterectomy
- Low rectal surgery
- Complex pelvic surgery

16

SCREENING PROCESS

4. Medications associated with UI:

- Central nervous system (Sedatives, hypnotics, smooth muscle relaxants)
- Autonomic nervous system (Drugs with antimuscarinic action)
- Fluid balance (Diuretics and alcohol)

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SCREENING PROCESS

Generally, patients will not share UI problems out of their own, it is important to ask simple questions like:

- Are you leaking urine during the day/ when you cough/ when you run / during sexual intercourse?
- Do you feel an urge to constantly go to the bathroom/ how many times a day do you go to the bathroom/ when you go is it a full bladder emptying or only a little bit?
- Do you still feel like your bladder is not emptied after you've been to the toilet?
- Some patients may answer no to all these questions, however after multiple questions/ further discussions, they will talk about pad use, which is a good que to work from.

18

INITIAL STEPS FOR ALL PRIMARY HEALTH CARE PRACTITIONERS FOR UI MANAGEMENT

19

GENERAL EVALUATION

1. Find out urinary history, showing where QoL is affected:
    - o frequency (daytime), nocturia, urgency, urgency UI/stress UI
    - o constant leakage (which may rarely indicate fistula).
    - o hesitancy, straining to void, poor or intermittent urinary stream.
    - o sensation of incomplete emptying, post-micturition dribbling.

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GENERAL EVALUATION

2. Categorise UI as SUI, MUI, UUI/ OAB. (For MUI treat predominant symptom.)
3. Urodynamic testing is not required before initiating conservative management
4. Medical history: contribution or exacerbating factors: mental health, cognitive impairment and disorders of the:
    - neurological system (e.g. multiple sclerosis, spinal cord injury, Parkinson's disease,
    - cerebrovascular accident, cauda equina syndrome, pelvic plexus injury)
    - metabolic system (e.g. diabetes)
    - cardiorespiratory system
    - renal system

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GENERAL EVALUATION

5. Obstetric and Gynaecological history: number and type of deliveries, menstrual history and menopausal status, and urovaginal prolapse symptoms
6. General assessment: UI social and functional impact, desire for treatment, expectation and motivation.
7. Consider social circumstances: Home environment, personal relationships, occupational history, lifestyle factors (Smoking/ BMI)
8. Undertake a urine dipstick test for all UI patients to detect presence of blood, glucose, protein, leucocytes and nitrites. Continue treatment as per dipstick results.

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GENERAL EVALUATION

9. Bladder diaries in initial assessment: Document cycle of voiding and filling over min 3 days (Frequency, urgency, diurnal and nocturnal cycles, functional bladder capacity and total urine output) Records leakage episode, fluid intake, pad changes and indicates severity of wetness, and can monitor treatment effects
10. Pad tests: Not part of routine test
11. In initial assessment DO NOT use: multichannel cystometry, ambulatory urodynamics, videourodynamics, Q-tip, Bonney, Marshall and Fluid Bridge test, Cystoscopy, Imaging (MRI, CT, X-ray)

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WHEN TO REFER

The most important objective:

Patients shouldn't get lost in the system.

Even if you feel uncomfortable managing UI/ unaware of how to manage UI, please always make sure you at least address the condition, by referring the patient to someone capable of treating the patient.

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WHEN TO REFER

Referring to a specialist:

- Haematuria, persistent bladder or urethral pain, recurrent UTI
- Refer women with UI who have symptomatic prolapse that is visible at or below the vaginal introitus to a specialist.
- In women with UI, further indications for consideration for referral to a specialist service include:

- clinically benign pelvic masses	- suspected urogenital fistulae
- associated faecal incontinence	- previous continence surgery
- suspected neurological disease	- previous pelvic cancer surgery
- symptoms of voiding difficulty	- previous pelvic radiation therapy

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GENERAL MANAGEMENT

Patient Advice:

Women presenting with symptoms of UI need information that helps them to understand the various types of UI, their symptoms, investigations and the treatments recommended.

Women with UI should also be given information on where else to go for help and support.

The International Continence Society defines 'conservative treatment' as therapies that are usually low cost, and managed principally by the person with UI with instruction/supervision from a healthcare professional.

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CONSERVATIVE MANAGEMENT

Lifestyle Interventions:

- Trial caffeine reduction to OAB patients/ bladder irritants
- Advise on modification of high/ low fluid intake
- Advice regarding weight loss with a BMI >30

Behavioural training:

- Bladder training for min 6 weeks for UUI/ MUI
- Combine bladder training and OAB drug if bladder training alone is not beneficial for frequency symptoms

Physical therapy:

- Supervised pelvic floor muscle training of at least 3 months for SUI/ MUI
- Continue exercise program if pelvic floor muscle training is beneficial

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CONSERVATIVE MANAGEMENT

Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as:

- a coping strategy pending definitive treatment
- an adjunct to ongoing therapy
- long-term management of UI only after treatment options have been explored.

Do not use intravaginal and intraurethral devices for the routine management of UI in women. Do not advise women to consider such devices other than for occasional use when necessary to prevent leakage, for example during physical exercise

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PREVENTION

Offer pelvic floor muscle training to women in their first pregnancy as a preventive strategy for UI, or to any women who have risk factors for UI during the evaluation.

If a woman chooses not to have further treatment for urinary incontinence:

- offer her advice about managing urinary symptoms, **and**
- explain that if she changes her mind at a later date, she can book a review appointment to discuss past tests and interventions and reconsider her treatment options.

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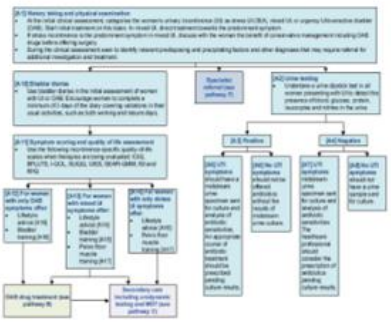
NICE 2013 GUIDELINE: INITIAL ADVICE AND CONSERVATIVE TREATMENT



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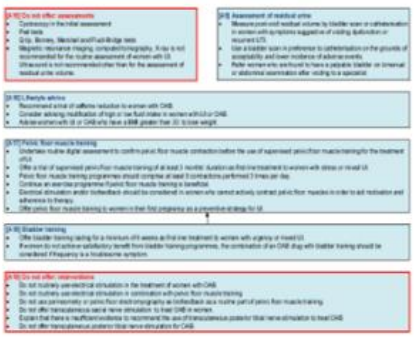
NICE 2013 GUIDELINE: INITIAL ADVICE AND CONSERVATIVE TREATMENT



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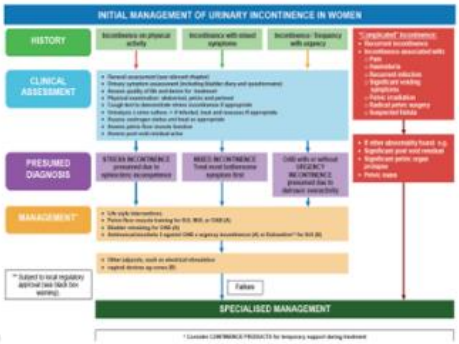
INTERNATIONAL CONTINENCE SOCIETY GUIDELINE 2017



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ADDENDUM L: TABLE 1 - FACILITIES INCLUDED

An overview of the names of the included facilities as indicated by participants, as well as the number of questionnaire responses received from each facility.

District municipality	Facility name	Number of questionnaires received
Cape town metropole	Albow Gardens	1
	Albow Gardens CDC	1
	Bishop Lavis Day Hospital	1
	District 6 CDC	3
	Dr Abdurahman CDC	1
	Dr. J Visagie	1
	Eastridge	2
	Eastridge clinic	6
	Eerste River CHC	1
	Eerste River Hospital	1
	False Bay Hospital	1
	Kemtique pharmacy	1
	Kraaifontein	1
	Lady Michaelis CDC	1
	Michael Mapongwana CHC	1
	Occuprime	1
	Parow	1
	Ravensmead	2
	Ravensmead CDC	1
	Sarepta Clinic	8
	Spencer Road Clinic	1
	Tygerberg Hospitaal	3
	Tygerberg Hospital ID Clinic	1
	Vanguard CHC	1

District municipality	Facility name	Number of questionnaires received
Garden Route	Knysna Hospital	1
Central Karoo	-	0
West coast	Radie Kotze Hospital	2
	Vredenburg Provincial Hospital	1
Cape winelands	WCDC	1
	Worcester CDC	2
	Worcester daghosp	1
	Langberg sub-district facilities - several	1
	Stellenbosch subdistrik	1
	De Doorns Clinic	1
Overberg	Botrivier clinic	1
	Hermanus hospitaal	1
	Struisbaai Mediese Praktyk	1

Random stratified sampling was used to select government facilities in the Western Cape. Department of health clearance was obtained for; Cape winelands (Op die berg clinic), Cape town metropole (Blue downs clinic, Sarepta clinic, Durbanville clinic, Albow Gardens clinic, Spencer Road clinic, Silvertown clinic, Eastridge clinic, Parkwood clinic) and the West coast (Citrusdal clinic, Darling clinic, Piketberg clinic, Saldanha clinic, Vanrhynsdorp clinic, Wesbank clinic). Cape winelands district (Drakenstein subdistrict: Simodium clinic and TC Newman community day centre) denied participation as they were preparing for a COVID 19 wave and vaccinations. Access to other facilities was done via snowball sampling.

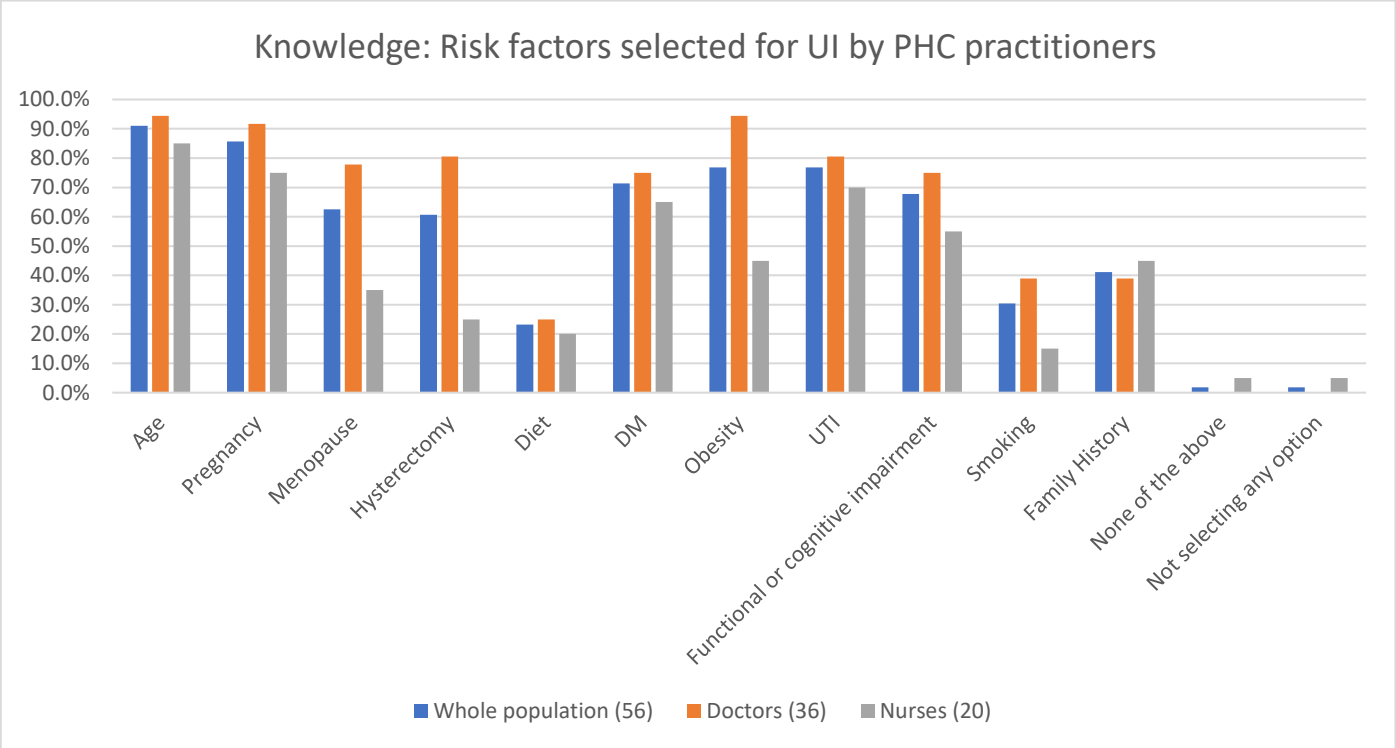
ADDENDUM M: TABLE 2 PRIVATE AND GOVERNMENT POPULATION DEMOGRAPHICS

HCP demographics					
	Private (n=5)			**Government (52)**	
	Doctors (n=3)	**Nurses (n=2)**		**Doctors (n=34)**	**Nurses (n=18)**
Age: (Years)	(Mean:48, SD:7.6)	(Mean:52, SD:6.4)		(Mean:35, SD:8.1)	(Mean:40, SD:10.5)
	(Median:51, IQR:7)	(Median:51.5, IQR:4.5)		(Median:36, IQR:14)	(Median:39, IQR:14)
Gender					
Male: n (%)	1 (33.3)	0 (0)		8 (23.5)	0 (0)
Female: n (%)	2 (66.7)	2 (100)		26 (76.5)	18 (100)
Job qualifications					
Doctor (MBChB): n (%)	3 (100)	0 (0)		34 (100)	0 (0)
Advanced diploma in Midwifery: n (%)	0 (0)	0 (0)		0 (0)	0 (0)

Higher certificate Auxillary nursing qualification: n (%)	0 (0)	0 (0)		0 (0)	3 (16.7)
Diploma in nursing: staff nurse: n (%)	0 (0)	0 (0)		0 (0)	2 (11.1)
Bachelors degree in nursing and midwifery: n (%)	0 (0)	1 (50)		0 (0)	7 (38.9)
Post graduate diploma in nursing / midwifery/ accoucheur/ primary care nursing: n (%)	0 (0)	1 (50)		0 (0)	5 (27.8)
Not selected: n (%)	0 (0)	0 (0)		0 (0)	1 (5.6)
Years in practice:	(Mean:22.3, SD:10.8)	(Mean:28.5, SD:9.2)		(Mean:9.9, SD:7.9)	(Mean:13.2, SD:9.5)
	(Median:27, IQR:10)	(Median:28.5, IQR:6.5)		(Median:15.5, IQR:12.5)	(Median:12, IQR:14)
Years at current facility	(Mean:6, SD:2.6)	(Mean:5.5, SD:4.9)		(Mean:4, SD:4.5)	(Mean:5.9, SD:7.7)
	(Median:7, IQR:2.5)	(Median:5.5, IQR:3.5)		(Median:2, IQR:5.8)	(Median:3, IQR:7)
District municipalities					
West Coast: n (%)	0 (0)	0 (0)		3 (8.8)	0 (0)

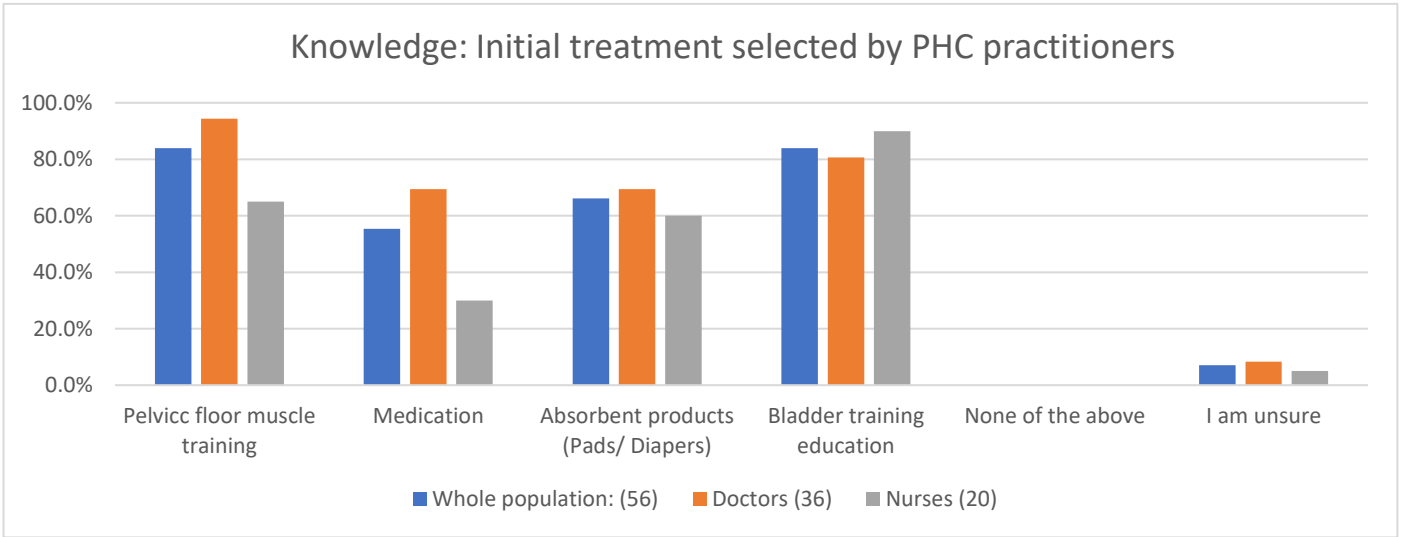
Cape Winelands: n (%)	1 (33.3)	0 (0)		7 (20.6)	0 (0)
Overberg: n (%)	1 (33.3)	0 (0)		2 (5.9)	0 (0)
Garden Route: n (%)	0 (0)	0 (0)		1 (2.9)	0 (0)
Central Karoo: n (%)	0 (0)	0 (0)		0 (0)	0 (0)
Cape town Metropole: n (%)	1 (33.3)	2 (100)		21 (61.8)	18 (100)
Setting Type:					
Clinic: n (%)	1 (33.3)	1 (50)		14 (41.2)	16 (88.9)
Community Day Centre: n (%)	1 (33.3)	0 (0)		16 (47.1)	2 (11.1)
Doctors' rooms: n (%)	3 (100)	0 (0)		3 (8.8)	0 (0)
Other: n (%)	0 (0)	1 (50)		9 (26.5)	0 (0)
Other setting type specified included: District hospitals (n=4) Hospitals (n=4) Specified infection clinic at Tygerberg (Ravens mead primary referral facility) (n=1) Private nurse practice (n=1) These participants were all still included in the study as they were visiting primary health care settings whilst being based at hospitals.					
Notes: (one doctor worked in both private and government, which is why all populations don't compare directly to whole number).					
(n=7) participants selected more than one setting type. SD: Standard deviation, IQR: Interquartile range					

Addendum Figure one elaborates on the risk factors for UI that HCPs selected.



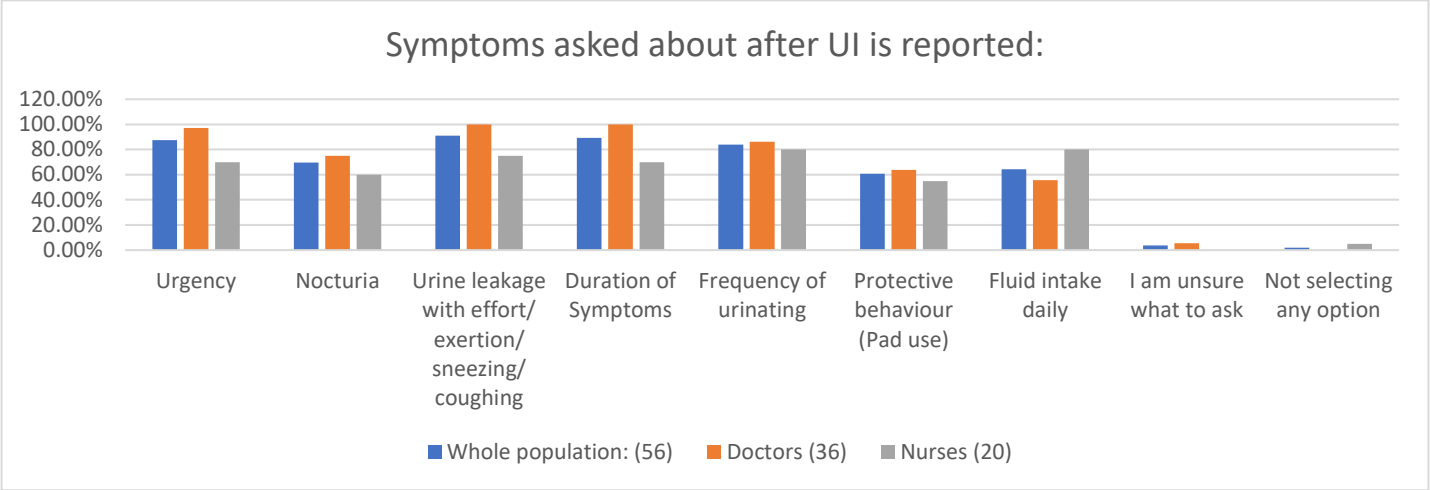
ADDENDUM N: FIGURE 1: RISK FACTORS FOR UI

Addendum figure two demonstrates the initial treatment options for UI that HCPs selected.



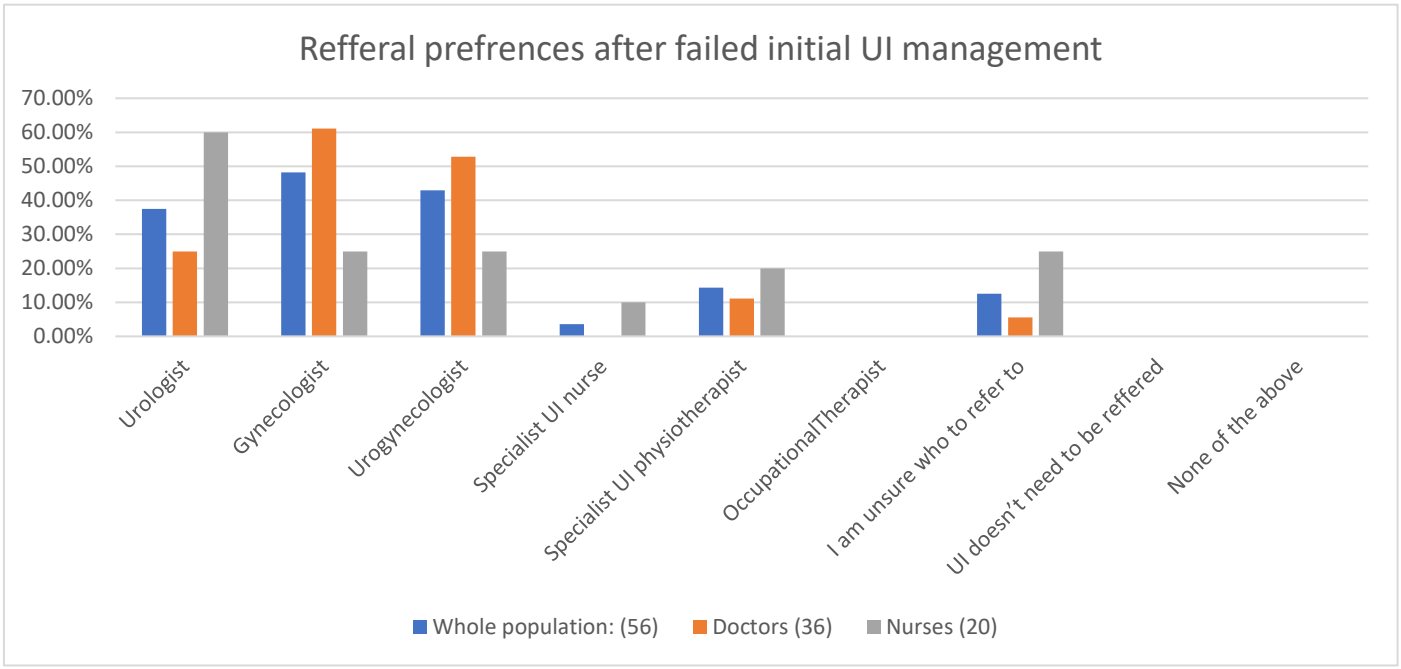
ADDENDUM O: FIGURE 2: INITIAL UI TREATMENT

Addendum figure three elaborates on specific UI symptoms HCPs asked about after UI was reported.



ADDENDUM P: FIGURE 3: UI SYMPTOMS

Addendum figure four indicates which UI specialists HCPs preferred to refer to.



ADDENDUM Q: FIGURE 4: SPECIALIST REFERRAL