



## Women's Health Strategy: Call for Evidence

The Pelvic Partnership is a national charity offering support and information about pregnancy-related pelvic girdle pain (PGP) to women with PGP, their families and carers. This painful and debilitating condition can affect around one in five women<sup>1</sup> during pregnancy and postnatally for months or even years, leading to physical immobility, including difficulty walking, and associated mental health impacts.

We work with women and healthcare professionals to raise awareness that PGP is a biomechanical joint problem which can be safely and effectively treated with manual therapy during or after pregnancy, and we support a timely, individualised and multidisciplinary approach to assessment and treatment, coordinated with mental health support as required.

Through our volunteer helpline and Facebook support group for women with PGP, we hear directly from women about their experiences of PGP, in engaging with healthcare professionals and accessing treatment. To develop our response to the call for evidence, we surveyed women with PGP<sup>2</sup> to ask their views on access to healthcare to supplement the results of an earlier survey we undertook in June 2018<sup>3</sup>. Please note we were unsure how our written response would be analysed and therefore there is some repetition in our responses as many elements applied to more than one of your core themes.

We have developed recommendations of ways that the healthcare system can be more responsive to the needs of women with PGP, improve their care and outcomes, and reduce costs to the NHS.

The recommendations were based on the results from March 2021 survey and include quotes in italics and focus on increasing awareness, better identification and early intervention, reducing inequalities in access to care and investment in better evidence about the physical, mental and economic impacts of PGP. We propose:

1. all women with symptoms of PGP to be able to self-refer to NHS physiotherapy services, which should include provision of hands-on manual therapy in all trusts and hospitals country wide.
2. wider training and information sharing among relevant healthcare professionals to include:
  - understanding of the symptoms of PGP,
  - how it can be safely and effectively treated with hands-on manual therapy,
  - how to look out for signs of PGP during pregnancy and postnatally,
  - how to refer for manual therapy and/or additional mental health support, or support women to self-refer for treatment, and
  - how to signpost to available information and support services, e.g. to the Pelvic Partnership, perinatal mental health services, consultant midwives.
3. resourcing of NHS physiotherapy services to ensure each woman referred can have a timely individualised assessment and an individualised treatment plan, including manual therapy and rehabilitative exercises.
4. investment in community awareness of PGP and how it can be treated, so that women are better

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<sup>1</sup> Albert H., Godsken M., Westergaard K., (2001) Prognosis in four syndromes of pregnancy-related pelvic pain. Acta Obstet Gynecol Scand 80:505-510: <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1034/j.1600-0412.2001.080006505.x>

<sup>2</sup> Access to healthcare survey, March 2021: In total we had 53 responses, 60% had experienced PGP for less than 12 months. Summary of data available here: <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>3</sup> PGP survey, June 2018: In total we had over 360 responses, including women with current or previous experience of PGP. Summary of data available here: <https://pelvicpartnership.org.uk/womens-health-strategy/>

informed about their condition and their treatment options, e.g. signposting to NHS physiotherapy services and to the Pelvic Partnership.

5. resourcing of primary healthcare professionals to assess for PGP at the booking appointment, during pregnancy and at the six-week postnatal check and to refer for further treatment as needed, including manual therapy and mental health support
6. a study to be undertaken in the UK to quantify the number of lost working days due to PGP to gather economic evidence supporting investment in manual therapy treatment early after symptom onset
7. development of information around best practice to support women with PGP in the workplace, and concessions available for employers to provide this support to keep women with PGP in work
8. greater research involving women with PGP, with a particular focus on:
  - investigating the efficacy of hands-on manual therapy vs exercise and advice only on PGP
  - investigating the effectiveness, rationale for and frequency of women with PGP being offered an induction or early caesarean birth for PGP, and whether and in what circumstances this benefits women (noting that PGP can continue for months or years postnatally)
  - comparing the clinical and cost effectiveness of these interventions (induction or early caesarean birth) with early intervention with manual therapy to prevent deterioration.
9. NHS to fund private manual therapy treatment to address the current backlog in referrals for NHS physiotherapy since the start of the pandemic (in the same way that surgery is being offered to clear waiting lists)
10. prioritised investment in maternal mental health support for women who have been pregnant during the pandemic, especially women with PGP, given the high coincidence of women with reported mental health issues and PGP

## **Core Theme 1: Placing women's voices at the centre of their health and care**

PGP is a common condition, affecting around one in five pregnant women<sup>4</sup> and can continue for months or years postnatally. Despite it being a frequently associated consequence of pregnancy for a high number of women each year, very little is known about PGP by women contemplating pregnancy, in the wider population and importantly, among healthcare practitioners.

A major concern among women with PGP is that their symptoms are being ignored by healthcare practitioners. In our 2018 survey of over 360 women with PGP<sup>5</sup>, 43% of women felt they weren't taken seriously when they developed PGP symptoms and discussed these with a healthcare professional.

*"Getting any help with PGP on the NHS was impossible! I was told oh put up with it and it will go once baby is here! I had it from 16 weeks. Without the Pelvic Partnership I would have been so lost as I would not have known who to go to!"<sup>6</sup>*

Women are researching the condition themselves and even self-diagnosing (36%<sup>7</sup>) and therefore having to access treatment independently of the NHS because they are not being offered appropriate care and support by the NHS clinicians.

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<sup>4</sup> Albert H., Godsken M., Westergaard K., (2001) Prognosis in four syndromes of pregnancy-related pelvic pain. Acta Obstet Gynecol Scand 80:505-510: <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1034/j.1600-0412.2001.080006505.x>

<sup>5</sup> Pelvic Partnership survey June 2018, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>6</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>7</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

Many women with PGP report difficult conversations with primary healthcare professionals, especially GPs and midwives, who aren't familiar with the condition, dismiss symptoms of PGP or give incorrect and out of date information, which can mislead women to think PGP is not treatable.

We also frequently hear reports of women with PGP not being referred for NHS physiotherapy by their GPs or midwives, which serves to mask the level of unmet need. Common reasons include:

- misunderstanding about treatment and referral options;
- PGP being dismissed as a normal part of pregnancy;
- the waiting list is too long;
- the woman is advised to wait and see if it gets better without treatment;
- the woman is told it is too late in their pregnancy and they will have given birth by the time they reach the top of the waiting list; and
- not to worry as the baby is going to be born soon.

The latter is based on a belief that PGP will resolve itself after birth, which is not the case for most women.

*"I think women who complain of the pain are sometimes just told that it's normal in pregnancy. I think at the first sign of PGP a physio referral should be sent."*<sup>8</sup>

*"I was on crutches at the end of my pregnancy due to PGP and was told it would get better after birth. I struggled to get access to physio through the NHS [...] I'm 10 weeks postpartum and the pain is still there impacting my sleep and my ability to walk very far."*<sup>9</sup>

*"Starting with the fact that as soon as you mention it the response is 'ah it is just one of those pregnancy things - we can't do anything about it I'm afraid. It'll just get worse'. Mentally it's the worst thing you can hear when you're already struggling with it both mentally and physically. No one took the time to discuss it with me further or suggest anything to help."*<sup>10</sup>

As a result, women are needlessly staying in pain, relying on pain medication to manage their pain and in some cases seeking early induction or caesarean birth. Please see testimonials in our appendices to hear directly from women with PGP on this issue.

This concept, increasingly referred to as "medical gaslighting" not only severely affects the women's physical health, resulting in increasing pain and immobility, as well as on their mental health because symptoms are being ignored, but can also, longer term, impact on women's capacity and willingness to trust and engage with the healthcare system and ask for treatment. The past 18 months have highlighted the continuing importance of fostering trust and engagement between the healthcare system and the people who use it.

Those women who are fortunate enough to be referred to NHS physiotherapy services are increasingly not seen face-to-face, not receiving a hands-on assessment to correctly diagnose PGP and not receiving hands-on manual therapy to treat the PGP. Women report being sent to group exercise classes (sometimes now online), being provided with generic exercise sheets and/or provided with a support belt<sup>11</sup>. We recognise that exercises and support belts can offer some relief alongside manual therapy and as part of a broader treatment plan, but without manual therapy, exercises and support belts are unlikely to treat the cause of the pain.

*"The NHS told me no manual therapy unless extremely severe but would do video calls and I just thought it was unbelievable because I needed manual therapy so badly. I was considered moderate to severe in that I didn't need crutches but I was in a huge amount of pain at all times of day and I was*

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<sup>8</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>9</sup> Comment provided to the Pelvic Partnership April 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>10</sup> Comment provided to the Pelvic Partnership April 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>11</sup> Pelvic Partnership survey June 2018, <https://pelvicpartnership.org.uk/womens-health-strategy/>

*emotionally really upset by it all.*"<sup>12</sup>

As a consequence, those who can afford it seek private treatment, and those who cannot remain incapacitated.

Interestingly, we have heard from a minority of women (10%<sup>13</sup>) who have been given manual therapy on the NHS, but often this is only when they have asked for it or pushed for it. This leads to an inequality of access between those who have the information and confidence to push back and make their voices heard and those who do not.

*"I had to fight for over a year to get manual therapy on the NHS - when I finally got it, I was allowed 9 sessions. I think putting pressure on NHS to provide MT for PGP, reminding them that even though the NICE guidelines are guidelines they highlight best practice, which shouldn't be ignored. The negative affect PGP has had on myself and my family could have been reduced if they'd followed the guidance."*<sup>14</sup>

**As a result of our engagement with women with PGP seeking NHS treatment, we propose:**

- **all women with symptoms of PGP to be able to self-refer to NHS physiotherapy services, which should include provision of hands-on manual therapy in all trusts and hospitals country wide.**
- **wider training and information sharing among relevant healthcare professionals to include:**
  - **understanding the symptoms of PGP,**
  - **how it can be safely and effectively treated with hands-on manual therapy,**
  - **how to look out for signs of PGP during pregnancy and postnatally,**
  - **how to refer for manual therapy and/or additional mental health support, or support women to self-refer for treatment, and**
  - **how to signpost to available information and support services, e.g. to the Pelvic Partnership, perinatal mental health services, consultant midwives.**

## **Core Theme 2: Improving the quality and accessibility of information and education on women's health**

We find there is a concerning lack of awareness of PGP in the wider community despite it impacting around 1 in 5 women during pregnancy and postnatally<sup>15</sup>. PGP is a severe and painful condition, often felt most when getting in and out of bed, climbing the stairs, walking or standing for long periods of time. As well as this severe and persistent pain, PGP often can often leave women immobile with many also experiencing associated mental health problems.

*"I was in incredible pain and as this is my first pregnancy (will be my last too) I didn't know what to expect. I asked my midwife at 20 weeks and she said "what do you expect, you're pregnant"."*<sup>16</sup>

The lack of awareness and understanding by healthcare professionals is particularly damaging when primary healthcare professionals, e.g. GPs and midwives, are not fully aware of PGP, its symptoms and potential severity, and the fact that it can continue post birth. Women are given incorrect information that PGP is caused by hormones, rather than being a biomechanical joint dysfunction which can be treated. Women are also frequently told that PGP will go away after the birth, and when it does not they are often left without treatment and feeling hopeless. It is difficult to estimate accurately how many women

<sup>12</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>13</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>14</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>15</sup> Albert H., Godsken M., Westergaard K., (2001) Prognosis in four syndromes of pregnancy-related pelvic pain. Acta Obstet Gynecol Scand 80:505-510: <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1034/j.1600-0412.2001.080006505.x>

<sup>16</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

experience PGP postnatally but our 2018 survey showed over 50% continued to experience symptoms after they gave birth.

*"When I mentioned my ongoing PGP to my GP at the 6 week check she told me to come back if it was still bad in 6 months... because it's "normal". Better education for GPs needed!"<sup>17</sup>*

Women report that healthcare professionals are also unaware of the benefits of referring women to NHS physiotherapy services or signposting to private manual therapists to safely and effectively treat the cause of their pain during pregnancy or postnatally. Evidence underlines the benefits of early intervention in assessing and treating PGP with hands-on manual therapy<sup>18</sup>.

*"Somehow educating healthcare professionals about the importance of being given manual therapy asap as everyone I saw (midwife, GP and NHS physio) said there was nothing that would help me and that it would go away after pregnancy. No manual therapy offered by any of them at any point."<sup>19</sup>*

Information on PGP and how it can be safely and effectively treated is not available equally to all women, because provision is limited on the NHS. Frequently it is only those women who have researched the condition and have the information and confidence to push for treatment who receive it on the NHS. Our survey showed that most women (90%<sup>20</sup>) who receive manual therapy treatment do so privately. Needless to say, this is not affordable for many women, especially those from groups traditionally underrepresented in healthcare. As such, we are particularly concerned about the potential impact on women from these groups who may not have the information or confidence to have these difficult conversations, who are less able to research the condition and available treatment options, less able to push for manual therapy and less able to pay for private treatment.

Unfortunately, the result is that women with PGP are left to manage the pain themselves, risking further physical and mental health impact during pregnancy and postnatally.

*"Improve awareness and knowledge - easier said than done but more funding is key. You kept me pregnant and surviving by having a local recommended private practitioner on your website, thank you."<sup>21</sup>*

*"It would be great if midwives were all educated in the severity of PGP and were able to direct women to your website."<sup>22</sup>*

Despite broad awareness of potential issues with pelvic floor during and after pregnancy, PGP can often be another surprising side effect of pregnancy for women and that in itself can foster feelings of disappointment and frustration, potential precursors to maternal mental health problems. Furthermore, the persistent myth that PGP will cease once the baby is born can exacerbate feelings of frustrating and disappointment postnatally (see below).

Maternal mental health problems are increasingly common both during pregnancy and postnatally. According to our survey from 2018<sup>23</sup>, two thirds of women with PGP also experienced a mental health problem during pregnancy or postnatally, as severe pain, physical immobility and isolation can understandably lead to feelings of anxiety and depression for some women. Our recent 2021 recent survey

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<sup>17</sup> Comment provided to the Pelvic Partnership April 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>18</sup> Clinical Practice Guideline, Management of Pelvic Girdle Pain in Pregnancy and Postpartum, 2014, Chartered Physiotherapists Women's Health and Continence and Directorate of Strategy and Clinical Programmes Health Service Executive: <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/management-of-pelvic-girdle-pain-in-pregnancy-and-post-partum.pdf>

<sup>19</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>20</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>21</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>22</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>23</sup> Pelvic Partnership survey June 2018, <https://pelvicpartnership.org.uk/womens-health-strategy/>

of women with PGP showed that 81% of respondents<sup>24</sup> had experienced a mental health problem during pregnancy or postnatally and 98% of these women listed PGP as one of the causes.

*“I don’t think NHS offers enough support to those with PGP and that the mental health impact is understood. It took such a toll on me last time.”<sup>25</sup>*

**As a result of our engagement with women with PGP seeking NHS treatment we propose:**

- **all women with symptoms of PGP to be able to self-refer to NHS physiotherapy services, which should include provision of hands-on manual therapy in all trusts and hospitals country wide to avoid the current postcode lottery.**
- **wider training and information sharing among relevant healthcare professionals to include:**
  - **understanding the symptoms of PGP,**
  - **how it can be safely and effectively treated with hands-on manual therapy,**
  - **how to look out for signs of PGP during pregnancy and postnatally,**
  - **how to refer for manual therapy and/or additional mental health support, or support women to self-refer for treatment, and**
  - **how to signpost to available information and support services, e.g. to the Pelvic Partnership, perinatal mental health services, consultant midwives.**

### **Core Theme 3: Ensuring the health and care system understands and is responsive to women’s health and care needs across the life course**

Unfortunately, women report that NHS provision of manual therapy in some parts of the UK is lacking, with 90% of respondents to our survey<sup>26</sup> not having been offered manual therapy on the NHS.

Instead of receiving an individual assessment and then hands-on manual therapy, women may be invited to a group exercise class, irrespective of the severity of their condition. At these sessions, women report they are given advice, exercises and a support belt only, which are unlikely to treat the cause of the pain without being used in conjunction with manual therapy. PGP can present very differently so an individualised approach including manual therapy is needed for each woman. During COVID-19 this has been reduced still further to simple phone calls with advice and no face-to-face contact.

While we understand a small minority of women with PGP have been able to access manual therapy on the NHS by asking/pushing for it, the majority of women unable to do this may be left without appropriate treatment. For many women, their symptoms will persist; we receive constant enquiries from women who have not recovered from their symptoms weeks, months or years postnatally and who are trying to access treatment and information.

As a result, to be able to access manual therapy, women are increasingly required to pay for manual therapy from a private physiotherapist, osteopath or chiropractor. At an average of £50-80 per appointment, this is a significant barrier to treatment for many women. Many women reach out to us expressing frustrating and worry that the only reliable treatment for their PGP is out of reach due to their finances.

*“The NHS told me no manual therapy unless extremely severe but would do video calls and I just thought it was unbelievable because I needed manual therapy so badly. I was considered moderate to severe in that I didn’t need crutches but I was in a huge amount of pain at all times of day and I was emotionally really upset by it all. Luckily I could afford to get in private but only was able to even book that by 30 weeks, a full 10 weeks after I was first in pain. After four treatments it is pretty much gone which is such a shame that I didn’t have it sooner. I am so sad for women who cannot afford what I had*

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<sup>24</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>25</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>26</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

*and the NHS and midwives need to realise that belts exercise and pain killers are not the answer.* <sup>27</sup>

We are very concerned about the widening gap in the physical and mental health outcomes between those able to pay for treatment and those unable to pay.

*“I understand NHS physios face limitations but I think it’s terrible that getting support depends on if you can afford to go private.”*<sup>28</sup>

In particular, we are concerned about the potential impact on women from disadvantaged backgrounds who may not have the information and confidence to have these difficult conversations, research the condition and available treatment options and push for manual therapy, and may be unable to pay for private treatment. Furthermore, reports about the inequality of access to healthcare from some communities, especially Black and minority ethnic communities (BAME) indicates a further social disadvantage aspect to accessing treatment.

*“Women from ethnic minorities are voicing their concerns that they face endemic structural racism when seeking and accessing healthcare, and they feel that their symptoms and signs are more often dismissed.”*<sup>29</sup>

As explored in earlier sections, it is important for healthcare professionals to be fully informed about the symptoms of PGP, how it can present during pregnancy and postnatally, relevant referral pathways for manual therapy treatment and the associated mental health impacts. Rather than relying on women to fight for their treatment in isolation, we would strongly encourage healthcare professionals to focus on assessing for PGP at different intervention points, e.g. at the booking appointment during pregnancy and at the six week postnatal check, and refer for further treatment as needed including manual therapy and mental health support.

**As a result of our engagement with women with PGP seeking NHS treatment, we propose:**

- **resourcing of NHS physiotherapy services to ensure each woman referred can have a timely individualised assessment and an individualised treatment plan, including manual therapy and rehabilitative exercises**
- **investment in community awareness of PGP and how it can be treated, so that women are better informed about their condition and their treatment options, e.g. signposting to NHS physiotherapy services and the Pelvic Partnership**
- **resourcing of primary healthcare professionals to assess for PGP at the booking appointment, during pregnancy and at the six-week postnatal check and to refer for further treatment as needed, including manual therapy and mental health support.**

#### **Core Theme 4: Maximising women’s health in the workplace**

As outlined above, women with PGP are often in severe pain, are physically immobile and may be experiencing associated mental health problems during their pregnancy and after their baby is born.

In some cases, women are unable to continue working for the full term of their pregnancy, and have difficulty returning to work postnatally as planned, especially in more mobile and active roles where they

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<sup>27</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>28</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>29</sup> Lokugamage, A, Meredith, A. Women from ethnic minorities face endemic structural racism when seeking and accessing healthcare. The BMJ Opinion. <https://blogs.bmj.com/bmj/2020/03/05/women-from-ethnic-minorities-face-endemic-structural-racism-when-seeking-and-accessing-healthcare>

need to be on their feet all day. In many cases, employment that requires staff to be active and on their feet includes teaching, childcare, retail and hospitality, where the average income is much lower than more professional occupations where you are more likely to sit in an office or work from home. A recent study describes PGP as a major public health issue due to the “negative effects on activities of daily living” and because it causes long sick leave; indeed the study reports “PGP accounts for 37-72% of sick leave in pregnancy”, lasting 12-15 weeks on average<sup>30</sup>.

For women who work in the home with family responsibilities, PGP can also impact on their capacity to look after their children and may require additional support from family, friends or financial support through government benefits.

Women report finding it difficult to explain PGP to employers and accessing mechanisms to support them to stay at work, such as flexible working conditions, an ergonomic assessment, support from an occupational therapist or a phased return to work postnatally. We recognise that support for employers may be required to keep women in work as long as possible during pregnancy and enable them to return to work as planned once they have had their baby.

There is a broader economic cost downstream from delaying diagnosis and treatment from PGP, aside from the health and wellbeing of the woman. All this underlines the importance of early intervention assessment and treatment for PGP<sup>31</sup>, which can reduce the risk of PGP being exacerbated, reducing the likelihood of severe pain and immobility, and in turn reducing the likelihood of lost work days and slower recovery and return to work.

**As a result of our engagement with women with PGP seeking NHS treatment, we propose:**

- **a study be undertaken in the to quantify the number of lost work days due to PGP to gather economic evidence supporting investment in manual therapy early after symptom onset**
- **development of information around best practice to support women with PGP in the workplace, and concessions available for employers to provide this support to keep women with PGP in work**

## **Core Theme 5: Ensuring research, evidence and data support improvements in women’s health**

We welcome Secretary of State Hancock’s position regarding the lack of Randomised Controlled Trials (RCTs) and studies involving pregnant and postnatal women. The limited number of RCTs and studies leads to too many women not receiving best practice in treatment and risks women’s symptoms and experiences being overlooked or ignored. In particular, we consider there is a lack of scientific evidence relating to PGP, how it can be treated and how it can affect the woman’s likelihood of an induction or caesarean birth.

An important example for women with PGP was noted in the recent draft of the National Institute for Health and Care Excellence’s (NICE) Antenatal guideline<sup>32</sup>; while pelvic girdle pain was included in the guideline, recommended treatment was only a belt and exercises, which is not best practice in treatment according to various professional guidelines<sup>33</sup>. In the project’s evidence review<sup>34</sup>, it noted that while manual therapy was

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<sup>30</sup> Malmqvist, S. et al (2015) The association between pelvic girdle pain and sick leave during pregnancy; a retrospective study of a Norwegian population. BMC Pregnancy Childbirth 15:237 <https://pubmed.ncbi.nlm.nih.gov/26437972/>

<sup>31</sup> Clinical Practice Guideline, Management of Pelvic Girdle Pain in Pregnancy and Postpartum, 2014, Chartered Physiotherapists Women’s Health and Continence and Directorate of Strategy and Clinical Programmes Health Service Executive: <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/management-of-pelvic-girdle-pain-in-pregnancy-and-post-partum.pdf>

<sup>32</sup> NICE Guideline, Antenatal care, in development: <https://www.nice.org.uk/guidance/indevelopment/gid-ng10096>

<sup>33</sup> Pelvic, Obstetric & Gynaecological Physiotherapy, 2015, Pregnancy-related Pelvic Girdle Pain for Health Professionals: <https://pogp.csp.org.uk/publications/pregnancy-related-pelvic-girdle-pain-pgp-health-professionals>

<sup>34</sup> NICE Guideline, Antenatal care Evidence review U Management of pelvic girdle pain in pregnancy: <https://www.nice.org.uk/guidance/gid-ng10096/documents/evidence-review-12>



accepted as one of the recommended treatments, there were insufficient studies and RCT data to support this being included.

Members of our Facebook support group have also increasingly reported being offered an induction or early caesarean birth due to their PGP. Given that there is no guarantee that PGP symptoms will stop after the women have given birth<sup>35</sup>, we consider the rationale for, frequency of and perceived benefits of this approach require further examination. The cost of this additional intervention compared to a few sessions of manual therapy is significant.

**As a result of our engagement with women with PGP seeking NHS treatment, we propose:**

- **research involving women with PGP, with a particular focus on:**
  - **investigating the efficacy of hands-on manual therapy vs exercise and advice only on PGP**
  - **investigating the effectiveness, rationale for and frequency of women with PGP being offered an induction or early caesarean birth for PGP, and whether and in what circumstances this benefits women (noting that PGP can continue postnatally)**
  - **comparing the clinical and cost-effectiveness of these interventions (induction and caesarean birth) with early intervention with manual therapy to prevent deterioration.**

## **Core Theme 6: Understanding and responding to the impacts of COVID-19 on women's health**

At the start of the COVID-19 pandemic, all NHS and private face-to-face manual therapy was stopped so women with PGP could no longer access treatment for PGP. At a time when women were carrying the majority of the workload at home, with unprecedented childcare and homeschooling demands and working from home, the lack of treatment for women with PGP exacerbated an already difficult situation both in terms of physical and mental ill health.

Later in the year as restrictions were eased, private practitioners could resume offering face-to-face appointments as necessary, as their work was deemed an essential medical service. However, due to the demands on the NHS from COVID-19, face-to-face NHS physiotherapy services have still not resumed in many areas of the UK and where appointments have resumed, there is a significant backlog.

*"The NHS told me no manual therapy unless extremely severe but would do video calls and I just thought it was unbelievable because I needed manual therapy so badly. I was considered moderate to severe in that I didn't need crutches but I was in a huge amount of pain at all times of day and I was emotionally really upset by it all."<sup>36</sup>*

Therefore, to be able to access manual therapy, women are increasingly required to pay for private manual therapy from a private physiotherapist, osteopath or chiropractor. At an average of £50-80 per appointment, this is a significant barrier to treatment for many women. Many women reach out to us expressing frustration and worry that the only reliable treatment for their PGP is out of reach due to their finances. Indeed, 85% of the women in our survey<sup>37</sup> who hadn't had private manual therapy cited affordability as the reason.

As such, women who have the capacity to pay for private treatment have been able to seek some relief from the pain and treat the cause of their PGP, while women who are unable to pay for private treatment are left without a solution, leading to wider socioeconomic impacts (the women can't work and need extra childcare or financial support), downstream health impacts (more likely to have an instrumented birth,

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<sup>35</sup> In our June 2018 survey, more than 50% of respondents continued to experience PGP postnatally.

<https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>36</sup> Comment provided to the Pelvic Partnership Access to healthcare survey March 2021,

<https://pelvicpartnership.org.uk/womens-health-strategy/>

<sup>37</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>

ongoing physical health impacts) and ongoing mental health impacts.

As we noted above, we are very concerned about the widening gap in the physical and mental health outcomes between those able to pay for treatment and those unable to pay. Given the current backlog, we can't see this situation changing unless urgent action is taken. We call upon the government to pay for private manual therapy for the most severe cases to ensure that women in severe pain can get relief as soon as possible.

With regards to maternal mental health, a broad range of research has been published recently, underlining the current crisis for pregnant women and new parents<sup>38</sup>, but we consider the specific experience of women with PGP also needs to be considered. Demand for our support services have more than doubled in this period, as women are becoming increasingly desperate for support and relief from their pain. With 81% of respondents to our survey<sup>39</sup> reporting a mental health problem during or after their pregnancy, this is clearly a very pressing concern.

It is worth noting, however, that the move to more flexible working and use of technology for meetings and appointments has been a positive step for many women with PGP who may be physically immobile with family responsibilities.

**As a result of our engagement with women with PGP seeking NHS treatment, we propose:**

- **resourcing of NHS physiotherapy services to ensure each woman referred can have a timely hands-on assessment and an individualised treatment plan, including manual therapy as early as possible**
- **NHS to fund private manual therapy to address the current backlog in referrals for NHS physiotherapy since the start of the pandemic**
- **prioritised investment in maternal mental health supports for women who have been pregnant during the pandemic, especially women with PGP, given the high coincidence of women with reported mental health issues and PGP**

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<sup>38</sup> In particular, the Maternal Mental Health Alliance and Centre for Mental Health's report, Maternal mental health during a pandemic: A rapid evidence review of COVID-19's impact (2021) <https://maternalmentalhealthalliance.org/mmhpdemic/> and the recent debate in the House of Commons on Maternal mental health led by Sarah Olney MP: <https://hansard.parliament.uk/commons/2021-03-10/debates/EF641F3F-77B9-4FA6-B3E7-709CE4F66E71/MaternalMentalHealth>

<sup>39</sup> Pelvic Partnership Access to healthcare survey March 2021, <https://pelvicpartnership.org.uk/womens-health-strategy/>