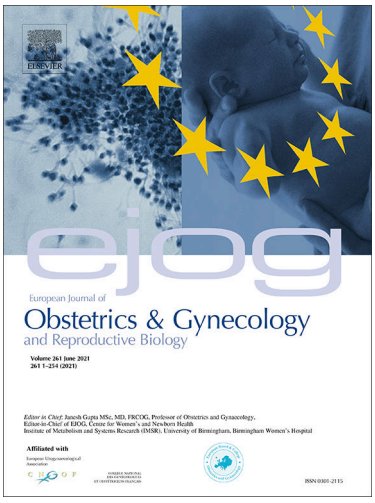
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Full length article

Are we doing enough for antenatal pelvic floor health? A cross-sectional survey of postpartum women's experiences of symptom enquiry, education and preventive care

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Are We Doing Enough for Antenatal Pelvic Floor Health? A Cross-Sectional Survey of Postpartum Women's Experiences of Symptom Enquiry, Education and Preventive Care

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Abstract

Are We Doing Enough for Antenatal Pelvic Floor Health? A Cross-Sectional Survey of Postpartum Women's Experiences of Symptom Enquiry, Education and Preventive Care

Objectives: Pelvic floor dysfunction (PFD) is common during and after pregnancy, yet symptoms are frequently normalised and opportunities for prevention may be missed. This study evaluated PFD risk factors, antenatal symptom screening, and access to pelvic health information and support.

Study Design: A cross-sectional survey was conducted among postpartum women at a tertiary maternity hospital in South London, United Kingdom. Questionnaire responses were analysed alongside electronic health records. Free-text responses were evaluated using inductive content analysis.

Results: Of 139 women approached, 124 completed the questionnaire (response rate 89.2%). The median age was 33 years. At least one recognised PFD risk factor was present in 115 women (92.7%), and 84 (67.7%) had two or more. The most prevalent risk factors were age >30 (62.9%), body mass index >25kg/m^2 (48.4%), multiparity (27.4%) and constipation (12.9%). Forty-eight women (38.7%) reported no antenatal screening for PFD symptoms. Reported screening rates were 58.1% for urinary symptoms, 35.5% for bowel symptoms, 20.2% for sexual symptoms and 16.9% for prolapse symptoms. Pelvic floor health was discussed with 68.5%; however, 41.9% were not advised to perform pelvic floor muscle exercises (PFME) and only 19.4% received practical instruction. Of eight women who reported PFD symptoms to a healthcare professional during pregnancy, four (50.0%) were referred for specialist pelvic health support.

Conclusions: Despite a high prevalence of recognised PFD risk factors, 38.7% of women reported no antenatal PFD symptom enquiry, and only 19.4% received practical PFME instruction. These findings highlight opportunities to improve the consistency of antenatal pelvic floor care through routine symptom enquiry, preventative education and targeted specialist support, in accordance with national recommendations.

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Keywords: antenatal care, pelvic floor dysfunction, pelvic floor muscle exercises, pregnancy, prevention, screening

1. INTRODUCTION

Pelvic floor dysfunction (PFD) encompasses a range of disorders arising from impaired pelvic floor function, including urinary incontinence, storage lower urinary tract symptoms, voiding dysfunction, pelvic organ prolapse, pelvic pain, as well as sexual and anorectal dysfunction [1].

Pregnancy and childbirth are important periods for the onset and progression of PFD. Approximately one in five women experience urinary and flatal incontinence at six months postpartum, while 2.8% report faecal incontinence [2, 3]. Maternal and obstetric factors such as advanced maternal age, elevated body mass index (BMI), multiparity, fetal macrosomia, operative vaginal delivery and obstetric anal sphincter injury, have been associated with an increased risk of PFD [4, 5].

PFD can adversely impact a woman's quality of life, emotional wellbeing, sexual function and social participation [6-9]. Urinary incontinence, for example, is associated with greater odds of depression and anxiety [10]. Among parous women in the United Kingdom, the lifetime risk of undergoing surgery for pelvic organ prolapse, urinary incontinence or faecal incontinence has been estimated at 12.2% by 80 years of age [11]. The economic burden is also substantial: urinary incontinence among women was estimated to account for €55.7 billion in costs across the European Union in 2023 [12].

There is growing consensus that pregnancy provides an important opportunity to prevent PFD, identify women at risk and initiate early intervention. The National Institute for Health and Care Excellence (NICE) recommends embedding PFD prevention within routine maternity care through universal education about symptoms and modifiable risk factors, promotion of pelvic floor muscle exercises (PFME) during pregnancy and after birth, and targeted supervised training for women at increased risk [13]. In England, Perinatal Pelvic Health Services were established to support implementation of these recommendations through multidisciplinary pathways extending from pregnancy to at least 12 months postpartum [14].

Despite these recommendations, PFD symptoms are often normalised or dismissed as inevitable consequences of pregnancy and childbirth [13]. A mixed-methods systematic review of 86 studies from high-income countries found that women commonly normalised PFD symptoms after childbirth and therefore did not seek care. Women also reported that their symptoms were trivialised or deprioritised by healthcare professionals, who often did not ask about them [15].

This study aimed to evaluate the prevalence of recognised PFD risk factors and postpartum women's reported experience of antenatal pelvic floor health care,

focusing on symptom screening, education, preventative advice, PFME support and access to specialist care. A secondary aim was to explore women's concerns and recommendations for improving antenatal pelvic floor health services.

2. MATERIALS AND METHODS

2.1. Study design and setting

A cross-sectional survey was conducted at a tertiary hospital in South London, with recruitment undertaken over 11 non-consecutive days between December 2024 to February 2025.

2.2. Participants

Women admitted to the postnatal ward following delivery were invited to complete a 10-item questionnaire retrospectively evaluating their experiences of antenatal pelvic floor health care (Supplementary Table 1). Women who had received antenatal care at another National Health Service trust were excluded. When a language barrier was identified, the questionnaire was administered with line-by-line interpretation provided by an approved professional interpreting service.

2.3. Questionnaire development and outcomes

A study-specific structured questionnaire was developed by two senior urogynaecology clinicians (A.T. and A.R.), informed by NICE guideline NG210 on the prevention and non-surgical management of PFD. It assessed women's reported antenatal experiences of:

i) screening for urinary, bowel, sexual and prolapse symptoms;
ii) timing of pelvic floor health discussions;
iii) provision of information on PFD symptoms, prevention and available local services;
iv) PFME advice and support;
v) counselling about the potential effects of different modes of birth on pelvic floor health; and
vi) access to specialist pelvic health services.

Free-text questions explored women's concerns about the effects of pregnancy and childbirth on their pelvic floor and invited recommendations for service improvement. The questionnaire was pilot-tested among 20 healthcare staff and patients to improve readability, clarity, and accessibility. Pilot participants were excluded from the final study sample.

Questionnaire responses were analysed alongside a retrospective review of electronic health records to identify documented antenatal discussions about pelvic floor health and the presence of recognised PFD risk factors. Risk factors were defined in accordance with NICE guideline NG210 and categorised as modifiable or non-modifiable, with the latter including pregnancy- and labour- related factors. Patient-reported experiences and clinical documentation were analysed separately, recognising that discussions may have occurred without being documented.

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2.4. Data analysis

Continuous data were summarised using the median, interquartile range (IQR) and range. Categorical data were presented as frequencies and percentages. For multiple-response questions, response categories were not mutually exclusive. Quantitative analyses were performed using Microsoft Excel, with data checked for completeness and consistency and calculations verified against the original datasheet. Exploratory post hoc univariable analyses were performed using Python to examine associations between maternal characteristics and reported PFD symptom enquiry using two-sided Fisher's exact tests. Absolute differences in proportions were calculated with 95% confidence intervals.

Free-text responses were analysed using inductive content analysis, consistent with the framework by Hsieh and Shannon [16]. One researcher (K.L.) coded responses sequentially, refining the coding framework iteratively. Coding uncertainties were resolved through discussion with A.T.

2.5. Ethical and governance considerations

The study was classified as a service evaluation and therefore did not require review by an National Health Service Research Ethics Committee.

3. RESULTS

3.1. Participant characteristics

Of the 139 women approached, three (2.2%) declined to participate and 12 (8.6%) did not complete the questionnaire because of fatigue or the demands of caring for their newborn. This yielded 124 complete responses and a response rate of 89.2%.

The median age of respondents was 33 years (IQR 30-37; range 14-45). The largest ethnic groups were White or White British (58/124, 46.8%), Black or Black British (34/124, 27.4%) and Asian or Asian British (16/124, 12.9%). Thirty-four women (27.4%) were multiparous.

3.2. Risk factors for pelvic floor dysfunction

Overall, 115 women (92.7%) had at least one recognised modifiable or non-modifiable PFD risk factor, and 84 (67.7%) had two or more. The most common modifiable risk factors were BMI >25 kg/m^2 (48.4%) and constipation (12.9%). Two women (1.6%) had pre-existing diabetes, and 29 (23.4%) had gestational diabetes. The most prevalent non-modifiable risk factors were maternal age >30 (62.9%), multiparity (27.4%), and a family history of urinary incontinence, overactive bladder or faecal incontinence (11.3%).

During their most recent labour and delivery, 30 women (24.2%) experienced at least one additional PFD risk factor. These included an active second stage of labour lasting >1 hour (18.5%), assisted vaginal birth (8.9%), and obstetric anal sphincter injury (1.6%) (Table 1).

3.3. Management of modifiable risk factors

Among women with BMI >25 kg/m^2, healthy diet and exercise were discussed with 48.3% and 53.3%, respectively. All seven current smokers were offered referral to a smoking cessation service. Of the 16 women reporting constipation, four (25.0%) were advised either to increase dietary fibre intake or to use over-the-counter laxatives.

3.4. Antenatal screening for pelvic floor dysfunction

All documented antenatal screening for PFD symptoms occurred in midwifery-led care; no routine PFD screening was documented during obstetrician-led antenatal consultations.

Urinary symptoms were the most frequently assessed domain (72/124, 58.1%), followed by bowel symptoms (44/124, 35.5%), sexual symptoms (25/124, 20.2%), and prolapse symptoms (21/124, 16.9%). Forty-eight women (38.7%) reported that they had not been screened for any PFD symptoms.

Exploratory univariable analyses identified no statistically significant associations between reported antenatal PFD symptom enquiry and maternal age >30 years, BMI >25 kg/m^{2,} gestational diabetes, constipation or smoking (Supplementary Table 2)

3.5. Pelvic floor health information and counselling

Pelvic floor health was discussed with 85 women (68.5%) during at least one trimester. Discussions were most frequently reported during the second trimester (44/124, 35.5%), followed by the third trimester (43/124, 34.7%) and first trimester (39/124, 31.5%). Thirty-nine women (31.5%) reported that pelvic floor health had not been discussed at any stage of pregnancy.

Thirty women (24.2%) recalled receiving information about PFD symptoms, while 32 (25.8%) recalled receiving general advice on PFD prevention. Forty-four women (35.5%) reported receiving information on how to access local services, including antenatal classes and support from the perinatal pelvic health midwife. Thirty-one women (25.0%) recalled a discussion about the potential effects of different modes of birth on pelvic floor health.

3.6. Pelvic floor muscle exercise advice and support

Seventy-two women (58.1%) were advised by a healthcare professional to perform PFME during pregnancy; 52 (41.9%) received no such advice. Only 24 (19.4%) were shown how to perform PFME during an antenatal appointment, and five (4.0%) were referred to a perinatal pelvic health midwife.

Other support included information leaflets (43/124, 34.7%), signposting to PFME applications such as Squeezy (32/124, 25.8%), and encouragement to attend virtual

pelvic health classes (24/124, 19.4%). Nine women (7.3%) independently consulted a private physiotherapist.

3.7. Management of pelvic floor dysfunction during pregnancy

Of eight women who reported urinary incontinence, anal incontinence or prolapse symptoms to a healthcare professional during pregnancy, four (50.0%) reported referral to a pelvic floor physiotherapist or perinatal pelvic health midwife.

3.8. Women's perceptions and concerns

Sixty-five women (52.4%) were concerned about the effects of pregnancy or childbirth on their pelvic floor. Among the 34 women who provided free-text responses of their specific concerns, urinary incontinence and bladder dysfunction were the most frequently identified theme (13/34, 38.2%), followed by other PFD symptoms (10/34, 29.4%) and the potential long-term effects of pregnancy or childbirth (9/34, 26.5%).

Responses also highlighted existing or previous pelvic floor symptoms, concerns arising from the experiences of family and friends, and uncertainty about the effects of pregnancy, mode of delivery and preventative measures (Table 2).

3.9. Recommendations for service improvement

Thirty-two women provided free-text recommendations for service improvement. The predominant theme was a need for more comprehensive, earlier and more consistent pelvic floor health counselling throughout pregnancy (22/32, 68.8%). Women also requested practical exercise resources and demonstrations, better access to personalised specialist pelvic floor assessment, and routine postnatal screening and follow up. Several reported relying on friends, family or external antenatal groups because pelvic floor health had not been prioritised in routine antenatal care (Table 3).

4. DISCUSSION

4.1. Principal findings

This study identified a substantial gap between national UK recommendations for perinatal pelvic health and women's reported experiences of routine antenatal care. Almost all women (92.7%) had at least one recognised risk factor for PFD, and more than two-thirds (67.7%) had multiple risk factors. Despite this, 38.7% reported no antenatal screening for PFD symptoms. Although 58.1% were advised to perform PFME, only 19.4% received practical instruction and only 4.0% were referred to the perinatal pelvic health service. These findings suggest that pelvic health care was not consistently embedded within the antenatal pathway.

4.2. Standardising antenatal screening

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Screening varied considerably across PFD domains. Urinary symptoms were assessed most frequently, whereas bowel, sexual and prolapse symptoms were assessed less often. Although the reasons were not examined, urinary symptoms may be more familiar to healthcare professionals, while other PFD symptoms may require more sensitive questioning or specialist knowledge. Professional education alone may not ensure consistent practice. In a German survey, most healthcare professionals demonstrated good knowledge of postpartum PFD, yet routine screening was not universal (79.8%) [17]. The validated International Consultation on Incontinence Questionnaire- Perinatal Pelvic Health Self-Assessment Questionnaire (ICIQ-PPHSAQ), which assesses for PFD risk factors and symptoms, is a welcome tool that could support systematic antenatal screening, reduce selective questioning and facilitate earlier identification and referral [18].

4.3. Universal pelvic floor muscle exercise education and barriers to delivery

The high prevalence of PFD risk factors in this cohort underscores the importance of antenatal pelvic floor education. In accordance with national guidance, all pregnant women should receive information on PFD symptoms, preventative strategies and available local services, alongside PFME advice and access to practical instruction. Additional interventions, including supervised pelvic floor muscle training, should be guided by individual symptoms and clinical indications. Women should also receive balanced, individualised counselling regarding the potential effects of pregnancy and different modes of birth on pelvic floor health.

Practical PFME instruction is important because structured pelvic floor muscle training during pregnancy and the postpartum period can reduce the risk of urinary incontinence [19]. Effective PFME support extends beyond simply advising women to perform the exercises; it requires clear instruction, confirmation of correct technique, appropriate progression, and support with adherence. In a prospective observational study, 57% of women assessed in the early postpartum period demonstrated incorrect technique, including straining, breath-holding and inappropriate recruitment of accessory muscles such as the gluteal muscles [20]. Where clinically indicated, digital vaginal examination may be offered by appropriately trained practitioners, with informed consent and consideration of patient preferences, to assess pelvic floor muscle function and inform guided PFME instruction. [21, 22].

The observed variation in pelvic health education may reflect implementation barriers rather than an absence of guidance. The UK APPEAL programme identified limited training, insufficient confidence, competing clinical priorities, time constrains, language barriers, and the absence of prompts in electronic maternity records as barriers to effective PFME support by midwives. Training delivered through APPEAL improved midwives' confidence and increased women's reported receipt of practical PFME instruction [23].

When healthcare professionals are unable to provide this level of support because of time, training, or service constraints, women with PFD symptoms or increased risk should be referred to an appropriately trained practitioner such as a perinatal pelvic health midwife or pelvic health physiotherapist for supervised training and feedback.

Clear referral pathways should be established, and women should receive information about self-referral where available.

4.4. Postnatal reassessment and pelvic floor rehabilitation

Antenatal assessment alone is insufficient, as approximately one in four women surveyed experienced at least one intrapartum PFD risk factor. Structured postnatal reassessment, including the use of the ICIQ-PPHSAQ postnatal and symptom questionnaires, may identify newly acquired risk factors and postnatal PFD, facilitating timely follow-up and referral.

French national guidance provides an example of a structured postnatal rehabilitation model, offering 10 state-subsidised supervised sessions during the postpartum period [24].

4.5. Strengths and limitations

This study achieved a high response rate and included an ethnically diverse maternity population. Data collection during the immediate postpartum period shortened the recall interval, while review of electronic health records complemented patient-reported experiences with documented clinical information. Free-text responses also provided additional insights into women's experiences of antenatal pelvic floor care.

Several limitations should be acknowledged. First, recruitment at a single tertiary centre on 11 non-consecutive days may have introduced selection bias and limited generalisability to other UK maternity settings. Second, the study-specific questionnaire was pilot-tested but not formally validated, introducing potential measurement bias. Despite the relatively short recall interval, retrospective reporting remains susceptible to recall bias, and patient-reported experiences may not fully reflect the care delivered. Although the assessed risk factors were recognised in NICE guidance, their associations with individual PFDs vary, and their cumulative presence does not provide a valid measure of individual risk. The small number of women reporting PFD symptoms to healthcare professionals (n=8) limited conclusions regarding referral practices, while the optional free-text responses from approximately one-quarter of participants may not reflect the perspectives of the wider cohort. Finally, postnatal pelvic floor care was not evaluated, precluding assessment of subsequent symptom screening, preventative advice, specialist referral or treatment.

5. CONCLUSION

This single-centre survey of postpartum women at a tertiary maternity hospital in London identified that, despite a high prevalence of recognised PFD risk factors and substantial concern among women, antenatal pelvic floor screening, education and access to specialist support were inconsistent. Although many women were advised to perform pelvic floor muscle exercises, comparatively few received practical instruction or specialist support.

These findings suggest a potential gap between national pelvic health recommendations and women's reported experiences of antenatal care. Standardised and accessible counselling, practical PFME instruction, clear specialist referral pathways and structured postnatal follow up are needed to support earlier identification, prevention, and management of PFD across a woman's life course. Further multicentre studies are warranted to assess the generalisability of these findings and evaluate the effectiveness of proposed interventions in improving perinatal pelvic floor health outcomes.

Author contributions

Kar Yee Lor : study design, data collection, manuscript writing, manuscript editing

Angie Rantell: study design, manuscript writing

George Araklitis: manuscript editing

Annika Taithongchai: study design, data collection, manuscript editing

Dudley Robinson: manuscript editing

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Table 1: Prevalence and burden of pelvic floor dysfunction risk factors among surveyed women, based on NICE [NG210] guidance

Modifiable risk factors		Risk factor present, n/N	Percentage, %
	BMI >25 kg/m^2	60/124	48.4
	Smoking	7/124	5.6
	Constipation	16/124	12.9
	Diabetes mellitus	2/124	1.6
Non modifiable risk factors			
	Age >30	78/124	62.9
	Multiparity	34/124	27.4
	Family history of urinary incontinence, overactive bladder or faecal incontinence	14/124	11.3
	Previous major gynaecological surgery	0/124	0.0
	Previous gynaecological cancer	0/124	0.0
	Fibromyalgia	0/124	0.0
	Chronic respiratory disease and cough	2/124	1.6
	Assisted vaginal birth	11/124	8.9
	Occipital-posterior vaginal delivery	1/124	0.8
	Active second stage >1hour	23/124	18.5
	Obstetric anal sphincter injury	2/124	1.6
Risk factor burden			
	No risk factors for PFD	9/124	7.3
	At least one risk factor for PFD	115/124	92.7

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	≥2 risk factors	84/124	67.7

Lack of exercise, identified as a risk factor in NICE guideline NG210, was excluded because it could not be reliably assessed.

Table 2: Themes identified from free- text responses regarding concerns about the effect of pregnancy on pelvic floor health (n=34)

Theme	**Example of concerns**	**n (%)**
Urinary incontinence or bladder dysfunction	Urinary leakage, inability to retain urine, bladder weakness and future pad use	13 (38.2)
Other pelvic floor symptoms	Prolapse, pelvic or sexual pain, bowel dysfunction and impaired sexual function	10 (29.4)
Long-term or worsening pelvic floor dysfunction	Persistent consequences of childbirth or deterioration of existing symptoms	9 (26.5)
Pregnancy and birth related factors	Mode of birth, perineal trauma or stitches, birthweight and multiple pregnancies	9 (26.5)
Personal or vicarious experience and information needs	Previous symptoms, experiences of family and friends, misconceptions and insufficient counselling	10 (29.4)

Themes are not mutually exclusive; responses could be assigned to more than one theme

Table 3: Themes identified from free-text responses regarding suggestions on how to improve services surrounding antenatal pelvic floor health (n=32)

Theme	**Example of suggested improvements**	**n (%)**	**Illustrative quotations**
More, earlier and consistent information	Introduce pelvic floor health at booking, revisit it throughout pregnancy, improve communication	22 (68.8)	“Give information at initial appointment and encourage mothers throughout pregnancy.”

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	and provide consistent advice		
Practical resources and exercise instruction	Provide leaflets, emails, apps, videos, classes and supervised demonstrations of pelvic floor muscle exercises	9 (28.1)	“Midwife can send letters or add most important information to an email.”
Personalised assessment and access to specialists	Improve access to pelvic floor physiotherapy, offer individual assessment and respond appropriately to appropriate symptoms	9 (28.1)	“More in-depth/ personalised intervention, especially from specialists, as everyone has different needs… better availability of pelvic health physiotherapist.”
Postnatal follow-up and screening	Provide routine postnatal assessment, and clearer information about available support	3 (9.4)	“Everyone [should] have screening after birth as standard- I didn’t realise I could access support for months after my first pregnancy.”
Reliance on external resources	Women reported obtaining information from friends, family, yoga classes or National Childbirth Trust leaders rather than antenatal services	3 (9.4)	“I did pelvic floor training based on a friend’s advice; this was not discussed or brought up by my midwife.”
Positive experiences	Satisfaction with midwifery care and existing support services	2 (6.3)	“Impressed with midwives and Baby Steps. Feel supported.”

Themes are not mutually exclusive; responses could be assigned to more than one theme

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Supplementary Table 1: Questions included in the 10-item survey along with question type and response options.

Introduction:

We are conducting a survey with women who have delivered at this hospital to understand their experiences with pelvic floor health during pregnancy. The pelvic floor muscles support the bladder, bowel and uterus and they prevent incontinence of bladder and bowel, prolapse and are also important in sexual function.

Question	Question type	Response Options
1. Do any members of your close female relatives (eg. mother, aunt or sister) have a history of pelvic floor problems such as urinary incontinence, overactive bladder, faecal incontinence or pelvic organ prolapse?	Single choice	Yes No
2. In your antenatal period, were you asked about whether you had any of the following symptoms? *Select all that apply*	Multiple choice	Urinary symptoms (i.e. leaking of urine, urgency) Bowel symptoms (i.e. constipation, leakage of stool or wind) Sexual symptoms (i.e. discomfort) Prolapse symptoms (i.e. feeling a bulge or heaviness in the vagina) None of the above
3. At what stage or stages of pregnancy, if any, was pelvic floor health discussed with you? *Select all that apply.*	Multiple choice	First trimester (conception to 12+6 weeks) Second trimester (13 weeks to 26+6 weeks)

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		Third trimester (27 weeks until delivery) Not discussed at all
4. During your antenatal care, were you given information about any of the following? *Select all that apply*	Multiple choice	Symptoms of pelvic floor dysfunction during pregnancy (ie. urinary, bowel, pain, prolapse and sexual symptoms) How to prevent pelvic floor dysfunction during pregnancy (i.e. maintaining a healthy weight, stopping smoking, avoiding constipation) How to access local services during pregnancy (i.e. antenatal classes, pelvic health midwife) None of the above
5. What advice or support dud you receive regarding pelvic floor muscle exercises during pregnancy? *Select all that apply*	Multiple choice	Information leaflets Signposted to an app such as Squeezy Shown how to perform the exercises during antenatal appointments Referred to a perinatal pelvic health midwife Encourage to attend a pelvic floor class I saw a physiotherapist privately No advice or support
6. If you experienced urinary or faecal incontinence before or during pregnancy, were you advised that there is an increased risk that these symptoms could worsen during pregnancy or persist after birth?	Single choice	Yes No Not applicable

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7. Did anyone discuss with you how different modes of delivery might affect your pelvic floor or pelvic floor symptoms	Single choice	Yes No
8. a) Are you concerned about the effect of pregnancy or birth on your pelvic floor?	Single choice	Yes No
b) If yes, please describe your concerns	Free text	
9. Do you have any comments or suggestions about how we can improve our services surrounding antenatal pelvic floor health?	Free text	

Supplementary Table 2: Exploratory associations between maternal characteristics and reported patient-reported antenatal PFD symptom enquiry

Maternal characteristic	Symptom enquiry with characteristic n/N (%)	Symptom enquiry without characteristic n/N (%)	Absolute difference, pp (95% CI)	p-value
Maternal age >30 years	44/78 (56.4)	32/46 (69.6)	-13.2 (-29.0 to +4.6)	0.183
BMI >25 kg/m^2	39/60 (65.0)	37/64 (57.8)	+7.2 (-9.8 to +23.5)	0.463
Gestational diabetes	15/29 (51.7)	61/95 (64.2)	-12.5 (-31.9 to +7.2)	0.278
Constipation	13/16 (81.3)	63/108 (58.3)	+22.9 (-2.9 to +38.3)	0.101

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Current smoking	6/7 (85.7)	70/117 (59.8)	+25.9 (-12.1 to +40.7)	0.247

Exploratory post hoc univariable analyses (n=124). The outcome was any patient-reported antenatal enquiry about at least one urinary, bowel, sexual or prolapse symptom. Values are the number of women reporting symptom enquiry divided by the number with or without each maternal characteristic.

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Highlights

1. Almost all women (92.7%) had at least one recognised pelvic floor dysfunction (PFD) risk factor
2. No antenatal PFD symptom screening was reported by 38.7% of women
3. Only 19.4% received practice instruction in pelvic floor muscle exercises.
4. Half of women reporting PFD symptoms were referred for specialist support
5. 52.4% were concerned about the effects of pregnancy or childbirth on their pelvic floor.

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