Accepted Manuscript

British Journal of General Practice

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DOI: https://doi.org/10.3399/BJGP.2023.0356

To access the most recent version of this article, please click the DOI URL in the line above.

Received 17 July 2023
Revised 16 November 2023
Accepted 03 January 2024

Title:

The GP's role in supporting Women with Anal Incontinence after Childbirth Injury.

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Abstract

Background

Obstetric anal sphincter injury is the most common cause of anal incontinence (AI) for women, which often has profound impacts on women's lives. GPs offer a first line of contact for many, but we know that very few women experiencing AI postnatally report discussing it with their GPs.

Aim

The study aims to identify key ways GPs can support women with AI due to childbirth injuries.

Design and setting

Qualitative study investigating women's experiences with their GP and GPs' perspectives about providing such care.

Method

This qualitative study combined two phases: firstly, a series of in-depth semi-structured interviews with women experiencing anal incontinence caused by childbirth injuries (n=41); secondly, focus groups with GPs (n=13) stratified by experience. Thematic analysis was conducted and relevant themes from across the two datasets were examined.

Results

Mediating factors in GP care for women with anal incontinence caused by childbirth injuries centred around three key themes: Role of the GP, Access and Pathways, and Communication.

Conclusion

The findings demonstrate multifactorial challenges in identifying the problem and supporting women experiencing AI after childbirth injury within primary care settings. Many GPs lacked confidence in their role in supporting women and women were often reluctant to seek help. Those who did often experienced frustrations consulting with their GPs. In a context where women are often reluctant to ask for help, concerns are not always taken seriously, and where GPs do not routinely ask about AI, potential AI after childbirth injury appears to be often missed in a primary care setting.

Keywords:

Women's Health; Primary Health Care; General Practice

How this fits in:

Anal incontinence after childbirth injury has profound impacts on women's lives and many find they cannot access healthcare and support. GPs can play a crucial role, but we know that very few women speak to their GPs about their symptoms. In combining GPs' and women's views, we show how anal incontinence after childbirth injury is often missed in a primary care setting. Drawing on these findings, we highlight the key ways GPs can provide support for such women.

Introduction

Anal incontinence (AI) is the inability to control bowels and/or flatus (1), associated with faecal urgency and estimated to affect 1-10% of adults (2). It is more prevalent in women, with 20% experiencing AI (3), most commonly caused by obstetric anal sphincter injury (4). AI due to childbirth injury often has profound impacts on women's day-to-day lives, identity, and emotional wellbeing (5, 6). Many women experience AI soon after giving birth, but some have worsening or even new-onset symptoms at the time of the menopause (7). However, despite such prevalence, there are no clear follow up pathways for women experiencing AI when the injury is not identified immediately during or after childbirth (8).

For most women, their GPs will be first line for suggesting a likely diagnosis, as well as support and management, of AI. This wider support could include advice related to diet and self-management, and signposting to resources. Women may benefit from onward referral to specialists such as women's health physiotherapists, gynaecologists, and colorectal surgeons. However, we know that very few women experiencing AI postnatally report having discussed this with healthcare professionals and that many were not asked by their GPs about AI during routine postnatal checks (9). Recently, the Women's Health Strategy for England (10) highlighted that postnatal care is lacking, that women's concerns are often dismissed, and their pain normalised, by healthcare professionals. Such a context suggests there are many women with AI after childbirth injury who are not accessing care and support. This study examines this gap by exploring the experiences of women in relation to contacting their GP and GPs' perspectives about providing care to such women. This article refers to women however the concepts herein apply to all birthing people.

Methods

This qualitative study combined two phases: firstly, a series of in-depth interviews conducted between October 2021 and May 2022 with 41 women who had AI due to childbirth injury, and, secondly, videocall focus groups with GPs conducted in March 2022 [see Supplementary Box 1]. Using a narrative approach, we explored those women's experiences and access to healthcare services and GPs' experiences of, and views about, providing care to women with such injuries. Throughout the study we worked closely with two women who are injured mothers and work closely with The MASIC Foundation (AC and SE). As co-investigators on the study they attended regular study meetings; provided feedback on study documents; piloted the interview schedule [see Supplementary Box 2]; commented on findings; helped develop dissemination materials; advised on terminology; co-authored papers; and generally provided their perspective as and when relevant.

The fieldwork was carried out by two qualitative health researchers (AE, JP) with guidance from the study PI (SH). Interview participants were recruited via hospitals and social networks of related organisations and received a shopping voucher as reimbursement for their time. Women were eligible if they were over 18 and had AI because of childbirth injury. Women under 18, unable to provide consent and those with no history of a vaginal birth were excluded from the study. Using a maximal variation approach, we purposively sampled 41 participants with aims to ensure a diverse sample in terms of ethnicity, socioeconomic status, and age. We also sampled those experiencing AI within 7 years of childbirth, as well as those with worsening (or new) symptoms around the time of the menopause (see table 1). Women were interviewed via videocall (n=33) or phone (n=8) (depending on their preference). Thirteen GPs were recruited via social media and networks and

stratified into focus groups according to their years practicing as a GP (three trainees, five with under 5 years; five with over 5 years) (see table 2).

Table 1: Participants' Background – Injured Women

	Within 7 years of childbirth (n= 25)	**Menopause (n= 16)**
Mean age (range)	36 (20-47)	55 (41-75)
Ethnicity n (%)		
White British	17 (62)	14 (88)
White Polish	2 (8)	
White other	2 (8)	
British Asian	3 (12)	
British Pakistani		1 (6)
British Indian		1 (6)
Black Caribbean	1 (4)	
Deprivation score n (%)		
1st quintile	6 (24)	2 (13)
2nd quintile	5 (20)	7 (44)
3rd quintile	3 (12)	2 (13)
4th quintile	7 (28)	3 (19)
5th quintile	4 (16)	2 (13)

Table 2: Participants' Demographic and Practice Background - GPs

Experience (Trainee: <5 yrs: 5+ yrs)	**Gender (F:M)**	**Mean age (Range)**	**Practice Deprivation (Affluent: Mixed: Deprived)**	**Practice Rurality (Rural: Mixed: Urban)**
3:5:5	11:2	39 (29-44)	3:4:6	3:1:9

Data Analysis

Interview and focus group recordings were transcribed verbatim, anonymised, and uploaded to NVivo. Guided by reflexive thematic analysis (11), two researchers (AE, JP) carried out familiarisation with the datasets, followed by coding and initial theme generation. The themes were then developed and reviewed in discussion with the wider team, and finally themes were refined and defined. A proportion of data were dual coded to scrutinise quality of code development.

Combining data

The women we spoke with discussed their experiences in depth during interviews and findings about their broader experiences are presented elsewhere (12, 13). For this paper, interview data organised into codes relevant to primary care were exported and analysed using the OSOP (one sheet of paper) method (14). The OSOP analytical method allows researchers to map and group content, and identify patterns, within coded data to create a conceptual map. This conceptual map was examined alongside the themes developed from analysis of focus group data and overarching themes across both datasets were identified and summarised. These were scrutinised and refined with the wider study team.

Ethical Approval

Ethical approval was obtained from the East of England - Essex Research Ethics Committee (REC21/EE/0167).

Findings

The women we spoke with had varied experiences when consulting their GPs. Many described difficulties encountered, others referred to times they felt particularly supported, and some talked about not consulting their GP about this issue (13). All the GP participants were highly engaged and interested in discussing how to help women, but confidence levels varied in how to support women with AI. The GPs with over 5 years' experience discussed the complexities of such consultations and the issues entailed, some referring to previous consultations with women with this presentation.

In-depth analysis of the women's and GP datasets allowed further exploration of nuances of how GP care is accessed and carried out in reality. We identified themes that were grouped into 3 overarching areas: 1) Role of the GP, 2) Access and Pathways, and 3) Communication during Consultation.

1. Role of the GP

We identified three subthemes related to the 'role of the GP' including a) confidence in the GP role for women with AI, b) limitations and strengths of primary care, and c) importance of listening and 'sowing the seed' so women reconsult.

a) Confidence in the GP role for women with AI

GP participants varied in confidence when discussing how they would support women with AI due to childbirth injury. The GPs with over five years' experience spoke most confidently, drawing on experience of previous consultations. Some GPs talked about how they had not encountered this presentation and lacked confidence in the best way to support women. The lack of direct experience for some meant they spoke about consultations in hypothetical terms and how they would seek advice from colleagues.

> *"I'm pretty much out of my depth to be honest so I think I would get some advice and guidance" GP, A1*

Some participants felt their GPs supported them well, listened, and referred them appropriately. Others did not feel confident that their GP knew how to support them and were frustrated with previous unsuccessful consultations. In some cases, women saw GPs as gatekeepers to appropriate

care, rather than a source of healthcare and guidance, and many said they independently gathered information and decided on their preferred course of action before seeing their GP.

> *"My experience shows that when I go to the GP, I already need to know where I want to go in a way." Woman, p.33*

Across all focus groups, GPs concurred that their training in this presentation was lacking or non-existent. Some noted they felt more confident and well trained in consulting women with urinary incontinence due to childbirth injury than AI. They highlighted that any relevant training was limited to secondary care, which is not always relevant to how women would present in primary care.

> *"We get taught about, you know, urinary incontinence, stress, versus, you know, urgency and things like that but there isn't really anything targeted for faecal incontinence" GP, A1*

b) Constraints of primary care

There was recognition from both women and GPs that this presentation typically required specialist input. When acknowledging their lack of confidence, some GPs noted long delays for secondary care, meaning that women needed interim treatment and support.

GPs also highlighted lack of primary care resources as a key limitation to providing care. They talked about how other issues may take priority during consultations, giving examples of safeguarding, babies' needs and lack of time. Some also talked about how continuity and follow up care was challenging.

> *"[There was] a woman who spoke entirely Pashto. There was no interpreter arranged, so she phoned her daughter five minutes into the consultation. And we then had to conduct it three-way on the telephone. And halfway through this, doing the, her postnatal, I discovered that her baby had Down's Syndrome and had a whacking murmur. And so when she asked me to examine her perineum, I basically had to say no. And I'm, I'm still feeling bad about it." GP, B5*

c) Importance of listening and 'sowing the seed' so women reconsult

It is apparent from women's and GPs' accounts that AI due to childbirth injury typically takes a long time to be recognised by both women themselves, and the healthcare professionals they consult. This appears to be due to various reasons, including uncertainty as to whether symptoms are 'normal' after childbirth and likely to resolve without intervention, prioritisation of baby's needs over that of the mother's, confusion with other diagnoses (such as irritable bowel syndrome (IBS) or potential cancer), and women's reluctance to disclose embarrassing symptoms.

One key finding was the role GPs could play in 'sowing the seed' to enable women to feel they could reconsult. Some of the more experienced GPs discussed reading tacit cues in women reluctant to disclose AI, by their body language and phrasing. Efforts to listen and make women feel comfortable were rewarded when women booked a follow up appointment to address the problem. There were

examples within women's accounts where a GP that took the time to listen helped them to return for help.

> *"[The patient] wasn't very complete in her answer […] So I could tell […] she was resistant of, to talk much further about it. And I think I said something like, "Well, if you were having problems with your bowels, there may well be things we could do to help you." And that obviously planted a seed in her mind, because she didn't talk about her bowels on that consultation, but she did return a couple of weeks later". GP, B4*

> *"Just to listen to people and understand that effects and physically, mentally, emotionally […] She didn't force anything on me. And two weeks later I'm ringing her back." Woman, p.36*

2. Access and Pathways

Key areas influencing access and pathways included: a) inadequacy of postnatal checks; b) uncertainty about pathways; c) lack of follow up; and d) proactive/reluctant women.

a) Inadequacy of postnatal checks

GP postnatal checks typically take place around 6-8 weeks after birth. An issue identified in both GP focus group and women's interview data was how babies' needs are prioritised, meaning there is less impetus, and limited time, to address issues women might be experiencing. Some of the GPs talked about ensuring there is a dedicated appointment for the woman. However, others judged that in some cases women are less likely to attend if an appointment was made separately for them and their baby.

GPs agreed that limited time during postnatal checks was a barrier to comprehensively addressing issues women may be facing and they are often unable to carry out an internal examination within that time. Many GPs said they did not routinely ask about AI at postnatal checks unless there was a specific reason (e.g., third degree tear recorded in notes) and that it was not part of the standardised checklist. Many GPs felt the timing of the postnatal check at 6-8 weeks was too soon, due to potential that problems were temporary, women's focus on baby needs and a possibility that women are not ready to disclose problems.

> *"If I try to deal with it all in that six to eight week check I'd worry that I'd just be, kind of, rushing through it massively." GP, A3*

> *"That postnatal six-week GP check. It was probably about 80% about the baby really, and maybe 20% about me. […] I felt like, oh, I've got another patient and I really, really need to rush you through and I still didn't really touch on half of the stuff I was experiencing." Woman, p.33*

Notwithstanding the importance of having a routine GP appointment for postnatal women, there was a strong view that the time constraints and complexity of postnatal checks meant the current setup was not adequate.

b) Uncertainty about pathways

Complexities of women's circumstances and differences in local services mean a 'one-rule-fits-all' pathway is unavailable. Thus, it was unsurprising that there was uncertainty regarding subsequent

onward referral. More experienced GPs drew on previous consultations and explained how women's circumstances influence referral decisions. For example, surgery may not be suitable for women wanting more children and older women are more likely to be referred onto a 2 week wait pathway to determine if symptoms are caused by cancer.

There was also lack of clarity regarding what would happen once referrals were made. Some GPs were concerned about "overpromising" services in secondary care and so limited the information they gave women. GPs also highlighted the long delays to care meant it was unclear *when* women would access the services they needed, leaving GPs to help women in the meantime.

> *"Locally for us there are routine gynae referrals that got to two years where they're seen at the moment and certainly that would be wholly inappropriate for this kind of issue" GP, A5*

Some women were unaware of which services would help them and found that their GPs did not appear to know either. Others did not expect their GPs to know, and so did their own research and visited their GP with a referral in mind. Some women, aware of the delays to secondary care, decided to access care privately instead.

c) Lack of follow up

GPs recognised that the 'red flag' pathway meant – once given test results ruling out cancer – many did not have a subsequent appointment to readdress the AI. Overstretched resources meant practices are unable to follow up such patients and often GPs are unaware of negative test results processed by administrative teams. This was apparent in some women's accounts who found there was no follow up after testing for cancer. Similarly, when some women felt their GPs judged their symptoms to be 'normal' they were reluctant to return. The lack of robust follow-up with women experiencing AI relies on women to take the initiative to make follow-up appointments to revisit the problems they are experiencing.

> *"[GP] referred me quickly because they wanted to rule out cancer […] The only thing is is where I've still got the issue" Woman, p.19*

d) Proactive/reluctant women

Access to care was in part influenced by how proactive or reluctant women were in seeking help. Some women talked about how they were proactive when trying to access care, by being assertive, independently gathering information and preparing for consultations, returning when issues were not addressed and, in some cases, consulting a different GP.

> *"I felt very self-motivated that if I'd not kept complaining it wouldn't have happened and then I think it was very hard to access" Woman, ppt.6*

Other women were reluctant to seek help from their GP. Some talked about how they found their symptoms embarrassing and so found it difficult to discuss with their GP. Some were reluctant as they did not think there would be help available, or they were previously told their symptoms were 'expected' or 'normal' after childbirth. Some put it off and talked about mentioning it next time they were in for another appointment.

"I've kind of just put it on a on a on a hold. […] I'll probably will mention it when I when I get a face-to-face consultation, but to be to be honest I just live with it. I just put up with it" Woman, p.21

GPs also recognised that women were often reluctant in coming forward. They talked about the stigma associated with AI and compared it to urinary incontinence which is more commonly discussed. GPs recalled consultations where women described the problem as "disgusting" and one woman who "had to apologise profusely before she could even talk to me about it". They also felt some women do not know help is available and may delay seeking help whilst trying to cope alone.

"I haven't seen lots of women with anal incontinence, I've definitely seen women with other vulval conditions or urinary incontinence who have said, you know, "I've never done anything about this because I didn't think there was anything I could do. I thought this was normal, I just have to live with it. No one's ever told me anything different." And I think that probably, would be my guess, would also apply to faecal and flatus incontinence." GP, C1

3. Communication

Participants across all three focus groups recognised the apparent rarity of AI following a childbirth injury may be because it is going undetected. They acknowledged that the way in which GPs communicate during consultations can be a key factor in enabling women to present with, and identification of, the problem. Three subthemes were identified in relation to communication including: a)Need for clear sensitive discussion, b)Long-term listening and taking time, and c)Language barriers.

a) Need for clear sensitive discussion

As women may be reluctant to come forward, GPs recognised the importance of the GP initiating a conversation about potential AI with postnatal women. However, they also recognised that there was a balance between clearly noting potential problems whilst being sensitive, as some women may need careful encouragement. The importance of sensitive, but direct, discussion was reinforced by interview data. Some women talked about instances when their GP had been insensitive, and they found this upsetting. Others talked about how they appreciated it when their GP spoke directly about their issues as they felt they were being taken seriously.

"[My GP] crossed her legs like this and said, "That gives me the creeps," […] that made me really upset." Woman, p.38

"it's embarrassing enough anyway without then struggling to find the words […] Typically medical professionals can be quite direct and I, you know, I understand they're trying to get the facts and everything, but I think that can sometimes then make you withdraw into yourself." Woman, p.8

Responses to such discussion are likely to vary between women and balancing of clear yet sensitive language whilst being responsive may be challenging.

b) Long-term listening and taking time

Potential for other causes (e.g., IBS or cancer) and the period of recovery after childbirth means there is often uncertainty initially as to whether symptoms have other causes or will improve without intervention (see 'Lack of follow up' above). Thus, AI caused by childbirth injury may not be diagnosed during an initial consultation and require multiple consultations.

However, many women were left feeling like their concerns were not taken seriously, dismissed as being something else and that their problems were normalised. This led to some internalising their problems, feeling alone and not reconsulting. Many older women who had a test result ruling out cancer did not consider returning to the GP with an issue that they felt had already been investigated.

Some GPs recognised the importance of taking the time to listen and women talked about times that had been particularly useful for them. Speaking to the 'sowing the seed' subtheme, it appears to be important for GPs to make it clear to women that they are being taken seriously and to encourage women to make a follow up appointment.

> *"one of the key things is being, being that doctor that listened. And if you were once that doctor that listened, that is probably the only way you're gonna get that patient back" GP, B5*

> *"I've told him [my GP] what level of tear I had and and how traumatic it was. But again, even with that I felt like he took no notice." Woman, p.33*

c) Language barriers

GPs highlighted times when language barriers between themselves and women whose first language is not English made consultations particularly difficult. It was not always clear if patients had understood advice and following up with the patient was challenging.

> *"Her consultations with me were often about different things but would always also be about this [AI]. And it was always very difficult to understand what her understanding was of when this problem could be fixed. And she wanted more children, but she also wanted to have the operation before she was having more children. And it was, you know, these, sort of, circular consultations" GP, B3*

Some women also highlighted a problem with understanding medical terminology hindering their understanding of the problems and advice.

> *"They were saying to me 'oh well it's your internal sphincter' […] I didn't have a clue what that is. What does that do? What does that mean? And you know I've had to go away and find out for myself" Woman, p.8*

Many said they did not understand information during the consultation and that they spent time later gathering their own information. Discussion in lay terms during consultations may help women to understand and give opportunities for further questions.

Discussion

Summary

It is clear there are missed opportunities when AI after childbirth injury could be detected in various healthcare settings (13). GP consultations offer an opportunity to initiate care; these findings combine women's and GPs' perspectives to provide unique insights into reasons why it is often not identified by GPs and ways in which care can be improved.

Postnatal women are not routinely asked about AI, and GPs are unsure if it is appropriate to do so at every postnatal check. GPs often do not feel confident and report a lack of training in this area. Women are often reluctant to seek help, and those who are proactive in seeking help often feel as though their concerns are not taken seriously. Adding to the confusion, AI may be due to other issues, such as IBS or cancer. Some women find the cause is misdiagnosed as IBS which then limits access to appropriate advice and secondary care (13). Findings from the interviews and focus groups suggests a lack of robust follow-up for women referred onto a 2 week wait pathway to rule out cancer, which typically relies on women (who may have been previously reluctant to seek help) to re-present to their GP for further assessment after receiving their negative cancer test result.

During the focus groups, GPs recognised having insufficient time for complex postnatal consultations, lack of robust follow up and women's reluctance to talk about AI as contributing to missed diagnoses. Drawing on their own experiences, some GPs discussed the importance of showing they are listening and 'sowing the seed' by mentioning potential AI and that there is help available. In doing this, women appear more willing to return if they are experiencing issues.

There was uncertainty regarding the GP role in supporting women identified across both datasets, suggesting a lack of awareness regarding the support GPs can provide. However, this study demonstrates the value of sensitively initiating discussions ('sowing the seed') about AI during the postnatal check (or equivalent) to encourage women to feel more comfortable in disclosing their issues. GPs can also remind women to make follow up appointments when sending a test for cancer, to ensure follow up. The RCGP – in conjunction with the research team – recently released an online learning tool that provides a useful resource for GPs and other healthcare professionals looking to increase their knowledge and understanding in how they can support women with this condition (15).

Strengths and Limitations

In combining women's and GPs' perspectives, this study provides a balanced and comprehensive overview of challenges of – and ways to – support women with AI after childbirth injury in primary care from multiple perspectives. Qualitative methods allowed in-depth exploration of their experiences and the complexities of such consultations. One-to-one in-depth interviews enabled a good rapport to be gained between women and the researcher and women appeared to be open and comfortable when sharing their experiences. This was the case for both modes of interview; videocalls and phone calls.

We interviewed women from a range of backgrounds. Whilst we translated posters, advertised via ethnic minorities women's organisations, community groups, and employed an interpreter to invite women to take part, we did not manage to include any women who were not fluent in English.

As GPs volunteered to give up their time to take part in focus groups, it is possible that participants were particularly engaged GPs with an interest in women's health. This allowed thoughtful discussion but may mean other perspectives were missing. Nonetheless, the fact that omissions in knowledge and confidence were highlighted by this group is suggestive that this may be the case even more so for GPs without a women's health interest.

Comparison with Existing Literature

Women's feelings of embarrassment and shame are well documented (5, 16, 17) and surveys have shown that women rarely seek help from healthcare professionals about this problem (18, 19). Our findings also show how women were reluctant to seek help due to prioritisation of babies' needs

and feeling embarrassed to talk about it. Conversely, there were also examples of women who were particularly proactive in seeking help, gathering information, making repeated visits to their GP, and deciding their preferred course of action before the consultation. This may be reflective of a sample that included a higher proportion of affluent women, who are more likely to be health literate (20) and confident during medical consultations (21).

Previous studies show that most postnatal women are not asked about AI by healthcare professionals (8, 9), and therefore it was unsurprising that most GPs said they would not routinely ask about AI and it was often not incorporated in their postnatal checklists. During deliberations, GPs questioned whether it is appropriate to *always* initiate such discussions during postnatal checks. Current NICE guidelines for postnatal care recommend that GPs ask about bowel incontinence, but this is amongst a myriad of other items with little prominence (22). Our findings also showed how GPs find there is typically a lot of content to cover during postnatal checks with little time available, and language barriers (e.g., women who do not speak English and medical terminology) add complexity to such consultations.

Women often felt like their concerns were not taken seriously and framed as being a 'normal' part of recovery from giving birth. The NICE guidelines state that "there does seem to be some spontaneous resolution of symptoms" for women with AI after childbirth (2), whereas others argue it is not a 'normal' consequence of giving birth and women ought to be empowered to seek help (8). Inconsistency in information suggests some confusion amongst professionals. Normalisation is seen more broadly, as the recent Women's Health Strategy showed that women often feel that they are not listened to by healthcare professionals and their symptoms are normalised as 'to be expected' (10).

This study showed examples of proactive women who sought help, and GPs who took concerns seriously and sensitively asked women about potential AI. However – based on the overall study findings and literature – this appears to be exceptional rather than routine. In a context where women are often reluctant to ask for help, concerns are not always taken seriously, and where GPs do not routinely ask about AI, it is easy to see how potential AI after childbirth injury is often missed in a primary care setting.

Implications for Research and Practice.

GP consultations can provide a first point of contact for access to care and referrals, but these findings demonstrate multifactorial challenges in identifying the problem and supporting women experiencing AI after childbirth injury within primary care settings. As discussed, there are various issues with postnatal checks and lack of robust follow up in detecting women with this issue. Ideally GPs would have more time and resource to address these issues, but this is not the reality of modern primary care where resources are often stretched and there are other issues to contend with (e.g., other health issues, baby's health, language barriers, reluctance to discuss). In such a setting, providing adequate care is problematic and without addressing the broader issue of overstretched resources, it is hard to see how this could be overcome.

As with many areas of healthcare access, diagnosis of AI due to childbirth presents a particular challenge in women from certain demographic groups. In the UK, women from less affluent backgrounds, and teenagers, are less likely to attend postnatal checks (23, 24). We also know that women with Asian ethnicity are significantly more likely on average to sustain such injuries during childbirth (25, 26) thus focus on support and research for specific groups may be beneficial.

Drawing on the study findings, there are key ways that GPs can support women with AI after childbirth injuries, which are also detailed in an RCGP eLearning module: Anal incontinence in women with previous childbirth injury (15). These include: -

- Asking women directly about AI and difficulty controlling bowels after childbirth, and asking on more than one occasion, which may help women to voice their concerns.
- Being aware that Asian women are at higher risk and acknowledging potential cultural differences in discussing sensitive subjects. An independent translator should be used wherever possible for those that don't speak English.
- Being aware that the biopsychosocial implications of AI after childbirth can be profound and should be explored.
- Not suggesting that AI is normal; but instead give simple advice (pelvic floor exercises, diet) and making referrals to a women's health physiotherapist/pelvic floor clinic, tailored to individual need and severity of symptoms, where possible.
- Signposting women to charities that provide support including The MASIC Foundation (27) and the Birth Trauma Association (28).

Conflicts of interest

Professor Michael Keighley is President of the MASIC Foundation, and Professor Debra Bick is Chair of Trustees of MASIC but this has not impacted on conduct of the study or publication. Professor Keighley is the CEO of Keighleycolo Ltd and involved with court medical reports for OASI patients. He is a trustee for Friends of Vellore UK which has helped to understand impact of OASI in the Asian community in India. He is the joint holder of two i4i NIHR grants for a device for the treatment of fistula which could be of value to some OASI patients.

There are no further declared conflicts of interest from authors on this paper.

Funding

This study/project is funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference Number NIHR202172). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Acknowledgements

We would like to thank the women and GPs who gave up their time to participate in interviews and focus groups.

We would also like to acknowledge the recruitment support we gained from MASIC (a charity which supports women who have sustained birth injuries: MASIC.org.uk) and participating hospitals.

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