



International Organization of Physical Therapists in Women's Health

A sub-group of WCPT



PRESIDENT'S REPORT

Dear friends and colleagues,

I have just returned from the American Physical Therapy Association's midwinter meeting, the Combined Sections Meeting, in New Orleans, Louisiana. It was a very busy time for me but I was able to attend the pre-conference seminar on real-time ultrasound in the use of treating and examining patients with needs for pelvic stabilization. The speaker referenced Dr. Ursula Peschers a number of times. Dr. Peschers will be one of the speakers for the IOPTWH seminar on **"Pelvic Floor re-**

habilitation, What is the evidence?" to be held in Slovenia this coming September. I was very excited to know I will be hearing from Dr. Peschers along with other notable speakers (including IOPTWH Vice-President, Dr. Kari Bo!) at this wonderful conference. Please see the Upcoming Events section of the newsletter for more in-depth information on the course. Also look for information on our website (www.ioptwh.org). We hope to have a great turnout. Many thanks to our Slovenian members and to IOPTWH Secretary Rebecca Stephenson for working so diligently on this course! Publication committee chairperson, Beth Shelly, is hard at work trying to obtain sponsorship from medical vendors for the course, so if you have ideas on sponsorship, let Beth know, or contact me (boissj@surgery.wisc.edu).

Since last fall, IOPTWH Member-At-Large, Meena Sran, from Canada, has begun our outreach project. Look for her report later in this newsletter. I am very pleased we have launched this endeavor as it is one of the objectives of IOPTWH. The goal is to reach out to other countries and share the knowledge and expertise we collectively own in the area of women's health physical therapy. Thank you, Meena, for taking this project on! As a member-country of IOPTWH, we may call on you to assist countries that respond to our offer for assistance. Stay tuned!

In New Orleans, I had the opportunity to meet briefly with IOPTWH practice committee chair, Judy Florendo of Chicago, IL. Judy will be renewing the efforts of the practice committee to work with WCPT and the WHO to disseminate our position on condemnation of female circumcision in alignment with the position of the WHO. If you are a member of that committee, expect to hear from Judy soon and if you are not and wish to be involved with this effort, kindly let me know and I will pass this information on to Judy.

(Continued on page 2)

WHAT'S INSIDE...

Feature Article-The 37-year-old primiparous woman: A Challenge	2
Treasurer's Report	3
Meet the Executive	3
IOPTWH Outreach Project	7
Upcoming Events	8

(Continued from page 1)

Finally, many of you know I was appointed to the WCPT International Scientific Committee for the planning of the WCPT Congress in June, 2007 in Vancouver, Canada. The committee has been hard at work trying to get a framework in place for the congress, and looking at potential speakers and types of programming. I have been asked to help solicit and coordinate subgroup involvement and to develop guidelines for pre and post-congress courses. I am happy to be involved on such a level and am pleased to have the opportunity to not only represent North America, but IOPTWH as well. Look to the WCPT website for information as it becomes available and mark your calendars now! IOPTWH will likely hold a pre or post congress course. The details will be finalized when the Executive Committee meets in conjunction with the Slovenian course.

All the best,
Jill Boissonnault, PT PhD
President IOPTWH

THE 37-YEAR-OLD PRIMIPAROUS WOMAN: A CHALLENGE TO THE WOMEN'S HEALTH PHYSIOTHERAPIST?

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Abstract

Women who give birth for the first time over the age of 35 years are termed 'elderly primigravidae'. The present paper examines the differences between the 'standard primigravida' and the 37-year-old or 'elderly primigravida', possible reasons for the increasing number of older first-time mothers, and the potential risks involved. An evaluation of recent literature was performed to determine whether the issues presenting to women's health physiotherapists will stimulate their interest and test their capabilities, and whether they possess the skills necessary to meet the needs of the elderly primigravida.

Keywords: elderly primigravidae, older mothers, primiparous women, risks.

INTRODUCTION

The term 'primipara' is defined as 'a woman who has given birth for the first time only, or is about to do so' (Allen *et al.* 1999). Women over the age of 35 years delivering first babies are frequently called 'elderly primigravidae' in the literature (Katwijk & Peeters 1998; Suwanrath & Pinjaroen 1998), while 'standard primigravidae' have been described by Cleary *et al.* (1996) as being 'aged 20–34 years'.

The present paper examines the differences between the 'standard primigravida' and the 37-year-old or 'elderly primigravida' (EP), possible reasons for the increasing number of older first-time mothers, and the potential risks involved. According to Mantle (1994), the role of the women's health physiotherapist (WHP) working in obstetrics is 'to promote health throughout the childbearing period, and to help women to adjust advantageously to both the physical and psychological changes of pregnancy and the postnatal period so that the stresses of childbearing are minimised'. A challenge can be defined as 'a difficulty which stimulates interest or effort; a task, undertaking etc., to test one's powers and capabilities to the full' (Allen *et al.* 1999).

An evaluation of recent literature was performed to determine whether the issues presenting will stimulate the WHP's interest and test her capabilities, and whether the WHP possesses the skills necessary to meet the EP's needs.

(Continued on page 4)

IOPTWH TREASURER'S REPORT SPRING 2005

The past six months have been a quiet time for me as treasurer, but this is beginning to change as we prepare for our September conference in Slovenia.

The first notice to chief delegates requesting payment of their 2005 dues has been sent and thank you to the UK who have paid already. Please can I encourage the rest of the members to arrange prompt payment as our expenditure this year will undoubtedly be higher than usual because of the forthcoming conference.



Outgoings since I last reported have been on maintenance and development of the website, the cost of our newsletter, and the administrative secretary's pay. Income and expenditure since 31st July 2004 are as follows:-

Income	£ 892.45
Expenditure	£ 1,407.75
Funds at 31 st January 2005	<u>£ 6,207.12</u>

Gill Brook
Treasurer

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(Continued from page 2)

DISCUSSION

The literature suggests that the EP has an increased risk of numerous obstetric complications, including pregnancy-induced hypertension, type II diabetes mellitus, leiomyomas, maternal and perinatal mortality, multiple pregnancy and foetal malpresentation (Katwijk & Peeters 1998; Suwanrath & Pinjaroen 1998). The WHP's involvement in antenatal care, and her comprehensive knowledge of potential obstetric complications, suggest that she should be an essential member of the multidisciplinary team (MDT), integrally involved in the management of the woman. Once contact is made with the EP, either through antenatal education provision or referral, a thorough assessment, coupled with listening skills, will alert the WHP to possible obstetric problems. Discernment to refer within the MDT is essential.

An undisputed fact, arising from the extensive range of literature, is that of an increasing Caesarean delivery (CD) rate with increasing age (Edge & Laros 1993; Katwijk & Peeters 1998; Rosenthal & Paterson-Brown 1998; Suwanrath & Pinjaroen 1998; Bell *et al.* 2001; Ecker *et al.* 2001), a fact that warrants further discussion.

CAESAREAN DELIVERY

Both CD pre-labour and emergency CD during labour increase with advancing maternal age (Rosenthal & Paterson-Brown 1998; Ecker *et al.* 2001). The reasons listed for the increased incidence of CD, without a trial of labour, include prior myomectomy for uterine leiomyomas, malpresentation, chronic medical conditions and hypertensive complications of pregnancy. Failure to progress and foetal distress have been given as reasons for emergency CD (Ecker *et al.* 2001). Deterioration in uterine function with increasing age (Katwijk & Peeters 1998; Rosenthal & Paterson-Brown 1998; Bell *et al.* 2001) is cited as increasing the likelihood of CD caused by reduced efficiency of uterine contractions and, therefore, failure to progress.

The ever-increasing CD rate, especially among the EP group, offers numerous challenges to the WHP, and allows her many fields of expertise to be utilized fully to the benefit of her client. The WHP's teaching skills, and her knowledge of movement and mechanics are valuable to the EP during the antenatal period. She is in a prime position to give advice regarding positions of ease during the different stages of labour, and to teach breathing awareness and relaxation to assist with pain management (Brayshaw & Wright 1994). Motivating the EP client to consider her own wishes during labour will empower her to cope with the demands placed upon her, knowing that she has minimized the risk of medical intervention.

Should pre-labour CD be imperative, the WHP again has much to offer the EP preoperatively. The WHP's positive approach and educational abilities afford the EP a knowledge of comfortable positions to encourage rest and ease of mobility postnatally.

Following CD, the WHP is an essential member of the MDT, instrumental in planning and delivering a treatment

regime to facilitate recovery and a return to normal function. The WHP's ability to take the anatomical and physiological adaptations of pregnancy into consideration, accurate assessment skills, and analytical approach make her the ideal focus for other professionals with regard to the management of musculoskeletal problems.

Re-education of the abdominal and pelvic floor musculature in order to reduce the incidence of long-term problems is of particular relevance because of an age-related decrease in skeletal muscle mass (Harley 1995, cited in Katwijk & Peeters 1998). Separation of the linea alba may occur during pregnancy or delivery. Lo *et al.* (1999) reported that older mothers and those who delivered by Caesarean section were at increased risk of diastasis of the rectus abdominis muscle (DRAM). Accurate assessment skills and a knowledge of the management of DRAM allow the WHP to limit client activities which are likely to widen the diastasis, provide a suitable abdominal support and plan a specific exercise programme encouraging approximation of the recti. Following re-education of the transversus abdominis (TrA) muscle, Sheppard (1996) documented successful reduction of DRAM and a decrease in postnatal back pain. The importance of re-education of the deep stabilizing muscles of the trunk, including the TrA, has been well documented. Richardson & Jull (1995) devised a specific programme of exercises to increase spinal stability. Postural correction and advice regarding positions for feeding and routine baby care are vital to promote the EP's involvement in the care of her new infant, while minimizing the strain on her own body and her spine in particular.

Applying her comprehensive knowledge of postnatal recovery rates, and considering the EP's unique needs and lifestyle, the WHP is qualified to offer appropriate advice to facilitate her client's safe return to activities of daily living, exercise and sport, and the workplace. The WHP's excellent communication skills, utilized during liaison with the EP's partner and family, will provide all those involved in supporting the EP postnatally with realistic expectations of the recovery period.

The implications of pelvic floor re-education and the management of dysfunction are of prime importance to the WHP, and as such, justify inclusion separately.

Whilst obstetric complications partly account for the increased CD rate in EPs, they do not explain all cases (Edge & Laros 1993; Bell *et al.* 2001; Ecker *et al.* 2001), indicating the contribution made by psychological factors.

PSYCHOSOCIAL FACTORS

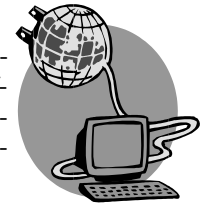
Primiparous women presenting at 37 years of age may well have taken a considerable length of time to achieve their pregnancy, either as a result of reduced fertility brought about by advanced maternal age or because the pregnancy is a result of assisted conception. As a result, they are often considered to be at high risk (Edge & Laros 1993; Katwijk & Peeters 1998). Rosenthal & Paterson-Brown (1998) com-

(Continued on page 5)

IOPTWH listserv

There has been an exciting increase in use of all the listserv's that are set up. Fascinating questions regarding pudendal nerve pain, pelvic pain in a teenager and RSD management and labour/delivery planning in a pregnant woman, have all conjured up a flurry of excellent responses, suggestions and critical thinking. The sharing of information clearly demonstrates the learning opportunities that are available and how easy it is to facilitate accessibility to resources. It also provides support and encouragement for physiotherapists who may be new to the area of women's health and may not have a mentor or more experienced women's health physiotherapist nearby. The listserv is an excellent sounding board for hypotheses and strategies.

Please keep the lines of communication open and email Beth Shelley, Publications Chair at bethshelly@prodigy.net if you would like to register or have questions, concerns, suggestions, or difficulties of any type. This is an exciting venture and wonderful opportunity for professional development and lifelong learning, please consider joining. The more people who are involved, the more everyone benefits.



(Continued from page 4)

mented that the EP is frequently well informed, both about labour and its possible complications, suggesting a further reason for perceived risk and increased intervention. Both the EP and her obstetrician may favour CD to minimize the risk of an adverse outcome.

The risk of chromosomal abnormalities (e.g. Down syndrome) also increases with advancing maternal age (1.5% of babies born to 37-year-old mothers have Down syndrome), increasing the EP's likelihood of being offered invasive diagnostic procedures antenatally. Such tests and decisions based on their outcome, added to an increased level of antenatal care, may contribute to increased anxiety levels. The WHP's listening skills and empathy with the client are paramount in helping to alleviate the EP's concerns or to provide support where necessary.

The EP is often a well-educated career woman of higher socio-economic status who has chosen to delay childbearing (Katwijk & Peeters 1998; Suwanrath & Pinjaroen 1998). These are factors with significant implications during pregnancy and beyond. The disruption that even a much-longed-for baby may cause to the EP's possibly very ordered lifestyle is likely to come as a shock, and may have the potential to cause problems unless it is addressed. Through antenatal contact with the EP at parenthood education sessions, the WHP is ideally placed to discuss future lifestyle changes, offer practical advice, and ensure that the EP and her partner have realistic expectations. The EP may have increased body awareness and an interest in her own well-being, providing the WHP the opportunity for promoting health education (Dr A. Quinn, personal communication). Of particular relevance to the EP is the WHP's knowledge of back and pelvic care, and pelvic floor education in order to encourage good habits and reduce the incidence of future problems.

The importance of postnatal support cannot be over-

emphasized. The EP is often left feeling isolated. Friends' children may be older, leading to a lack of peer support and she may have lost contact with work colleagues. Contact with professionals and other new mothers through postnatal exercise or breast-feeding support groups is vital. The WHP is able to organize a safe, effective postnatal exercise programme, including relaxation, to facilitate recovery and, through the professional relationship established with her client, offer psychological support and be able to 'refer on' should there be any variations outside 'normal' postnatal mood swings.

PELVIC FLOOR DYSFUNCTION

A great deal of clinical research cites pregnancy and childbirth, especially first deliveries, as possible causes of damage to the innervation and musculature of the pelvic floor (Allen *et al.* 1990; Sultan *et al.* 1994; Marshall *et al.* 1996; Wilson *et al.* 1996), and increasing age as having a detrimental effect on pelvic floor function (Dimpfl 1998; MacLennan 2000). Persson *et al.* (2000) concluded from their study that increasing maternal age at first delivery was associated with an increased incidence of future surgery for stress urinary incontinence, with women in the 35-39-year-old age group being most significantly affected. There are conflicting opinions with regard to the protective influence of CD to the pelvic floor. Wilson *et al.* (1996) described women who had undergone a first CD as having a reduced incidence of urinary incontinence compared to women who had delivered vaginally, but MacLennan *et al.* (2000) reported no significant reduction in the risk of pelvic floor dysfunction following CD. Since alterations in levels of pregnancy hormones affect connective tissue extensibility and the weight of the foetus places a strain on the supporting structure of the pelvic floor, it would seem reasonable to anticipate some reduction in pelvic floor muscle (PFM) function postpartum, regardless

(Continued on page 6)

(Continued from page 5)

of the mode of delivery. Because PFMs, along with a competent urethral sphincter, are important contributors to continence (Laycock *et al.* 2001), this may be compromised in the EP.

Even without considering the implications of increasing age on the incidence of incontinence, as many as 34.3% of women admit to having urinary incontinence 3 months postpartum (Wilson *et al.* 1996), highlighting an obvious challenge to the WHP. With her comprehensive understanding of the anatomy of the pelvic floor, and the physiology of muscle function and its re-education, the WHP should be the prime facilitator in the management of pelvic floor dysfunction. Wilson *et al.* (1996) also described daily antenatal pelvic floor exercises as having a protective effect against incontinence, offering the WHP a reason for instigating a programme of PFM exercises for the EP. A recent review of 'effective physiotherapy' stated that 'women with urinary incontinence can be helped with pelvic floor muscle training' (Herbert *et al.* 2001), with Bø (1995) providing the WHP with a thorough review of the exercise science of PFM re-education and the efficacy of such re-education in the management of stress urinary incontinence. Pelvic floor muscle contractions can facilitate co-contraction of the TrA (Richardson & Jull 1995). The WHP is trained to observe correct muscle activity and, once achieved, she has the knowledge to progress exercises through a functional programme, thus encouraging compliance.

A less common, but extremely distressing, consequence of childbirth can be that of faecal incontinence (FI), with some 4% of women reported as developing new FI following delivery (MacArthur *et al.* 1997). MacLennan *et al.* (2000) found increasing age and parity strongly associated with pelvic floor disorders, including FI, in agreement with a study by Jameson *et al.* (1994). Listening skills, empathy and approachability may mean such problems are shared with the WHP, and whilst much can be done to alleviate symptoms with relevant advice and PFM exercise regimes, the WHP should use her discernment and liaise with appropriate members of the MDT. Conversely, constipation is a problem for as many as 32% of primiparous clients (Marshall 1996), and because straining to defecate raises intra-abdominal pressure, it may be a contributing factor to urinary incontinence. Despite being a relatively new field for the WHP, there is already substantial evidence to promote the physiotherapist as a valuable member of the MDT involved in the management of anorectal dysfunction (Markwell 1998).

Continued education of the MDT, including general practitioners, community midwives and health visitors, will ensure prompt, appropriate referral to the WHP of clients following discharge from the ward, thus promoting early intervention for persisting problems.

CONCLUSION

There is no doubt that the 37-year-old primiparous woman presents a challenge to the MDT involved in her obstetric care. Whilst obstetric management may not directly involve

the WHP, her comprehensive knowledge of potential problems is essential in ensuring early recognition of symptoms, and prompt, appropriate client referral. With diligent antenatal care and responsive labour management, the EP has every right to anticipate an excellent pregnancy outcome. Many challenges are presented to the WHP by the EP's increased likelihood of CD, pelvic floor dysfunction and musculoskeletal problems, challenges different to those presented by the younger primipara. However, since each client is an individual with a unique set of needs, all women offer a challenge to the WHP.

The broad spectrum of skills learned at undergraduate level, enhanced by her comprehensive acquired knowledge of the anatomical and physiological adaptations of pregnancy and the puerperium, allow the WHP to modify her approach to suit the needs of individual clients in a holistic manner. Prioritizing continuing professional development, critical review of current, pertinent literature and exchanges of ideas through the network of her clinical interest groups ensure that the WHP expands her knowledge and continues to offer best practice to this important, ever-increasing client group. The WHP is a highly-skilled practitioner, ideally equipped with the skills required to meet the challenges presented by the 37-year-old primiparous woman.

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(Continued on page 7)

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Valerie Clarke MCSP SRP is a Senior I Physiotherapist at the Royal Alexandra Hospital, Paisley. She graduated from Queen's College, Glasgow, in 1983. Valerie has successfully completed the Physiotherapy in Women's Health modules at the University of Bradford (2001–2002) and is a full member of the ACPWH.

Sue Barton MSc DipEd MCSP DipTP DipRG&RT DipTHRf (YMCA&RSA) is a health senior lecturer at the School of Health Studies, University of Bradford, Bradford, where she is the coordinator of the undergraduate and postgraduate Physiotherapy in Women's Health modules. Sue is also a full member of the ACPWH.

The paper presented here is based upon Valerie's critical assignment, which formed part of the assessment process for the Physiotherapy in Women's Health 1 module at the University of Bradford.

IOPTWH OUTREACH PROJECT



Over the past 8 months I have been working on a project on behalf of the executive committee of the IOPTWH. The purpose of this project is:

1. to introduce WCPT member countries to the organization (those who are not currently IOPTWH members), including our objectives and purpose
2. to ask if their country has a group of physical therapists with a special interest in women's health
3. to offer assistance if their country's physical therapy association or schools would like more information on women's health physical therapy

All recipients of the outreach package were invited to visit the IOPTWH website (www.ioptwh.org). Each package included a letter introducing IOPTWH, the position paper on scope of practice, a brochure, a membership application form and a copy of one of our newsletters.

To date packages have been sent to **45 countries** including Argentina, Bolivia, Botswana, Brazil, Barbados, Bermuda, Bulgaria, Colombia, Costa Rica, Cameroon, Chile, Egypt, Czech Republic, Cyprus, Ecuador, Estonia, Fiji, Germany, Jamaica, Iran, Lebanon, Lithuania, Poland, Malawi, Malta, Namibia, Mexico, Malaysia, Luxembourg, Liechtenstein, Latvia, Indonesia, Iceland, Hungary, Guatemala, Japan, Greece, Ghana, Peru, Nepal, Nigeria, Republic of Panama, Philippines, Sri Lanka, Singapore.

We see this as an important step toward achieving the IOPTWH objectives listed below:

1. To foster cooperation between physical therapists practicing in women's health throughout the world.
2. To encourage improved standards and consistency of practice in women's health care by physical therapists.
3. To advance practice by communication and exchange of information.
4. To encourage scientific research and promote opportunities for the spread of knowledge of new developments in the field of women's health. To assist WCPT member countries in the development of recognized Sub-sections in women's health.

I welcome your comments on this project.

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UPCOMING EVENTS

Update on Pelvic Floor Research and Rehabilitation Preliminary Program Ljubljana, Slovenia at Hotel Slon: September 17, 18 2005

Friday September 16, 2005

17.00 Registration
19.00 Opening ceremony

Saturday September 17, 2005

8.00 Registration
9.30 Welcome Gabrijela Gaber, Jill Boissonnault, Tanja Dobnik
9.30 - 10.15 **Updated Exercise Science**
Prof. Kari Bø, PhD, PT, exercise scientist
Professor Norwegian University of Sport and Physical Education, Oslo, Norway
10.15 – 11.00 **PFM Exercises are Effective, but How Does it Work?**
Prof. Kari Bø, PhD, PT, exercise scientist
11.00 – 11.30 Coffee break
11.30 – 12.15 **Neurophysiology of Micturition: Windows of Opportunity for Therapeutic Intervention**
Assistant Professor Simon Podnar, MD, DSc
Neurologist and Clinical Neurophysiologist, Division of Neurology, Slovenia
12.15 – 13.30 **Imaging in Urogynecology**
Assistant Professor Ursula Peschers, MD, PhD
Obstetrician and Gynecologist, specialist in Urogynecology, Dachau, Germany
13.30 – 14.30 Lunch
14.30 – 15.15 **Are there Limits for Conservative Treatment of Female Urinary Incontinence?**
Assistant Professor Adolf Lukanovi, MD, PhD
Obstetrician and Gynecologist, specialist in Urogynecology, Slovenia
17.00 – Sightseeing in Ljubljana
20.00 – Dinner



Sunday September 17, 2005

9.00 – 9.30 **Abdominals or PFM training, what is the evidence?**
Prof. Kari Bø, PhD, PT, exercise scientist
9.30 – 10.15 **Pelvic organ prolapse and PFM training**
Prof. Kari Bø, PhD, PT, exercise scientist
10.15 – 10.45 Coffee break
10.45 – 11.45 **Exercise class for all participants led by:**
Prof. Kari Bø, PhD, PT, exercise scientist
12.30 – Tour (lunch included)
18.00 – Back to the hotel

HOTEL SLON, LJUBLJANA SLOVENIA

Room Rates

Single room + breakfast \$144 (110,00 EUR/night) – 10% discount
Double room + breakfast \$210 (161,00 EUR/night) – 10% discount
www.matkurja.com/en/country-info/ <<http://www.matkurja.com/en/country-info/>>
www.ijs.si/slo/ljubljana/table.html <<http://www.ijs.si/slo/ljubljana/table.html>>
www.lju-airport.si/ <<http://www.lju-airport.si/>>
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For more information contact Rebecca Stephenson-IOPTWH Secretary-rgspt@comcast.net
For Registration cost and forms contact Gill Brook-IOPTWH Treasurer-gill.brook@lineone.net
Registration Fee £170, €245 or 317 USD