President’s Message

WCPT 2015: a Celebration for Women’s Health PT

It is both a pleasure and an honour to be writing this, my first newsletter message as president of the Organization. It is now two months since the WCPT Congress in Singapore, and I have had time to reflect on our meetings there plus the months and years ahead. I am delighted to be working with ‘old’ executive committee friends and colleagues Meena Sran and Darija Šćepanović and new officers Melissa Davidson and Robyn Willcock. I am also delighted that newsletter editor Hana Al Šobayel offered to continue in the role!

Continued...
President’s Message (Continued)

To follow on from great former presidents Rebecca Stephenson and Jill Boissonnault is a daunting prospect, but I guarantee you my full commitment. In UK politics they talk of the ‘father’ of the House of Commons; that is, the longest serving member of parliament. Therefore, I think I can now assume the position of ‘mother’ of the IOPTWH executive committee, being the only person who has been in office since we first met in 1999!

Singapore was a very busy but equally rewarding experience for me. Elsewhere in the newsletter you will read a report of Talli Rosennbaum’s extremely successful and well-attended pre-Congress study day, our IOPTWH social reception and the women’s health networking session. In addition, we ran a very well-attended subgroup seminar on Trauma-induced pelvic floor disorders: implications for physical therapists. Rebecca Stephenson, New Zealand chief delegate & Chair of the Practice Committee Ruth Broom, Nigerian chief delegate Jovita Daniel and I, along with Worldwide Fistula Fund board member Tracy Spitznagle participated in this ninety minute session focusing on female genital mutilation and obstetric fistula. I was immensely proud of everyone involved, particularly Jovita who spoke as a women’s health physiotherapist in a country where both FGM and fistula still occur. (Note – since we met Nigeria has announced a ban on FGM). The seminar handout is available at <http://www.wcpt.org/sites/wcpt.org/files/files/wpt15/SG-8-WomensHealth-handout.pdf>.

At the Congress opening ceremony, former IOPTWH vice-president Kari Bø was bestowed with Mildred Elson Award for her outstanding contribution to international leadership in the profession through her pioneering, sustained, evidence based and highly influential work in the field of women’s health. Kari was the first physiotherapist within the specialty to receive this prestigious award which was truly deserved.
During the Congress, Rebecca and I participated in a meeting of subgroup chairs, attended in part by WCPT secretary general Brenda Myers. It was a pleasure to meet representatives of other groups and to discuss common challenges.

Throughout the Congress, IOPTWH members manned a table in the exhibition hall, sharing both written and verbal information about the Organization, and practice within our member countries. Many of our delegates brought along information from their national group and spent time at the stand during the breaks and lunchtimes, for which I thank them.

For me, the most significant event in Singapore was our four-yearly general business meeting. This was attended by representatives from 16 of our member countries, plus members-elect Chile and Kuwait who were unanimously voted in as full members. There was an opportunity to thank and bid farewell to not only retiring president Rebecca Stephenson, but also treasurer Ros Thomas and Chair of the Practice Committee Ruth Broom.

Minutes of the meeting have been circulated to chief delegates and delegates in all our member countries and the new executive committee will hold a conference call this month to plan the way forward based on outcomes of the discussions, which were held, and motions passed.
To summarise some of the points under discussion:

- **Support for new IOPTWH member groups**;
- **WCPT Congress 2017 in Cape Town, South Africa and plans for IOPTWH involvement.** The move by WCPT from four-yearly to two-yearly congresses will undoubtedly have an impact on subgroups;
- **A further consultation within the membership on the Organization’s name**;
- **The way forward for the IOPTWH website, a presence on social media and the potential for other forms of electronic communication & discussion**;
- **Increasing the membership of IOPTWH from within WCPT member countries**;
- **The role of physiotherapists in the fitting and management of vaginal pessaries for pelvic organ prolapse**;
- **Student membership**; and
- **Sharing of patient information literature in different languages**.

You can expect more about all of the above over the forthcoming months.

Finally, I hope to see some of you at next year’s WCPT European Region Congress in Liverpool, United Kingdom from 11th-12th November 2016, where Kari Bø will present a keynote speech. IOPTWH, along with our UK member group Pelvic, Obstetric & Gynaecological Physiotherapy (POGP) have submitted a proposal for a networking session and await a decision from the organising and scientific committees.

My very best wishes to you all.

*Gill Brook*
New Members of Executive Committee

Melissa Davidson

Born and raised in Wellington, New Zealand, Melissa moved to Queenstown with her family in 2001 after living in Canada for 6 years and seeking the mountains and cold back home in NZ. She qualified in 1990 with a Diploma in Physiotherapy, and has spent a large amount of time and effort on further post-graduate education, most recently graduating with first class honours from The University of Melbourne with a research masters.

She has been running her private physiotherapy practice, Remarkable Physios, for over 14 years, with clinics located in Central Queenstown and Frankton. Along with seeing ACC and private patients for injuries and medical conditions, Remarkable Physios is a leading provider for manual handling training, workplace safety and vocational rehabilitation.

Besides running her own successful business, she has been an active member of PNZ, the professional organisation for physiotherapists in New Zealand for many years, and in the last 6 years she has been involved at the national level as part of their marketing group, leadership group, and as the secretary for the Pelvic, Women’s and Men’s Health special interest group.

In her spare time, she enjoys a variety of activities including running her black Labrador Pippa, cycle touring with her family - husband of 24 years Simon and children Peter and Michael - skiing, bee keeping, gardening and cooking.

Robyn Willcock

I would like to introduce myself to you all. I have recently joined the IOPTWH committee as a member at large and will be assisting Hana with the newsletter. This means you will see the odd email from me requesting a contribution to the newsletter.

I graduated in Sydney 36 years ago and have worked in Women’s Health for 34 of those years. I have been involved on various State and National Committees in the physiotherapy profession and in the broader community.

Throughout my career I have remained principally a clinician. I enjoy the challenge of adapting my practice based on new knowledge and evidence, balanced by refining and practicing my core skills. I am passionate about sharing the latest knowledge with my colleagues and my clients and perhaps this is where my best skills lie.

I am looking forward to working with you all. It will be exciting to share our knowledge and experiences.

Contributions to the newsletter are welcome, please contact the editor:

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IOPTWH Newsletter

July 2015

IOPTWH Informal Social

Ruth Broom
New Zealand

What a joyous time we had at this simple reception, nicely hosted by the executive. It was an effective forum for wonderful camaraderie as friends met again from all corners of the world and new comers were made welcome, creating a warm, buzzy atmosphere.

It was exciting to hear comments such as “would you come to our country and present a course?” And the enthusiasm of researchers in the membership as they asked, “please come to my poster presentation”. Even at such a social occasion, mentoring and hunger for new learning were evident. How proud our founding President, Jill Boissonnault, would have been.

There was a poignant note as the President, Rebecca Stephenson, welcomed everyone knowing that this would be her last informal gathering in this role. But how proud she must have been to know that the organization is in such good health, and one that has consolidated into a warm global family with good collegiality and outstanding role models reflected in the Mildred Elson prize awarded to Kari Bø. As the WCPT notes say, “Mildred believed strongly in the benefits of working together nationally and globally”. And I am sure a social occasion such as this serves to enhance the benefits further.

Workshop WCPT 2015

By: Sonia Scharfbillig from Australia

It was with great anticipation that I ascended the extremely high escalator at the Suntec Convention Centre, Singapore, the location of WCPT 2015. I had heard Talli Rosenbaum give a podium presentation at the First World Congress of Abdominal and Pelvic Pain in Amsterdam in 2013, and had thoroughly enjoyed her talk ‘Addressing Psychosexual Components of Pelvic Pain in Medical and Physical Therapy Practice’. I had hoped to get an opportunity to hear her talk again and was delighted to learn that she was presenting a workshop in Singapore.

The workshop certainly lived up to my expectations. Talli was originally trained as a physiotherapist and worked for many years in the area of Women’s Health. On receiving the qualifications of a sex therapist, she used her skills in both areas. These days Talli consults only as a sex therapist.

The workshop was titled ‘Addressing Sex in Women’s Health Physiotherapy Practice: Foundations and Skills.’ Talli covered many aspects of sexual health from the physiology of sex to female sexuality through the life stages, including pregnancy, menopause and ageing.

We ended the day focusing on sexual pain and the overactive pelvic floor and how pelvic floor physiotherapy and sex therapy are both useful management tools. Talli particularly expanded upon the psychological components of sexual pain and how mindfulness can be a helpful strategy to self-regulate pain.

The day was extremely pleasant. The location was lovely (although the air conditioning worked too well!) and the catering was delicious. It was great to be amongst colleagues from different countries with their varied cultures. Learning about the sexual health and sexual cultures of other nationalities was fascinating and humbling.

I was very grateful to have had the opportunity to attend Talli’s workshop. Many thanks to Talli and the IOPTWH committee for organizing the event.
WCPT Congress 2015
Women’s health networking session

Reports collated by Gill Brook, IOPTWH President
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June 2015

On Monday 4th May 2015 the International Organization of Physical Therapists in Women’s Health (IOPTWH) hosted a networking session for Congress attendees from 07.00-08.30. Despite the early hour, 62 delegates from at least 23 countries attended a very animated and interactive meeting, during which attendees had the opportunity to discuss a range of relevant topics chosen by IOPTWH delegates who had responded to an earlier request for ideas. Those present could choose to stay within one group for the entire session, or change subjects once or twice. Each on the 5 groups was facilitated by two IOPTWH members. Notes were taken, and there was an opportunity for each group to feedback pertinent points from their discussions during a plenary session at the end.

Thank you to all concerned, particularly those who facilitated discussions, took notes, gave feedback within the session, and/or subsequently provided the following information. Please note: these are thoughts and comments from those present, as noted during the discussions. Apologies for any omissions, and it is accepted that practice and opinion may vary within a country or organization so the following is not intended to represent the view of any group, nation or IOPTWH.

**Pessary use for pelvic organ prolapse (POP) in physical therapy practice**
Facilitators & recorder: Sonia Scharfbillig (Australia); Netta Beyar (Israel) – submitted report.

**Obstetric anal sphincter injuries (OASIS)**
Facilitators & recorder: Monika Olsen (Sweden); Ros Thomas (UK); Linda FitzGerald (Ireland) – submitted report.

**High risk pregnancy**
Facilitators & recorder: Rebecca Stephenson (USA); Pat Wolfe (USA); Cristine Ferreira (Brazil) – submitted report

**Paediatric incontinence**
Facilitators & recorder: Margaret Mason (Ireland) – submitted report; Darija Šćepanović (Slovenia)

**Overactive pelvic floor**
Facilitators & recorder: Tracy Spitznagle (USA); Meena Sran (Canada) – submitted report
Paediatric incontinence

Few physiotherapists at this session had any experience of treating children. A small number of therapists had treated a very small number of children and 2 therapists were treating young boys who had sustained falls onto the sacrum and now had anal sphincter injuries.

It was felt that there was a general lack of awareness of the extent of the problem in children and that health professionals who do deal with the problem might be unaware of the role that physiotherapy could play in the treatment and therefore children were not referred. It was also noted that therapists might lack confidence in their ability to treat children.

There was a perception that treatment of paediatric incontinence could be compromised by poor compliance of the child and reduced use of modalities in particular electrical modalities. Treatment generally consists of explanation, use of picture books, breathing exercises, moving on ball. The problem of dysfunctional voiding in girls appears to be world-wide with consequent tight pelvic floors and over-active abdominal muscles. One participant spoke of the reluctance by a very experienced urologist who felt that these girls should not be sent for physiotherapy as ‘the last thing they need is pelvic floor exercises’ thus highlighting the lack of understanding of the work of physiotherapists. It would appear that urologists do refer children with urgency/frequency and sometimes enuresis but in many countries it was nurses or occupational therapists who dealt with these problems.

Towards the end of this session a Singaporean physiotherapist joined the group and said she had completed a module on paediatric incontinence as part of a course she did in Melbourne. She briefly explained how she treats children by working with parents and schoolteachers. Treatment obviously depends on the developmental stage the child is at but may consist of timed voiding programmes, holding programmes tailored to the child to encourage normal habits/patterns and motivating and rewarding the child. It is also important to make sure there is no UTI particularly low grade chronic.

It was also felt that education on bladder habits/pelvic floor could happen in schools perhaps as part of sexual education or even physical education classes.

It was suggested that Incontinence 5th edition 2013 (report of the 5th International Consultation on Incontinence) has a section on paediatric incontinence which might be worth looking at [http://www.icud.info/incontinence.html](http://www.icud.info/incontinence.html).

It was felt that in order to address the problems in this area:

- There needs to be increasing awareness amongst physiotherapists and other health professionals about paediatric incontinence
- Health professionals need to be aware of the roles and responsibilities of all the members of the team

There needs to be (more) training of physiotherapists world-wide
Pessary use for pelvic organ prolapse (POP) in physical therapy practice

Countries in which pessaries are fitted by some physical therapists: Australia, United Kingdom (Addenbrooke’s Hospital, Cambridge has a programme (staffed by a women’s health physiotherapist) for women to self-manage their pessary) and Austria.

Countries in which pessaries are fitted by nurses (via nurse-led pessary clinics): United Kingdom, United States of America, Canada.

Countries in which pessaries are fitted only by gynaecologists: Slovenia, Spain, Japan, Hong Kong, Korea, France, Norway, Israel.

Barriers to a role for physical therapists in the use of pessaries:

- In some countries, there is no way to bill for pessary use (that is, there is no way of the physical therapist being paid for fitting a pessary).
- No time for the role. There are not enough pelvic floor physical therapists in some countries and they are already extremely busy!

Some physical therapists from countries in which only gynaecologists / urogynaecologists fit pessaries, use a Contiform for patients with stress urinary incontinence (e.g. Slovenia). This is a type of pessary. Using a pessary for pelvic organ prolapse is just as easy as using one for stress urinary incontinence, as long as the algorithm for management of pelvic organ prolapse with pessaries is followed (patient adheres to the correct self-management and their medical professional - GP or gynaecologist - is informed/aware of the involvement of the physical therapist and can do a speculum examination once a year).

Websites for guidelines and algorithm:
Guidelines for the Use of Support Pessaries in the Management of Pelvic Organ Prolapse available from:
or
The clinical management algorithm is available from:
The Addenbrooke’s Hospital program:
http://qir.bmj.com/content/3/1/u206180.w2533.full.pdf+html

- Concern about the acceptance of physical therapists fitting pessaries by the gynaecologists/urogynaecologists (and general practitioners [GPs] in the USA) who are the only health professionals fitting pessaries in some countries. Some might view physios fitting pessaries as ‘competition’ for their surgical procedures.

- Concern about the scope of practice for those who work alongside nurse-led pessary clinics. For some, the nurse-led clinics are very well managed and they work harmoniously with the physical therapists. Hence there is perhaps not a need for physical therapist involvement in such countries.

- Lack of experience with fitting pessaries and dealing with complications.

- Lack of knowledge about pelvic organ prolapse management using pessaries (e.g. uncertainty about the indications for pessary use and which stage of POP was suitable - there was an assumption that only stage I prolapse would be managed with pessaries). Lack of knowledge about the ‘Guidelines for the Use of Support Pessaries in the Management of Pelvic Organ Prolapse’.

- There is no course available on pessary management, other than in Australia and UK.
Eleven different countries were represented. *Note that the points below were the experiences of the individual therapists who attended* the workshop and there were differences between therapists from the same country.

**Sweden** has OASIS guidelines (2013) which are only available in Swedish.

**Summary:**
- No evidence for physiotherapy in the acute phase
- Better evidence for pelvic floor exercises
- Limited level evidence for biofeedback
- Very low degree of evidence for muscle stimulation
- Very low degree of evidence for percutaneous tibial nerve stimulation
- No studies on transcutaneous nerve stimulation
- No studies on acupuncture
- Risk factors: baby > 4 Kgs prolonged 2nd stage 3rd degree tear instrumental delivery

**Examples of practice:**
**Australia**

**General Hospital in urban area:**
- All 3rd degree tears are reviewed on the ward by a physiotherapist
- At 6 months, they will have an endo-anal ultrasound but can call a physiotherapist in the meantime if symptomatic
- No weekend cover and patients can be missed
- All 3rd/4th degree tears asked to make a physiotherapy appointment (but may not) for pelvic floor assessment and specialist urogynaec physiotherapy (checked for symptoms, internal exam and education)
- Typically seen for 6 months but can be longer if required

**Regional hospital:**
- Referred to physiotherapist if 3rd/4th degree tear
- Phone follow-up initially and then assessment at 6 weeks
- Can be quite ad hoc depending on where you deliver as there may be no specialist physiotherapist in the area

**Private physiotherapist working in hospital:**
- Every woman with 3rd degree tear seen for 10-15 minute consultation on one-to-one basis
- Physiotherapist checks the birth register
- Provide 6 day cover

N.B. Recent push for home births, causes difficulty in getting access to patients with tears. Midwife education in Australia - There is an on-line course available from the Continence Foundation of Australia on the Pelvic Floor – The Importance of the Midwife. It is free and accessible to midwives online (not available to other disciplines)

**Brazil:**
- Maternity hospitals do not necessarily have physiotherapists
- No early intervention
- When seen, get pelvic floor training and pain symptoms are treated

**Denmark:**
- All women with 3rd or 4th degree tears are seen within a day. Usually are in hospital for 2-3 days
- Taught how to breastfeed by physiotherapists
- Initially asked if they can feel a contraction
- May be followed-up at 3 weeks by midwife but women can call the physiotherapist or nurse at any time
- Work closely with midwives
- Full seven day service and no woman should be missed
France:
- Women’s health physiotherapists often only found in large towns
- Women may not get treatment

Hong Kong:
- Women are usually referred to physiotherapy; definitely if have greater than a first degree tear
- Given advice on pelvic floor exercises and perineal care
- Followed up in out-patients and good communication with doctors
- If faecal incontinence, referred to a surgeon for an endo-anal ultrasound
- Multidisciplinary teams have physiotherapists, nurses and dieticians

India:
- All women have episiotomies
- Many women deliver at home with a reported increased incidence of OASIS
- If large tear on episiotomy, have immediate surgery and physiotherapy

Ireland:
- Seen immediately and then followed up with a phone call at 2 weeks and an appointment 6-12 weeks post-delivery
- If 3rd degree tear, an experienced surgeon will do a rectal check
- Doctors not necessarily doing internal examinations at routine 6 week check-up
- Noted that large tears tend to come in clusters - why (other countries agreed with this)
- Poor access to dietitians; physiotherapists often give the advice
- Recent increase in OASIS due to “hands off “ approach by midwives but this is changing back to hands on

Kenya:
- It is common for women with 2nd/3rd or 4th degree tears to be referred to physiotherapy
- Biofeedback treatment often used
- If pregnant again, have an ultrasound and then told if can have a normal delivery or not
- Can come for physiotherapy at any stage and can be in contact in the long term
- In some hospitals monthly case meetings about OASIS are attended by gynaecologists, obstetricians, physiotherapists and gastroenterologists.
- In some universities physiotherapy students can choose to do a one month placement in women’s health

Japan:
- Have recently started a women’s health group
- Don’t see women’s health patients and would like advice on what point do you intervene

Singapore:
- Episiotomy is routine for all women; felt that this is not reducing the incidence of large tears
- Obstetricians refer all 3rd/4th degree tears for physiotherapy.
- In the early stages, pain relief, ice, postural advice and support of the perineum
- Initially taught a gentle quick contraction, then referred for further physiotherapy

South Africa:
- Women with tears are mainly seen in private practice as there are few women’s health physiotherapists in the public sector in Kwazulu Natal
- The problem is not been managed by physiotherapists

Sweden:
- Guidelines for physiotherapists working with women with obstetric anal injury
- Was funded by hospitals and the Association
- All patients with 3rd/4th degree tears have surgery and are put on a programme
- Routine follow up with midwife, physiotherapist and doctor
- Given laxatives

United Kingdom:
- All 3rd/4th degree tears have surgery and are seen
by a physiotherapist on the ward

- Reported an increase in OASIS due to a “hands off” approach by midwives following new guidelines. Going back to hands on
- A letter is then sent offering an appointment for three weeks later
- Consultant follow up is at six weeks
- Need for guidelines
- Need to educate midwives more
- Episiotomy is considered a risk factor for OASIS in the U.K.

Summary:
- Disparity of care across the counties; no care in some countries and very regional in others
- Midwife education was seen as very important
- Some countries do episiotomy routinely
- Women are usually referred for physiotherapy if it is available
  
  The group suggested a Survey Monkey across all countries

**High risk pregnancy**

**Group 1**

- Referrals from hospital – musculoskeletal dysfunctions
- Referred mainly for woman’s twin/triple pregnancy
- Pregnant women with drug dependency
- Pubic subluxation
- Premature contractions
- Treatment - compression stockings, bed rest, posture advice, ankle & toe exercises, any mobilization exercises that don’t add abdominal pressure

*Perth (Australia):* a multidisciplinary team – clinical psychologist, social counsellors, physiotherapists.

*Chile:* private; for poor social economic background; sometimes expect pain is normal in pregnancy; education to providers.

*Spain:* 5 days protocol; insurance for 5 sessions; antenatal education; sexual, musculoskeletal, urinary incontinence; perineal/ vulva edema; lymphatic drainage in the vagina; pelvic floor muscle exercises.

*USA:* need consent to do undertake digital vaginal palpation.

*Hong Kong:* Birthball and transcutaneous electrical nerve stimulation (TENS) for labor.

**Group 2**

*Israel:* the only time there are physical therapists in the maternity wards is when students learn women’s health; it is not routine. Interventions - light pelvic floor muscle exercises (PFME); low intensity resistance training; change posture to achieve comfort (posture counselling). Women are usually afraid of doing PFME. The physios make the clinical decision of the exercise protocol, and if in doubt they ask the doctor.

Facilitator Rebecca Stephenson asked - *If you contract PFM are you going to cause any damage?* Following personal views of individuals present:

- This is not a problem in Australia
- Canada - allied health professionals and physios may fear working with high risk pregnant women
- USA - physios should care for these patients at home from a functional point of view

**Group 3**

*UK:* It is not clear what we can do and what we cannot do with these patients

*South Korea:* There are a few physios working with women’s health. Doctors may think that physios don’t, or shouldn’t, work with high risk pregnant women

*Chile:* Doctors in general do not recommend exercise for pregnant women, even for low risk pregnant women

*Brazil:* Physios are not routinely involved in the care of high risk pregnant women. Sometimes they receive referrals for low back pain.
Summary (Cristine Ferreira)
In most of the countries physios are not routinely working with high risk pregnant women. The greatest barrier seems to be the fear of exercises by the doctors and sometimes by the allied health team and pregnant women. Colleagues from some countries (Australia, New Zealand) reported a very positive experience working with fewer constraints and less fear as part of an interdisciplinary team. However, many colleagues have stated their own lack of confidence in making clinical decisions related to high risk pregnant women. This seems to be related to the paucity of evidence on the safety of interventions and the lack of guidelines to assist in physios’ clinical decision making.

Overactive pelvic floor

How to define an overactive pelvic floor?
- Palpate resting muscle tension; guided palpation; variety of measures; electromyography (EMG)
- Breathing: why we use breathing before we touch
- Pressure: what are we feeling? Fight or flight: bearing down vs pulling up
- Counterbalance: opposite muscle activity - overactive and lengthened vs overactive and shortened
- Feel pain elsewhere - visceral somatic reflex
- Often people think the touch will hurt but it doesn’t always
- Fecal incontinence: often see overactive pelvic floor but no pain

Intervention for overactive pelvic floor:
- Need to have normal function, length etc., before patient can gain strength or endurance
- Coordination - firing when needed

Looking beyond the pelvic floor:
- C1, C2
- Obturator internus: at what length are the muscles contracting?
- Exam from neutral so they don’t change pelvis, hips etc., to turn on pelvic floor
- Tight hip flexors
- PTs treating pelvic floor and other musculoskeletal clients:
  - What about clients seeing more than 1 PT for different issues vs 1 PT dealing with all issues?
  - Pelvic floor therapists can relieve anxiety through education, sharing knowledge etc.

What causes muscle to shut off?
- Pain, surgical intervention, spinal injury
- What turns it on?

What treatments are non-invasive and can be used when we can’t perform internal work?
- Breathing
- Manually releasing diaphragm to allow it to move through full range of movement
- EMG biofeedback
- Habitual postures of the hip may help e.g. hip internal rotation, abduction, external rotation, allowing relaxation of the PFM.

Kenya delegate: gap in training despite cultural acceptance of treatment if it were available

Closing comments

These notes confirm that the session was an opportunity for a large number of delegates to share their thoughts and experiences, and to hear those of others. The IOPTWH executive committee will discuss these notes and consider further action where appropriate. Please let us know if you use the information, or have any queries or comments.
In Slovenia, the Chartered Physiotherapists in Women’s Health and Continence (SSPWH) group currently has 27 members. There are 4 members on the executive committee. Darija Šćepanović is the current Chairperson.

The current year’s schedule of past and upcoming activities and events of the Slovenian Section of Physiotherapists on Women's Health (SSPWH) is extremely rich. As several past years in a row, we organised and implemented two 30-hour spring courses entitled 'Physical activity in pregnancy – basic course' and two 12-hour courses entitled 'Therapeutic exercise for spinal segmental stabilization in low back pain'. The total number of participants, predominantly physiotherapists and nurses, amounted to nearly 150. This year we organized the first course on Conservative management of urinary incontinence in adults which was very well received.

In autumn, we are planning to organise first one day course entitled ‘Prenatal physiotherapy’

On request of the Croatian association of physiotherapists in women's health, we gave a three-day course on 'Therapeutic exercise for spinal segmental stabilization in low back pain', 'Physical activity in pregnancy – basic course' and course on Conservative management of urinary incontinence in adults.

Again this year the SSPWH closely cooperated with the following societies and associations: Slovenian Menopause Society, Association of Patients with Osteoporosis, Slovenian Urogynecological Society and Nurses and Midwives Association of Slovenia.

In May two delegates of SSPWH attended IOPTWH General meeting in Singapore. At the end of the year two members are going to attend the conference organized by Mediterranean Incontinence and Pelvic Floor Society which will be held in Ljubljana, Slovenia.

Our plans for the future: 
- Raise awareness of the need for women’s health physical therapy curricular content in professional education
- Foster research related to women’s health physical therapy
- Offer financial assistance to physiotherapy students who participate in the research on women’s health as part of their diploma work, especially when the research results might influence the development of women’s health physical therapy
- Update the website
- Recruit new members

On the occasion of their 30th anniversary, the AG GGUP of Germany is holding a 2-day symposium on 09th / 10th October after Frankfurt.
Activities in Turkey in 2015

Women and Physiotherapy Rehabilitation Symposium, 5-7 March 2015, İzmir, Turkey.
Women’s Health subgroup of our physiotherapy association organized this symposium with Dokuz Eylül University. There were many sessions in this symposium including physiotherapy for pelvic floor dysfunctions, women and dance therapy, violence against women and physiotherapy rehabilitation, obstetric physiotherapy and rehabilitation, gynecological physiotherapy and rehabilitation, breast cancer and physiotherapy rehabilitation.

Translation of "KNGF guideline for physical therapy in patients with stress urinary incontinence" into Turkish language by Women's Health subgroup of Turkish Physiotherapy Association with collaboration Bary Berghmans. It will be published as an e-book.

Establishing Facebook group named as "Turkish Physiotherapy Association Women's Health Subgroup" to improve communication between physiotherapists.

Establishing a mail network to improve communication between physiotherapists.

Future activities

September (date to be announced):
One-day physiotherapy symposium for pelvic floor dysfunctions in İstanbul. It will be organized in collaboration between women’s health subgroup and International Physiotherapists Association. In this meeting urologists, urogynecologists and gastroenterologists will also attend as speakers.

October
There will be a half-day physiotherapy session named as "Evidence-Based Physiotherapy for Pelvic Floor Dysfunctions" in the 7th National Urogynecology Congress, 15-18 October 2015, İstanbul, Turkey.

Saudi Arabia

The Saudi Physical Therapists in Women’s Health (SPTWH) celebrated the World Continence week on 25 & 26 of June 2015. The event included an information booth during a charity event for women, incorporating information and advice on incontinence and physical therapy rule in such conditions. A training course on Pilates for physical therapists was also organized in collaboration with a ladies’ recreation center; all was held in Riyadh city. The group launched their social medial accounts (twitter, instagram, & snapchat) during this week. Physical therapy student group under the SPTWH supervision manages the accounts.
IOPTWH NEWSLETTER
July 2015

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