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6 Help-seeking behaviour for pelvic floor 7 dysfunction in women over 55: drivers and 8 barriers

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49 **Abstract**

50 *Objective*

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

53 *Methods*

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

60 *Results*

61 Of the 376 women (mean [SD] age 68.6 [10.5] years) included in the study 67% reported
62 symptoms of PFD and 98.7% scored >0 on the APFQ. Women were more likely to seek help
63 if they scored higher on the APFQ ($p < 0.001$). The main barrier to seeking help was the
64 perception that PFD was a normal part of ageing (22.4%). Of those who did seek help (50%)
65 the main factor was increased level of symptom bother (51.4%).

66 There was no difference in age or education level between those women who did and those
67 who did not seek help for their PFD.

68 *Conclusion*

69 Women are more likely to seek help if scoring higher on the APFQ or symptoms are
70 becoming more bothersome, and less likely to seek help if they view their symptoms as

71 normal. Future direction should be taken to raise awareness of normal pelvic floor function
72 as well as the availability of help for PFD.

73 *Keywords*

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

75 *Brief summary*

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

78 *Abbreviations*

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

81

82 **1.0 Introduction**

83

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

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

93 Positive associations between symptoms of PFD and depression, psychological distress,

94 deterioration in personal relationships, low self-esteem and lower satisfaction with life have
95 also been established [4, 7, 8].

96 Despite several successful treatment options for PFD being available there is a poor display
97 of help-seeking behaviour in the ageing female [9]. Whilst inherent traits such as age [10-
98 12] and education levels [13, 14] have been investigated as potential barriers and drivers to
99 seeking help for PFD, no general consensus has been reached. A perception of PFD as a
100 normal part of ageing, low bother, shame and embarrassment [15-18], have been attributed
101 reasons for this behaviour, as well as a poor awareness of services available for help [15,
102 16, 18] and cost of and difficulty in accessing treatment [18, 19]. When women are driven to
103 seek help for PFD, increased symptom severity, especially when linked with declining
104 physical and psychosocial wellbeing, is usually the driving force [16, 20]. Apart from an
105 Australian cohort of women in a study examining help-seeking for sexual dysfunction [21],
106 there have not been any other Australian studies identifying help-seeking behaviour for other
107 forms of PFD in the older woman.

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

113

114 **2.0 Method**

115 **2.1 Study design**

116 A cross-sectional survey using electronic and paper questionnaires.

117 **2.2 Ethical Approval**

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

120 **2.3 Participants**

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

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

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

134 **2.4 Study questionnaire**

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

140 Additional questions to assess help-seeking behaviour were adapted from the Barriers to
141 Incontinence Care Seeking Questionnaire [24]. This identifies factors such as healthcare

142 professionals accessed and relationships with them, cost, fear and inconvenience of seeking
143 help as common barriers. Further questions related to embarrassment, lack of knowledge of
144 services, low bother and acceptance of PFD as normal part of ageing were added based on
145 literature review on barriers and drivers to seeking help for PFD in this population [16, 19,
146 25]. Questions based on increased severity, bother, impact on quality of life and new
147 knowledge of services were included to assess factors that motivate people to seek help [16]
148 (See Appendix 1 for the full questionnaire).

149 **2.5 Data analysis**

150 Symptoms of PFD reported on the APFQ were assessed using the scoring system described
151 in Baessler [23]. Descriptive statistics were used to summarise demographic characteristics.
152 Help-seeking behaviours, scores and presence of PFD were based on frequency
153 distributions and means, standard deviations and ranges for categorical and continuous data
154 respectively. Univariate analyses using χ^2 and Fisher exact tests were used to assess any
155 significant relationships between symptoms of PFD, age, education level, self-reported PFD
156 and the barriers and drivers of help-seeking behaviours. The APFQ subsection scores were
157 compared between the groups self-reporting symptoms or not using independent groups t-
158 tests. Reporting of PFD symptoms was based on the question 'Please tick which symptoms
159 you are experiencing: bladder, bowel, prolapse and/or sexual dysfunction, none'. P values
160 <0.05 were considered statistically significant. Data were recorded on Qualtrics Survey
161 Software (Provo, Utah) and analysed using SPSS version 24.0 (Armonk, NY).

162

163 **3 Results**

164 Four hundred and twenty seven completed the questionnaire. The response rates were 27%
165 from the paper survey and 5% from the facebook post (calculated by dividing the completed
166 electronic surveys with the total reach on the post, unfortunately it could not be ascertained if

167 the post was viewed or not, so response rate may have been higher than this). In the
168 returned questionnaires, 11 were excluded not having signed consent, 11 excluded as out of
169 the age range and 28 questionnaires were incomplete. Questionnaires were classified as
170 incomplete if participants didn't answer all of the APFQ and were not included in data
171 analysis. Any participants with missing data from the additional questions on help-seeking
172 behaviours and participants' characteristics, such as height and weight, were still included as
173 part of data analysis. In the final analysis, 376 women were included, the mean (SD) age
174 was 68.6 (10.5) years, level of education achieved <Year 12 (27.9%), Year 12(13.8%),
175 >Year 12 (Certificate level, Advanced Diploma or Diploma) (22.6%) and Tertiary (Bachelor,
176 Masters or Doctoral degree) school (28.2%) (Table 1).

177

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

186 There were no statistically significant associations between PFD scores and age (years)
187 ($p=0.64$) or education levels ($p=0.76$) (Table 1). Women's help-seeking behaviours were not
188 associated with their age ($p=0.25$) or education levels ($p=0.53$) (Table 1).

189

190

191 After completing the APFQ women were surveyed if they felt they had any pelvic floor
192 symptoms or had experienced symptoms in the past (Question 44 in Appendix 1). This
193 question “was answered by 349 women, with 234 (67%) indicating they had experienced or
194 were experiencing symptoms of PFD. A higher proportion 72.2%, of women reporting
195 symptoms sought help than when help-seeking behaviour was analysed based on a positive
196 score on APFQ where only 50.1% had sought help ($p<0.001$). This is summarised in Table
197 3.

198

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

206

207 From the women who sought help for PFD the most common treatment offered was advice
208 84 (48.6%), followed by pelvic floor exercises 83 (48.0%), medications 67 (38.8%), surgery
209 61 (35.3%), vaginal oestrogens 51 (29.5%), bladder training 34 (19.7%), support pessary 7
210 (4.0%), other 6 (3.6%), colonoscopy 4 (2.4%) and for 3 (1.8%) no treatment was offered.

211 The different treatment offered for each specific dysfunction bladder, bowel, sexual
212 dysfunction and POP is shown in Table 4.

213

214 All subjects reported moderate to high level of satisfaction with their healthcare practitioner
215 (75-100%) with the highest level of satisfaction reported was with continence and women's
216 health physiotherapists (100%) and female GPs (94.1%) followed by other physiotherapist
217 (92.9%), urogynaecologist (87.5%), colorectal surgeon (81.8%), male GP (81.1%),
218 gynaecologists (81%), gastroenterologist (80%), urologist (78.6%) and continence nurse
219 (75%).

220

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

227

228 Of the women who sought help for PFD, drivers for help-seeking included increased bother
229 89 (51.4%), worsening symptoms 85 (49.1%), discovery of available treatment 53 (30.6%) ,
230 affected physical activities 33 (19.1%), impacted on social activities 26 (15%) and impacted
231 on mental health 23 (13.3). The drivers that contributed to women seeking help by specific
232 dysfunction: bladder, bowel, sexual dysfunction and POP is shown in Table 6.

233

234 The higher the APFQ score, the more likely women were to seek help. Of the 352 women
235 who scored in the lower tertile of the total PFD, 48.3% had sought help, whereas 83.3% of
236 the 19 women who scored in the moderate tertile had sought help (p=0.009).

237 A similar pattern was observed in each of the subcategories with a smaller proportion of
238 women from the lower tertile seeking help than from the upper tertiles.

239

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.

265 For those women in our study that reported symptoms but did not seek help, the four most
266 common barriers for seeking help for all four dysfunctions was a perception that symptoms
267 were a normal part of ageing (28.8 %), self-managing their symptoms (21.3%) condition not
268 being serious enough (18.4%) and embarrassment (13.2%). The findings of this study are
269 widely reflected in other studies however the proportion of women reporting these barriers
270 were at lower levels previously reported, with respective scores of normal part of ageing, 53-
271 78% [11, 14, 18], self-management, 57-89% [18, 20], not serious enough, 61-80% [11, 16,
272 20] and embarrassment, 23-53% , the difference may be justified by the lower scores on the
273 APFQ as indicated above, hence women feeling treatment was not warranted. When
274 comparing the four different conditions, the perception of PFD being a normal part of ageing
275 and the self-management of symptoms were the top two barriers for all, however
276 embarrassment rated higher for POP (12.2%) than the other three dysfunctions (sexual
277 dysfunction 7.5%, bowel dysfunction 6.4% and bladder dysfunction 6.2%).

278

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

283

284 The most important drivers for help-seeking in our sample were an increased level of bother
285 (51.4%), worsening of symptoms (49.1%) and the discovery of treatment (30.6%) these were
286 consistent across the four categories and demonstrates consistency with existing literature
287 [16, 26, 27]. It was most common to seek help for POP, followed by bowel, bladder and then
288 sexual dysfunction. Not being aware of treatment is frequently documented as hindering
289 women to seek help [15, 16, 18] and this study it was found that becoming aware of

290 available treatment was a major driver for seeking treatment for bladder, sexual and bowel
291 dysfunctions, and POP but to a lesser extent. The impact all four dysfunctions had on
292 quality of life all served as drivers like other studies [16], but to varying degrees in each
293 condition - an impact on physical activity was seen to be a common driver for seeking
294 treatment for POP and bowel dysfunction, but not as common for bladder and sexual
295 dysfunction; an impact on social activities was more common for bowel dysfunction but less
296 so in bladder, POP and sexual dysfunction; and an impact on mental health for bowel and
297 sexual dysfunction was more commonly noted as a driver than in bladder and POP.

298

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

303

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

309

310 The variation in findings on the effect of age and level of education between our study and
311 others could be due to different sample populations or other factors like past medical history
312 and symptoms severity. Morrill et al (2007) found that frequent episodes of urinary tract
313 infection affect women's help-seeking [10]. Our study did not include questions on other
314 health conditions; it is possible that if women were suffering other more serious health

315 conditions this may have taken priority over help-seeking for mild symptoms of PFM
316 dysfunction. With the majority of women experiencing mild symptoms of PFD, they may have
317 been more likely to self-manage their own condition. A wider range of PFD severities may
318 increase generalizability of the results.

319

320 The most common health professional accessed for help for PFD were GPs with 89% of all
321 women who sought help accessing their GP. It has previously been demonstrated that 78%
322 of women prefer female GPs for at least one type of health condition [10, 28].

323 Gynaecologists were the most commonly sought specialist for all dysfunctions, followed by
324 urologists for bladder dysfunction (25.2%) and colorectal surgeons (30.8%) for bowel
325 dysfunction. There was a low level of involvement of urogynaecologists in the management
326 of bladder dysfunction (11.7%) and POP (16.7%) as well as continence nurses in bladder
327 (15.5%) and bowel (8.3%) dysfunction. This may reflect the lower number of
328 urogynaecologists compared to gynaecologists and the lower number of continence nurses
329 than physiotherapists in the public and private sectors and the access clients have to these
330 services.

331

332 The most common treatment offered were advice (48.6%), PFMT (48%) followed by
333 medication (38.8%) and surgery (35.3%). These results indicate that the ICS guideline for
334 conservative management as first line management [9] have been observed . When
335 comparing the four dysfunctions advice was commonly offered for treatment of bladder and
336 bowel dysfunction and POP but less frequent with sexual dysfunction and PFMT featured
337 strongly in the management of all four dysfunctions. Medications were common treatment
338 options in the management of all dysfunctions except POP, where surgery was commonly
339 accessed (52.8%).

340

341 All subjects reported a moderate to high level of satisfaction with their healthcare
342 practitioner, the highest level of satisfaction was with continence and women's health
343 physiotherapists (100%), female GPs (94.1%) followed by other physiotherapist (92.9%).
344 There was also high satisfaction with urogynaecologist (87.5%), male GPs (81%) and
345 gynaecologists (81%). Advice and pelvic floor exercises were the most common treatment
346 offered overall, in keeping with the international Continence society guidelines for
347 conservative management as first line treatment. Continence and women's health
348 physiotherapists offer low cost, level 1, evidence based conservative management
349 programs. As these programs are monitored over a period of time it allows time to build
350 client rapport and may be a reason for this satisfaction rate.

351

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

362

363 The findings of this study highlight the importance of education or awareness campaigns to
364 the public and GPs on PFD. Encouragement for GPs to ask routine patient screening

365 questions to assess for early symptoms of PFD to address the issue of women not
366 recognising their PFD or accepting it as being normal, hence not seeking help. Continence
367 and women's health physiotherapists and continence nurses should work in collaboration
368 with the specialists, and GPs to encourage early referral for conservative management of all
369 forms of PFD as first line management due the evidence of good treatment outcomes.

370

371 The strength of the study is that a validated self-report questionnaire was used. However
372 there were some limitations. One of the limitations was that for those who scored positively
373 in more than one section of the APFQ, the inability to isolate the degree to which each driver
374 and barrier was associated with each dysfunction (i.e if more than one dysfunction was
375 reported no questions were asked which was the greatest bother). For example, some may
376 have stress urinary incontinence for years and it not be bothersome then have one episode
377 of faecal incontinence and sought help). Secondly, in this study we did not ask about other
378 coexisting health conditions or cultural differences. In the population of women over 55 it is
379 common to have more than one health concerns [29]. If women were dealing with more
380 serious health issues these may have been of higher importance than seeking help for PFD.
381 Culture may be an important aspect of whether women feel comfortable discussing
382 symptoms of PFD and could be a barrier to help-seeking, if so education could be an
383 important driver to ensure women of all cultures are awareness of treatment options. In
384 future research it would be important to consider the subject's general health and cultural
385 differences. Thirdly, the relationship with PFD, help-seeking and BMI was unable to be
386 established due to the number of missing self-reported entries for height.

387

388 In interpreting the results, the lower scores for PFD limit the finding of the study being able to
389 be generalised to all populations, however the barriers and drivers reported are similar to
390 several other studies on help seeking behaviour.

391

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

400

401 **5 Conclusion**

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

407

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495 **Appendix Legend**

496 **Appendix 1- Questionnaire**

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

Characteristic	Group	All	Bladder dysfunction	Bowel dysfunction	Sexual dysfunction	POP	PFD	Help-seeking behaviour	
								No N=174 (50.1%) n (%)	Yes N=173 (49.9%) n (%)
		<i>n=376</i>	<i>n=355</i> (94.4%)	<i>n=357</i> (94.9%)	<i>n=106/136</i> <i>sexually active</i> (77.9%)	<i>n=90</i> (23.9%)	<i>n=371</i> (98.7%)		
Age (yr) <i>mean (SD)</i>		68.6 (10.5)	68.7 (10.6)	68.6 (10.5)	62.0 (6.2)	67.9 (10.8)	68.6 (10.5)	-	-
Age category n (%):									
	<60	81 (21.5)	79 (22.3)	76 (21.3)	43 (40.6)	25 (27.8)	81 (21.8)	47 (58.0)	34 (42.0)
	60-65	84 (22.3)	75 (21.1)	83 (23.2)	36 (34)	19 (21.1)	84 (22.6)	42 (50.0)	42 (50.0)
	66-70	46 (12.2)	44 (12.4)	43 (12)	10 (9.4)	11 (12.2)	46 (12.4)	25 (55.6)	20 (44.4)
	71-80	79 (21)	75 (21.1)	72 (20.2)	12 (11.3)	20 (22.2)	75 (20.2)	34 (43.6)	44 (56.4)
	>80	57 (15.2)	56 (15.8)	55 (15.4)	1 (0.9)	11 (12.2)	57 (15.4)	24 (42.1)	33 (57.9)
Education Level n (%):									
	<Year 12	105 (27.9)	101 (28.5)	100 (28)	19 (17.9)	23 (25.6)	104 (28)	53 (51.0)	51 (49.0)
	Year 12	52 (13.8)	48 (13.5)	47 (13.2)	10 (9.4)	11 (12.2)	51 (13.7)	30 (57.7)	22 (42.3)
	>Year 12	85 (22.6)	82 (23.1)	80 (22.4)	33 (31.1)	16 (17.8)	84 (22.6)	38 (44.7)	47 (55.3)
	Tertiary	106 (28.2)	99 (27.9)	103 (28.9)	40 (37.7)	36 (40)	105 (28.3)	52 (49.5)	53 (50.5)

515 Abbreviations: PFD, pelvic floor dysfunction; POP, pelvic organ prolapse

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517 **Table 2 Australian pelvic floor questionnaire (APFQ) subsection scores for women**
 518 **with scores of > 0.**

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

519 Abbreviations: PFD, pelvic floor dysfunction

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531 **Table 3 Help sought within APFQ subsections by experience of symptom and by**
 532 **APFQ score >0**

	Seek help if APFQ score>0	Seek help if experience specific symptom
	Yes n(%)	Yes n(%)
Bladder	169 (51.4)	122 (69.7)
Bowel	170 (51.7)	92 (80.0)
Sexual	49 (48.0)	18 (60.0)
Prolapse	59 (67.8)	66 (90.4)
PDF	172 (50.1)	169 (72.2)

533 Abbreviations: APFQ, Australian pelvic floor questionnaire; PDF, pelvic floor dysfunction

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548 **Table 4: Help sought from health professional and treatment offered by PFD in each**
549 **subsection for those who scored on the APFQ.**

	Total n=173	Bladder dysfunction n=103	Bowel dysfunction n=65	POP n=36	Sexual dysfunction n=7
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551 Abbreviations: APFQ, Australian pelvic floor questionnaire; POP, pelvic organ prolapse; n,
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Treating professional:	n (%)	n (%)	n (%)	n (%)	n (%)
Female GP	102 (59.0)	65 (63.1)	44 (67.7)	20 (55.6)	5 (71.4)
Male GP	53 (30.6)	33 (32.0)	27 (41.5)	9 (25.0)	2 (28.6)
Gynaecologist	63 (36.4)	41 (39.8)	18 (27.7)	24 (66.7)	2 (28.6)
Urologist	28 (16.7)	26 (25.2)	13 (20.0)	4 (11.1)	-
Urogynaecologist	16 (9.2)	12 (11.7)	7 (10.8)	6 (16.7)	-
Colorectal surgeon	-	11 (10.7)	20 (30.8)	1 (2.8)	1 (14.3)
Continence and Women's Health Physiotherapist	23 (13.2)	21 (8.3)	8 (12.3)	12 (33.3)	1 (14.3)
Other Physiotherapist	50 (28.8)	30 (29.1)	41 (62.3)	12 (33.3)	15 (21.4)
Continence Nurse	37 (21.3)	16 (15.5)	3 (4.6)	3 (8.3)	1 (14.3)
Gastroenterologist	32 (18.4)	31 (12.3)	30 (10.3)	9 (16.7)	-
Other	23 (13.2)	3 (2.8)	7 (10.8)	10 (27.8)	8 (11.4)
Afraid to discover serious problem offered:	5 (2.9)	5 (2.0)	5 (1.7)	3 (5.6)	1 (1.0)
Did not know if treatment available	7 (4.1)	57 (55.3)	39 (60.0)	15 (41.7)	2 (28.6)
Medications	-	44 (42.7)	34 (52.3)	5 (13.9)	8 (42.9)
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)

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562 **Table 5: Barriers for those who reported experiencing PFD symptoms but did not seek**
563 **help**

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565 Abbreviations: POP, pelvic organ prolapse

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Appointment scheduling	3 (1.8)	1 (0.4)	1 (0.3)	1 (1.9)	1 (1.0)
Wait too long at appointment	3 (2.3)	2 (0.8)	2 (0.7)	1 (1.9)	-
Clinic hours are limited	4 (1.2)	2 (0.8)	3 (1.0)	4 (7.4)	1 (1.0)
Too expensive	5 (2.4)	2 (0.8)	3 (1.0)	1 (1.9)	2 (2.0)
No transport	3 (1.2)	2 (0.8)	3 (1.0)	-	1 (1.0)
Do not have a healthcare professional for this condition	2 (1.2)	2 (0.8)	1 (0.3)	-	1 (1.0)
My healthcare professional not interested	2(1.2)	1 (0.4)	-	1 (1.9)	1 (1.0)
My healthcare professional does not explain	-	-	-	-	-
Afraid of healthcare professional	1 (0.5)	-	-	1 (1.9)	-
Do not like examinations/questions	6 (3.5)	6 (2.4)	6 (2.1)	3 (5.6)	-

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574 **Table 6: Drivers for seeking help for those who reported experiencing PFD symptoms**

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

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