WHAT ARE THE BARRIERS AND FACILITATORS FOR POSTNATAL WOMEN ACCESSING CARE FOR POSTNATAL PROLAPSE?

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Aim of the study:

Pelvic organ prolapse is a common stigmatising condition, severely impacting quality of life **(QOL)** in women. Between **33-79%** of postnatal women have prolapse on examination up to one year after giving birth **(10)**, and up to **43%** of women report severe symptoms **(11)**. As well as the impact on physical QOL, prolapse can also have psychological consequences for new mothers **(12)**. Postnatal women report not being able to fulfil their parental caring responsibilities, are less like to exercise, will adapt activities of daily living and are less likely to return to work **(12-15)**.

There has been limited research on women's and clinicians' perspectives of the barriers and facilitators to postnatal women accessing treatment for prolapse in the context of this varied practice.

To address this knowledge gap, we sought to explore the perceived barriers and facilitators of accessing conservative treatment for prolapse for postnatal women.

A PVC ring pessary

'...there wasn't anything I could do, I said "we could try a ring pessary but it's not really going to stay up there, ...I think you just need to go [to gynaecology] and that was before they had a 2-year waiting list'
Nurse 1

Study design, materials and methods

Qualitative semi-structured interviews were conducted with clinicians treating postnatal prolapse in the UK, women from Cambridge University Hospital NHS Foundation Trust and national online support groups. The Consolidated Reporting of Qualitative Research (COREQ) checklist (23) was used to report findings.

Women who birthed a baby in the past 2-years and were over the age of 18-years with prolapse symptoms were invited to take part in the study.

Clinicians treating postnatal women with over two years' experience were also invited to take part. We recruited participants through social media posts for clinician specialist interest groups (Royal College of Nursing, Pelvic Obstetric and Gynaecological Physiotherapy, and General Practitioners with Specialist Interests in Women's Health).

Interviews were conducted with physiotherapists, nurses and GPs working in private clinics, and primary or secondary care.

Reflective thematic analysis was used to analyse the data. Major themes were rechecked against initial coding and the raw data. To ensure rigor, a second reviewer checked the raw data against themes. A full review of the analysis was completed by a PPIE member.

'...I always very much grab the opportunity to listen to a nice quiet baby's chest and heart sounds while its sleeping and then obviously you wake [the baby] up because you are undressing it.....[the baby] is now crying because you have examined it, why would you then talk to the mother about, oh so are you having any pelvic floor issues?...'
GP 1

'...the GP didn't even consider it to be a problem, an issue, it was just like, you know, that's what you are stuck with now, almost get on with it, carry on.'
Woman 1

Results and interpretation

Eight semi-structed qualitative interviews were conducted with women and clinicians. Those included were: women using an NHS service **(n=1)**, women using private services **(n=1)**, practice nurse **(n=1)**, secondary care nurse **(n=1)**, pelvic health physiotherapist **(n=2)** and GPs **(n=2)**. Duration of interviews varied between **35** and **60** minutes. Full details of participant demographics are shown in **Table 1**.

Table 1. Demographics

	Women (n=2)	Clinicians (n=6)
Age (years) mean (SD)	33.5 (1.5)	44.5 (6.1)
Years treating prolapse mean (SD)	n/a	16 (5.3)
Working in NHS services (%)	n/a	5 (83)
Working in private services (%)	n/a	1 (17)
Gender n (%) female	2 (100)	6 (100)
Parity mean (SD)	1.5 (0.5)	n/a
Type of birth	Woman 1: Vaginal delivery (n=1) Woman 2: Forceps (n=1); Emergency Caesarean (n=1)	n/a

Interview Themes

In relation to the aims of this study, five themes emerged from the interviews: **screening, cultural approach to symptoms, the ideal care pathway, health literacy and education for women, and clinical pathways.**

Sub-themes for barriers included impracticalities of joint women and baby screening appointments, indirect questioning, inconsistencies of vaginal examination, symptom dismissal, lack of importance given to women's health, age bias with pessary treatment, poor quality of pelvic health education, lack of equipment in primary care, and clinics in rural locations.

Sub-themes for facilitators included standardisation at the screening appointment, using opportunities at other appointments to ask direct pelvic floor health related questions, only offering face-to-face appointments, tailoring screening appointment, training, clinician-led education included professional networks, monitored social media and education around correct vaginal anatomy after birth, self-referral, timely appointments, female clinicians, and flexible appointment.

Conclusions

This study aimed to explore the perceived barriers and facilitators of accessing conservative treatment for prolapse for postnatal women. In relation to this we found five key themes: screening, cultural approach to symptoms, the ideal care pathway, health literacy and education for women, and clinical pathways. New findings suggest pessary association with older women is limiting younger women's choices in prolapse management.

We suggest a dedicated service for postnatal women with prolapse is needed and research into the effective treatments for this population is required.

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