Help-seeking behaviour for pelvic floor dysfunction in women over 55: drivers and barriers

AUTHORS: Amy Tinetti, Nicole Weir, Usanee Tangyotkajohn, Angela Jacques, Judith Thompson, Kathy Briffa.

Institutional affiliation of all authors is Curtin University

Affiliation Address: Curtin University, School of Physiotherapy and Exercise Science, Building 408, Brand Drive, Bentley, Western Australia, Australia, 6102

Corresponding author: Amy Tinetti | Email: amytinetti@hotmail.com

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**Authors contribution to the manuscript**

A Tinetti: Project development collection, data analysis, manuscript writing.

N Weir: Project development collection, data analysis, manuscript writing

U Tangyotkajohn: Project development collection, data analysis, manuscript writing

A Jacques: Data analysis, manuscript writing

Dr J Thompson: Project development analysis, data analysis, manuscript writing

Dr K Briffa: Project development analysis, data analysis, manuscript writing

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Abstract

Objective

To identify the help-seeking behaviour, drivers and barriers of older women living independently in Australia with pelvic floor dysfunction (PFD).

Methods

Women, aged ≥55 years, were recruited to this cross-sectional study during July and August 2016. Bladder, bowel, pelvic organ prolapse (POP) and sexual dysfunction were assessed with the Australian Pelvic Floor Questionnaire (APFQ). Help-seeking behaviours, drivers and barriers were based on the Barriers to Incontinence Care Seeking Questionnaire. Univariate analyses were used to assess any significant relationships between PFD, age, education level, self-reported PFD, barriers and drivers on help-seeking behaviours.

Results

Of the 376 women (mean [SD] age 68.6 [10.5] years) included in the study 67% reported symptoms of PFD and 98.7% scored >0 on the APFQ. Women were more likely to seek help if they scored higher on the APFQ (p<0.001). The main barrier to seeking help was the perception that PFD was a normal part of ageing (22.4%). Of those who did seek help (50%) the main factor was increased level of symptom bother (51.4%). There was no difference in age or education level between those women who did and those who did not seek help for their PFD.

Conclusion

Women are more likely to seek help if scoring higher on the APFQ or symptoms are becoming more bothersome, and less likely to seek help if they view their symptoms as
normal. Future direction should be taken to raise awareness of normal pelvic floor function as well as the availability of help for PFD.

Keywords
Help-seeking, pelvic floor, dysfunction, barriers, drivers, women

Brief summary
Help-seeking behaviour for pelvic floor dysfunction in community dwelling women over 55 years living independently in Australia: the drivers and barriers and presence of dysfunction

Abbreviations
Pelvic floor dysfunction (PFD), pelvic organ prolapse (POP), Australian Pelvic Floor Questionnaire (APFQ), pelvic floor muscle (PFM), pelvic floor muscle training (PFMT)

1.0 Introduction

Pelvic floor dysfunction (PFD) is an umbrella term encompassing bladder, bowel, pelvic organ prolapse (POP) and sexual dysfunction [1]. It is a large problem affecting the ageing female population which comes at a significant financial cost to society [2] as well as a physical, mental and psychosocial cost to the individual [3, 4].

There are large variations within the literature in reported rates and types of PFD in older women. This is thought to be due to the sensitive nature of PFD and that women may not recognize the symptoms of dysfunction. Pelvic floor dysfunction affects quality of life and has been linked with declining physical function, including increased risk of falls and fractures as well as increased dependency on others for activities of daily living [5, 6].

Positive associations between symptoms of PFD and depression, psychological distress,
deterioration in personal relationships, low self-esteem and lower satisfaction with life have also been established [4, 7, 8].

Despite several successful treatment options for PFD being available there is a poor display of help-seeking behaviour in the ageing female [9]. Whilst inherent traits such as age [10-12] and education levels [13, 14] have been investigated as potential barriers and drivers to seeking help for PFD, no general consensus has been reached. A perception of PFD as a normal part of ageing, low bother, shame and embarrassment [15-18], have been attributed reasons for this behaviour, as well as a poor awareness of services available for help [15, 16, 18] and cost of and difficulty in accessing treatment [18, 19]. When women are driven to seek help for PFD, increased symptom severity, especially when linked with declining physical and psychosocial wellbeing, is usually the driving force [16, 20]. Apart from an Australian cohort of women in a study examining help-seeking for sexual dysfunction [21], there have not been any other Australian studies identifying help-seeking behaviour for other forms of PFD in the older woman.

To address this knowledge gap, we aimed to investigate symptoms of PFD and drivers and barriers of the help-seeking behaviours of older women in Australia, including which health professionals are accessed for help through using validated questionnaires. Personal traits such as age and education levels as potential influences on help-seeking behaviours were explored.

2.0 Method

2.1 Study design

A cross-sectional survey using electronic and paper questionnaires.

2.2 Ethical Approval
The study has been ethically approved by the Curtin University Human Research Ethics Committee (HRE2016-0116).

2.3 Participants

Female participants, aged ≥55 years old, living independently in Australia were recruited during July and August 2016. Women were excluded if they were unable to read or understand English.

Participants were recruited through letter box drops to 3 independent retirement villages (2 from Western Australia and 1 from Victoria), 2 GP clinics and Facebook. A Facebook post limited to women over 55 year old within Australia was completed to invite the target population to complete an online survey. Various channels were used for recruitment to ensure a suitable cross section of this population. 4980 participants were invited (808 paper invite and 4172 social media reach). 4553 participants declined to participate. 208 participants completed survey through Facebook and 219 from retirement villages.

Questionnaires were completed independently and anonymously to ensure validity and show due respect to the sensitive nature of information being obtained [22]. Participants’ informed consent was gained at the beginning of the questionnaire.

2.4 Study questionnaire

Demographic data such as age and level of education were collected. The Australian Pelvic Floor Questionnaire (APFQ) was used to generate PFD scores. This is a valid and reliable tool with high internal consistency that examines four elements of PFD; bladder, bowel, POP and sexual dysfunction [23]. It includes questions about the presence and severity of symptoms as well as levels of bother.

Additional questions to assess help-seeking behaviour were adapted from the Barriers to Incontinence Care Seeking Questionnaire [24]. This identifies factors such as healthcare
professionals accessed and relationships with them, cost, fear and inconvenience of seeking help as common barriers. Further questions related to embarrassment, lack of knowledge of services, low bother and acceptance of PFD as normal part of ageing were added based on literature review on barriers and drivers to seeking help for PFD in this population [16, 19, 25]. Questions based on increased severity, bother, impact on quality of life and new knowledge of services were included to assess factors that motivate people to seek help [16] (See Appendix 1 for the full questionnaire).

2.5 Data analysis

Symptoms of PFD reported on the APFQ were assessed using the scoring system described in Baesslar [23]. Descriptive statistics were used to summarise demographic characteristics. Help-seeking behaviours, scores and presence of PFD were based on frequency distributions and means, standard deviations and ranges for categorical and continuous data respectively. Univariate analyses using $\chi^2$ and Fisher exact tests were used to assess any significant relationships between symptoms of PFD, age, education level, self-reported PFD and the barriers and drivers of help-seeking behaviours. The APFQ subsection scores were compared between the groups self-reporting symptoms or not using independent groups t-tests. Reporting of PFD symptoms was based on the question 'Please tick which symptoms you are experiencing: bladder, bowel, prolapse and/or sexual dysfunction, none'. P values <0.05 were considered statistically significant. Data were recorded on Qualtrics Survey Software (Provo, Utah) and analysed using SPSS version 24.0 (Armonk, NY).

3 Results

Four hundred and twenty seven completed the questionnaire. The response rates were 27% from the paper survey and 5% from the facebook post (calculated by dividing the completed electronic surveys with the total reach on the post, unfortunately it could not be ascertained if
the post was viewed or not, so response rate may have been higher than this). In the returned questionnaires, 11 were excluded not having signed consent, 11 excluded as out of the age range and 28 questionnaires were incomplete. Questionnaires were classified as incomplete if participants didn’t answer all of the APFQ and were not included in data analysis. Any participants with missing data from the additional questions on help-seeking behaviours and participants’ characteristics, such as height and weight, were still included as part of data analysis. In the final analysis, 376 women were included, the mean (SD) age was 68.6 (10.5) years, level of education achieved <Year 12 (27.9%), Year 12(13.8%), >Year 12 (Certificate level, Advanced Diploma or Diploma) (22.6%) and Tertiary (Bachelor, Masters or Doctoral degree) school (28.2%) (Table 1).

From our sample 371 women (98.7%) scored greater than zero on the AFPQ. Only 5 women scored a total APFQ score of zero. The majority of women, (352 [93.6%]), had scores in the lower tertile, with a few in the moderate (19 [5.1%]) and none in the high tertile. Scores within the subsections for each dysfunction are summarised in Table 2. The majority of women (355 [94.4%]) scored greater than zero for bladder, bowel (357 [94.9%]) and sexual dysfunction (106 [77.9%] of the 136 who answered the sexually activity section), fewer women scored positively for symptoms of POP (90 [23.9%]) in comparison to other forms of PFD. The mean scores in each of the subsections were low at less than 2.2 out of 10.

There were no statistically significant associations between PFD scores and age (years) (p=0.64) or education levels (p=0.76) (Table 1). Women’s help-seeking behaviours were not associated with their age (p=0.25) or education levels (p=0.53) (Table 1).
After completing the APFQ women were surveyed if they felt they had any pelvic floor symptoms or had experienced symptoms in the past (Question 44 in Appendix 1). This question “was answered by 349 women, with 234 (67%) indicating they had experienced or were experiencing symptoms of PFD. A higher proportion 72.2%, of women reporting symptoms sought help than when help-seeking behaviour was analysed based on a positive score on APFQ where only 50.1% had sought help (p=<0.001). This is summarised in Table 3.

Of those women who scored on the APFQ 102 (59%) sought help from a female GP, followed by 63 (36.4%) from a gynaecologist, 53 (30.6%) from a male GP, 40 (23.1%) from a continence and women’s health physiotherapist, 28 (16.2%) from a urologist, 22 (12.7%) from a colorectal surgeon, 16 (9.2%) from a urogynaecologist, 16 (9.2%) from a continence nurse, 14 (8%) from other physiotherapists, 5 (2.9%) from gastroenterologist and 3 (1.7%) other. The proportion of women seeking care by specific dysfunction bladder, bowel, sexual dysfunction and POP is shown in Table 4.

From the women who sought help for PFD the most common treatment offered was advice 84 (48.6%), followed by pelvic floor exercises 83 (48.0%), medications 67 (38.8%), surgery 61 (35.3%), vaginal oestrogens 51 (29.5%), bladder training 34 (19.7%), support pessary 7 (4.0%), other 6 (3.6%), colonoscopy 4 (2.4%) and for 3 (1.8%) no treatment was offered. The different treatment offered for each specific dysfunction bladder, bowel, sexual dysfunction and POP is shown in Table 4.
All subjects reported moderate to high level of satisfaction with their healthcare practitioner (75-100%) with the highest level of satisfaction reported was with continence and women’s health physiotherapists (100%) and female GPs (94.1%) followed by other physiotherapist (92.9%), urogynaecologist (87.5%), colorectal surgeon (81.8%), male GP (81.1%), gynaecologists (81%), gastroenterologist (80%), urologist (78.6%) and continence nurse (75%).

The main barriers for help-seeking for PFD were a perception of PFD as a normal part of ageing 50 (28.8%); they felt they could self-manage their condition 37 (21.3%); they felt their condition was not serious enough to warrant treatment 32 (18.3%); they were embarrassed to seek help 23 (13.2%); and the symptoms didn’t bother them 23 (13.2%). The other barriers reported and barriers to seeking care by specific dysfunction: bladder, bowel, sexual dysfunction and POP is shown in Table 5.

Of the women who sought help for PFD, drivers for help-seeking included increased bother 89 (51.4%), worsening symptoms 85 (49.1%), discovery of available treatment 53 (30.6%), affected physical activities 33 (19.1%), impacted on social activities 26 (15%) and impacted on mental health 23 (13.3). The drivers that contributed to women seeking help by specific dysfunction: bladder, bowel, sexual dysfunction and POP is shown in Table 6.

The higher the APFQ score, the more likely women were to seek help. Of the 352 women who scored in the lower tertile of the total PFD, 48.3% had sought help, whereas 83.3% of the 19 women who scored in the moderate tertile had sought help (p=0.009).
A similar pattern was observed in each of the subcategories with a smaller proportion of women from the lower tertile seeking help than from the upper tertiles.
4. Discussion

In this study 98.7% of the participants recorded a positive score on the APFQ by recording a positive answer to any of the questions. A positive score on the APFQ represents a deviation from normal bladder, bowel, sexual and pelvic organ function as defined by the International Continence Society (ICS), and confers with current literature that pelvic floor dysfunction is known to be prevalent in the ageing female population [9]. Whilst a positive score may be an indication of symptoms of pelvic floor dysfunction only 67% of the women who scored positively on the APFQ reported themselves as having some form of dysfunction. This could indicate that either the participants were experiencing mild levels of dysfunction, as was seen by lower scores on the questionnaire with the average PFD total score 4.6/40 (Table 2), or were adopting behaviours to manage their symptoms, such as not drinking as much or toileting frequently to avoid leakage. It could also have been that they were not bothered by symptoms, or they may not have had any PFD/disease. Alternatively, it could possibly reflect a lack of understanding of normal pelvic floor function hence an inability to recognise abnormal symptoms of PFD and this may place them at risk of worsening PFD.

Of the women who scored positively on the APFQ only half the women (50.1%) had sought help, however of those that recognised and reported symptoms a greater proportion (72.2%) sought help (Table 3). In our study the majority of positive scores on the APFQ were in the low ranges (Table 2) and may have affected the need for women to seek help. A previous study on help seeking for PFD in a wider age range of women 25-84 years found 57% of women reporting symptoms in their population sort help, with a greater help-seeking in the older age group [10]. As our study was on older women this may explain the slightly higher proportion of help-seeking.
For those women in our study that reported symptoms but did not seek help, the four most common barriers for seeking help for all four dysfunctions was a perception that symptoms were a normal part of ageing (28.8%), self-managing their symptoms (21.3%) condition not being serious enough (18.4%) and embarrassment (13.2%). The findings of this study are widely reflected in other studies however the proportion of women reporting these barriers were at lower levels previously reported, with respective scores of normal part of ageing, 53-78% [11, 14, 18], self-management, 57-89% [18, 20], not serious enough, 61-80% [11, 16, 20] and embarrassment, 23-53% , the difference may be justified by the lower scores on the APFQ as indicated above, hence women feeling treatment was not warranted. When comparing the four different conditions, the perception of PFD being a normal part of ageing and the self-management of symptoms were the top two barriers for all, however embarrassment rated higher for POP (12.2%) than the other three dysfunctions (sexual dysfunction 7.5%, bowel dysfunction 6.4% and bladder dysfunction 6.2%).

Several other barriers to help-seeking were reported in low ranges and demonstrated consistency across all four PFD, however fear of discovering a serious problem, barriers with the appointment itself (expense, limitation of clinic hours, appointment scheduling) and not liking examinations or questioning about the problem all rated the highest in POP.

The most important drivers for help-seeking in our sample were an increased level of bother (51.4%), worsening of symptoms (49.1%) and the discovery of treatment (30.6%) these were consistent across the four categories and demonstrates consistency with existing literature [16, 26, 27]. It was most common to seek help for POP, followed by bowel, bladder and then sexual dysfunction. Not being aware of treatment is frequently documented as hindering women to seek help [15, 16, 18] and this study it was found that becoming aware of
available treatment was a major driver for seeking treatment for bladder, sexual and bowel
dysfunctions, and POP but to a lesser extent. The impact all four dysfunctions had on
quality of life all served as drivers like other studies [16], but to varying degrees in each
condition - an impact on physical activity was seen to be a common driver for seeking
treatment for POP and bowel dysfunction, but not as common for bladder and sexual
dysfunction; an impact on social activities was more common for bowel dysfunction but less
so in bladder, POP and sexual dysfunction; and an impact on mental health for bowel and
sexual dysfunction was more commonly noted as a driver than in bladder and POP.

There was no relationship between education level and seeking treatment in this study which
is supported by one previous study [10]. However, other studies have reported conflicting
results, some found that illiterate women were more likely to seek help [8, 14], in contrast
another study that showed more educated women were more likely to seek help [15].

In this study there was no statistically significant difference noted in women who sought help
in terms of age. One study showed that the most likely age group to seek help for urinary
incontinence (UI) were the 50 -59 years [6] and that older women were less likely to seek
help [12]. However, it has also been reported that increased age was positively associated
with help-seeking for POP, UI and anal incontinence (AI) [2].

The variation in findings on the effect of age and level of education between our study and
others could be due to different sample populations or other factors like past medical history
and symptoms severity. Morrill et al (2007) found that frequent episodes of urinary tract
infection affect women’s help-seeking [10]. Our study did not include questions on other
health conditions; it is possible that if women were suffering other more serious health
conditions this may have taken priority over help-seeking for mild symptoms of PFM dysfunction. With the majority of women experiencing mild symptoms of PFD, they may have been more likely to self-manage their own condition. A wider range of PFD severities may increase generalizability of the results.

The most common health professional accessed for help for PFD were GPs with 89% of all women who sought help accessing their GP. It has previously been demonstrated that 78% of women prefer female GPs for at least one type of health condition [10, 28]. Gynaecologists were the most commonly sought specialist for all dysfunctions, followed by urologists for bladder dysfunction (25.2%) and colorectal surgeons (30.8%) for bowel dysfunction. There was a low level of involvement of urogynaecologists in the management of bladder dysfunction (11.7%) and POP (16.7%) as well as continence nurses in bladder (15.5%) and bowel (8.3%) dysfunction. This may reflect the lower number of urogynaecologists compared to gynaecologists and the lower number of continence nurses than physiotherapists in the public and private sectors and the access clients have to these services.

The most common treatment offered were advice (48.6%), PFMT (48%) followed by medication (38.8%) and surgery (35.3%). These results indicate that the ICS guideline for conservative management as first line management [9] have been observed. When comparing the four dysfunctions advice was commonly offered for treatment of bladder and bowel dysfunction and POP but less frequent with sexual dysfunction and PFMT featured strongly in the management of all four dysfunctions. Medications were common treatment options in the management of all dysfunctions except POP, where surgery was commonly accessed (52.8%).
All subjects reported a moderate to high level of satisfaction with their healthcare practitioner, the highest level of satisfaction was with continence and women's health physiotherapists (100%), female GPs (94.1%) followed by other physiotherapist (92.9%). There was also high satisfaction with urogynaecologist (87.5%), male GPs (81%) and gynaecologists (81%). Advice and pelvic floor exercises were the most common treatment offered overall, in keeping with the international Continence society guidelines for conservative management as first line treatment. Continence and women’s health physiotherapists offer low cost, level 1, evidence based conservative management programs. As these programs are monitored over a period of time it allows time to build client rapport and may be a reason for this satisfaction rate.

It was shown in the study that women will be driven to seek help if their symptoms become more severe, more bothersome and impact on function but they also need to become aware of treatment options available for them. Global community education on PFD, the recognition of early symptoms of dysfunctions and making people aware of the available management options may help drive women in this demographic to seek help. Despite the fact that many women in this study perceived their symptoms to be a normal part of ageing and they felt they were able to manage themselves, it may be helpful for women to have an understanding of normal bladder, bowel and pelvic floor muscle function and dysfunction to encourage early help seeking behaviour to minimise dysfunctions and reduce the long term morbidity of PFD.

The findings of this study highlight the importance of education or awareness campaigns to the public and GPs on PFD. Encouragement for GPs to ask routine patient screening
questions to assess for early symptoms of PFD to address the issue of women not
recognising their PFD or accepting it as being normal, hence not seeking help. Continence
and women’s health physiotherapists and continence nurses should work in collaboration
with the specialists, and GPs to encourage early referral for conservative management of all
forms of PFD as first line management due the evidence of good treatment outcomes.

The strength of the study is that a validated self-report questionnaire was used. However
there were some limitations. One of the limitations was that for those who scored positively
in more than one section of the APFQ, the inability to isolate the degree to which each driver
and barrier was associated with each dysfunction (i.e if more than one dysfunction was
reported no questions were asked which was the greatest bother). For example, some may
have stress urinary incontinence for years and it not be bothersome then have one episode
of faecal incontinence and sought help). Secondly, in this study we did not ask about other
coexisting health conditions or cultural differences. In the population of women over 55 it is
common to have more than one health concerns [29]. If women were dealing with more
serious health issues these may have been of higher importance than seeking help for PFD.
Culture may be an important aspect of whether women feel comfortable discussing
symptoms of PFD and could be a barrier to help-seeking, if so education could be an
important driver to ensure women of all cultures are awareness of treatment options. In
future research it would be important to consider the subject’s general health and cultural
differences. Thirdly, the relationship with PFD, help-seeking and BMI was unable to be
established due to the number of missing self-reported entries for height.
In interpreting the results, the lower scores for PFD limit the finding of the study being able to be generalised to all populations, however the barriers and drivers reported are similar to several other studies on help seeking behaviour.

Based on the findings of this study, future research should explore if a program based around educating women in this population on normal bladder, bowel, sexual and pelvic organ function and the early recognition of symptoms of dysfunction along with the treatment that is available for PFD would affect their help-seeking behaviour. Given that a positive scoring on the APFQ may indicate early signs of PFD, it may be important to educate women on what is normal and that good bladder and bowel habits may be helpful in preventing worsening PFD. It would be of further interest to assess the impact on help seeking behaviour for PFD by addressing these knowledge gaps.

## 5 Conclusion

Pelvic floor muscle dysfunction in women over 55 years is extremely common, however, along with women not recognising their symptoms as being abnormal, many other factors deter them from seeking help. Future direction should be taken to raise awareness of normal bladder, bowel, pelvic organ and sexual function and the availability of help for such dysfunction.

## 6 Acknowledgements

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7 Funding

There is no funding associated with this study.

8 References


Appendix Legend

Appendix 1- Questionnaire
Table 1  Demographic characteristics of all participants and those with >0 AFPQ scores for bladder, bowel, POP and sexual dysfunction, total PFD score and help-seeking behaviour.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group</th>
<th>All (n=376)</th>
<th>Bladder dysfunction (n=355) (94.4%)</th>
<th>Bowel dysfunction (n=357) (94.9%)</th>
<th>Sexual dysfunction (n=106/136) sexually active (77.9%)</th>
<th>POP (n=90) (23.9%)</th>
<th>PFD (n=371) (98.7%)</th>
<th>Help-seeking behaviour</th>
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<tbody>
<tr>
<td>Age (yr) mean (SD)</td>
<td></td>
<td>68.6 (10.5)</td>
<td>68.7 (10.6)</td>
<td>68.6 (10.5)</td>
<td>62.0 (6.2)</td>
<td>67.9 (10.8)</td>
<td>68.6 (10.5)</td>
<td>-</td>
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<tr>
<td>Age category n (%)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;60</td>
<td></td>
<td>81 (21.5)</td>
<td>79 (22.3)</td>
<td>76 (21.3)</td>
<td>43 (40.6)</td>
<td>25 (27.8)</td>
<td>81 (21.8)</td>
<td>47 (58.0)</td>
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<tr>
<td>60-65</td>
<td></td>
<td>84 (22.3)</td>
<td>75 (21.1)</td>
<td>83 (23.2)</td>
<td>36 (34)</td>
<td>19 (21.1)</td>
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<td>66-70</td>
<td></td>
<td>46 (12.2)</td>
<td>44 (12.4)</td>
<td>43 (12)</td>
<td>10 (9.4)</td>
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<td>71-80</td>
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<td>75 (21.1)</td>
<td>72 (20.2)</td>
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<td>20 (22.2)</td>
<td>75 (20.2)</td>
<td>34 (43.6)</td>
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<td>&gt;80</td>
<td></td>
<td>57 (15.2)</td>
<td>56 (15.8)</td>
<td>55 (15.4)</td>
<td>1 (0.9)</td>
<td>11 (12.2)</td>
<td>57 (15.4)</td>
<td>24 (42.1)</td>
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<td>Education Level n (%)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;Year 12</td>
<td></td>
<td>105 (27.9)</td>
<td>101 (28.5)</td>
<td>100 (28)</td>
<td>19 (17.9)</td>
<td>23 (25.6)</td>
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<td>Year 12</td>
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<td>16 (17.8)</td>
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<td>Tertiary</td>
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<td>106 (28.2)</td>
<td>99 (27.9)</td>
<td>103 (28.9)</td>
<td>40 (37.7)</td>
<td>36 (40)</td>
<td>105 (28.3)</td>
<td>52 (49.5)</td>
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</table>

Abbreviations: PFD, pelvic floor dysfunction; POP, pelvic organ prolapse
Table 2 Australian pelvic floor questionnaire (APFQ) subsection scores for women with scores of > 0.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group</th>
<th>Bladder dysfunction n=355 (94.4%)</th>
<th>Bowel dysfunction n=357 (94.9%)</th>
<th>Sexual dysfunction n=106/136 sexually active (77.9%)</th>
<th>Pelvic Organ Prolapse n=90 (23.9%)</th>
<th>PFD n=371 (98.7%)</th>
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</thead>
<tbody>
<tr>
<td>Category</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Score*</td>
<td>mean(SD) [min-max]</td>
<td>1.7 (1.3) [0.2-7.1]</td>
<td>1.9 (1.1) [0.3-8.2]</td>
<td>2.1 (1.4) [0.5-5.7]</td>
<td>2.2 (1.9) [0.7-10.0]</td>
<td>4.6 (3.3) [0.2-19.5]</td>
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<td>Score tertile categories:</td>
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<tr>
<td>None</td>
<td>21 (5.6)</td>
<td>19 (5.1)</td>
<td>30 (8.0)</td>
<td>286 (76.1)</td>
<td>5 (1.3)</td>
<td></td>
</tr>
<tr>
<td>Lower tertile</td>
<td>129 (34.3)</td>
<td>126 (33.5)</td>
<td>36 (9.6)</td>
<td>31 (8.2)</td>
<td>352 (93.6)</td>
<td></td>
</tr>
<tr>
<td>Middle tertile</td>
<td>120 (31.9)</td>
<td>85 (22.6)</td>
<td>36 (9.6)</td>
<td>29 (7.7)</td>
<td>19 (5.1)</td>
<td></td>
</tr>
<tr>
<td>Upper tertile</td>
<td>106 (28.2)</td>
<td>146 (38.8)</td>
<td>34 (9.0)</td>
<td>30 (8.0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: PFD, pelvic floor dysfunction
Table 3 Help sought within APFQ subsections by experience of symptom and by APFQ score >0

<table>
<thead>
<tr>
<th></th>
<th>Seek help if AFPQ score&gt;0</th>
<th>Seek help if experience specific symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes n(%)</td>
<td>Yes n(%)</td>
</tr>
<tr>
<td>Bladder</td>
<td>169 (51.4)</td>
<td>122 (69.7)</td>
</tr>
<tr>
<td>Bowel</td>
<td>170 (51.7)</td>
<td>92 (80.0)</td>
</tr>
<tr>
<td>Sexual</td>
<td>49 (48.0)</td>
<td>18 (60.0)</td>
</tr>
<tr>
<td>Prolapse</td>
<td>59 (67.8)</td>
<td>66 (90.4)</td>
</tr>
<tr>
<td>PDF</td>
<td>172 (50.1)</td>
<td>169 (72.2)</td>
</tr>
</tbody>
</table>

Abbreviations: AFPQ, Australian pelvic floor questionnaire; PDF, pelvic floor dysfunction
Table 4: Help sought from health professional and treatment offered by PFD in each subsection for those who scored on the APFQ.

<table>
<thead>
<tr>
<th></th>
<th>Total n=173</th>
<th>Bladder dysfunction n=103</th>
<th>Bowel dysfunction n=65</th>
<th>POP n=36</th>
<th>Sexual dysfunction n=7</th>
</tr>
</thead>
</table>

Abbreviations: APFQ, Australian pelvic floor questionnaire; POP, pelvic organ prolapse; n, number
Table 5: Barriers for those who reported experiencing PFD symptoms but did not seek help

<table>
<thead>
<tr>
<th>Treating professional:</th>
<th>Total n=173</th>
<th>Bladder Dysfunction n=252</th>
<th>Bowel Dysfunction n=292</th>
<th>POP n=54</th>
<th>Sexual Dysfunction n=99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female GP</td>
<td>102 (59.0)</td>
<td>65 (63.1)</td>
<td>44 (67.7)</td>
<td>20 (55.6)</td>
<td>5 (71.4)</td>
</tr>
<tr>
<td>Male GP</td>
<td>53 (30.6)</td>
<td>33 (32.0)</td>
<td>27 (41.5)</td>
<td>9 (25.0)</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>63 (36.4)</td>
<td>41 (39.8)</td>
<td>18 (27.7)</td>
<td>24 (66.7)</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td>Urologist</td>
<td>28 (16.4)</td>
<td>26 (25.3)</td>
<td>12 (18.9)</td>
<td>4 (11.1)</td>
<td>3 (10.1)</td>
</tr>
<tr>
<td>Urogynaecologist</td>
<td>16 (9.2)</td>
<td>12 (11.7)</td>
<td>7 (10.8)</td>
<td>6 (16.7)</td>
<td>4 (13.1)</td>
</tr>
<tr>
<td>Colorectal surgeon</td>
<td>2 (1.2)</td>
<td>1 (1.0)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continece and Women’s Health Physiotherapist</td>
<td>30 (17.4)</td>
<td>24 (7.2)</td>
<td>12 (12.3)</td>
<td>2 (1.9)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td>Pelvic Floor Exercise Physiotherapist</td>
<td>50 (28.8)</td>
<td>41 (14.0)</td>
<td>12 (22.2)</td>
<td>15 (15.2)</td>
<td>-</td>
</tr>
<tr>
<td>Gastroenterologist</td>
<td>5 (2.9)</td>
<td>5 (2.0)</td>
<td>5 (1.7)</td>
<td>3 (5.6)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>Continence Nurse</td>
<td>37 (21.3)</td>
<td>31 (12.3)</td>
<td>30 (10.3)</td>
<td>9 (16.7)</td>
<td>-</td>
</tr>
<tr>
<td>Support Pessary</td>
<td>23 (13.2)</td>
<td>17 (6.7)</td>
<td>10 (18.5)</td>
<td>3 (8.3)</td>
<td>-</td>
</tr>
<tr>
<td>Dilators</td>
<td>2 (1.2)</td>
<td>1 (1.0)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Surgery</td>
<td>6 (4.1)</td>
<td>5 (2.0)</td>
<td>4 (2.1)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

| Does not bother | 23 (13.2) | 21 (8.3) | 8 (14.0) | 17 (30.6) | 7 (7.1) |
| Perceived as normal part of ageing | 50 (28.8) | 41 (14.0) | 12 (22.2) | 15 (15.2) | - |
| Self-managed | 37 (21.3) | 31 (12.3) | 30 (10.3) | 9 (16.7) | - |
| Not serious enough | 32 (18.4) | 31 (12.3) | 30 (10.3) | 9 (16.7) | - |
| Embarrassed | 23 (13.2) | 17 (6.7) | 10 (18.5) | 3 (8.3) | - |
| Afraid to discover serious problem | 5 (2.9) | 5 (2.0) | 5 (1.7) | 3 (5.6) | 1 (1.0) |

| Did not know if treatment available | 44 (25.3) | 34 (28.3) | 4 (5.1) | 8 (23.6) | - |
| Medications | 39 (50.0) | 50 (39.8) | - | 2 (28.6) | - |

| Vaginal Oestrogens | 51 (29.5) | 32 (31.1) | 21 (32.3) | 15 (41.7) | 5 (71.4) |
| Pelvic Floor Exercises | 83 (48.0) | 60 (58.3) | 23 (35.4) | 25 (69.4) | 3 (42.9) |
| Bladder Training | 34 (19.7) | 30 (29.1) | 12 (18.5) | 10 (27.8) | 1 (14.3) |
| Support Pessary | 7 (4.0) | 4 (3.9) | 1 (1.5) | 3 (8.3) | - |
| Dilators | 2 (1.2) | 1 (1.0) | - | - | - |
| Surgery | 61 (35.3) | 35 (34.0) | 23 (35.4) | 19 (52.8) | 1 (14.3) |

Abbreviations: POP, pelvic organ prolapse
Table 6: Drivers for seeking help for those who reported experiencing PFD symptoms

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Total n= 173</th>
<th>Bladder dysfunction n=103</th>
<th>Bowel dysfunction n=65</th>
<th>Prolapse n=36</th>
<th>Sexual dysfunction n=7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovered treatment was available</td>
<td>53 (30.6)</td>
<td>39 (37.9)</td>
<td>16 (24.6)</td>
<td>7 (19.4)</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td>Symptoms worsened</td>
<td>85 (49.1)</td>
<td>55 (53.4)</td>
<td>35 (53.8)</td>
<td>17 (47.2)</td>
<td>3 (42.9)</td>
</tr>
<tr>
<td>Level of bother increased</td>
<td>89 (51.4)</td>
<td>53 (51.5)</td>
<td>36 (55.4)</td>
<td>21 (58.3)</td>
<td>4 (57.1)</td>
</tr>
<tr>
<td>Affected mental health</td>
<td>23 (13.3)</td>
<td>12 (11.7)</td>
<td>14 (21.5)</td>
<td>7 (19.4)</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td>Affected physical activities</td>
<td>33 (19.1)</td>
<td>20 (19.4)</td>
<td>16 (24.6)</td>
<td>10 (27.8)</td>
<td>1 (14.3)</td>
</tr>
<tr>
<td>Affected social activities</td>
<td>26 (15.0)</td>
<td>19 (18.4)</td>
<td>16 (24.6)</td>
<td>7 (19.4)</td>
<td>1 (14.3)</td>
</tr>
</tbody>
</table>