Women's experience of accessing information, diagnosis and treatment of pelvic floor dysfunction in the postnatal period in New Zealand—a qualitative descriptive study

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ABSTRACT

AIM: This study aims to explore the experiences of women with pelvic floor dysfunction within the postnatal period (1 year after birth), specifically their experience in accessing information, diagnosis and treatment for their symptoms.

METHODS: Qualitative semi-structured interviews were conducted with women during the postnatal period (1 year after birth) and key informant health professionals involved in perinatal healthcare. Data were analysed using reflexive thematic analysis.

RESULTS: Postnatal women participants reported a very poor experience of accessing information, diagnosis and treatment of their pelvic floor symptoms in the year after giving birth. Women's symptoms were normalised or dismissed, with multiple other barriers in place to accessing the appropriate treatment. Key informants acknowledged the societal and health system barriers to postnatal pelvic floor dysfunction treatment and rehabilitation.

CONCLUSION: The study highlights significant, avoidable gaps in perinatal healthcare provision, which is based on a specialised model of care, not suitable for a highly prevalent health issue for women. A specific maternal postnatal primary care check, in addition to a national pelvic floor dysfunction clinical guideline with appropriate training of perinatal health professionals, is likely to significantly improve women's experience of pelvic floor dysfunction in the postnatal period.

A healthy, functioning pelvic floor is fundamental to women's physical and psychological wellbeing. Pelvic floor dysfunction is known to have a negative impact on women's quality of life and long-term health outcomes.[1,2] International research has established a high prevalence of pelvic floor dysfunction in the female population, with symptoms often arising at a particularly vulnerable time for women—after the birth of their child.[3,4] Studies from countries comparable to New Zealand consistently report unmet need for pelvic health services, with women reporting numerous barriers to seeking the care they need.[5–8]

Limited pelvic floor dysfunction prevalence studies have been conducted in New Zealand; however, data from the 2014/2015 New Zealand Health Survey found that urinary incontinence, the most prevalent symptom of pelvic floor dysfunction, was highly prevalent in New Zealand women.[9] Considering the likely high prevalence of pelvic floor dysfunction in postnatal women in New Zealand, there has been minimal literature exploring women's experience of pelvic floor dysfunction after birth. A study exploring New Zealand mothers' perceived barriers to physical activity found that women no longer trusted their pelvic floor, especially during exercise. The study highlights that these women lacked information about their pelvic floor symptoms or where to seek support.[10] Women's absence of knowledge of pelvic floor dysfunction and the lack of information on where to seek support was subsequently reported in a study exploring women's postpartum recovery in New Zealand. In addition to poor awareness of pelvic floor dysfunction, mothers reported minimal support from the public health system, which created financial barriers to treatment.[11] Due to the scarcity of information on women's experience of pelvic floor dysfunction in the postnatal period and the lack of national consistency of publicly available postnatal rehabilitative services for New Zealand women, it is not known if there is an unmet need for pelvic floor dysfunction health services for postnatal women in New Zealand. This study

aimed to explore the experiences of women with pelvic floor dysfunction within the postnatal period (1 year after birth), specifically their experience in accessing information, diagnosis and treatment for their symptoms.

Methods

Ethics approval was granted by XXX Ethics Committee on 8 March 2024.

Data were collected using individual semi-structured interviews with women during the postnatal period. To provide a wider clinical and maternal health system context, key informant interviews were held with health professionals involved in perinatal healthcare. Postnatal women participants were recruited via responses to advertisements displayed via social media, health services or non-government organisations (e.g., Continence NZ). Key informants were recruited through snowball sampling from initial contact with relevant health professionals. All key informants were experienced in their clinical field and had broader maternal health system knowledge.

The inclusion criteria for postnatal women were all women who had given birth (via any mode) within 12 months in New Zealand and who could speak English. Nine women who contacted the researcher and were eligible to partake in the research were interviewed. Table 1 shows the demographic details of the postnatal women. Due to small numbers of participants, aggregate figures for location, parity and months postpartum are displayed. To maintain confidentiality of the participants, ethnicity and age are not reported. All women had spontaneous vaginal births. Reported pelvic floor dysfunction symptoms varied across the participant group from mild urinary incontinence during impact activity to severe pelvic organ prolapse symptoms. Four key informant participants were interviewed and consisted of: a midwife with community, hospital and academic experience; a pelvic physiotherapist with public, private and teaching experience; an experienced general practitioner (GP) with an interest in women's health; and a women's postnatal support charity chief executive.

Participants were given a study information sheet prior to the interview and provided verbal consent before the interview began. Interviews were conducted via the online platform Google Meet and were password protected. Only the primary researcher and participant were present in the interview. A set of semi-structured questions based on the research question was used to guide the interviews. Interviews were recorded and transcribed verbatim. These recordings were de-identified, and transcriptions were checked by both authors. Transcripts were transferred into NVivo to facilitate coding.

A pragmatic, qualitative descriptive approach was used to maintain closeness to the data. Authors reflected on their prior theoretical assumptions and knowledge and actively repeated this process throughout the analysis. Braun and Clarke's six-phase reflexive thematic analysis process was used to analyse the data and group them into themes.[12] These steps were as follows: familiarising with the dataset, generating initial codes, searching for themes, reviewing themes, defining and naming themes and collating the report. Both authors discussed the codes and preliminary themes to ensure they accurately captured the data before consolidating the final themes.

Results

Four themes were generated from the data collected: women have not been prepared for pelvic floor dysfunction symptoms following childbirth; pelvic floor dysfunction symptoms were dismissed and normalised; barriers prevented women from getting help; and health professionals gave limited, delayed, unrealistic or contradictory advice.

Table 1: Postnatal women participant demographic details.

Months postpartum	Location	Parity
Mean—8.5 months	Wellington Region = 4 Auckland Region = 6 Canterbury Region = 1 Nelson Region = 1	1 live birth = 4 2 live births = 4 3 live births - 1

Theme one: women have not been prepared for pelvic floor dysfunction symptoms following childbirth

This theme highlighted that many of the participants were not aware of pelvic floor dysfunction or its symptoms, and if they were, they associated it with much older women. In addition to limited knowledge of pelvic floor dysfunction symptoms, participants were unprepared for the disruption it caused in their lives, including emotional and physical health, but also practical day-to-day activities. Participants perceived a significant educational gap, in that they had not been prepared for the possibility of pelvic floor dysfunction during pregnancy or postnatally from antenatal education providers or their midwife. Due to the lack of education provided by healthcare professionals, participants sought information on the internet; however, they found it challenging to source reputable and useful information. Participants found the best way to find out about pelvic floor dysfunction was through other mothers during mother and baby social or exercise classes, and were often shocked at how many other women were experiencing similar symptoms.

Key informants emphasised the importance of pelvic floor education antenatally, including informed discussions between health professionals and pregnant women about their risk of pelvic floor dysfunction, which may impact birth-plan decisions. Key informants highlighted that, in addition to a lack of awareness and education of pelvic floor dysfunction among women, large numbers of health professionals lacked knowledge of pelvic floor dysfunction and hence were not able to educate or inform women of what symptoms to be aware of. Key informants recommended that all health professionals involved in perinatal care should receive appropriate training in basic assessment and treatment for pelvic floor dysfunction.

Theme two: pelvic floor dysfunction symptoms were dismissed and normalised

This theme highlighted that women's symptoms of pelvic floor dysfunction following birth were normalised by health professionals, friends and family. This normalisation of symptoms led to women feeling that they must cope with the symptoms and not seek help. Participants reported that female family members and friends who had children often dismissed symptoms, explaining that pelvic floor symptoms were a normal aspect of having children that women just need to cope with. In addition to normalisation from friends and family, participants also expressed that midwives and GPs normalised and dismissed their pelvic floor symptoms as normal healing after birth, often not providing any advice or referral for treatment. Some participants thought that this dismissal of their symptoms was due to the health professional's attention moving from their maternal health to the baby. Participants' experience of shifted healthcare attention from their health to their baby resulted in women not having the opportunity to discuss their pelvic health

Table 2: Quotes supporting "women have not been prepared for pelvic floor dysfunction symptoms following childbirth".

"*I didn't know that it would be so bad, particularly straight after birth, for those first couple of weeks, just like stepping 100 metres down the road and I'd leak through a pad.*" – Participant 1
"*I've got this injury, don't really understand it. I don't know how long it's going to go on for and I don't know how much of an effect it's going to have on my day, like when you can't vacuum the house or you can't clean the house because of pain then what does the long-term look like…*" – Participant 8
"*I wish at antenatal class there was more focus on your pelvic floor. Actually, I wish at high school there was more focus on your pelvic floor as a—well not even females because males I've learned can experience it as well—the importance of your pelvic floor and it's not just doing a few Kegels* [a type of exercise] *here and there … and that but I think there needs to be more seriousness put on it because of the effects later on.*" – Participant 3
"*It's surprising how much you find out just hanging out with other mums, right? So, by the time that I was diagnosed, I've self-diagnosed because in conversation with other mums I was like, oh, but that's what I'm feeling. So I guess—I haven't done an awful lot of Googling because I feel like it makes it worse … it's reassuring to something that is already helping a lot is just engaging with the mums and bubs Pilates group and that kind of thing … it's reassuring to talk to other mums that have the same issues.*" – Participant 5

Table 3: Quotes supporting "pelvic floor dysfunction symptoms were dismissed and normalised".

"*Do you know what, this just happens after birth. Then I also had like my mother-in-law telling me that, you know, she's always been incontinent. That's just what happens when you have babies. Had so many people just say, 'yep, this is just a part of motherhood that nobody tells you about'. I was like, what the hell? So, that was all the information that I was getting.*" – Participant 6
"*I guess what does make talking about it harder is the fact that sometimes within a group of mums, you know that all of them have issues and so you—it's okay to talk about it, but at some stage you can also see that it's just a fact—a thing of, yeah, we're all struggling with these things and we're all just coping with it. So it's like, it's just part of the process, so just get on with it.*" –Participant 5
"*I found post-birth everything revolves around the baby … the doctor was the first—the GP when I went and said I'm not coping, he was the first person that said, 'well, how are you? I'm not—I don't care how the baby is, how are you?' But up until that point, everything had Plunket visits, everything had been about the baby … I feel like everything is on the baby and you're just kind of like this vessel that supports, there should be focus on the mum and particularly her pelvic floor.*" – Participant 3
"*Baby went in for her 6-week immunisations and bits and pieces, they booked her in for a 6-week GP check but didn't book anything in for me, or the doctor didn't ask anything about me or anything like that … I don't actually know if this is a thing, but how the baby gets the free GP appointments, if it was just one that was for the mum at 6 weeks or something. Even if it wasn't a pelvic floor physio, even if the GPs maybe were more educated on pelvic floor health to then have that free appointment and then discuss perhaps.*" – Participant 9

with a healthcare professional. Participants were shocked that the 6-week postnatal check with their GP was solely focussed on their baby, which they perceived to be a missed opportunity to discuss or check their pelvic health.

Key informants raised multiple issues that contribute to women's poor experience and dismissal of symptoms. The lack of time health professionals get to spend with women was cited as a reason for not adequately assessing pelvic floor symptoms or engaging with the wider multidisciplinary team, which is often required to successfully manage women's symptoms. In addition, as previously mentioned, some health professionals lacked the knowledge of pelvic floor dysfunction to screen or assess pelvic floor dysfunction symptoms.

Theme three: barriers prevented women from getting help

Participants reported multiple structural and personal barriers to getting the help they needed for their pelvic floor dysfunction symptoms. Many participants expressed frustration that they were recommended by many sources—such as their midwife, exercise instructor, GP or online information—to seek treatment from pelvic physiotherapists; however, there were multiple barriers to accessing services. Participants reported exceedingly long wait times to see a pelvic physiotherapist through the public health system. Due to the wait times, in some cases up to 1 year, some women sought treatment from private pelvic physiotherapists; however, the cost of this was a barrier, even with Accident Compensation Corporation (ACC) subsidies. In addition to wait times and cost, the availability of suitably trained pelvic physiotherapists was challenging, especially outside of main urban areas. In addition to structural barriers such as cost, availability and location, participants reported personal barriers to accessing care and treatment, such as time and embarrassment. Some participants expressed frustration at their lack of time to complete pelvic floor muscle exercises or rehabilitation to help with their symptoms in their busy lives with a baby. Embarrassment about pelvic floor dysfunction symptoms was also cited as a barrier to seeking help, and some women found discussing symptoms with healthcare professionals uncomfortable.

Key informant participants also expressed frustration at the multiple barriers in place preventing women from seeking help. The lack of a maternal 6-week postnatal check was raised as a missed opportunity to screen women for pelvic floor dysfunction. The barriers to pelvic physiotherapy were also raised as a big issue for women. Key informant participants, in addition to the postnatal women, reported that the wait lists for

Table 4: Quotes supporting "barriers prevented women from getting help".

"*My first birth I paid privately for that* [pelvic physiotherapy] *and then my midwife referred me through the public system, but it took about 8 months to get to see anybody … the first time around it took 6 or 8 months to get a group physio class and from there I still had to wait a few weeks to get a private physio appointment through the hospital.*" – Participant 1
"*It is also tricky as well because although there is the ACC funding there is still the part of charge you have to pay so quite often my appointments end up being $80 per appointment … but we're fortunate that we're in this position where I can pay and get the help sooner than wait on the hospital list … so then it was like, what is a priority to me right now and is that that I utilise savings to pay for care now or do I wait? I didn't want to wait.*" – Participant 8
"*I was supposed to go back next week, which will be a month, but it was going to be 2 weeks but it's just like it was almost an hour for us to get there.*" – Participant 2
"*To be honest, I think the doctor that we saw, we hadn't actually seen before, it was just whoever we could get at the time, but I don't think I would've felt comfortable chatting with them. Unless they asked, I wouldn't have necessarily felt comfortable, I'd probably have gone back* [to a trusted known health professional]." – Participant 9
"*I think the last time we tried buying them* [pessaries] *in the clinic, they were something like $70–$80. Of course, you usually need a couple of sizes because you put one in and the woman goes away and it's too small or too big, then they come back and you change it … they're expensive things that women can't afford to buy; you can't suddenly afford to pay $160 for a couple of them until you find the size that fits right.*" – GP key informant

Table 5: Quotes supporting "health professionals gave limited, delayed, unrealistic or contradictory advice".

"*We* [midwife] *talked about Kegels quite soon after birth, maybe a couple of weeks after birth, and she acknowledges that wasn't her area of expertise.*" – Participant 1
"*She* [physio] *had basically told me that I couldn't—I was not allowed to lift anything more than 10 kilograms. Basically, for me, the physio is telling me that I'm not going to be able to lift anything. I was just like, that's not an option. I mean, my baby at that stage, she was well over 10 kilograms. So, my physio had told me I can't lift my baby, I can't lift a basket of washing, I have to get my husband to lift suitcases for me, and I was like, are you insane. I can't function like this. She* [physio] *even told me that vacuuming was too much strain on my pelvic floor. So, I was like, yeah, this is not going to work.*" – Participant 6
"*I think it would be variable, depending on who the midwife is* [asking and assessing pelvic floor dysfunction]*. Again, I think that there is no real guidance in a sense of what are the questions you should ask, and what support and information you should provide.*" – Midwife key informant

pelvic physiotherapy were extremely long and cost was still a barrier to physiotherapy even with ACC subsidies for some birth injuries. In addition to cost barriers for physiotherapy appointments, key informants highlighted unnecessary cost barriers to procedures that can be undertaken in primary care, such as inserting pessaries.

Theme four: health professionals gave limited, delayed, unrealistic or contradictory advice

This theme highlights how women had to navigate through various health professionals to get evidence-based guidance and treatment for their symptoms. Participants expressed their surprise that their midwife or GP did not have the expertise to accurately assess their pelvic floor dysfunction symptoms or prescribe the right course of treatment/rehabilitation, especially once they had learnt how widespread the problem was. Participants also reported that they received different advice and information from a range of health professionals about their treatment plans and prognosis, which caused distress and frustration. In addition to varying advice, women reported that the advice was often unrealistic for life as a mother of a baby and young children. Participants were shocked at the lack of treatment options for pelvic floor dysfunction available to them. In addition to the lack of treatment options,

women were upset that they had to wait until they had finished their families before surgical interventions would be conducted. Women reported that treatment from pelvic physiotherapists helped manage and understand their symptoms. However, some participants reported that finding the right physiotherapist with current knowledge and training was challenging.

Key informants reported that many health professionals looking after women in the postnatal period are not competent in assessing or treating pelvic floor dysfunction, which supports the experience of many of the postnatal women participants. Key informants believed that all health professionals involved in perinatal care should have education about assessment, treatment and appropriate referral pathways. In addition to this general pelvic floor dysfunction training, procedures to treat pelvic floor dysfunction symptoms, such as the insertion of pessaries, should be more readily available to avoid the specialisation of the treatment of pelvic floor dysfunction.

Discussion

This study highlights that health professionals involved in perinatal healthcare have underprepared women for the likelihood of experiencing pelvic floor dysfunction symptoms in the postnatal period. Participants often had no prior knowledge of pelvic floor dysfunction, and due to a lack of information resources available turned to family and friends who unhelpfully normalised their symptoms, leaving them to feel they must deal with their symptoms alone. Compounding the circulating misinformation that pelvic floor dysfunction symptoms are normal, practitioners treated pelvic floor dysfunction as a specialist issue, disregarding that symptoms are likely endemic in the female population. This ring-fencing of knowledge created further barriers for women accessing appropriate information from their primary healthcare providers or their midwives who had been providing them care through their perinatal journey. This finding is not unique to New Zealand, with a recent study in the United States of America (USA) reporting that primary healthcare providers did not have the knowledge or capability to assess or treat women for pelvic floor dysfunction.[13] This USA-based study found that primary healthcare providers felt more confident referring women with pelvic floor dysfunction to the appropriate services when they had a specialist, such as a gynaecologist, as part of their multidisciplinary team, which is very rarely the case within the New Zealand public health system.

The phenomenon of normalisation is recognised internationally. Feminist scholars argue that the fallacy of normalcy underpins women's perceptions that this morbidity is part of motherhood.[14,15] While it is beyond the scope of this article to explore normalisation in more detail, there is a substantial body of clinical, sociological and feminist scholarship that claims that health systems deprioritise women's bodies, pain and long-term wellbeing.

In the New Zealand context, the absence of national guidelines results in an *ad hoc* approach to postnatal pelvic floor treatment. The National Institute for Health and Care Excellence, based in the United Kingdom (UK), recommends a period of supervised pelvic floor exercises as the first non-invasive management option for women with pelvic floor dysfunction.[16] However, in New Zealand there is inequitable access to pelvic floor rehabilitation due to the specialisation of pelvic floor dysfunction treatment, causing access issues to pelvic physiotherapists. The participants in this study report multiple barriers to accessing pelvic physiotherapy due to extended wait times of (in some cases) over a year through the public health system, or cost and availability barriers in the private system. Poor access to pelvic physiotherapy is an international problem, with other studies describing postnatal women's challenging pursuits of appropriate treatment.[17–19]

Both participants and key informants called for a dedicated 6-week postnatal primary care check to screen women for pelvic floor dysfunction, provide education and assess and refer on for treatment if necessary. Both the UK and French postpartum guidelines recommend a 6-week check to support women's rehabilitation postbirth.[20,21] Pelvic floor questionnaires and screening tools already exist internationally and could be adopted into the New Zealand primary care setting.[22,23]

This study identified key areas across the New Zealand maternal health system that could be improved to better support women with pelvic floor dysfunction symptoms in the postnatal period. We recommend raising awareness through education and providing resources to women antenatally. A readily actionable step would be to provide all antenatal women with the Continence NZ *Pregnancy Guide*. This guide would

provide women with evidence-based, accurate information on what to expect and how to manage pelvic floor dysfunction.[24] In addition to education for women, the development of a national clinical guideline and education package for health professionals involved in perinatal healthcare would tackle the specialisation of a very common postnatal presentation. Given that this is an endemic issue, we recommend that pelvic floor dysfunction and its treatment is a fundamental topic that should be taught in undergraduate physiotherapy education.

Strengths and limitations

This study conforms to qualitative research measures of rigour, including trustworthiness, through the presentation of robust findings and an examination of the possible wider implications of these findings. The findings were triangulated through interviewing both women and health professionals.

The semi-structured in-depth interviews with postnatal women uncovered rich data about women's experiences with pelvic floor dysfunction in the year after birth. The interviews with key informants from the wider health system provided clinical context and confirmation of many of the barriers to care that the postnatal women identified.

The main limitation of this study was the limited demographic variability within the group of postnatal women. The group of women were predominantly educated women of higher socio-economic means, with limited ethnic diversity. Future research could focus on other demographic groups of women, such as Māori women, to understand whether their experiences of living with pelvic floor dysfunction differ.

Conclusion

This qualitative study has highlighted that after birth women with pelvic floor dysfunction symptoms are met with multiple barriers to accessing the care they need. The findings from this research recommend a national approach to tackling the specialism and normalisation culture of pelvic floor dysfunction and improving women's access to education, prevention and treatment options.

COMPETING INTERESTS
Nil?

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