CHARTERED SOCIETY OF PHYSIOTHERAPY

The Royal College of Midwives

RCM/CSP Joint statement on Pelvic Floor Muscle Exercise

Improving health outcomes for women following pregnancy and birth

Introduction

The Chartered Society of Physiotherapy (CSP) and Royal College of Midwives (RCM) believe that access to high quality maternity services should include preventive measures that promote good reproductive health outcomes for women during pregnancy and post-birth. This relies on those involved working in partnership with women and their families, to encourage self-efficacy to improve their health.

This is why we support early intervention for pelvic floor muscle exercise training for childbearing women, to prevent pelvic floor damage and avoid problems associated with continence or pelvic organ prolapse in later life.

Background

The 'State of Midwifery Services 2012' reported there had been 700,000 births in the previous year, managed by 26,000 Full time Equivalent Midwives in the UK in 2011.[1] The report made strong recommendations that in all four countries, midwives need to be given the resources to deliver on public health and improving the lives of children. Quality antenatal and postnatal care should be as important within Maternity Services, as the birth itself.

Currently, the teaching of Pelvic Floor Muscle Exercise (PFME) in the antenatal period falls between GPs, midwives, physiotherapists and obstetricians. A recent study of patients and health care professionals showed that a majority of pregnant women would prefer to be taught PFME by their midwife. This was also the case for midwives, because a majority in the study agreed with the women. However, many midwives feel that they would benefit from a better understanding of PFME and improved support in delivering more effective PFME.[2]

The benefits of early intervention

The benefits of early intervention in pelvic floor muscle training to prevent incontinence and prolapse in later life are well documented.[3] It is particularly important to offer PFME training to all women in their first and subsequent pregnancies, combined with other lifestyle advice including weight management, reducing alcohol consumption and caffeine intake, smoking cessation, and to encourage uptake in physical exercise.

The size of the problem

Bladder and bowel dysfunction, including incontinence, can be distressing and socially disruptive for women, as any of these conditions may restrict participation in leisure activities, cause embarrassment, and could have an impact on employment and educational opportunities which can lead to exclusion.[4] Estimates of urinary incontinence range from between 14 per cent to 71 per cent of women: however, there is little data on the prevalence or impact on Black Minority Ethnic women, but it is known that cultural issues and embarrassment prevent them from coming forward.[5]

It is the second most common reason for admission to a nursing home in later life.[6] Due to the sensitive nature of this issue some women can take up to 10 years before seeking help, because they are unaware that effective treatments are available.[7]

The financial cost

There is also a high financial cost associated with urinary incontinence in terms of non treatment or containment. A recent study estimated the combined healthcare, personal and societal cost to be £248 per person, with the cost to the UK National Health Service estimated at around £117 million per year.[8]

The benefits of prompt treatment

Evidence shows that early identification of women requiring specialist physiotherapy intervention can minimise long term damage to the pelvic floor muscles and reduce gynaecological, urological and bowel problems in later life.[7]

The RCM and CSP believe that maternity services providers should support and adopt the following recommendations:

- All women, in the antenatal period, should be given evidence based information and advice about PFME and an opportunity to discuss pelvic care with a qualified healthcare professional
- Maternity services providers develop clear standards and a referral pathway to specialist physiotherapy for women:
  - Who are at risk of developing problems relating to pelvic floor dysfunction; specifically, those with second degree tears, suspected bladder or bowel injury during a caesarean section, or forceps/ven touse delivery. .
  - With a previous history of bladder/bowel/pelvic floor problems as a result of obstetric or gynaecological conditions.

- Heads of midwifery services ensure that midwives are trained to a standard commensurate with their role in order to provide accurate advice and support to women. Training should include issues of cultural imperatives and norms, religious beliefs and their relationship to the uptake of services, that meets the criteria for a culturally competent service as defined by the NHS
- Maternity services providers work with obstetric physiotherapists to identify local opportunities to deliver effective training on PFE to midwives and those who work directly with women.
- Maternity service providers signpost midwives to the RCM learning resources, to include information on the anatomy and function of the pelvic floor, teaching effective PFME and how to identify dysfunction, appropriate for referral
- Midwives adhere to their responsibility to ensure that they are up to date in their knowledge of these issues in order to provide advice and support to women.

References

1. Royal College of Midwives. State of maternity services 2012. London: Royal College of Midwives; 2012. Available from: http://www.rcm.org.uk/college/policy-practice/government-policy/state-of-maternity-services/

2. Guerrero K, Owen L, Hirst G, et al. Antenatal pelvic floor exercises: A survey of both patients' and health professionals alike. Journal of Obstetrics and Gynaecology. 2007;27(7):684-7.

3. National Institute for Health and Clinical Excellence. Urinary incontinence: the management of urinary incontinence in women. CG40. London: National Institute for Health and Clinical Excellence; 2006. Available from: http://guidance.nice.org.uk/CG40

4. Papanicolaou S, Pons M, Hampel C, et al. Medical resource utilisation and cost of care for women seeking treatment for urinary incontinence in an outpatient setting. Examples from three countries participating in the PURE study. Maturitas. 2005 Nov 30;52 (Suppl 2):S35-47.

5. Doshani A, Pitchforth E, Mayne CJ, et al. Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester. Fam Pract. 2007 Dec;24(6):585-93.

6. McGrother C, Donaldson M, Shaw C, et al. Storage symptoms of the bladder: prevalence, incidence and need for services in the UK. BJU International. 2004 Apr;93(6):763-9. Available from: http://onlinelibrary.wiley.com/store/10.1111/j.1464-410X.2003.04721.x/asset/j.1464-410X.2003.04721.x.pdf?v=1&t=h9a47rfb&s=ee5840d157cf13e1c004cf9023db3c04ec564a25

7. Hermansen IL, O'Connell BO, Gaskin CJ. Women's explanations for urinary Incontinence, their management strategies, and their quality of life during the postpartum period. Journal of Wound Ostomy & Continence Nursing. 2010;37(2):187-92.

8. Imamura M, Abrams P, Bain C, et al. Systematic review and economic modelling of the effectiveness and cost-effectiveness of non-surgical treatments for women with stress urinary incontinence. Health Technol Assess. 2010 Aug;14(40):1-188, iii-iv. Available from: http://www.hta.ac.uk/execsumm/summ1440.htm

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Publication date July 2013

Review date July 2016