National Institute for Health and Care Excellence

Final

Pelvic floor dysfunction: prevention and non-surgical management

[H] Information provision about management of pelvic floor dysfunction (most effective ways)

NICE guideline number NG210

Evidence review underpinning recommendations 1.4.5 (first bullet), 1.4.6 and 1.4.7 in the NICE guideline

Evidence reviews

December 2021

Final

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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ISBN:978-1-4731-4364-7

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Information provision about management of pelvic floor dysfunction (most effective ways)

Review question

What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

Introduction

Providing visual aids, written tools to communicate information may be important for women to successfully manage their symptoms or manage their day to day living, and coping with pelvic floor dysfunction. Different strategies of providing this information may be more effective than other strategies, and these differences should be explored.

The objective of this review is to determine what information provision strategies are effective for improving outcomes for women with symptoms associated with pelvic floor dysfunction and their partners and/or their carers.

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction

Intervention	• Any tool which is used to provide information on pelvic floor dysfunction
	  ○ Booklet
	  ○ Digital information such as:
	  - Online information (including online support groups)
	  - Phone app
	  ○ Leaflets
	  ○ Patient decision aids
	  ○ Auditory tool
	• Taught group education/information exchange
	• Individual education/information exchange
	• Peer-support groups (online or face to face)

Comparison	• Any alternative information tool • Alternative group or individual education/information exchange • Alternative peer-support group design
Outcome	**Critical** • Satisfaction with the information tool • Satisfaction with care received • Self-efficacy (empowerment) using validated tools only • Knowledge of pelvic floor dysfunction • Adherence to current treatment plan • Subjective measure of change in the following symptoms (only validated tools will be used):

	○ urinary incontinence ○ emptying disorders of the bladder ○ faecal incontinence ○ emptying disorders of the bowel ○ pelvic organ prolapse ○ sexual dysfunction ○ chronic pelvic pain syndrome **Important** • Anxiety and depression (validated scales only) • Quality of life (validated scales only)

For further details, see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Clinical evidence

Included studies

Eleven randomised controlled trials (RCTs) were included for this review from 12 publications: (Araujo 2019, Brazell 2015, Bulmer 2001, Caagbay 2020, Gezginci 2018, Hui 2006, Myers 2014, Sampselle 2017, Shannon 2018, Shirreff 2020, Sjöström 2013, Sjöström 2015)

The included studies are summarised in Table 2.

Three studies compared written with digital information (Araujo 2019, Bulmer 2001, Sjöström 2013). Araujo 2019 compared a mobile pelvic floor muscle training (PFMT) app with written instructions. Bulmer 2001 compared a touchscreen information system about lower urinary tract symptoms (LUTS) with a leaflet. Sjöström 2013 compared an internet based urinary incontinence (UI) treatment programme (including e-mail support) with a written treatment programme sent by post.

One study compared a video with an in-person class (Sampselle 2017). One study compared a video-conferencing continence service with an in-person continence service (Hui 2006).

One study compared verbal with written information for overactive bladder (OAB) symptoms (Gezginci 2018).

Five studies looked at the use of additional information aids to enhance standard information giving (Brazell 2015, Caagbay 2020, Myers 2014, Shannon 2018, Shirreff 2020). Brazell 2015 evaluated the additional benefit of a decision aid to standard discussion about pelvic organ prolapse (POP) and its treatment options. Caagbay 2020 compared the use of an informational flip chart to standard discussion about POP. Myers 2014 evaluated the benefit of a web-based application to personalise discussions about POP compared to standard discussions. Shannon 2018 looked at the impact of adding a short video about PFMT to a standard leaflet. Shirreff 2020 evaluated the benefit of a handwritten list added to standard discussions about OAB.

One of the studies was in women with pelvic floor disorder (Shannon 2018), 3 in women with POP (Brazell 2015, Caagbay 2020, Myers 2014), 3 in women with OAB symptoms (Bulmer 2001, Gezginci 2018, Shirreff 2020) and 4 in women with stress urinary incontinence (SUI) or UI (Araujo 2019, Hui 2006, Sampselle 2017, Sjöström 2013).

Four studies took place in the USA (Brazell 2015, Myers 2014, Sampselle 2017, Shannon 2018). One study took place in Brazil (Araujo 2019), 1 in the UK (Bulmer 2001), 1 in Nepal (Caagbay 2020), 1 in Turkey (Gezginci 2018), 1 in Hong Kong (Hui 2006), 1 in Canada (Shirreff 2020), and 1 in Sweden (Sjöström 2013).

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies

Study	Population	Intervention	Comparison	Outcomes
Araujo 2019 RCT Brazil	N=21 women with SUI starting PFMT Age, years mean (SD) Intervention group 47.2 (10.6); Control group 53.3 (13.2)	A mobile app that prompted the woman to do PFMT, provided advice and recorded progress n=12	Women were given instructions to do PFMT twice a day n=9	• Adherence • Change in symptoms • Quality of life
Brazell 2015 RCT USA	N=104 women presenting with POP Age, years mean (SD): Intervention group 61.0 (13.2); control group 60.4 (11.0)	Standard counselling (discussion about POP and treatment options) plus a decision aid with details on nonsurgical and surgical treatment options, risks associated with surgery, and postoperative expectations n=51	Standard counselling (discussion about POP and treatment options) n=53	• Self-efficacy
Bulmer 2001 RCT UK	N=40 women referred for urodynamic assessment Age, years mean (range):	A computer generated touchscreen information system with information on the cause, investigation and treatment of LUTS	A printed leaflet with information about the cause, investigation and treatment of LUTS n=20	• Satisfaction • Knowledge

Study	Population	Intervention	Comparison	Outcomes
	Intervention group 58.6 (36-76); Control group 61.5 (43-81)	n=20		
Caagbay 2020 RCT Nepal	N=140 women with newly identified POP (stage I to III POP-Q) Age, years (mean, SD): 47.87 (12.9)	Instruction on PFMT and lifestyle advice delivered verbally and with an informational flip-chart n=69	Standard counselling (brief verbal discussion on PFMT) n=67	• Change in symptoms • Quality of life
Gezginci 2018 RCT Turkey	N=60 women with OAB symptoms with or without SUI Age, years (n): 30-49: 16/45 50-69: 24/45 >70: 5/45	Structured educational materials for behavioural therapy on lower urinary tract symptoms. There were 3 groups: (1) verbal instructions and an educational leaflet; (2) only verbal instructions; and (3) only a leaflet n=15 each	Standard counselling comprised verbal instructions about continence care n=15	• Change in symptoms
Hui 2006 RCT Hong Kong	N=64 older women with UI Age, years mean (SD): Intervention group 73.6 (5.); Control group 73.5 (3.8)	Telemedicine continence service (verbal instruction on PFMT, anatomy/ physiology and lifestyle advice; plus leaflet on urge & SUI management) n=27	In-person outpatient continence service (verbal instruction on PFMT, anatomy/ physiology and lifestyle advice; plus leaflet on urge & SUI management) n=31	• Change in symptoms
Myers 2014 RCT USA	N=90 women presenting with POP Age, years mean (SD): Intervention group 59.1 (14.1); Control group 60.7 (11.5)	Standard counselling about POP symptoms plus a web-based application. The application allowed providers to insert each patient's individual POP-Q exam into the program and then provided an animated custom example of normal support and then the patient's particular support defect	Standard counselling about POP symptoms. This was verbal counselling, drawings, diagrams, and/or 2D/3D models n=44	• Satisfaction • Knowledge • Anxiety/depression

Study	Population	Intervention	Comparison	Outcomes
		n=46		
Sampselle 2017 RCT USA	N=647 women with UI Age, years mean (SD): Intervention group 63.03 (5.43); Control group 62.79 (5.91)	A 20-minute DVD video - which was an abbreviated version of the 2-hour class. Women could take this home to watch in their own time n=315	A single 2-hour long group class with 2 presenters (a urologist and a nurse specialist) who provided instruction in non-invasive prevention practices n=332	• Change in symptoms
Shannon 2018 RCT USA	N=200 women with PFD, referred to pelvic floor physiotherapy Age, years mean (SD): Intervention group 57.32 (16.12); Control 56.77 (17.00)	One page, typed handout highlighting the role of physiotherapy in PFD plus a 4.5-minute video highlighting the role of physiotherapy in PFD n=100	One page, typed handout highlighting the role of physiotherapy in PFD n=100	• Adherence • Change in symptoms
Shirreff 2020 RCT Canada	N=72 women with newly diagnosed OAB Age, years mean (SD): Intervention group 54.5 (14.1); Control 57 (15.9)	Standard counselling + written list: verbal information on treatment recommendations for OAB plus a written supplement on the 6 treatment strategies for OAB n=34	Standard counselling: verbal information on treatment recommendations for OAB n=38	• Knowledge
Sjöström 2013; Sjöström 2015 Sweden RCT	N=250 women with SUI Age, years mean (SD): Intervention group 47.9 (10.6); Control 49.4 (9.8)	An Internet-based treatment programme, including e-mail support and cognitive behavioural, therapy assignments. The programme included information on SUI and associated lifestyle factors, PFMT and training reports (frequency, time spent) n=124	A treatment programme sent by post. The programme included information on SUI and associated lifestyle factors, PFMT and training reports (frequency, time spent) n=126	• Satisfaction • Change in symptoms • Quality of life

LUTS: lower urinary tract symptoms; OAB: overactive bladder; PFD: pelvic floor dysfunction; PFMT: pelvic floor muscle training; PFPT: pelvic floor physiotherapy; POP: pelvic organ prolapse; POP-Q: Pelvic organ prolapse quantification; RCT: randomised controlled trial; SD: standard deviation; SUI: stress urinary incontinence

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Quality assessment of studies included in the evidence review

See the evidence profiles in appendix F.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline. Two economic study were identified which was relevant to this question (Jones 2018, Sjöström 2015).

See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

Economic studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the economic evidence review

See the economic evidence tables in appendix H and economic evidence profiles in appendix I.

Jones (2018) undertook a cost-utility analysis alongside a RCT. The analysis compared a "virtual" clinic to a standard clinic for women aged > 18 years and referred to a urogynaecology unit with urinary incontinence. Resource use data was collected at the initial consultation and at 6 months' follow-up and an analysis was undertaken using an NHS perspective on patients with complete cost and otcome data. Consultation costs were lower for the virtual clinic due to their much shorter duration. However, this reduction was more than offset by increases in costs in the "virtual" clinic arm during the 6 months' follow-up, driven primarily by more gynaecology outpatient visits. Health state utilities were estimated using the SF-6D and QALYs were 0.0095 lower (95% confidence interval: -0.3199 to 0.0130) for women attending the "virtual" clinic. Therefore, the deterministic analysis showed that the standard clinic dominated, being cheaper and more effective, although the differences in costs and effects were not statistically significant. Probabilistic sensitivity analysis suggested that there was a 35% probability that the "virtual" clinic was cost-effective at a cost-effectiveness threshold of £20,000 per QALY, although this rose to 48% when imputing for missing data. However, the authors note 2 problems in a simple interpretation of their results. First, they claim that the inclusion of costs that do not relate to the consultation may introduce bias as well as additional uncertainty. Second, they query the extent that the SF-6D will capture all the benefits of the "virtual" clinic.

A Swedish study (Sjöström 2015) undertook a cost-utility analysis alongside an RCT to compare an Internet based treatment programme against a programme sent by post for women with stress urinary incontinence (SUI). The economic analysis additionally included a no treatment comparator. Pelvic Floor Muscle Training (PFMT) was the main focus of both programmes but they also included SUI information and relevant lifestyle factors. The analysis included relevant costs that arose over the course of 1-year although for a no treatment alternative it was assumed that costs and utilities would remain the same as for the study population at baseline. The ICIQ-LUTSqol questionnaire was used to assess quality of life and QALYs were derived from that questionnaire using a preference based index. The incremental cost-effectiveness ratio (ICER) for the postal programme relative to no treatment

was €2,389 per QALY. The ICER for the Internet programme relative to the postal programme was €31,600 per QALY. In the UK context the postal programme would appear to be cost-effective relative to no treatment and the Internet programme would appear to be of borderline cost-effectiveness relative to the postal programme. No probabilistic sensitivity analysis was undertaken to quantify uncertainty and one-way sensitivity analysis was limited to a societal perspective.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation as recommendations were unlikely to have significant resource implications.

Brief summary of evidence

Written versus digital information

- There was low quality evidence that women were more satisfied with an internet based treatment programme for UI than with a programme sent by post.
- There was moderate quality evidence that a mobile app increased adherence to PFMT when compared with written instructions.
- There was low quality evidence that a mobile app increased quality of life when compared with written instructions.
- The quality of evidence for the other outcomes, including satisfaction with a touch screen based programme compared to a leaflet based programme, knowledge and change in symptoms, and quality of life was very low to moderate; and no clinically important differences were seen.

Written ± verbal instructions versus verbal instructions alone

- There was low quality evidence that verbal instruction plus an educational leaflet is more effective than either modality alone for bladder training in women with overactive bladder and urge UI in terms of change in UI symptoms.
- Low quality evidence showed no clinically important differences between leaflet alone versus verbal instructions alone, for any outcomes.

Video versus in-person class

- There was moderate quality evidence that an abbreviated 20-minute video version of a 2-hour in-person class on non-invasive prevention of stress urinary incontinence is as effective as the class itself, when measured using change in UI symptoms.

Videoconference continence program versus in-person continence program

- There was low quality evidence that a videoconference continence program was as effective as a conventional outpatient continence program in the management of urinary incontinence symptoms.

Standard counselling versus standard counselling plus an information aid

- The quality of evidence was very low to moderate quality; in general no clinically important differences were seen in the reported outcomes, including satisfaction, self-efficacy, knowledge, adherence, change in symptoms and anxiety and depression, indicating that standard counselling was relatively effective in most studies.
- Low quality evidence from 1 study supported the use of an in-depth information aid on pelvic anatomy, pelvic organ prolapse and treatment options compared to standard care (brief verbal instruction on PFMT) for women with POP in terms of change in symptoms and quality of life.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The critical outcomes were satisfaction, self-efficacy, adherence, improvement in knowledge and symptoms. Non-surgical management typically requires a woman to carry out exercises and other lifestyle changes: the better the woman understands how and why to do these, the better her motivation and adherence will be and ultimately her symptom improvement. Anxiety and depression and quality of life were important outcomes because information and peer-support groups can provide relief and reassurance for women with pelvic floor dysfunction.

The quality of the evidence

The quality of the evidence was assessed using GRADE and ranged from medium to low. This was predominantly due to serious risk of bias due to a lack of blinding in all included studies, and serious imprecision for many outcomes. Evidence was identified for all critical and important outcomes, however there was a lack of evidence about peer-support groups.

Benefits and harms

The evidence favoured the use of a combination of verbal and written information supplemented with additional information aids. This supported the recommendation to supplement verbal and written information with anatomical models and diagrams and digital information aids. The committee noted their experience that often patients only remember part of the information provided verbally.

The committee agreed, based on experience that any information would need to be tailored to the woman's needs and cross referred to the existing NICE guideline on patient experience of adult NHS services as well as the NICE guideline on babies, children and young people's experience of healthcare where this is covered in detail (for a link to this guideline see the 'other considerations' section below).

There was low to moderate quality evidence that a mobile app could improve adherence to pelvic floor muscle training and that an internet based treatment programme for urinary incontinence was more satisfactory than a written treatment programme. This supported the recommendation to consider using digital applications to support information provision for women with pelvic floor dysfunction. The committee noted that increased adherence to correctly performed pelvic floor muscle training is likely to lead to improved pelvic floor dysfunction symptoms. They noted that any digital information provision still needs to tackle the challenge of ensuring the exercises are performed correctly. In relation to digital information provision the committee also discussed their experience from the COVID-19 pandemic where some women preferred remote digital consultations because they felt less embarrassed (see also evidence report G information valued by women with pelvic floor dysfunction) but they also noted that there may be other women who may under-report symptoms when consultations are digital due to embarrassment.

The committee did not identify any harms associated with recommendations for information and communication.

Cost effectiveness and resource use

One UK study (Jones 2018) compared a "virtual" clinic to a standard clinic for women with urinary incontinence. The NHS costs were found to £108 higher (95% confidence interval: -£347 to £564) with the virtual clinic due to increased costs of outpatient visits more than offsetting the lower costs of a virtual consultation, although the overall difference in costs was not statistically significant. The analysis found that the "virtual" clinic resulted in an

incremental loss of 0.0095 QALYs (95% confidence interval: -0.3199 to 0.0130) although again the difference fell a long way short of statistical significance at the 5% level. Probabilistic sensitivity analysis suggested there was a 35% probability that the "virtual" clinic was cost-effective rising to 48% when imputing missing data. However, the authors caution against a simplistic interpretation of these numbers noting that the inclusion of costs subsequent to the initial consultation introduces uncertainty and the potential for bias. Furthermore, they query whether the generic utility measure used to estimate QALYs would be capable of detecting subtle effects.

A Swedish economic evaluation alongside a randomised controlled trial (Sjöström 2015) compared Internet based and postal approaches to stress urinary incontinence, focusing mainly on PFMT, against each other but also against no treatment. In the base case analysis, the study found that the Internet based approach had an incremental cost-effectiveness ratio of €5,310 relative to no treatment and an incremental cost-effectiveness ratio of €31,600 relative to the postal approach which could be considered borderline cost-effective at a cost-effectiveness threshold of £20,000 to £30,000 per QALY using the exchange rate at the time of writing (£1 = €1.3796, https://www.bankofengland.co.uk/statistics/exchange-rates).

The committee thought that a weak recommendation to consider digital approaches to support women with pelvic floor dysfunction was warranted based on the economic evidence on the cost-effectiveness of Internet based approaches. Whilst the committee recognised that the economic evidence did not provide strong cost-effectiveness evidence to support "virtual" consultation formats, they noted that the UK study (Jones 2018) reported much lower costs and duration for the "virtual" clinic and that it was only the inclusion of possibly irrelevant costs after the initial consultation that resulted in the failure to demonstrate cost-effectiveness for the "virtual" clinic. The committee noted from their experience of the COVID-19 pandemic that some women appreciated these remote consultations and felt less embarrassed (however they also acknowledged that this depends on personal preferences and some women may be more embarrassed and under-report symptoms when consultations are digital). Therefore, given that remote consultations can be cheaper than face-to-face consultations, the committee thought they were likely to be cost-effective for women who favoured this format.

Other considerations

The committee referred to the communication section in the NICE guideline on patient experience of adult NHS services as well as the NICE guideline on babies, children and young people's experience of healthcare where there is general guidance about communicating with patients including what formats can be used. They also referenced the NICE guideline on behaviour change: digital and mobile health interventions for information on how to plan and develop digital tools to encourage behavioural change.

Recommendations supported by this evidence review

This evidence review underpins recommendations 1.4.5 (first bullet), 1.4.6 and 1.4.7 in the NICE guideline.

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Appendices

Appendix A – Review protocol

Review protocol for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

Table 3: Review protocol

ID	Field	Content
0.	PROSPERO registration number	CRD42020164480
1.	Review title	Information provision
2.	Review question	What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?
3.	Objective	The objective of this review is to determine what information provision strategies are effective for improving outcomes for women with symptoms associated with pelvic floor dysfunction and their partners and/or their carers. Providing visual aids, written tools to communicate information may be important for women to successfully manage their symptoms or manage their day to day living, and coping with pelvic floor dysfunction. Different strategies of providing this information may be more effective than other strategies, and these differences should be explored. This is a quantitative review, and will be considered alongside review question: "What information is valued by women with symptoms associated with pelvic floor dysfunction and their partners or carers? A qualitative review; however, we will not combine the data from the reviews; therefore, no meta-synthesis will be carried out on the two reviews together.
4.	Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • CINAHL or Emcare • PsycINFO Searches will be restricted by: • Date limit: 1980 onwards (see section 10 for justification) • English language

ID	Field	Content
		• Human studies Other searches: Inclusion lists of potentially relevant systematic reviews The full search strategies for MEDLINE database will be published in the final review. For each search, the principal database search strategy is quality assured by a second information scientist using an adaptation of the PRESS 2015 Guideline Evidence-Based Checklist.
5.	Condition or domain being studied	The following symptoms will be addressed as long as they are associated with pelvic floor dysfunction: urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes.
6.	Population	Inclusion • Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction Exclusion • Studies which include women, with urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes which are not due to pelvic floor dysfunction will be excluded. For example, women who have urinary incontinence due to a neurological condition or pelvic cancer will be excluded. During the screening stage, the reported inclusion/exclusion criteria of studies will be examined carefully. We do not anticipate studies on urinary incontinence, emptying disorders of the bladder or pelvic organ prolapse will explicitly state "*associated with pelvic floor dysfunction*" therefore this will be a pragmatic decision based on the description of the condition provided by the study authors. Some of these symptoms (for example urinary incontinence) are most often due to a failure in the pelvic floor and therefore unless the exclusion criteria states a different cause, these studies are likely to be included. However, for studies on faecal incontinence, emptying disorders of the bowel, sexual dysfunction and pelvic pain the causes are more numerous. As such for these symptoms unless the study specifically states "*associated with pelvic floor dysfunction"* they will be excluded. If any ambiguity exists, at least two reviewers will make the final decision if to include or exclude the study. • Men • Babies and children
7.	Intervention/Exposure/Test	• Any tool which is used to provide information on pelvic floor dysfunction ○ Booklet ○ Digital information such as: - Online information (including online support groups) - Phone app ○ Leaflets

ID	Field	Content
		○ Patient decision aids ○ Auditory tool • Taught group education/information exchange • Individual education/information exchange • Peer-support groups (online or face to face)
8.	Comparator/Reference standard/Confounding factors	• Any alternative information tool • Alternative group or individual education/information exchange • Alternative peer-support group design
9.	Types of study to be included	• Systematic reviews of RCTs • RCTs If there is no RCT evidence then other studies designs will be considered, namely • Non-randomised controlled studies • Comparative prospective cohort studies • Comparative retrospective cohort studies *Note: For further details, see the algorithm in appendix H, Developing NICE guidelines: the manual.*
10.	Other exclusion criteria	• Studies with a mixed population (for instance women with symptoms such as urinary incontinence which are associated with pelvic floor dysfunction and women with symptoms that are not associated with pelvic floor dysfunction) will be excluded, unless subgroup analysis for those women with symptoms associated with pelvic floor dysfunction has been reported • Conference abstracts will be excluded because these do not typically provide sufficient information to fully assess risk of bias • Qualitative studies will not be included • Only articles published after 1980 will be included. This was agreed by the committee as this is the date that the condition "pelvic floor dysfunction" was recognised to include agreed terminology on symptoms. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815805/
11.	Context	Included studies will be relevant for developing and improving information provided to women with symptoms associated with pelvic floor dysfunction within a health care setting. Although relevant to the health care setting, they may be relevant on a wider context, providing information that is valued once women are in the home environment, and the community and living with pelvic floor dysfunction.
12.	Primary outcomes (critical outcomes)	• Satisfaction with the information tool • Satisfaction with care received • Self-efficacy (empowerment) using validated tools only • Knowledge of pelvic floor dysfunction

ID	Field	Content

		• Adherence to current treatment plan
		• Subjective measure of change in the following symptoms (only validated tools will be used):
		  ○ urinary incontinence
		  ○ emptying disorders of the bladder
		  ○ faecal incontinence
		  ○ emptying disorders of the bowel
		  ○ pelvic organ prolapse
		  ○ sexual dysfunction
		  ○ chronic pelvic pain syndrome

13.	Secondary outcomes (important outcomes)	• Anxiety and depression (validated scales only) • Quality of life (validated scales only)
14.	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. Dual sifting will not be conducted for this review question. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer. Information to be extracted from studies includes: study type, study dates, location of study, funding, inclusion and exclusion criteria, participant characteristics, and details of the intervention and comparator.
15.	Risk of bias (quality) assessment	Risk of bias of individual studies will be performed using the following checklists: • ROBIS tool for systematic reviews • Cochrane RoB tool v.2 for RCTs and quasi-RCTs • Cochrane ROBINS-I tool for non-randomised (clinical) controlled trials and cohort studies The quality assessment will be performed by one reviewer and this will be quality assessed by a senior reviewer.
16.	Strategy for data synthesis	Depending on the availability of the evidence, the findings will be summarised narratively or quantitatively. <u>Data Synthesis</u> Where possible, pair wise meta-analyses will be conducted using Cochrane Review Manager software. A fixed effect meta-analysis will be conducted and data will be presented as risk ratios for dichotomous outcomes. Peto odds ratio will be used for outcomes with zero events Mean differences or standardised mean differences will be calculated for continuous outcomes.

ID	Field	Content
		Heterogeneity Heterogeneity in the effect estimates of the individual studies will be assessed using the I^2 statistic. I^2 values of greater than 50% and 80% will be considered as significant and very significant heterogeneity, respectively. In the presence of heterogeneity sub-group analysis will be conducted *(a) According to risk of bias of individual studies* *(b) According to socioeconomic status of population included* *(c) By ethnicity of included populations* Exact subgroup analysis may vary depending on differences identified within included studies. If heterogeneity cannot be explained through subgroup analysis, then a random effects model will be used for meta-analysis. If heterogeneity remains above 80% reviewers will consider if meta-analysis is appropriate given the characteristics of included. Minimal important differences (MIDs) For outcomes where validated tools are included (for example ICIQ), then the published MIDs will be used. Where no published MID is available, default MIDs will be used: • For risk ratios: 0.8 and 1.25. • For continuous outcomes: ○ For one study: the MID is calculated as +/-0.5 times the baseline SD of the control arm. ○ For two studies: the MID is calculated as +/-0.5 times the mean of the SDs of the control arms at baseline. If baseline SD is not available, then SD at follow up will be used. ○ For three or more studies (meta-analysed): the MID is calculated by ranking the studies in order of SD in the control arms. The MID is calculated as +/- 0.5 times median SD. ○ For studies that have been pooled using SMD (meta-analysed): +0.5 and -0.5 in the SMD scale are used as MID boundaries. ○ Validity The confidence in the findings across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group: http://www.gradeworkinggroup.org/
17.	Analysis of sub-groups	All data will initially be pooled for overall analysis; however, if data is available, separate analysis will also be conducted on: • Women who are pregnant • Women before and after gynaecological surgery • Women aged 65 or older • Young women (aged 12 to 18)

ID	Field	Content			
		• Women with physical disabilities • Women with cognitive impairment • According to those who do not identify themselves as women, but who have female pelvic organs *Recommendations will apply to all those with pelvic floor dysfunction unless there is evidence of a difference in these stratified groups*			
18.	Type and method of review	☒	Intervention		
		☐	Diagnostic		
		☐	Prognostic		
		☐	Qualitative		
		☐	Epidemiologic		
		☐	Service Delivery		
		☐	Other (please specify)		
19.	Language	English			
20.	Country	England			
21.	Anticipated or actual start date	TBC			
22.	Anticipated completion date	August 2021			
23.	Stage of review at time of this submission	**Review stage**	**Started**	**Completed**	
		Preliminary searches	☒	☒	
		Piloting of the study selection process	☐	☐	
		Formal screening of search results against eligibility criteria	☐	☐	
		Data extraction	☐	☐	
		Risk of bias (quality) assessment	☐	☐	
		Data analysis	☐	☐	
24.	Named contact	**5a. Named contact** National Guideline Alliance **5b. Named contact e-mail**			

ID	Field	Content	
		PreventionofPOP@nice.org.uk **5e. Organisational affiliation of the review** National Institute for Health and Care Excellence (NICE) and National Guideline Alliance	
25.	Review team members	NGA Technical Team	
26.	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which receives funding from NICE.	
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10123/	
29.	Other registration details		
30.	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=164480	
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: notifying registered stakeholders of publication publicising the guideline through NICE's newsletter and alerts issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.	
32.	Keywords	Information provision, pelvic floor dysfunction,	
33.	Details of existing review of same topic by same authors	Not applicable	
34.	Current review status	☒	Ongoing
		☐	Completed but not published
		☐	Completed and published

ID	Field	Content	
		☐	Completed, published and being updated
		☐	Discontinued
35..	Additional information		
36.	Details of final publication	www.nice.org.uk	

CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of Abstracts of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; ICIQ: International Consultation on Incontinence Questionnaire; MID: minimally important difference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk of bias; ROBIS: Risk Of Bias In Systematic reviews; ROBINS: Risk Of Bias In Non-randomised Studies; SD: standard deviation

Appendix B – Literature search strategies

Literature search strategies for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction? (Quantitative)

Clinical Search

Database(s): Medline & Embase (Multifile) – OVID interface
Embase Classic+Embase 1947 to 2020 June 26; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to June 26, 2020
Date of last search: 29 June 2020

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

#	Searches
1	Pelvic Floor/ or Pelvic Floor Disorders/ or exp *Urinary Incontinence/ or *Urinary Bladder, Overactive/ or exp *Pelvic Organ Prolapse/ or *Rectocele/ or *Fecal Incontinence/ or Urinary Retention/ or Fecal Impaction/ or Vaginismus/
2	1 use ppez
3	pelvis floor/ or pelvic floor disorder/ or exp *urine incontinence/ or *overactive bladder/ or *bladder instability/ or exp *pelvic organ prolapse/ or *rectocele/ or *feces incontinence/ or urine retention/ or defecation disorder/ or Feces Impaction/ or female sexual dysfunction/ or vaginism/
4	3 use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
7	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
8	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
9	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
10	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
11	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
12	(SUI or OAB).ti.
13	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
14	(urinary adj3 bladder adj3 prolaps$).ti.
15	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
16	(splanchnoptos$ or visceroptos$).ti.
17	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
18	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
19	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
20	(urin$ adj3 (retention$ or retain$)).tw.
21	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
22	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
23	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
24	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
25	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
26	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
27	outlet$ dysfunction$ constipa$.tw.
28	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
29	(pelvi$ adj3 dyskines$).tw.
30	pelvi$ outlet$ obstruct$.tw.
31	anismus$.tw.
32	puborectal$ contract$.tw.
33	((rectal or rectum) adj3 urge$).tw.
34	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
35	(obstruct$ adj3 intercourse).tw.
36	(vagin$ adj3 laxity$).tw.

#	Searches
37	(vagin$ adj wind).tw.
38	vaginismus$.tw.
39	(vagin$ adj penetrat$ adj disorder$).tw.
40	or/2,4-39
41	Choice Behavior/ use ppez
42	Decision Making/ use ppez
43	Decision Support Techniques/ use ppez
44	decision making/ use emczd
45	decision support system/ use emczd
46	(decision$ or choic$ or preference$).tw.
47	or/41-46
48	Patient Compliance/ use ppez
49	Informed Consent/ use ppez
50	Treatment Refusal/ use ppez
51	exp Consumer Behavior/ use ppez
52	exp Consumer Participation/ use ppez
53	exp Health Education/ use ppez
54	patient compliance/ use emczd
55	informed consent/ use emczd
56	treatment refusal/ use emczd
57	exp consumer attitude/ use emczd
58	exp consumer/ use emczd
59	exp health education/ use emczd
60	or/48-59
61	(decision$ adj aid$).tw.
62	((women$ or woman$ or patient$) adj decision$).tw.
63	61 or 62
64	47 and 60
65	63 or 64
66	40 and 65
67	Patient Education as Topic/ use ppez
68	patient education/ use emczd
69	((patient$ or consumer$) adj3 (educat$ or skill$ or teach$ or train$ or coach$)).tw.
70	or/67-69
71	Communication/ use ppez
72	interpersonal communication/ use emczd
73	communicat$.tw.
74	Group Processes/ use ppez
75	group process/ use emczd
76	or/71-75
77	40 and 70 and 76
78	66 or 77
79	Information Services/ or Information Dissemination/ or Access to Information/ or Mass Media/ or Consumer Health Information/ or *Health Promotion/ or *Health Education/ or *Health Knowledge, Attitudes, Practice/ or *Patient Education as Topic/ or Patient Education as Topic/st or Patient Education Handout/ or Pamphlets/ or exp Computers, Handheld/ or Internet/ or *Internet-Based Intervention/ or Web Browser/ or Social Media/ or *Social Networking/ or Mobile Applications/ or Electronic Mail/ or Text Messaging/ or Hotlines/ or *Telephone/ or Television/ or Radio/ or Bibliotherapy/ or Health Literacy/ or Therapy, Computer-Assisted/mt or Patient Advocacy/ or Social Support/ or Self-Help Groups/ or Peer Group/ or Empowerment/ or *Shame/ or *Stigma/ or *Taboo/
80	79 use ppez
81	information service/ or information dissemination/ or access to information/ or *help seeking behavior/ or mass communication/ or consumer health information/ or *health promotion/ or *health education/ or education program/ or *attitude to health/ or *patient education/ or patient information/ or *medical information/ or *publication/ or personal digital assistant/ or internet/ or web-based intervention/ or web browser/ or social media/ or blogging/ or *social network/ or smartphone/ or mobile application/ or e-mail/ or text messaging/ or hotline/ or *telephone/ or *teleconsultation/ or television/ or radio/ or bibliotherapy/ or *health literacy/ or *computer assisted therapy/ or patient advocacy/ or social support/ or self help/ or exp support group/ or peer group/ or empowerment/ or *shame/ or *stigma/ or *taboo/
82	81 use emczd
83	(information adj (seek$ or gather$)).tw.
84	(helpseek$ or help-seek$ or healthcareseek$ or healthcare-seek$ or healthseek$ or health-seek$ or health care-seek$ or health careseek$ or health care seek$).tw.
85	(care-seek$ or careseek$ or care seek$).ti.
86	((information or informative) adj3 tool$).tw.
87	((written or audio$ or visual) adj tool$).tw.
88	((written or printed) adj3 (information or material$ or education$ or instruction$)).tw.
89	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj5 (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or smartphone$ or smart phone$ or online or on-line or on line or audiovisual or audio-visual or audio visual)).tw.
90	(pamphlet$ or booklet$ or brochure$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or bibliotherap$).ti.

#	Searches
91	((patient$ or fact$ or written or printed) adj (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$)).tw.
92	((inform$ or reading) adj5 (magazin$ or newspaper$)).tw.
93	((popular or women$ or woman$ or online) adj (magazin$ or newspaper$)).tw.
94	(newspaper adj cutting$).tw.
95	(information adj (card or cards)).tw.
96	flipchart$.tw.
97	((inform$ or campaign$) adj10 (television$ or TV or radio)).tw.
98	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj3 video$).tw.
99	dvd$.tw.
100	(auditory adj (inform$ or tool$)).tw.
101	(voiceover$ or voice-over$ or voice over$).tw.
102	(mobile adj (technolog$ or communicat$)).tw.
103	((smartphone$ or smart phone$ or phone$ or iphone$ or mobile$ or tablet$ or ipad$ or digital or android$) adj5 (app or app-based or apps or application$)).tw.
104	smartphone-based.tw.
105	(helpline$ or help-line$ or hotline$ or hot-line$).tw.
106	telephone-based intervention$.tw.
107	(dedicat$ adj (mobile$ or phone$ or telephone$)).tw.
108	((telephone$ or phone$) adj consultation$).tw.
109	(social$ adj media$).tw.
110	(social$ adj3 network$).tw.
111	(blogs or vlogs or blogger$ or vlogger$ or influencer$).tw.
112	(social$ adj influence$).tw.
113	(podcast$ or webinar$ or Facebook or Instagram or Skype or WeChat$).tw.
114	(Twitter$ or tweet$ or Youtube$).ti.
115	((online or on-line or on line or cyber$ or internet$ or discussion$) adj3 (forum$ or group$ or intervention$)).tw.
116	((online or on-line or on line or cyber$ or internet$) adj resource$).ti.
117	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$ or device$ or guidance$ or treatment$ or therap$ or access$ or recommend$) adj3 (app or app-based or apps or web$)).tw.
118	(website$ or web-site$ or web site$).tw.
119	internet-based$.tw.
120	((talk-based or text-based or visual) adj media$).tw.
121	(computer$ adj3 (handheld or palm top or palmtop or pda or tablet$)).tw.
122	(personal digital assistant$ or pocket pc$).tw.
123	((emotion$ or network$ or peer$ or organi?ation$ or social) adj support$).tw.
124	(support adj (group$ or intervention$ or network$)).tw.
125	((selfhelp or self-help or self help) adj3 group$).tw.
126	((self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj package$).tw.
127	(group$ adj (training or education)).tw.
128	(peer$ adj3 (advice$ or advis$ or counsel$ or help$ or mentor$)).tw.
129	peer network$.tw.
130	((public or patient or consumer) adj advoca$).tw.
131	(advoca$ adj (group$ or organization$)).tw.
132	((lay or support) adj person).tw.
133	(patient adj empower$).tw.
134	((psychoeducat$ or psycho-educat$ or psychosocial$ or psycho-social$) adj (support$ or group$ or intervention$)).ti.
135	(health adj literacy).tw.
136	(educat$ adj3 strateg$).tw.
137	(educat$ adj (material$ or workshop$)).tw.
138	(literature$ adj3 educat$).tw.
139	(elearn$ or e-learn$ or ehealth$ or e-health$ or mhealth$ or m-health$).tw.
140	((educat$ or inform$) adj5 exchange$).tw.
141	((information$ or disseminat$) adj (need$ or provi$ or strateg$)).tw.
142	source$ of information$.tw.
143	(patient$ adj (information or education)).tw.
144	((health$ or communicat$ or educat$ or prevent$ or inform$ or disseminat$) adj3 campaign$).tw.
145	((health or public or prevention or community) adj (information$ or education$)).tw.
146	(communit$ adj2 intervention$).tw.
147	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).ti.
148	((pelvi$ floor$ or continenc$ service$ or PFM or PFD or PFMT) adj5 awareness).tw.
149	(awareness adj (program$ or campaign$ or training)).tw.
150	(community adj awareness).tw.
151	(engag$ adj3 communit$).tw.
152	(address$ adj3 (stigma$ or shame or taboo$)).tw.
153	unspeakable.tw.
154	(charity or charities or promocon$).mp.

#	Searches
155	or/80,82-154
156	40 and 155
157	78 or 156
158	Pelvic Floor/ or Pelvic Floor Disorders/
159	158 use ppez
160	pelvis floor/ or pelvic floor disorder/
161	160 use emczd
162	5 or 6 or 159 or 161
163	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).tw.
164	162 and 163
165	157 or 164
166	limit 165 to english language
167	limit 166 to yr="1980 -Current" [General Exclusions filter applied]

Database(s): Cochrane Library – Wiley interface
Cochrane Database of Systematic Reviews, Issue 6 of 12, June 2020; **Cochrane Central Register of Controlled Trials**, Issue 6 of 12, June 2020
Date of last search: 2 July 2020

#	Searches
#1	MeSH descriptor: [Pelvic Floor] this term only
#2	MeSH descriptor: [Pelvic Floor Disorders] this term only
#3	((pelvi* NEXT (floor* or diaphragm*) NEAR/3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or "well being*" or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or "over activ*")):ti,ab,kw
#4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or "well being*" or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or "over activ*")):ti,ab,kw
#5	MeSH descriptor: [Urinary Incontinence] explode all trees
#6	MeSH descriptor: [Urinary Bladder, Overactive] this term only
#7	(((stress* or mix* or urg* or urin*) NEAR/5 incontinen*)):ti
#8	(((bladder* NEAR/5 (overactiv* or "over activ*" or instabilit* or hyperreflex* or "hyper reflex*" or incontinen*)))):ti
#9	(((detrusor* NEAR/5 (overactiv* or "over activ*" or instabilit* or hyperreflex* or "hyper reflex*")))):ti
#10	(((((urgency NEAR/2 frequency) or (frequency NEAR/2 urgency)))):ti
#11	(((((urin* or bladder*) NEAR/2 (urg* or frequen*)))):ti
#12	(((SUI or OAB))):ti
#13	MeSH descriptor: [Pelvic Organ Prolapse] explode all trees
#14	MeSH descriptor: [Rectocele] this term only
#15	(((pelvic* NEAR/3 organ* NEAR/3 prolaps*))):ti
#16	(((urinary NEAR/3 bladder NEAR/3 prolaps*))):ti
#17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR/3 prolaps*))):ti
#18	(((splanchnoptos* or visceroptos*))):ti
#19	(((hernia* NEAR/3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))):ti
#20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))):ti
#21	MeSH descriptor: [Fecal Incontinence] this term only
#22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR/5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))):ti
#23	MeSH descriptor: [Urinary Retention] this term only
#24	(((urin* NEAR/3 (retention* or retain*)))):ti,ab,kw
#25	(((voiding NEXT (disorder* or dysfunction* or problem*)))):ti,ab,kw
#26	(((empty* NEXT disorder* NEAR/3 (bowel* or bladder* or vesical* or stool*)))):ti,ab,kw
#27	((((urogeni* or anorec* or "ano rec*") NEAR/3 dysfunction*))):ti,ab,kw
#28	MeSH descriptor: [Fecal Impaction] this term only
#29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR/3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or "bowel movement*")))):ti,ab,kw
#30	(((obstruct* NEAR/3 (defecat* or defaecat*)))):ti,ab,kw
#31	((((defecat* or defaecat* or evacuat*) NEAR/3 (disorder* or dysfunction*)))):ti,ab,kw
#32	((outlet* dysfunction* constipa*)):ti,ab,kw
#33	(((dys?ynerg* NEXT (defecat* or defaecat*)))):ti,ab,kw
#34	(((pelvi* NEAR/3 dyskines*))):ti,ab,kw
#35	((pelvi* outlet* obstruct*)):ti,ab,kw
#36	((anismus*)):ti,ab,kw
#37	((puborectal* contract*)):ti,ab,kw
#38	((((rectal or rectum) NEAR/3 urge*))):ti,ab,kw
#39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))):ti,ab,kw
#40	(((obstruct* NEAR/3 intercourse))):ti,ab,kw
#41	(((vagin* NEAR/3 laxity*))):ti,ab,kw

#	Searches
#42	(((vagin* NEXT wind))):ti,ab,kw
#43	MeSH descriptor: [Vaginismus] this term only
#44	((vaginismus*)):ti,ab,kw
#45	(((vagin* NEXT penetrat* NEXT disorder*))):ti,ab,kw
#46	{or #1-#45}
#47	MeSH descriptor: [Choice Behavior] this term only
#48	MeSH descriptor: [Decision Making] this term only
#49	MeSH descriptor: [Decision Support Techniques] this term only
#50	((decision* or choic* or preference*)):ti,ab,kw
#51	#47 OR #48 OR #49 or #50
#52	MeSH descriptor: [Patient Compliance] this term only
#53	MeSH descriptor: [Informed Consent] this term only
#54	MeSH descriptor: [Treatment Refusal] this term only
#55	MeSH descriptor: [Consumer Behavior] explode all trees
#56	MeSH descriptor: [Community Participation] explode all trees
#57	MeSH descriptor: [Health Education] explode all trees
#58	#52 OR #53 OR #54 OR #55 OR #56 OR #57
#59	((decision* NEXT aid*)):ti,ab,kw
#60	(((women* or woman* or patient*) NEXT decision*)):ti,ab,kw
#61	#59 OR #60
#62	#51 AND #58
#63	#61 OR #62
#64	#46 AND #63
#65	MeSH descriptor: [Patient Education as Topic] this term only
#66	(((patient* or consumer*) NEAR/3 (educat* or skill* or teach* or train* or coach*))):ti,ab,kw
#67	#65 OR #66
#68	MeSH descriptor: [Communication] this term only
#69	MeSH descriptor: [Group Processes] this term only
#70	(communicat*):ti,ab,kw
#71	#68 OR #69 OR #70
#72	#46 AND #67 AND #71
#73	#64 OR #72
#74	MeSH descriptor: [Information Services] this term only
#75	MeSH descriptor: [Information Dissemination] this term only
#76	MeSH descriptor: [Access to Information] this term only
#77	MeSH descriptor: [Mass Media] this term only
#78	MeSH descriptor: [Consumer Health Information] this term only
#79	MeSH descriptor: [Health Promotion] this term only
#80	MeSH descriptor: [Health Education] this term only
#81	MeSH descriptor: [Health Knowledge, Attitudes, Practice] this term only
#82	MeSH descriptor: [Patient Education as Topic] this term only and with qualifier(s): [methods - MT]
#83	MeSH descriptor: [Patient Education Handout] this term only
#84	MeSH descriptor: [Pamphlets] this term only
#85	MeSH descriptor: [Computers, Handheld] explode all trees
#86	MeSH descriptor: [Internet] this term only
#87	MeSH descriptor: [Internet-Based Intervention] this term only
#88	MeSH descriptor: [Web Browser] this term only
#89	MeSH descriptor: [Social Media] this term only
#90	MeSH descriptor: [Social Networking] this term only
#91	MeSH descriptor: [Mobile Applications] this term only
#92	MeSH descriptor: [Electronic Mail] this term only
#93	MeSH descriptor: [Text Messaging] this term only
#94	MeSH descriptor: [Hotlines] this term only
#95	MeSH descriptor: [Television] this term only
#96	MeSH descriptor: [Radio] this term only
#97	MeSH descriptor: [Bibliotherapy] this term only
#98	MeSH descriptor: [Health Literacy] this term only
#99	MeSH descriptor: [Therapy, Computer-Assisted] this term only
#100	MeSH descriptor: [Patient Advocacy] this term only
#101	MeSH descriptor: [Social Support] this term only
#102	MeSH descriptor: [Self-Help Groups] this term only
#103	MeSH descriptor: [Peer Group] this term only
#104	MeSH descriptor: [Empowerment] this term only
#105	((information NEXT (seek* or gather*))):ti,ab,kw
#106	(helpseek* or healthcareseek* or healthseek* or ((help or healthcare or health) NEXT seek*)):ti,ab,kw
#107	(careseek* or (care NEXT seek*)):ti
#108	(((information or informative) NEAR/3 tool*)):ti,ab,kw
#109	(((written or audio* or visual) NEXT tool*)):ti,ab,kw
#110	(((written or printed) NEAR/3 (information or material* or education* or instruction*))):ti,ab,kw

#	Searches
#111	((((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or selfhelp* or “self help*” or selfmanag* or “self manag*”) NEAR/5 (pamphlet* or booklet* or poster or posters or brochure* or leaflet* or sheet* or handout or handouts or checklist* or "check list*" or smartphone* or "smart phone*" or online or "on line" or audiovisual or "audio visual")))):ti,ab,kw
#112	((pamphlet* or booklet* or brochure* or handout or handouts or checklist* or “check list*” or bibliotherap*)):ti
#113	((((patient* or fact* or written or printed) NEXT (pamphlet* or booklet* or poster or posters or brochure* or leaflet* or sheet* or handout or handouts or checklist* or “check list*”)))):ti,ab,kw
#114	(((inform* or reading) NEAR/5 (magazin* or newspaper*))):ti,ab,kw
#115	(((popular or women* or woman* or online) NEXT (magazin* or newspaper*))):ti,ab,kw
#116	((newspaper NEXT cutting*)):ti,ab,kw
#117	((information NEXT (card or cards))):ti,ab,kw
#118	(flipchart*):ti,ab,kw
#119	(((inform* or campaign*) NEAR/10 (television* or TV or radio))):ti,ab,kw
#120	((((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or selfhelp* or “self help*” or selfmanag* or “self manag*”) NEAR/3 video*))):ti,ab,kw
#121	(dvd*):ti,ab,kw
#122	((auditory NEXT (inform* or tool*))):ti,ab,kw
#123	(voiceover* or (voice NEXT over*)):ti,ab,kw
#124	((mobile NEXT (technolog* or communicat*))):ti,ab,kw
#125	(((smartphone* or “smart phone*” or phone* or iphone* or mobile* or tablet* or ipad* or digital or android*) NEAR/5 (app or apps or application*))):ti,ab,kw
#126	(smartphone NEXT based):ti,ab,kw
#127	(helpline* or hotline* or ((help or hot) NEXT line*)):ti,ab,kw
#128	(telephone NEXT based NEXT intervention*):ti,ab,kw
#129	((dedicat* NEXT (mobile* or phone* or telephone*))):ti,ab,kw
#130	(((telephone* or phone*) NEXT consultation*)):ti,ab,kw
#131	((social* NEAR/3 network*)):ti,ab,kw
#132	(social* NEXT media*):ti,ab,kw
#133	((blogs or vlogs or blogger* or vlogger* or influencer*)):ti,ab,kw
#134	((social* NEXT influence*)):ti,ab,kw
#135	((podcast* or webinar* or Facebook or Instagram or Skype or WeChat*)):ti,ab,kw
#136	((Twitter* or tweet* or Youtube*)):ti
#137	(((online or “on line” or cyber* or internet* or discussion*) NEAR/3 (forum* or group* or intervention*))):ti,ab,kw
#138	(((online or “on line” or cyber* or internet*) NEXT resource*)):ti
#139	((((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or selfhelp* or “self help*” or selfmanag* or “self manag*” or device* or guidance* or treatment* or therap* or access* or recommend*) NEAR/3 (app or apps or web*)))):ti,ab,kw
#140	(website* or (web NEXT site*)):ti,ab,kw
#141	(internet NEXT based*):ti,ab,kw
#142	(((talk or text) NEXT based NEXT media*) or (visual NEXT media*)):ti,ab,kw
#143	((computer* NEAR/3 (handheld or “palm top” or palmtop or pda or tablet*))):ti,ab,kw
#144	((“personal digital assistant*” or “pocket pc*”)):ti,ab,kw
#145	(((emotion* or network* or peer* or organi?ation* or social) NEXT support*)):ti,ab,kw
#146	((support NEXT (group* or intervention* or network*))):ti,ab,kw
#147	(((selfhelp or “self help”) NEAR/3 group*)):ti,ab,kw
#148	(((selfhelp* or “self help*” or selfmanag* or “self manag*”) NEXT package*)):ti,ab,kw
#149	((group* NEXT (training or education))):ti,ab,kw
#150	((peer* NEAR/3 (advice* or advis* or counsel* or help* or mentor*))):ti,ab,kw
#151	(peer NEXT network*):ti,ab,kw
#152	(((public or patient or consumer) NEXT advoca*)):ti,ab,kw
#153	((advoca* NEXT (group* or organization*))):ti,ab,kw
#154	(((lay or support) NEXT person)):ti,ab,kw
#155	((patient NEXT empower*)):ti,ab,kw
#156	(((psychoeducat* or psychosocial*) NEXT (support* or group* or intervention*))):ti
#157	((health NEXT literacy)):ti,ab,kw
#158	((educat* NEAR/3 strateg*)):ti,ab,kw
#159	((educat* NEXT (material* or workshop*))):ti,ab,kw
#160	((literature* NEAR/3 educat*)):ti,ab,kw
#161	((elearn* or ehealth* or mhealth*)):ti,ab,kw
#162	(((educat* or inform*) NEAR/5 exchange*)):ti,ab,kw
#163	(((information* or disseminat*) NEXT (need* or provi* or strateg*))):ti,ab,kw
#164	("source* of information*"):ti,ab,kw
#165	((patient* NEXT (information or education))):ti,ab,kw
#166	(((health* or communicat* or educat* or prevent* or inform* or disseminat*) NEAR/3 campaign*)):ti,ab,kw
#167	(((health or public or prevention or community) NEXT (information* or education*))):ti,ab,kw
#168	((communit* NEAR/2 intervention*)):ti,ab,kw
#169	(((rais* or increas* or lack* or level* or improv* or greater or further* or promot* or enhanc* or creat* or disseminat*) NEAR/3 awareness)):ti
#170	(((“pelvi* floor*” or “continenc* service*” or PFM or PFD or PFMT) NEAR/5 awareness)):ti,ab,kw
#171	((awareness NEXT (program* or campaign* or training))):ti,ab,kw
#172	((community NEXT awareness)):ti,ab,kw

#	Searches
#173	((engag* NEAR/3 communit*)):ti,ab,kw
#174	((charity or charities or promocon*)):ti,ab,kw
#175	{or #74-#174}
#176	#46 AND #175
#177	#73 OR #176
#178	#1 OR #2 OR #3 OR #4
#179	(((rais* or increas* or lack* or level* or improv* or greater or further* or promot* or enhanc* or creat* or disseminat*) NEAR/3 awareness)):ti,ab,kw
#180	#178 AND #179
#181	#177 OR #180 Publication Year from 1980 to current

Database(s): Database of Abstracts of Reviews of Effects (DARE); HTA Database – CRD interface

Date of last search: 29 June 2020

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN DARE,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN DARE,HTA
3	((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN DARE,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN DARE,HTA
7	(((stress* or mix* or urg* or urin*) NEAR5 incontinen*)) IN DARE, HTA
8	((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*))) IN DARE, HTA
9	((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*))) IN DARE, HTA
10	(((urgency NEAR2 frequency) or (frequency NEAR2 urgency))) IN DARE, HTA
11	(((urin* or bladder*) NEAR2 (urg* or frequen*))) IN DARE, HTA
12	((SUI or OAB)) IN DARE, HTA
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN DARE,HTA
14	MeSH DESCRIPTOR Rectocele IN DARE,HTA
15	((pelvic* NEAR3 organ* NEAR3 prolaps*)) IN DARE, HTA
16	((urinary NEAR3 bladder NEAR3 prolaps*)) IN DARE, HTA
17	(((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*)) IN DARE, HTA
18	((splanchnoptos* or visceroptos*)) IN DARE, HTA
19	((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*))) IN DARE, HTA
20	((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*)) IN DARE, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN DARE,HTA
22	(((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction))) IN DARE, HTA
23	MeSH DESCRIPTOR Urinary Retention IN DARE,HTA
24	((urin* NEAR3 (retention* or retain*))) IN DARE, HTA
25	((voiding NEXT (disorder* or dysfunction* or problem*))) IN DARE, HTA
26	((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*))) IN DARE, HTA
27	(((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*)) IN DARE, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN DARE,HTA
29	(((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*))) IN DARE, HTA
30	((obstruct* NEAR3 (defecat* or defaecat*))) IN DARE, HTA
31	(((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*))) IN DARE, HTA
32	(((outlet* NEXT dysfunction* NEXT constipa*))) IN DARE, HTA
33	((dys?ynerg* NEXT (defecat* or defaecat*))) IN DARE, HTA
34	((pelvi* NEAR3 dyskines*)) IN DARE, HTA
35	((pelvi* NEXT outlet* NEXT obstruct*)) IN DARE, HTA
36	((anismus*)) IN DARE, HTA
37	((puborectal* NEXT contract*)) IN DARE, HTA
38	(((rectal or rectum) NEAR3 urge*)) IN DARE, HTA
39	((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*))) IN DARE, HTA
40	((obstruct* NEAR3 intercourse)) IN DARE, HTA
41	((vagin* NEAR3 laxity*)) IN DARE, HTA
42	((vagin* NEXT wind)) IN DARE, HTA
43	MeSH DESCRIPTOR Vaginismus IN DARE,HTA

#	Searches
44	((vaginismus*)) IN DARE, HTA
45	((vagin* NEXT penetrat* NEXT disorder*)) IN DARE, HTA
46	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45
47	MeSH DESCRIPTOR choice behavior IN DARE,HTA
48	MeSH DESCRIPTOR decision making IN DARE,HTA
49	MeSH DESCRIPTOR decision support techniques IN DARE,HTA
50	((decision* or choic* or preference*)) IN DARE, HTA
51	#47 OR #48 OR #49 OR #50
52	MeSH DESCRIPTOR patient compliance IN DARE,HTA
53	MeSH DESCRIPTOR informed consent IN DARE,HTA
54	MeSH DESCRIPTOR treatment refusal IN DARE,HTA
55	MeSH DESCRIPTOR consumer behavior IN DARE,HTA
56	MeSH DESCRIPTOR community participation IN DARE,HTA
57	MeSH DESCRIPTOR health education IN DARE,HTA
58	#52 OR #53 OR #54 OR #55 OR #56 OR #57
59	((decision* NEXT aid*)) IN DARE, HTA
60	(((women* or woman* or patient*) NEXT decision*)) IN DARE, HTA
61	#59 OR #60
62	#51 AND #58
63	#61 OR #62
64	#46 AND #63
65	MeSH DESCRIPTOR Patient Education as Topic IN DARE,HTA
66	(((patient* or consumer*) NEAR3 (educat* or skill* or teach* or train* or coach*))) IN DARE, HTA
67	#65 OR #66
68	MeSH DESCRIPTOR Communication IN DARE,HTA
69	MeSH DESCRIPTOR Group Processes IN DARE,HTA
70	((communicat*)) IN DARE, HTA
71	#68 OR #69 OR #70
72	#46 AND #67 AND #71
73	#64 OR #72
74	MeSH DESCRIPTOR Information Services IN DARE,HTA
75	MeSH DESCRIPTOR Information Dissemination IN DARE,HTA
76	MeSH DESCRIPTOR Access to Information IN DARE,HTA
77	MeSH DESCRIPTOR Mass Media IN DARE,HTA
78	MeSH DESCRIPTOR Consumer Health Information IN DARE,HTA
79	MeSH DESCRIPTOR Health Promotion IN DARE,HTA
80	MeSH DESCRIPTOR Health Education EXPLODE ALL TREES IN DARE,HTA
81	MeSH DESCRIPTOR Health Knowledge, Attitudes, Practice IN DARE,HTA
82	MeSH DESCRIPTOR patient education as topic WITH QUALIFIER mt IN DARE,HTA
83	MeSH DESCRIPTOR Patient Education Handout IN DARE,HTA
84	MeSH DESCRIPTOR Pamphlets IN DARE,HTA
85	MeSH DESCRIPTOR Computers, Handheld IN DARE,HTA
86	MeSH DESCRIPTOR Internet IN DARE,HTA
87	MeSH DESCRIPTOR web browser IN DARE,HTA
88	MeSH DESCRIPTOR social media IN DARE,HTA
89	MeSH DESCRIPTOR social networking IN DARE,HTA
90	MeSH DESCRIPTOR mobile applications IN DARE,HTA
91	MeSH DESCRIPTOR electronic mail IN DARE,HTA
92	MeSH DESCRIPTOR Text Messaging IN DARE,HTA
93	MeSH DESCRIPTOR Hotlines IN DARE,HTA
94	MeSH DESCRIPTOR television IN DARE,HTA
95	MeSH DESCRIPTOR radio IN DARE,HTA
96	MeSH DESCRIPTOR Bibliotherapy IN DARE,HTA
97	MeSH DESCRIPTOR Health Literacy IN DARE,HTA
98	MeSH DESCRIPTOR Therapy, Computer-Assisted IN DARE,HTA
99	MeSH DESCRIPTOR Patient Advocacy IN DARE,HTA
100	MeSH DESCRIPTOR Social Support IN DARE,HTA
101	MeSH DESCRIPTOR Self-Help Groups IN DARE,HTA
102	MeSH DESCRIPTOR Peer Group IN DARE,HTA
103	((information NEXT (seek* or gather*))) IN DARE, HTA
104	((helpseek* or help-seek* or healthcareseek* or healthcare-seek* or healthseek* or health-seek*)) IN DARE, HTA
105	((care-seek* or careseek*)):TI IN DARE, HTA
106	(((information or informative) NEAR3 tool*)) IN DARE, HTA
107	(((written or audio* or visual) NEXT tool*)) IN DARE, HTA
108	(((written or printed) NEAR3 (information or material* or education* or instruction*))) IN DARE, HTA
109	(((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or self-help* or selfhelp* or self help* or self-manag* or selfmanag* or self manag*) NEAR5 (pamphlet* or booklet* or poster or posters or brochure* or leaflet* or sheet* or handout or handouts or hand-out or hand-outs or checklist* or check-list* or check list* or

#	Searches
	smartphone* or smart phone* or online or on-line or on line or audiovisual or audio-visual or audio visual))) IN DARE, HTA
110	((pamphlet* or booklet* or brochure* or handout or handouts or hand-out or hand-outs or checklist* or check-list* or check list* or bibliotherap*)):TI IN DARE, HTA
111	#74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90 OR #91 OR #92 OR #93 OR #94 OR #95 OR #96 OR #97 OR #98 OR #99 OR #100 OR #101 OR #102 OR #103 OR #104 OR #105 OR #106 OR #107 OR #108 OR #109 OR #110
112	(((inform* or reading) NEAR5 (magazin* or newspaper*))) IN DARE, HTA
113	(((popular or women* or woman* or online) NEXT (magazin* or newspaper*))) IN DARE, HTA
114	((newspaper NEXT cutting*)) IN DARE, HTA
115	((information NEXT (card or cards))) IN DARE, HTA
116	(flipchart*) IN DARE, HTA
117	(((inform* or campaign*) NEAR10 (television* or TV or radio))) IN DARE, HTA
118	(((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or self-help* or selfhelp* or self help* or self-manag* or selfmanag* or self manag*) NEAR3 video*)) IN DARE, HTA
119	(dvd*) IN DARE, HTA
120	((auditory NEXT (inform* or tool*))) IN DARE, HTA
121	((voiceover* or voice-over* or voice over*)) IN DARE, HTA
122	((mobile NEXT (technolog* or communicat*))) IN DARE, HTA
123	(((smartphone* or smart phone* or phone* or iphone* or mobile* or tablet* or ipad* or digital or android*) NEAR5 (app or app-based or apps or application*))) IN DARE, HTA
124	((smartphone-based)) IN DARE, HTA
125	((helpline* or help-line* or hotline* or hot-line*)) IN DARE, HTA
126	((telephone-based NEXT intervention*)) IN DARE, HTA
127	((dedicat* NEXT (mobile* or phone* or telephone*))) IN DARE, HTA
128	(((telephone* or phone*) NEXT consultation*)) IN DARE, HTA
129	((social* NEAR3 network*)) IN DARE, HTA
130	((social* NEXT media*)) IN DARE, HTA
131	((blogs or vlogs or blogger* or vlogger* or influencer*)) IN DARE, HTA
132	((social* NEXT influence*)) IN DARE, HTA
133	((podcast* or webinar* or Facebook or Instagram or Skype or WeChat*)) IN DARE, HTA
134	((Twitter* or tweet* or Youtube*)):TI IN DARE, HTA
135	(((online or on-line or on line or cyber* or internet* or discussion*) NEAR3 (forum* or group* or intervention*))) IN DARE, HTA
136	(((online or on-line or on line or cyber* or internet*) NEXT resource*)):TI IN DARE, HTA
137	(((inform* or educat* or illustrat* or advis* or advice* or train* or instruct* or self-help* or selfhelp* or self help* or self-manag* or selfmanag* or self manag* or device* or guidance* or treatment* or therap* or access* or recommend*) NEAR3 (app or app-based or apps or web*))) IN DARE, HTA
138	((website* or web-site* or web site*)) IN DARE, HTA
139	((internet-based*)) IN DARE, HTA
140	(((talk-based or text-based or visual) NEXT media*)) IN DARE, HTA
141	(personal digital assistant* or pocket pc*) IN DARE, HTA
142	(((emotion* or network* or peer* or organi?ation* or social) NEXT support*)) IN DARE, HTA
143	((support NEXT (group* or intervention* or network*))) IN DARE, HTA
144	(((selfhelp or self-help or self help) NEAR3 group*)) IN DARE, HTA
145	(((self-help* or selfhelp* or self help* or self-manag* or selfmanag* or self manag*) NEXT package*)) IN DARE, HTA
146	((group* NEXT (training or education))) IN DARE, HTA
147	((peer* NEAR3 (advice* or advis* or counsel* or help* or mentor*))) IN DARE, HTA
148	((peer NEXT network*)) IN DARE, HTA
149	(((public or patient or consumer) NEXT advoca*)) IN DARE, HTA
150	((advoca* NEXT (group* or organization*))) IN DARE, HTA
151	(((lay or support) NEXT person)) IN DARE, HTA
152	((patient NEXT empower*)) IN DARE, HTA
153	(((psychoeducat* or psycho-educat* or psychosocial* or psycho-social*) NEXT (support* or group* or intervention*))):TI IN DARE, HTA
154	((health NEXT literacy)) IN DARE, HTA
155	((educat* NEAR3 strateg*)) IN DARE, HTA
156	((educat* NEXT (material* or workshop*))) IN DARE, HTA
157	((literature* NEAR3 educat*)) IN DARE, HTA
158	((elearn* or e-learn* or ehealth* or e-health* or mhealth* or m-health*)) IN DARE, HTA
159	(((educat* or inform*) NEAR5 exchange*)) IN DARE, HTA
160	(((information* or disseminat*) NEXT (need* or provi* or strateg*))) IN DARE, HTA
161	((source* of information*)) IN DARE, HTA
162	((patient* NEXT (information or education))) IN DARE, HTA
163	(((health* or communicat* or educat* or prevent* or inform* or disseminat*) NEAR3 campaign*)) IN DARE, HTA
164	(((health or public or prevention or community) NEXT (information* or education*))) IN DARE, HTA
165	((communit* NEAR2 intervention*)) IN DARE, HTA
166	(((rais* or increas* or lack* or level* or improv* or greater or further* or promot* or enhanc* or creat* or disseminat*) NEAR3 awareness)):TI IN DARE, HTA
167	(((pelvi* floor* or continenc* service* or PFM or PFD or PFMT) NEAR5 awareness)) IN DARE, HTA

#	Searches
168	((awareness NEXT (program* or campaign* or training))) IN DARE, HTA
169	((community NEXT awareness)) IN DARE, HTA
170	((engag* NEAR3 communit*)) IN DARE, HTA
171	((charity or charities or promocon*)) IN DARE, HTA
172	#74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90 OR #91 OR #92 OR #93 OR #94 OR #95 OR #96 OR #97 OR #98 OR #99 OR #100 OR #101 OR #102 OR #103 OR #104 OR #105 OR #106 OR #107 OR #108 OR #109 OR #110 OR #111 OR #112 OR #113 OR #114 OR #115 OR #116 OR #117 OR #118 OR #119 OR #120 OR #121 OR #122 OR #123 OR #124 OR #125 OR #126 OR #127 OR #128 OR #129 OR #130 OR #131 OR #132 OR #133 OR #134 OR #135 OR #136 OR #137 OR #138 OR #139 OR #140 OR #141 OR #142 OR #143 OR #144 OR #145 OR #146 OR #147 OR #148 OR #149 OR #150 OR #151 OR #152 OR #153 OR #154 OR #155 OR #156 OR #157 OR #158 OR #159 OR #160 OR #161 OR #162 OR #163 OR #164 OR #165 OR #166 OR #167 OR #168 OR #169 OR #170 OR #171
173	#46 AND #172
174	#73 OR #173
175	(((rais* or increas* or lack* or level* or improv* or greater or further* or promot* or enhanc* or creat* or disseminat*) NEAR3 awareness)) IN DARE, HTA
176	#46 AND #175
177	#174 OR #176 Publication Year from 1980 to current

Database(s): EMCare – OVID interface

Date of last search: 29 June 2020

#	Searches
1	pelvis floor/ or pelvic floor disorder/ or exp *urine incontinence/ or *overactive bladder/ or *bladder instability/ or exp *pelvic organ prolapse/ or *rectocele/ or *feces incontinence/ or urine retention/ or defecation disorder/ or Feces Impaction/ or female sexual dysfunction/ or vaginism/
2	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
3	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
4	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
5	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
6	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
7	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
8	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
9	(SUI or OAB).ti.
10	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
11	(urinary adj3 bladder adj3 prolaps$).ti.
12	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
13	(splanchnoptos$ or visceroptos$).ti.
14	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
15	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
16	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
17	(urin$ adj3 (retention$ or retain$)).tw.
18	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
19	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
20	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
21	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
22	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
23	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
24	outlet$ dysfunction$ constipa$.tw.
25	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
26	(pelvi$ adj3 dyskines$).tw.
27	pelvi$ outlet$ obstruct$.tw.
28	anismus$.tw.
29	puborectal$ contract$.tw.
30	((rectal or rectum) adj3 urge$).tw.
31	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
32	(obstruct$ adj3 intercourse).tw.
33	(vagin$ adj3 laxity$).tw.
34	(vagin$ adj wind).tw.
35	vaginismus$.tw.
36	(vagin$ adj penetrat$ adj disorder$).tw.

#	Searches
37	or/1-36
38	decision making/
39	decision support system/
40	(decision$ or choic$ or preference$).tw.
41	or/38-40
42	patient compliance/
43	informed consent/
44	treatment refusal/
45	exp consumer attitude/
46	exp consumer/
47	exp health education/
48	or/42-47
49	(decision$ adj aid$).tw.
50	((women$ or woman$ or patient$) adj decision$).tw.
51	49 or 50
52	41 and 48
53	51 or 52
54	37 and 53
55	patient education/
56	((patient$ or consumer$) adj3 (educat$ or skill$ or teach$ or train$ or coach$)).tw.
57	55 or 56
58	interpersonal communication/
59	communicat$.tw.
60	group process/
61	or/58-60
62	37 and 57 and 61
63	54 or 62
64	information service/ or information dissemination/ or access to information/ or *help seeking behavior/ or mass communication/ or consumer health information/ or *health promotion/ or *health education/ or education program/ or *attitude to health/ or *patient education/ or patient information/ or *medical information/ or *publication/ or personal digital assistant/ or internet/ or web-based intervention/ or web browser/ or social media/ or blogging/ or *social network/ or smartphone/ or mobile application/ or e-mail/ or text messaging/ or hotline/ or *telephone/ or *teleconsultation/ or television/ or radio/ or bibliotherapy/ or *health literacy/ or *computer assisted therapy/ or patient advocacy/ or social support/ or self help/ or exp support group/ or peer group/ or empowerment/ or *shame/ or *stigma/ or *taboo/
65	(information adj (seek$ or gather$)).tw.
66	(helpseek$ or help-seek$ or healthcareseek$ or healthcare-seek$ or healthseek$ or health-seek$ or health care-seek$ or health careseek$ or health care seek$).tw.
67	(care-seek$ or careseek$ or care seek$).ti.
68	((information or informative) adj3 tool$).tw.
69	((written or audio$ or visual) adj tool$).tw.
70	((written or printed) adj3 (information or material$ or education$ or instruction$)).tw.
71	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj5 (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or smartphone$ or smart phone$ or online or on-line or on line or audiovisual or audio-visual or audio visual)).tw.
72	(pamphlet$ or booklet$ or brochure$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or bibliotherap$).ti.
73	((patient$ or fact$ or written or printed) adj (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$)).tw.
74	((inform$ or reading) adj5 (magazin$ or newspaper$)).tw.
75	((popular or women$ or woman$ or online) adj (magazin$ or newspaper$)).tw.
76	(newspaper adj cutting$).tw.
77	(information adj (card or cards)).tw.
78	flipchart$.tw.
79	((inform$ or campaign$) adj10 (television$ or TV or radio)).tw.
80	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj3 video$).tw.
81	dvd$.tw.
82	(auditory adj (inform$ or tool$)).tw.
83	(voiceover$ or voice-over$ or voice over$).tw.
84	(mobile adj (technolog$ or communicat$)).tw.
85	((smartphone$ or smart phone$ or phone$ or iphone$ or mobile$ or tablet$ or ipad$ or digital or android$) adj5 (app or app-based or apps or application$)).tw.
86	smartphone-based.tw.
87	(helpline$ or help-line$ or hotline$ or hot-line$).tw.
88	telephone-based intervention$.tw.
89	(dedicat$ adj (mobile$ or phone$ or telephone$)).tw.
90	((telephone$ or phone$) adj consultation$).tw.
91	(social$ adj media$).tw.
92	(social$ adj3 network$).tw.

#	Searches
93	(blogs or vlogs or blogger$ or vlogger$ or influencer$).tw.
94	(social$ adj influence$).tw.
95	(podcast$ or webinar$ or Facebook or Instagram or Skype or WeChat$).tw.
96	(Twitter$ or tweet$ or Youtube$).ti.
97	((online or on-line or on line or cyber$ or internet$ or discussion$) adj3 (forum$ or group$ or intervention$)).tw.
98	((online or on-line or on line or cyber$ or internet$) adj resource$).ti.
99	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$ or device$ or guidance$ or treatment$ or therap$ or access$ or recommend$) adj3 (app or app-based or apps or web$)).tw.
100	(website$ or web-site$ or web site$).tw.
101	internet-based$.tw.
102	((talk-based or text-based or visual) adj media$).tw.
103	(computer$ adj3 (handheld or palm top or palmtop or pda or tablet$)).tw.
104	(personal digital assistant$ or pocket pc$).tw.
105	((emotion$ or network$ or peer$ or organi?ation$ or social) adj support$).tw.
106	(support adj (group$ or intervention$ or network$)).tw.
107	((selfhelp or self-help or self help) adj3 group$).tw.
108	((self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj package$).tw.
109	(group$ adj (training or education)).tw.
110	(peer$ adj3 (advice$ or advis$ or counsel$ or help$ or mentor$)).tw.
111	peer network$.tw.
112	((public or patient or consumer) adj advoca$).tw.
113	(advoca$ adj (group$ or organization$)).tw.
114	((lay or support) adj person).tw.
115	(patient adj empower$).tw.
116	((psychoeducat$ or psycho-educat$ or psychosocial$ or psycho-social$) adj (support$ or group$ or intervention$)).ti.
117	(health adj literacy).tw.
118	(educat$ adj3 strateg$).tw.
119	(educat$ adj (material$ or workshop$)).tw.
120	(literature$ adj3 educat$).tw.
121	(elearn$ or e-learn$ or ehealth$ or e-health$ or mhealth$ or m-health$).tw.
122	((educat$ or inform$) adj5 exchange$).tw.
123	((information$ or disseminat$) adj (need$ or provi$ or strateg$)).tw.
124	source$ of information$.tw.
125	(patient$ adj (information or education)).tw.
126	((health$ or communicat$ or educat$ or prevent$ or inform$ or disseminat$) adj3 campaign$).tw.
127	((health or public or prevention or community) adj (information$ or education$)).tw.
128	(communit$ adj2 intervention$).tw.
129	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).ti.
130	((pelvi$ floor$ or continenc$ service$ or PFM or PFD or PFMT) adj5 awareness).tw.
131	(awareness adj (program$ or campaign$ or training)).tw.
132	(community adj awareness).tw.
133	(engag$ adj3 communit$).tw.
134	(address$ adj3 (stigma$ or shame or taboo$)).tw.
135	unspeakable.tw.
136	(charity or charities or promocon$).mp.
137	or/64-136
138	37 and 137
139	63 or 138
140	pelvis floor/ or pelvic floor disorder/
141	2 or 3 or 140
142	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).tw.
143	141 and 142
144	139 or 143
145	limit 144 to english language
146	limit 145 to yr="1980 -Current" [General Exclusions filter applied]

Database(s): PsycINFO 1806 to June Week 4 2020 **– OVID interface**

Date of last search: 29 June 2020

#	Searches
1	pelvis floor/
2	pelvic floor disorder/
3	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.

#	Searches
4	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
5	or/1-4
6	exp *Urinary Incontinence/
7	*overactive bladder/
8	*bladder instability/
9	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
10	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
11	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
12	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
13	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
14	(SUI or OAB).ti.
15	or/6-14
16	exp *pelvic organ prolapse/
17	*rectocele/
18	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
19	(urinary adj3 bladder adj3 prolaps$).ti.
20	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
21	(splanchnoptos$ or visceroptos$).ti.
22	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
23	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
24	or/16-23
25	exp *Fecal Incontinence/
26	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
27	25 or 26
28	urine retention/
29	(urin$ adj3 (retention$ or retain$)).tw.
30	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
31	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
32	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
33	defecation disorder/
34	feces impaction/
35	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
36	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
37	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
38	outlet$ dysfunction$ constipa$.tw.
39	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
40	(pelvi$ adj3 dyskines$).tw.
41	pelvi$ outlet$ obstruct$.tw.
42	anismus$.tw.
43	puborectal$ contract$.tw.
44	((rectal or rectum) adj3 urge$).tw.
45	or/28-44
46	female sexual dysfunction/
47	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
48	(obstruct$ adj3 intercourse).tw.
49	(vagin$ adj3 laxity$).tw.
50	(vagin$ adj wind).tw.
51	Vaginismus/
52	vaginismus$.tw.
53	(vagin$ adj penetrat$ adj disorder$).tw.
54	or/46-53
55	5 or 15 or 24 or 27 or 45 or 54
56	Choice Behavior/
57	Decision Making/
58	Decision Support Systems/
59	(decision$ or choic$ or preference$).tw.
60	or/56-59
61	compliance/
62	Informed Consent/
63	Treatment Refusal/
64	exp Consumer Behavior/
65	exp Consumer Attitudes/

#	Searches
66	exp Health Education/
67	or/61-66
68	(decision$ adj aid$).tw.
69	((women$ or woman$ or patient$) adj decision$).tw.
70	68 or 69
71	60 and 67
72	70 or 71
73	55 and 72
74	Client Education/
75	((patient$ or consumer$) adj3 (educat$ or skill$ or teach$ or train$ or coach$)).tw.
76	74 or 75
77	Interpersonal Communication/
78	communicat$.tw.
79	77 or 78
80	55 and 76 and 79
81	73 or 80
82	Information/ or Information Services/ or Information Dissemination/ or Information Seeking/ or exp Help Seeking Behavior/ or Health Education/ or Health Information/ or Health Promotion/ or exp Educational Programs/ or Health Knowledge/ or Health Attitudes/ or Client Education/ or Educational Audiovisual Aids/ or Reading Materials/ or Tablet Computers/ or Computers/ or Multimedia/ or exp Internet/ or *Digital Interventions/ or Websites/ or Social Media/ or *Online Social Networks/ or Blog/ or Mobile Applications/ or Smartphones/ or Computer Mediated Communication/ or Text Messaging/ or Hot Line Services/ or Telephone Systems/ or Television/ or Radio/ or Bibliotherapy/ or Health Literacy/ or exp Computer Assisted Therapy/ or Advocacy/ or Social Support/ or *Self-Care Skills/ or exp Support Groups/ or Empowerment/ or Shame/ or Stigma/ or Taboo/
83	(information adj (seek$ or gather$)).tw.
84	(helpseek$ or help-seek$ or healthcareseek$ or healthcare-seek$ or healthseek$ or health-seek$ or health care-seek$ or health careseek$ or health care seek$).tw.
85	(care-seek$ or careseek$ or care seek$).ti.
86	((information or informative) adj3 tool$).tw.
87	((written or audio$ or visual) adj tool$).tw.
88	((written or printed) adj3 (information or material$ or education$ or instruction$)).tw.
89	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj5 (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or smartphone$ or smart phone$ or online or on-line or on line or audiovisual or audio-visual or audio visual)).tw.
90	(pamphlet$ or booklet$ or brochure$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$ or bibliotherap$).ti.
91	((patient$ or fact$ or written or printed) adj (pamphlet$ or booklet$ or poster or posters or brochure$ or leaflet$ or sheet$ or handout or handouts or hand-out or hand-outs or checklist$ or check-list$ or check list$)).tw.
92	((inform$ or reading) adj5 (magazin$ or newspaper$)).tw.
93	((popular or women$ or woman$ or online) adj (magazin$ or newspaper$)).tw.
94	(newspaper adj cutting$).tw.
95	(information adj (card or cards)).tw.
96	flipchart$.tw.
97	((inform$ or campaign$) adj10 (television$ or TV or radio)).tw.
98	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj3 video$).tw.
99	dvd$.tw.
100	(auditory adj (inform$ or tool$)).tw.
101	(voiceover$ or voice-over$ or voice over$).tw.
102	(mobile adj (technolog$ or communicat$)).tw.
103	((smartphone$ or smart phone$ or phone$ or iphone$ or mobile$ or tablet$ or ipad$ or digital or android$) adj5 (app or app-based or apps or application$)).tw.
104	smartphone-based.tw.
105	(helpline$ or help-line$ or hotline$ or hot-line$).tw.
106	telephone-based intervention$.tw.
107	(dedicat$ adj (mobile$ or phone$ or telephone$)).tw.
108	((telephone$ or phone$) adj consultation$).tw.
109	(social$ adj media$).tw.
110	(social$ adj3 network$).tw.
111	(blogs or vlogs or blogger$ or vlogger$ or influencer$).tw.
112	(social$ adj influence$).tw.
113	(podcast$ or webinar$ or Facebook or Instagram or Skype or WeChat$).tw.
114	(Twitter$ or tweet$ or Youtube$).ti.
115	((online or on-line or on line or cyber$ or internet$ or discussion$) adj3 (forum$ or group$ or intervention$)).tw.
116	((online or on-line or on line or cyber$ or internet$) adj resource$).ti.
117	((inform$ or educat$ or illustrat$ or advis$ or advice$ or train$ or instruct$ or self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$ or device$ or guidance$ or treatment$ or therap$ or access$ or recommend$) adj3 (app or app-based or apps or web$)).tw.
118	(website$ or web-site$ or web site$).tw.
119	internet-based$.tw.
120	((talk-based or text-based or visual) adj media$).tw.

#	Searches
121	(computer$ adj3 (handheld or palm top or palmtop or pda or tablet$)).tw.
122	(personal digital assistant$ or pocket pc$).tw.
123	((emotion$ or network$ or peer$ or organi?ation$ or social) adj support$).tw.
124	(support adj (group$ or intervention$ or network$)).tw.
125	((selfhelp or self-help or self help) adj3 group$).tw.
126	((self-help$ or selfhelp$ or self help$ or self-manag$ or selfmanag$ or self manag$) adj package$).tw.
127	(group$ adj (training or education)).tw.
128	(peer$ adj3 (advice$ or advis$ or counsel$ or help$ or mentor$)).tw.
129	peer network$.tw.
130	((public or patient or consumer) adj advoca$).tw.
131	(advoca$ adj (group$ or organization$)).tw.
132	((lay or support) adj person).tw.
133	(patient adj empower$).tw.
134	((psychoeducat$ or psycho-educat$ or psychosocial$ or psycho-social$) adj (support$ or group$ or intervention$)).ti.
135	(health adj literacy).tw.
136	(educat$ adj3 strateg$).tw.
137	(educat$ adj (material$ or workshop$)).tw.
138	(literature$ adj3 educat$).tw.
139	(elearn$ or e-learn$ or ehealth$ or e-health$ or mhealth$ or m-health$).tw.
140	((educat$ or inform$) adj5 exchange$).tw.
141	((information$ or disseminat$) adj (need$ or provi$ or strateg$)).tw.
142	source$ of information$.tw.
143	(patient$ adj (information or education)).tw.
144	((health$ or communicat$ or educat$ or prevent$ or inform$ or disseminat$) adj3 campaign$).tw.
145	((health or public or prevention or community) adj (information$ or education$)).tw.
146	(communit$ adj2 intervention$).tw.
147	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).ti.
148	((pelvi$ floor$ or continenc$ service$ or PFM or PFD or PFMT) adj5 awareness).tw.
149	(awareness adj (program$ or campaign$ or training)).tw.
150	(community adj awareness).tw.
151	(engag$ adj3 communit$).tw.
152	(address$ adj3 (stigma$ or shame or taboo$)).tw.
153	unspeakable.tw.
154	(charity or charities or promocon$).mp.
155	or/82-154
156	55 and 155
157	81 or 156
158	((rais$ or increas$ or lack$ or level$ or improv$ or greater or further$ or promot$ or enhanc$ or creat$ or disseminat$) adj3 awareness).tw.
159	5 and 158
160	157 or 159
161	limit 160 to (english language and yr="1980 -Current") [General Exclusions filter applied]

Economic Search

One global search was conducted for economic evidence across the guideline.

Database(s): NHS Economic Evaluation Database (NHS EED); HTA Database – CRD interface

Date of last search: 3 February 2021

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN NHSEED,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN NHSEED,HTA
3	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
4	(((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)))) IN NHSEED, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN NHSEED,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
7	((((stress* or mix* or urg* or urin*) NEAR5 incontinen*))) IN NHSEED, HTA
8	(((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*)))) IN NHSEED, HTA
9	(((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*)))) IN NHSEED, HTA
10	((((urgency NEAR2 frequency) or (frequency NEAR2 urgency)))) IN NHSEED, HTA
11	((((urin* or bladder*) NEAR2 (urg* or frequen*)))) IN NHSEED, HTA
12	(((SUI or OAB))) IN NHSEED, HTA

#	Searches
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN NHSEED,HTA
14	MeSH DESCRIPTOR Rectocele IN NHSEED,HTA
15	(((pelvic* NEAR3 organ* NEAR3 prolaps*))) IN NHSEED, HTA
16	(((urinary NEAR3 bladder NEAR3 prolaps*))) IN NHSEED, HTA
17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*))) IN NHSEED, HTA
18	(((splanchnoptos* or visceroptos*))) IN NHSEED, HTA
19	(((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))) IN NHSEED, HTA
20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))) IN NHSEED, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN NHSEED,HTA
22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))) IN NHSEED, HTA
23	MeSH DESCRIPTOR Urinary Retention IN NHSEED,HTA
24	(((urin* NEAR3 (retention* or retain*)))) IN NHSEED, HTA
25	(((voiding NEXT (disorder* or dysfunction* or problem*)))) IN NHSEED, HTA
26	(((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*)))) IN NHSEED, HTA
27	((((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*))) IN NHSEED, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN NHSEED,HTA
29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*)))) IN NHSEED, HTA
30	(((obstruct* NEAR3 (defecat* or defaecat*)))) IN NHSEED, HTA
31	((((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*)))) IN NHSEED, HTA
32	((((outlet* NEXT dysfunction* NEXT constipa*)))) IN NHSEED, HTA
33	(((dys?ynerg* NEXT (defecat* or defaecat*)))) IN NHSEED, HTA
34	(((pelvi* NEAR3 dyskines*))) IN NHSEED, HTA
35	(((pelvi* NEXT outlet* NEXT obstruct*))) IN NHSEED, HTA
36	(((anismus*))) IN NHSEED, HTA
37	(((puborectal* NEXT contract*))) IN NHSEED, HTA
38	((((rectal or rectum) NEAR3 urge*))) IN NHSEED, HTA
39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))) IN NHSEED, HTA
40	(((obstruct* NEAR3 intercourse))) IN NHSEED, HTA
41	(((vagin* NEAR3 laxity*))) IN NHSEED, HTA
42	(((vagin* NEXT wind))) IN NHSEED, HTA
43	MeSH DESCRIPTOR Vaginismus IN NHSEED,HTA
44	(((vaginismus*))) IN NHSEED, HTA
45	(((vagin* NEXT penetrat* NEXT disorder*))) IN NHSEED, HTA
46	(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45) IN NHSEED, HTA

Database(s): Medline & Embase (Multifile) – OVID interfacce
Embase Classic+Embase 1947 to 2021 February 01; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to February 01, 2021
Date of last search: 3 February 2021

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

#	Searches
1	Pelvic Floor/ use ppez
2	Pelvic Floor Disorders/ use ppez
3	pelvis floor/ use emczd
4	pelvic floor disorder/ use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
7	or/1-6
8	exp *Urinary Incontinence/ use ppez
9	*Urinary Bladder, Overactive/ use ppez
10	exp *urine incontinence/ use emczd
11	*overactive bladder/ use emczd
12	*bladder instability/ use emczd
13	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.

#	Searches
14	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
15	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
16	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
17	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
18	(SUI or OAB).ti.
19	or/8-18
20	exp *Pelvic Organ Prolapse/ use ppez
21	exp *pelvic organ prolapse/ use emczd
22	*Rectocele/ use ppez
23	*rectocele/ use emczd
24	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
25	(urinary adj3 bladder adj3 prolaps$).ti.
26	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
27	(splanchnoptos$ or visceroptos$).ti.
28	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
29	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
30	or/20-29
31	*Fecal Incontinence/ use ppez
32	*feces incontinence/ use emczd
33	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
34	or/31-33
35	Urinary Retention/ use ppez
36	urine retention/ use emczd
37	(urin$ adj3 (retention$ or retain$)).tw.
38	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
39	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
40	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
41	defecation disorder/ use emczd
42	Fecal Impaction/ use ppez
43	Feces Impaction/ use emczd
44	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
45	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
46	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
47	outlet$ dysfunction$ constipa$.tw.
48	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
49	(pelvi$ adj3 dyskines$).tw.
50	pelvi$ outlet$ obstruct$.tw.
51	anismus$.tw.
52	puborectal$ contract$.tw.
53	((rectal or rectum) adj3 urge$).tw.
54	or/35-53
55	female sexual dysfunction/ use emczd
56	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
57	(obstruct$ adj3 intercourse).tw.
58	(vagin$ adj3 laxity$).tw.
59	(vagin$ adj wind).tw.
60	Vaginismus/ use ppez
61	vaginism/ use emczd
62	vaginismus$.tw.
63	(vagin$ adj penetrat$ adj disorder$).tw.
64	or/55-63
65	7 or 19 or 30 or 34 or 54 or 64
66	Economics/ use ppez
67	Value of life/ use ppez
68	exp "Costs and Cost Analysis"/ use ppez
69	exp Economics, Hospital/ use ppez
70	exp Economics, Medical/ use ppez
71	Economics, Nursing/ use ppez
72	Economics, Pharmaceutical/ use ppez
73	exp "Fees and Charges"/ use ppez
74	exp Budgets/ use ppez
75	health economics/ use emczd
76	exp economic evaluation/ use emczd
77	exp health care cost/ use emczd

#	Searches
78	exp fee/ use emczd
79	budget/ use emczd
80	funding/ use emczd
81	budget*.ti,ab.
82	cost*.ti.
83	(economic* or pharmaco?economic*).ti.
84	(price* or pricing*).ti,ab.
85	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
86	(financ* or fee or fees).ti,ab.
87	(value adj2 (money or monetary)).ti,ab.
88	or/66-87
89	65 and 88
90	limit 89 to english language

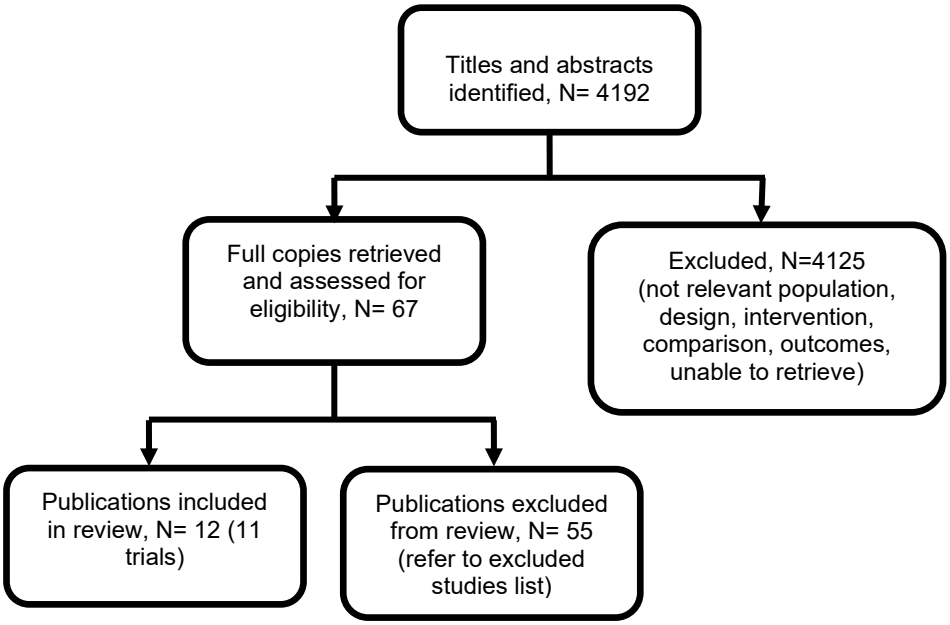
1

Appendix C – Clinical evidence study selection

Study selection for: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

The search for this review question also covered the evidence for review's A and G.

Figure 1: Study selection flow chart



1 Appendix D – Evidence tables

2 Evidence tables for review question: What information provision strategies are effective for women with symptoms 3 associated with pelvic floor dysfunction?

4 Table 4: Evidence tables

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Full citation Araujo, C. C., Marques, A. A., Juliato, C. R. T., The Adherence of Home Pelvic Floor Muscles Training Using a Mobile Device Application for Women With Urinary Incontinence: A Randomized Controlled Trial, Female pelvic medicine & reconstructive surgery, 08, 08, 2019 **Ref Id** 1196588 **Country/ies where the study was carried out** Brazil	**Sample size** N=21 **Characteristics** No significant differences between the groups in age, race, BMI, smoking, sedentary lifestyle, pregnancies, parity, QUID score, ICIQ score and PERFECT score **Inclusion criteria** Women with self-reported SUI symptoms were included. The SUI diagnosis was based on a demonstration of urinary leakage on straining or coughing. In those who presented with mixed urinary incontinence, the predominant type was SUI, based on the self-reported symptoms, using the Questionnaire for Urinary Incontinence Diagnosis (QUID) **Exclusion criteria** The exclusion criteria were neurologic impairment that affects comprehension, symptoms suggestive of neurogenic bladder (a dribbling stream when urinating, inability to	**Interventions** Both groups were instructed to do PFMT using the same exercise protocol. Each completed protocol comprised 8-second hold/8-second relaxation followed by 3 phasic contractions, repeated 8 times, with a total of 32 contractions and 152 seconds. The physiotherapist recommended that the patient did the completed protocol 2 times a day (sitting, lying down, or standing) for 3 months. Women were randomised to either 1) A mobile application that reminded them 2 times each day to do the PFMT (n=12). The app also had a dynamic sequence of images on the screen. These images presented a correlation with the exercise that was being requested. For example, an 8-second contraction would be represented by a larger graphic area, different from phasic short contractions (smaller spikes), comprising 152 seconds of	**Details** The patients were instructed to return for evaluations 4 times (initial, and at 1, 2, and 3 months). During each visit, the physiotherapist checked the adherence form, applied the questionnaires, and performed PFM examination. The International Consultation on Incontinence Questionnaire (ICIQ) — Vaginal Symptoms,15 Short Form,16 and QUID For both questionnaires, The higher the scores are, the worse the severity of the symptoms is.	**Results** **Adherence - number of protocol repetition (mean, SD)** 1 month • App group: 52.9 ± 5.5 • Control group: 43.7 ± 11.1 2 months • App group: 49.8 ± 8.1 • Control group: 33.6 ± 10.7 3 months • App group: 43.8 ± 8.7 • Control group: 17.7 ± 6.3 **Self-reported adherence - Score attribute by women from 0 to 10, regarding their commitment to exercises (mean, SD)** 1 month • App group: 9.5 ± 0.7	**Limitations** Cochrane risk of bias tool (v2) Domain 1: Randomisation 1.1 Yes, said to be computer generated 1.2 Probably yes, states that sequence was kept in sealed opaque envelopes 1.3 No, no significant differences between groups at baseline Low risk Domain 2: Deviations from intended interventions: 2.1 Yes, participants were aware of their group assignment 2.2 Yes, carers and people delivering the interventions were aware of participants' assignment

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Study type RCT **Aim of the study** The objective of this study was to evaluate the use of a mobile device application (app) for the treatment of urinary incontinence through adherence to home pelvic floor muscle training (PFMT) and its impact on urinary symptoms. **Study dates** 2016 - 2017 **Source of funding** Coordenação de Aperfeiçoamento de Pessoal de Nível Superior supported this study with a postgraduate scholarship to 1 of the authors (C.C.A.) and	fully empty the bladder, straining during urination, loss of bladder control, and difficulty determining when the bladder is full), alterations in PFM contraction (hyperactivity or complete inability to contract) after initial vaginal palpation, previous PFMT, pelvic organ prolapse (greater than stage I by Pelvic Organ Prolapse Quantification), urinary infections symptoms, and previous pelvic floor surgeries	animation. Music was synchronized with the contractions during the exercise and the volume changed when the exercises begin or finish. When the woman finished the exercise, she reported her perception of improvement on that day. Information was saved in the app and was available by remote access to the researcher. 2) Women in the control group (n=9) were instructed to do the exercise twice at any time of the day.		• Control group: 8.3 ± 1.5 2 months • App group: 9.9 ± 0.2 • Control group: 9 ± 1.3 3 months • App group: 9.9 ± 0.2 • Control group: 8.67 ± 1.3 **ICIQ-UI SF score, mean (SD)** 1 month • App group: 12.9 ± 4.6 • Control group: 12.4 ± 6.7 2 months • App group: 10.9 ± 6.9 • Control group: 11.3 ± 5.0 3 months • App group: 9.1 ± 6.6 • Control group: 9.7 ± 6.6 **ICIQ-VS score, mean (SD)** **Quality of life** 1 month • App group: 4.4 ± 4.3 • Control group: 3.9 ± 4.2 2 months • App group: 1.8 ± 3.2 • Control group: 3.1 ± 3.7	2.3 Probably no, there was some non-adherence, but this is not likely due to the trial context 2.6 Probably no, per protocol analysis was used which excluded participants who were lost to follow up 2.7 Probably yes, although there were no participants missing at 1 month follow up, but 20% missing at 2 months, and 36% at 3 months High risk Domain 3: missing outcome data: 3.1 No, although no participants missing at 1 month follow up, over 5% missing at both 2 and 3 months 3.2 No, no evidence that the results were not biased by missing data 3.3. Probably yes, although reasons for drop out are documented, some are vague for example 'not available' and some are related to the outcome for example 'reported no symptoms'.

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Eldorado Research Institute				3 months • App group: 5.6 ± 4.3 • Control group: 1.3 ± 2.9	3.4 Probably yes, differences between the groups in terms of the proportion of missing data (29% vs 44%) High risk Domain 4: Measurement of the outcome 4.1 No, validated questionnaires were used 4.2 No, measurement is unlikely to differ between groups 4.3 Yes, outcome assessors were aware as self-report measures were used 4.4 Probably not, as both groups received an active intervention Low risk Domain 5: Selection of the reported result: 5.1 Probably no, there is a published protocol, however the this does not include intentions for analysis 5.2 No, the protocol does include outcome measures which are reported in the paper 5.3 No information, an analysis plan is not reported

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
					Some concerns Domain 6: Overall judgement: High risk
Full citation Brazell, Hema D, O'Sullivan, David M, Forrest, Allison, Greene, John F., Effect of a Decision Aid on Decision Making for the Treatment of Pelvic Organ Prolapse, Female Pelvic Medicine & Reconstructive Surgery, 21, 231-5, 2015 **Ref Id** 1284218 **Country/ies where the study was carried out** USA **Study type** Randomized controlled trial **Aim of the study** The aim of this study was to	**Sample size** N=104 **Characteristics** Characteristic SC SC+DA Participants (N = 104) 51 53 Age, mean (SD), y 60.4 (11.0) 61.0 (13.2) Mean BMI, mean (SD) 27.8 (5.7) 27.8 (5.5) Median parity (IQR) 2 (2–3) 2 (2–3) Prior POP surgery, n (%) 9 (17.6) 5 (9.4) Prior incontinence surgery, n(%) 8 (15.7) 3 (5.7) Menopause, n (%) 38 (76.0) 42 (79.2) Smoke, past or present, n (%) 20 (39.2) 19 (35.8) **Inclusion criteria** English-speaking female patients aged 18 years and older who were scheduled for a consultation visit for POP were eligible for inclusion in this study **Exclusion criteria** Women who declined or expressed unwillingness to being contacted for participation, who did not answer their	**Interventions** 1) Standard counselling (new patient discussion about POP and treatment options; n=51). 2) Standard counselling plus a decision aid (DA; n=53). The DA defines POP, provides details on nonsurgical and surgical options for the treatment of prolapse, describes risks associated with surgery, and briefly details postoperative expectations. There are also testimonials, both from women who choose surgery and those who opt for more conservative measures.	**Details** Patients were randomized 1:1 using a random numbers table in blocks of 6. Standard office practice is to mail all new patients a personal health history form as well as pelvic floor disorder questionnaires, which are completed at home and brought with them to the initial visit. For patients in the DA arm, the aid was mailed along with these items for their review before the first visit. After the consultation, consenting patients completed a 16-item decisional conflict scale (DCS, Appendix 1) and short form general health survey (SF-12v2). The DA was given before the initial visit so that any questions that may have arisen as a result of reading the	**Results** **Self-efficacy (Decisional conflict score; mean, SD)** - SC group: 14.1 (16.1) - SC+DA group: 15.8 (13.9) Baseline characteristics, including pelvic prolapse examination measurements, did not significantly differ between groups	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: low risk, Domain 2: Deviations from intended interventions: low risk, Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns. Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns **Other information** One limitation of this study is the use of a non-validated DA, which does not include a discussion on treatment outcomes, only treatment choices.

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
evaluate if the addition of a decision aid (DA) decreases decisional conflict in women presenting for the management and treatment of pelvic organ prolapse (POP). **Study dates** 2012 - 2013 **Source of funding** The decision aid used for this study was developed by Healthwise and provided to the authors at no cost.	screening phone call, whose appointment was within 7 days of consult request, and those with a planned concomitant nongynecologic procedure were excluded		aid could have been addressed at that visit. In addition, most patients make their treatment plan decision at that first consultation visit. The DCS comprises 3 subscales: decision uncertainty, factors contributing to uncertainty, and perceived effective decision making. These Likert scales use response categories of strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree, which are scored as 0 to 4, respectively. The 16 items are then (a) summed, (b) divided by 16, and (c) multiplied by 25. Scores range from 0 to 100, and DCS scores greater than 37.5 are associated with decision delay or feeling unsure, whereas scores less than 25 are associated with implementing decisions. Thus, subjects with scores greater than 37.5 were classified as		The authors did not verify whether or not subjects actually read the aids. Thus, it is plausible that they did not see a difference between groups because study participants assigned to the SC + DA group did not read the aid.

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
			having high decisional conflict. As secondary outcome measure, was rates of regret associated with choice of treatment plan. Subjects were contacted 3 months after their treatment decision had taken effect to determine if they regretted their initial plan.		
Full citation Bulmer, P. J, James, M, Ellis-Jones, J, Smith, D, Timoney, A. G, Donovan, J., A randomized trial comparing the effectiveness and preference of a touch-screen computer system with a leaflet for providing women with information on urinary symptoms suggestive of detrusor instability, BJU International, 88, 532-5, 2001 **Ref Id** 1284219	**Sample size** N=40 **Characteristics** Age: mean (range): • Intervention group: 58.6 (36-76) • Control group: 61.5 (43-81) **Inclusion criteria** Women referred by their GP to a urodynamic unit for assessment **Exclusion criteria** Visual impairment or learning disability.	**Interventions** A computer generated information system (touchscreen; n=20) versus a printed leaflet (n=20). Both information systems contained identical information about the cause, investigation and treatment of LUTS. The written information in the leaflet was illustrated by diagrams and pictures. Information on the touch-screen system was given by a voice-over and illustrated with diagrams and video clips.	**Details** Women were randomised to receive either the touchscreen first or the leaflet first. A questionnaire about the information was done at baseline and again immediately after their allotted information system. After using both systems women were asked about the usefulness of the 2 systems and their preference.	**Results** **Satisfaction** • Computer generated: 20/20 • Leaflet: 20/20 **Knowledge (mean improvement, CI; 0-11)** • Computer generated: 3.6 (1.7, 5.5) • Leaflet: 2.8 (1.2, 4.4)	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: low risk, Domain 2: Deviations from intended interventions: low risk, Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns. Due to the cross over design questionnaire there may have been some carry over on question of whether the information was felt to be helpful & if the women felt they

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Country/ies where the study was carried out UK **Study type** RCT (crossover design) **Aim of the study** To evaluate how well women retained information given to them by either a leaflet or a computer-generated information system, and which system they preferred. **Study dates** 1999-2000 **Source of funding** Supported by a grant from The Kings Fund.					had a better understanding of their condition, Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns
Full citation Caagbay, D, Raynes-Greenow,	**Sample size** N=140 (N=136 analysed)	**Interventions** 1) The intervention group (n=69) were instructed on PFMT and	**Details** All of the participants in the intervention	**Results**	**Limitations** Cochrane risk of bias (Version 2.0)

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
C, Dangal, G, Mc Geechan, K, Black, K. I., Impact of an informational flipchart on lifestyle advice for Nepali women with a pelvic organ prolapse: a randomized controlled trial, International Urogynecology Journal, 31, 31, 2020 **Ref Id** 1284222 **Country/ies where the study was carried out** Nepal **Study type** Randomized controlled trial **Aim of the study** Aimed to evaluate the impact of an informational flipchart on PFMT and lifestyle advice on the quality of life (QOL) for Nepali	**Characteristics** Of the 136 women, mean age was 47.87 (SD 12.9) years, age of first pregnancy 21.28 (SD 4.0) years, BMI 24.93 (SD 4.3) kg/m2 and median parity 3 (range 0–10). There were 73 (54%) with POP-Q stage I, 53 (39%) with stage II and 10 (7%) with stage III and the mean years of reported POP symptoms was 4.8 years. The majority (66%) of women had a MOS of 2 or 3 out of 5. **Inclusion criteria** Eligible women were ≥ 18 years old with a symptomatic stage I–III POP as determined by the International Continence Society (ICS) Pelvic Organ Prolapse Quantification System (POP-Q) who attended the reproductive health screening camps and the outpatient gynecology clinic at the Public Health Concern Trust (phect-NEPAL) Kathmandu Model Hospital **Exclusion criteria** Stage IV POP was not included because conservative strategies are not effective on this degree of severity. Women were excluded if they had a stage 0 or IV POP, were pregnant, were planning pregnancy within the following 6 months, had previous or planned gynecological surgery or had a pessary in situ.	lifestyle advice through verbal instruction and an informational flip-chart. The flip-chart provided in-depth information about pelvic anatomy, pelvic organ prolapse (definition, causes, symptoms), lifestyle advice and treatment options. 2) The control group (n=67) were provided usual care: brief verbal instruction on PFMT.	group were provided the same lifestyle advice provided in the flipchart. The education was delivered individually and face-to-face. The flipchart provided in-depth information about pelvic anatomy, pelvic organ prolapse (definition, causes, symptoms) and treatment options. The lifestyle advice and conservative management for POP included information on a healthy diet, drinking water, quitting smoking, managing a chronic cough, maintaining a healthy weight range, exercise, toileting habits, correct posture, birthing with a skilled birthing attendant, heavy lifting techniques, how to wear a patuka and how to perform PFMT. Education about fluid consumption and eating a healthy diet is aimed at preventing constipation and managing a healthy weight. Instructions about toileting habits	**Change in symptoms (bulge/lump from or in vagina)** **Baseline** • Intervention group: 38/69 • Control group 29/67 **6 months** • Intervention group: 6/54 • Control group: 14//48 **Quality of life (POP-Q prolapse impact score; mean, range)** **Baseline** • Intervention group: 33.3 (0-100) • Control group: 33.3 (0-100) **6 months** • Intervention group: 0 (0-66) • Control group: 0 (0-66) Mean difference (95% CI): 12.52 (4.84, 20.20), p = .002 Only a small percentage (20%) of women were able to attend the 6-month clinical assessment so the authors were unable to assess the secondary outcomes.	Domain 1: Randomisation: low risk Domain 2: Deviations from intended interventions: low risk (score as: low risk, some concerns or high risk) Domain 3: Missing outcome data: some concerns 25% loss to follow-up at 6 months Domain 4: Measurement of the outcome: low risk outcome assessor was blinded Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
women with a POP. **Study dates** 2018 - 2019 **Source of funding** Dr. Albert S McKern Research Scholarship & National Health and Medical Research Council (of Australia) Career Development Fellowship #1087062.			involved advice to avoid straining when emptying the bladder and bowels, to take deep breaths and relax the stomach and to position with the knees above the hips either on a squat toilet or with a small step stool under the feet. Additional instruction was provided on how to correctly perform a pelvic floor muscle (PFM) contraction, how to know if you are incorrectly contracting the muscles and how to perform 'the knack'. A brief description was also provided on pessaries, POP surgery and where to seek help. Usual care for the conservative management of POP in Nepal includes brief verbal instruction on PFMT. Therefore, both groups were instructed to perform daily PFMT including 10 strong PFM squeezes and one 10-s hold. Additional instruction described how to correctly		

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
			contract the PFMs by asking the women to imagine squeezing the muscles around the examining doctor's finger as though trying to avoid passing gas' and to avoid breath holding and co-contraction of other muscles. They were also advised to build up gradually to a set of 10 squeezes and 10-s hold as they increase PFM strength. All participants were given a paper exercise diary and pen to record when they completed their daily PFM exercises throughout the 6 months. The P-QOL questionnaire was completed at baseline and then by telephone at 6 weeks, 12 weeks and 6 months by a Nepali research assistant. At the 6-month follow-up, all participants were invited to visit Kathmandu Model Hospital for the clinical re-examination.		

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Full citation Gezginci, E, Iyigun, E, Yilmaz, S., Comparison of 3 Different Teaching Methods for a Behavioral Therapy Program for Female Overactive Bladder: A Randomized Controlled Trial, Journal of Wound, Ostomy, & Continence NursingJ Wound Ostomy Continence Nurs, 45, 68-74, 2018 **Ref Id** 1284241 **Country/ies where the study was carried out** Turkey **Study type** RCT **Aim of the study** To compare the effect of 3 instructional methods for	**Sample size** N=60 **Characteristics** All were women with OAB symptoms aged 30 or older. **Inclusion criteria** Ambulatory females, 18 years or older with predominant OAB symptoms, with or without concomitant stress urinary incontinence (UI). Predominant OAB was defined as a higher number of urgency and UUI episodes when compared to stress incontinence episodes on a bladder diary **Exclusion criteria** Pregnancy, suspected neurogenic disease, stress predominant mixed UI, continuous urinary leakage, previous anti-incontinence surgery, incomplete bladder emptying with 2 or more post void residual volumes of more than 100 mL, genitourinary malignancies, current or previous behavioral therapy programs, previous or current use of antimuscarinic agents, symptomatic pelvic organ prolapse, or severe comorbid conditions such as congestive heart failure, chronic renal failure, or impaired cognitive function.	**Interventions** The study compared 3 different strategies for structured educational materials for behavioural therapy on lower urinary tract symptoms delivered in a planned manner under the supervision of a professional clinician such as a nurse. Three intervention groups received the following: (1) verbal instructions and an educational leaflet (n=15); (2) only verbal instructions (n=15); and (3) only a leaflet (n=15). There was also a control group (n=15) who received usual care comprised verbal instructions about continence care without an outline to guide instruction and structured explanations or supervision of training.	**Details** Subjects were randomized into 4 groups: group 1 received structured verbal instruction plus a leaflet, group 2 received structured verbal instruction, group 3 received a leaflet alone, and group 4 received usual care that included unstructured verbal counselling about continence care. The primary outcome measures were Incontinence Impact Questionnaire-7 (IIQ-7) and Urinary Distress Inventory-6 (UDI-6) scores. All outcomes were measured before and 6 to 8 weeks after the interventions.	**Results** **Change in symptoms (IIQ-7; median, range)** Baseline • Verbal instructions + leaflet: 33.3 (0-85.7) • Verbal: 57.1 (14.2-100) • Leaflet: 52.3 (0-95.2) Post-intervention • Verbal instructions + leaflet: 0 (0-4.7) • Verbal: 19.0 (0-38.1) • Leaflet: 23.8 (0-47.2) **Change in symptoms (UDI-6; median, range)** Baseline • Verbal instructions + leaflet: 38.8 (22.2-94.4) • Verbal: 61.1 (27.7-100) • Leaflet: 50.0 (16.6-88.8) Post-intervention • Verbal instructions + leaflet: 5.5 (0-11.1) • Verbal: 22.2 (11.1-38.8) • Leaflet: 27.7 (11.1-50.0)	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: some concerns allocation concealment unclear. Domain 2: Deviations from intended interventions: low risk Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns No blinding Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
behavioral therapy on lower urinary tract symptom (LUTS) severity and health-related quality of life (HRQOL) in women with overactive bladder. **Study dates** 2012 - 2013 **Source of funding** None reported				**Change in symptoms (I-QOL; median, range)** Baseline • Verbal instructions + leaflet: 70.0 (35.4-96.3) • Verbal: 64.5 (37.2-91.8) • Leaflet: 69.1 (33.6-98.1) Post-intervention • Verbal instructions + leaflet: 98.1 (94.5-99.1) • Verbal: 79.1 (56.3-98.1) • Leaflet: 80.9 (63.6-99.1)	
Full citation Hui, E., Lee, P.S.C., Woo, J., Management of urinary incontinence in older women using videoconferencing versus conventional management: a randomized	**Sample size** N=64 randomised, N=58 analysed **Characteristics** Mean age 74 years, 86% had good or excellent health. **Inclusion criteria** Community-dwelling women aged 60 years or over, with symptoms of urge or stress	**Interventions** At baseline, all women were assessed face-to-face for pelvic floor muscle strength, instrumental biofeedback and verbal feedback by vaginal palpation. A perinometer, was used to measure the vaginal squeeze pressure in mmHg. Both groups underwent an 8-week intervention period with one session per week, women were randomised to	**Details** Participants were asked to rate the severity of their existing bladder problem (0-none, 1-mild, 2-moderate, 3-severe). This was assessed before the intervention and after 8 weeks of the intervention.	**Results** **Change in symptoms (Incontinence symptoms; Incontinence severity index; mean, SD):** Baseline • Telemedicine group: 2.1 (0.7) • CS group: 1.8 (0.8) Post-intervention	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: low risk, Domain 2: Deviations from intended interventions: some concerns (digital palpation only used in the usual continence

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
controlled trial, Journal of Telemedicine and Telecare, 12, 343-347, 2006 **Ref Id** 1304231 **Country/ies where the study was carried out** Hong Kong **Study type** RCT **Aim of the study** To compare the efficacy of videoconferencing and conventional clinic-based methods in the management of urinary incontinence in older women. **Study dates** Not reported **Source of funding**	incontinence, with 1 or more incontinence episodes in a week **Exclusion criteria** None reported	receive this either through videoconferencing or face-to-face consultation. 1) Tele-medicine continence program (TCP; n=32): using video-conferencing 2) Usual continence service (CS; n=32): During the intervention period, all components of behavioural training given to either intervention group were the same, with 1 exception: in the TCP group, it was not possible for the nurse specialist to give feedback on pelvic floor contraction during follow-up, as digital assessment could not be performed. A series of talks from the second week covered the following topics: an overview of the anatomy and physiology of the urinary system, the causes and treatment alternatives, behavioural management such as urge suppression technique, pelvic floor exercise, fluid management and dietary factors that cause bladder irritation. A booklet on urge and stress incontinence management was issued to the participants for reference at home	Objective measures included the number of incontinent episodes, voiding frequency and voided volume as documented in a 3-day voiding diary, and pelvic floor muscle strength by digital assessment using the Oxford Scale. The video conference group were asked about satisfaction with the intervention - but not the continence service group.	• Telemedicine group: 0.7 (0.7) • CS group: 0.5 (0.6)	service group) Domain 3: Missing outcome data: some concerns (greater loss to follow-up in videoconference group (5/32 vs 1/32)) Domain 4: Measurement of the outcome: some concerns (lack of blinding) Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
The telemedicine equipment was supported by the SK Yee Medical Foundation.					
Full citation Myers, Erinn M, Robinson, Barbara L, Geller, Elizabeth J, Wells, Ellen, Matthews, Catherine A, Fenderson, Jacquia L, Crane, Andrea K, Jannelli, Mary, Connolly, AnnaMarie, Randomized trial of a web-based tool for prolapse: impact on patient understanding and provider counseling, International Urogynecology Journal, 25, 1127-32, 2014 **Ref Id** 1284283 **Country/ies where the study was carried out**	**Sample size** N=90 randomized, N=88 analysed **Characteristics** Mean age of 59.8±12.9 years and 13.9±2.4 years of education. The majority of the women were Caucasian (74.4 %). There were no differences in demographics between groups **Inclusion criteria** Women presenting to a female Pelvic Medicine and Reconstructive Surgery outpatient clinic for a new patient visit whose main symptom was seeing or sensing a vaginal bulge, who were older than 18 years, and were able to read and speak English. **Exclusion criteria** Not mentioned	**Interventions** Standard care with iPad (intervention, n=46). Standard care was defined as the counselling our providers routinely provide using verbal counselling alone, drawings, diagrams, and/or 2D/3D models. Standard care with iPad™ was defined as routine counselling while also using the prolapse web-based tool. This application allows providers to insert each patient's individual POP-Q exam into the program and then provides an animated custom example of normal support and then the patient's particular support defect. Standard care (control, n=44) or	**Details** Participants then completed a previsit Likert scale questionnaire that queries baseline satisfaction with knowledge of presenting bulge symptoms and related anxiety. Once this unvalidated questionnaire was completed, all patients underwent a new patient history and physical exam, including POP-Q. Participants were then randomized	**Results** **Satisfaction (satisfaction with counselling method)** • Standard care: 43/44 • Standard care + iPad: 46/46 **Knowledge (satisfaction with understanding of bulge symptoms)** Baseline • Standard care: 50% • Standard care + iPad: 43.5% After counselling • Standard care: 42/44 (95.5%) • Standard care + iPad: 45/46 (97.8%) **Anxiety (moderate to extreme anxiety)** Baseline • Standard care: 65.9% • Standard care + iPad: 73.9% After counselling • Standard care: 31.8%	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: low risk Domain 2: Deviations from intended interventions: low risk Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns No blinding Domain 5: Selection of the reported result: low risk, Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
USA **Study type** RCT **Aim of the study** To establish whether interactive patient/provider counselling using a web-based visual counselling tool would improve patient satisfaction with understanding prolapse symptoms compared with standard counselling. **Study dates** 2012 **Source of funding** None reported				• Standard care + iPad: 28.3%	
Full citation Sampselle, Carolyn M, Newman, Diane K, Miller, Janis M, Kirk, Keri, DiCamillo, Mary Ann, Wagner, Todd	**Sample size** N=647 **Characteristics** Mean age was 63 years and approximately 28% of the participants were African American, primarily from an urban setting. The 2 arms	**Interventions** 1) n=315. A 20-minute DVD video - which was an abbreviated version of the 2-hour class. Women could take this home to watch whenever they wanted.	**Details** Outcomes at baseline, and 3, 12 and 24 months were the scores on questions 1 to 3 of ICIQ-SF (International Consultation on	**Results** **Change in symptoms (ICIQ-SF; mean, SE; change score)** Baseline • Group class: 3.11 (0.15) • Video: 3.13 (0.15)	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
H, Raghunathan, Trivellor E, Diokno, Ananias C., A Randomized Controlled Trial to Compare 2 Scalable Interventions for Lower Urinary Tract Symptom Prevention: Main Outcomes of the TULIP Study, The Journal of urology, 197, 1480-1486, 2017 **Ref Id** 1284291 **Country/ies where the study was carried out** USA **Study type** Randomized Controlled Trial **Aim of the study** To compare 2-year urinary incontinence and urgency scores of older women who attended a 2-hour bladder health	were balanced on body mass index at baseline, age, race/ethnicity, education, employment status, income and marital status. **Inclusion criteria** Female and age 55 years or greater, have a score of 5 or less on ICIQSF questions 1 to 312 and no more than 3 drops of demonstrable urine leakage on the quantified standing stress paper towel test and be willing to undergo vaginal examination. **Exclusion criteria** Nonambulatory status (confined to bed or wheelchair), persistent pelvic pain (daily), history of neurological disease (stroke, Parkinson's disease, multiple sclerosis, epilepsy, spinal cord tumour or trauma, spina bifida or a symptomatic herniated disc), other urinary conditions or procedures that may affect continence status (for example bladder cancer, urethral diverticula, previous surgery for UI or prolapse), participation in another research project that may have influenced the results of the focal trial, pelvic organ prolapse protruding beyond the introitus upon straining, absolute absence of PFM strength manifested by a zero score on the Brink test for pressure and displacement, evidence of UTI or hematuria by urine dipstick test, history of 2 UTIs in the last year and more than 1 UTI in the last 6 months, and post-void residual urine volume 150 cc or greater.	2) n=332. A single 2-hour long group class with 2 presenters (a urologist and a nurse specialist) who provided instruction in an array of non-invasive prevention practices, including PFM exercises to increase PFM strength, bladder training to optimize the interval between voids, the Knack to suppress stress and urgency UI with anticipatory pre-emptive contraction and lifestyle changes to include fluid and dietary modification. Upon completion of the 2-hour class each participant received written descriptions of the preventive practices, that is PFM exercise, bladder training and the Knack, and a CD that included vocal commands to assist with PFM exercise.	Incontinence Short Form) as the primary outcome and on IUSS (Indevus Urgency Severity Scale).	3 months • Group class: 0.39 (0.45) • Video: -0.44 (0.2) 12 months • Group class: -0.23 (0.2) • Video: -0.3 (0.19) 24 months • Group class: -0.05 (0.31) • Video: -0.37 (0.23) **Change in symptoms (IUSS; mean, SE)** Baseline • Group class: 1.19 (0.03) • Video: 1.15 (0.03) 3 months • Group class: 0.02 (0.07) • Video: -0.03 (0.05) 12 months • Group class: -0.003 (0.05) • Video: -0.06 (0.07) 24 months • Group class: 0.04 (0.06) • Video: -0.09 (0.07)	Unclear allocation concealment. Block randomisation in blocks of 10 - so allocation could be guessed for some participants Domain 2: Deviations from intended interventions: low risk, Domain 3: Missing outcome data: low risk 16% lost to follow-up at 24 months Domain 4: Measurement of the outcome: low risk Assessor blinded Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
class vs those who viewed a 20-minute abbreviated class video for the purpose of urinary incontinence prevention **Study dates** Not reported **Source of funding** Supported by NINR (National Institute of Nursing Research) Grant R01NR012011.					
Full citation Shannon, M. B., Adams, W., Fitzgerald, C. M., Mueller, E. R., Brubaker, L., Brincat, C., Does Patient Education Augment Pelvic Floor Physical Therapy Preparedness and Attendance? A Randomized Controlled Trial, Female Pelvic Medicine & Reconstructive	**Sample size** N=200 **Characteristics** Mean age (SD) Intervention 57.32 years (16.12) control 56.77 years (17.00) BMI (SD) Intervention 32.48 kg/m^2(8.24) control 29.94 kg/m^2 (6.74) Type of incontinence Stress urinary incontinence, n: Intervention 9 (9.0%), control 25 (25%) Urgency urinary incontinence, n: Intervention 25 (25%), control 24 (24%) Mixed urinary incontinence, n: Intervention 34 (34%), control 21 (21%)	**Interventions** Enhanced counselling (n=100) or standard counselling (n=100) Intervention group: A 4.5-minute video highlighting the role of pelvic floor muscle training in the treatment of pelvic floor disorders and what to expect in the first appointment. The explanation was provided by the practice's attending physicians, 2 physical therapists and 1 patient. Some of the (clothed) manoeuvres were demonstrated in the video along with a patient's personal account. Control group: A 1-page handout describing the role of pelvic floor muscle training in the treatment	**Details** Both the enhanced and standard counselling were 1 off treatments The study measured the change in the patient's Urinary Distress Inventory 6 (UDI-6).	**Results** N=100 enhanced counselling, N=100 standard counselling **Adherence (completed half of recommended visits)** Intervention = 81%, Control = 70.4% **Change in symptoms (Urinary Distress Inventory 6 Questionnaire)** Intervention (n=100): post treatment 38.11 (18.37),	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1-randomisation: Some concerns 1.1: Yes, randomised using a 1 to 1 permutated block scheme 1.2: Yes, randomised using a secure research database

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
SurgeryFemale pelvic med, 24, 155-160, 2018 **Ref Id** 1176382 **Country/ies where the study was carried out** USA **Study type** Parallel group RCT **Aim of the study** To determine if the addition of video counselling to a standardised educational handout improves urinary distress, pelvic floor muscle training initiation or the proportion of completed visits **Study dates** August 2016-November 2017 (dates taken from the Clinical Trials Registry: NCT02875977)	Urgency-frequency syndrome, n: Intervention 27 (27%), control 20 (20%) Weak pelvic floor, n: Intervention 8 (8%), control 14 (14%) Defecatory dysfunction, n: Intervention 6 (6%), control 6 (6%) Pelvic organ prolapse, n: Intervention 10 (10%), control 12 (12%) Myofascial pain, n: Intervention 40 (40%), control 36 (36%) Other, n: Intervention 2 (2%), control 2 (2%) **Inclusion criteria** • Women referred for PFPT for a pelvic floor disorder • of at least 18 years of age • who spoke English or Spanish **Exclusion criteria** • Attending pelvic floor muscle training in the last 12 months	of pelvic floor disorders and what to expect in the first appointment.		Control (n=100) post treatment 26.91 (20.81)	1.3: Probably yes, baseline characteristics reported, but no analysis across arms reported. Some differences between groups appear relative, for example SUI at baseline 25% versus 9% Domain 2a-Deviations from intended interventions (effect of assignment to interventions): High risk 2.1: Yes, due to the nature of the intervention participants were aware of the interventions. 2.2. Yes 2.3. Probably No, no reported deviations 2.6. No information, study flow diagram states analysis conducted on all participants, but no clear information if this was done or how. Domain 2b-Deviations from intended interventions (effect of adhering to the interventions): High risk

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Source of funding Not reported					2.1: Yes 2.2. Yes 2.3. No Information 2.4. No 2.5. Probably yes, 2.6. No information Domain 3 - Risk of bias due to missing outcome data: High risk 3.1. No information 3.2. No 3.3. Probably yes 3.4. Probably yes Domain 4 - Measurement of the outcome: High risk 4.1. No 4.2. No 4.3. Yes, all measures self-report 4.4 Probably yes 4.5 Probably no Domain 5- Selection of the reported result: some concerns 5.1. No information 5.2. Probably no 5.3. No **Domain 6- Overall judgment of bias: High risk**

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Full citation Shirreff, Lindsay, Anderson, Michelle, McDermott, Colleen, Comparing written and verbal delivery of a treatment regimen to women with overactive bladder: a randomized controlled trial, Menopause (New York, N.Y.), 27, 76-81, 2020 **Ref Id** 1273967 **Country/ies where the study was carried out** Canada **Study type** RCT **Aim of the study** To determine if a transcribed list of 6 management	**Sample size** N=72 **Characteristics** Mean (SD) age was 57 (15.9) years for the verbal instruction group and 54.5 (14.1) for the written+verbal group. **Inclusion criteria** New clinic patients meeting the diagnostic criteria for OAB (symptoms of urinary urgency, frequency, and nocturia, with or without urge incontinence) were approached for consent once the OAB diagnosis was made. **Exclusion criteria** Women were excluded if they could not read or understand English or had signs of cognitive decline. They were also excluded if they had other concomitant urogynecologic diagnoses for which they received a separate set of treatment recommendations	**Interventions** 1) The intervention group (n=34) received both verbal instruction and a written supplement on the 6 treatment strategies for OAB. It was handwritten by the physician while verbally communicating the following 6 instructional points: avoid bladder irritants; daily water consumption of 1.2 L per day or 40 oz. per day; no significant fluid consumption 3 hours before bed; weight loss (if overweight or obese) or maintenance of a healthy weight (if normal body mass index); bladder training with a pelvic physiotherapist; and oral medication for bladder control. Participants in this group left the clinic with the transcribed list of recommendations. 2) Participants in the control group (n=38) received verbal information on treatment recommendations for OAB, but did not receive the written list of management strategies. All participants received a standard typed list of bladder irritants, and also a typed referral for pelvic physiotherapy. All verbal and written instructions were delivered by a single physician.	**Details** Approximately 10 minutes after receiving OAB instructions, before leaving the clinic, participants were asked to complete a demographic questionnaire (age, level of education, occupation, and first language) and respond to a verbal quiz assessing ability to recall the 6 treatment recommendations. The quiz was administered by a research assistant uninvolved in the circle of care. Participants were asked to list as many of the 6 OAB management strategies reviewed with them as possible. Whether participants in the intervention group referred to their written supplement was also documented. Two weeks later,	**Results** **Knowledge (Immediate total retention score; 0-6)** • Verbal + written: 5.9 (0.5) • Verbal only: 5.3 (1.0) P = .002 **Knowledge (Two-week total retention score; 0-6)** • Verbal + written: 4.8 (1.3.) • Verbal only: 4.7 (1.4) P = 0.70 Secondary analysis based on level of education showed significant differences among participants with postsecondary education, the written instruction group scoring significantly higher than the verbal instruction group (6/6 vs 5.6/6; P¼0.02). There was no difference in total score for participants with primary/secondary	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: low risk Domain 2: Deviations from intended interventions: low risk Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns not blinded, participants in the written group could refer to their written list when doing the quiz Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
strategies for overactive bladder improves immediate and delayed retention of these recommendations compared with a traditional verbal discussion. **Study dates** 2015 -2019 **Source of funding** Departmental grant from Mount Sinai Hospital (Department of Obstetrics and Gynecology)			participants were telephoned by the same research assistant and asked to recall as many of the 6 treatment recommendations as possible. Those in the intervention group were also asked if they referred to their written supplement during the call and where they were keeping the instruction sheet.	education. There was also no difference in recall for each individual recommendation except weight loss/healthy weight maintenance, which had significantly better retention in the written group (82% vs 100%; P¼0.01).	
Full citation Sjöström, M, Umefjord, G, Stenlund, H, Carlbring, P, Andersson, G, Samuelsson, E., Internet-based treatment of stress urinary incontinence: 1- and 2-year results of a randomized controlled trial with	**Sample size** N=250 **Characteristics** Mean (SD) age was 48.7 (10.2) years, 46% were postmenopausal, 8% were nulliparous. **Inclusion criteria** Female, Age 18–70 years, SUI 1 or more times/week, Ability to read and write	**Interventions** The women had 3 months of either; (1) An Internet-based treatment programme (n=124 women), including e-mail support and cognitive behavioural, therapy assignments (2) A treatment programme sent by post (n=126).	**Details** Both programmes included: 1 Information on SUI and associated lifestyle factors. 2 Pelvic floor muscle training. 3 Training reports (frequency, time spent). Progress was self-monitored, with individually tailored support by a	**Results** **Satisfaction (programme rated as good or very good) 4 months** • Internet group: 84.8% (89/105) • Postal group: 62.9% (71/113) **Satisfaction (satisfied with treatment at 1 year)**	**Limitations** See Sjöström 2013

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
a focus on pelvic floor muscle training, BJU International, 116, 955-64, 2015 **Ref Id** 1284300 **Country/ies where the study was carried out** Sweden **Study type** RCT **Aim of the study** To compare 2 treatment programmes for stress urinary incontinence (SUI) without face-to-face contact: 1 Internet-based and 1 sent by post. **Study dates** 2009 - 2011 (longer follow-up of Sjöström 2013 trial) **Source of funding**	Swedish, Access to computer with Internet connection **Exclusion criteria** Pregnancy, Previous UI surgery, Known malignancy in lower abdomen, Difficulties with passing urine, Macroscopic haematuria, Intermenstrual bleedings, Severe psychiatric disorders, or HADS score >15 for depression or anxiety, Neurological disease with affection on sensibility in legs or lower abdomen		urotherapist. The intensity of the pelvic floor muscle training gradually increased	• Internet group: 69.8% (60/86) • Postal group: 60.5% (46/76) **Change in symptoms (ICIQ-UI SF; change score; mean, SD)** **Baseline – 4 months** • Internet group: 3.4 (3.4) • Postal group: 2.9 (3.1) **Baseline – 1 year** • Internet group: 3.7 (3.3) • Postal group: 3.2 (3.4) **Health-specific QoL (EQ5D; change score)** **Baseline – 4 months** - Internet group: 3.7 (10.9) - Postal group: 1.9 (13.0) **Baseline – 1 year** - Internet group: 2.0 (13.3) - Postal group: 1.7 (12.9)	

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
The Swedish Council for Working Life and Social Research, The Swedish Society of Medicine, the Jämtland County Council, the Västerbotten County Council (ALF), and Visare Norr, Northern County Councils, Sweden					
Full citation Sjöström, M, Umefjord, G, Stenlund, H, Carlbring, P, Andersson, G, Samuelsson, E., Internet-based treatment of stress urinary incontinence: a randomised controlled study with focus on pelvic floor muscle training, BJU International, 112, 362-372, 2013 **Ref Id** 1284301	**Sample size** N=250 **Characteristics** Mean (SD) age was 48.7 (10.2) years, 46% were postmenopausal, 8% were nulliparous. **Inclusion criteria** Female, Age 18–70 years, SUI 1 or more times/week, Ability to read and write Swedish, Access to computer with Internet connection **Exclusion criteria** Pregnancy, Previous UI surgery, Known malignancy in lower abdomen, Difficulties with passing urine, Macroscopic haematuria, Intermenstrual bleedings, Severe psychiatric disorders, or HADS score >15 for depression	**Interventions** The women had 3 months of either; (1) An Internet-based treatment programme (n=124), including e-mail support and cognitive behavioural, therapy assignments (2) A treatment programme sent by post (n=126; “written” group).	**Details** Both programmes included: 1 Information on SUI and associated lifestyle factors. 2 Pelvic floor muscle training. 3 Training reports (frequency, time spent). Progress was self-monitored, with individually tailored support by a urotherapist. The intensity of the pelvic floor muscle training gradually increased	**Results** **Written vs internet treatment programme** **Satisfaction with programme at 4 months:** • Written 71/113 • Internet 89/107 • RR 0.76 (0.64 to 0.89) favours internet **Satisfaction with programme at 12 months:** • Written 46/76 • Internet 60/86 • RR 0.87 (0.69 to 1.09) not sig. **Change in symptoms (follow-up 4 months;**	**Limitations** Cochrane risk of bias (Version 2.0) Domain 1: Randomisation: some concerns Block randomisation in groups of 8 - some allocation could have been guessed Domain 2: Deviations from intended interventions: some concerns The Internet group was supervised by urotherapists, whereas the postal group completed the training on their own. The interaction with the urotherapist may have influenced

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Country/ies where the study was carried out Sweden **Study type** RCT **Aim of the study** To compare 2 treatment programmes for stress urinary incontinence (SUI) without face-to-face contact: 1 Internet-based and 1 sent by post. **Study dates** 2009 - 2011 (see Sjöström 2015 for longer follow-up) **Source of funding** The Swedish Council for Working Life and Social Research, The Swedish Society of Medicine, the Jämtland County Council, the Västerbotten	or anxiety, Neurological disease with affection on sensibility in legs or lower abdomen			**measured with: ICIQ-UI SF (reduction from baseline); range of scores: 0-21; Better indicated by higher values):** • MD 0.5 lower with written (95%CI 1.36 lower to 0.36 higher) **UI - Quality of life (follow-up 4 months; measured with: EQ5D increase from baseline; Range 0 to 100; Better indicated by higher values)** • MD 1.80 lower with written (4.96 lower to 1.36 higher) **UI - Quality of life (follow-up 12 months; measured with: EQ5D increase from baseline; Range 0 to 100; Better indicated by higher values)** • MD 0.80 lower with written (2.76 lower to 1.16 higher)	participants' compliance and motivation to training, and improved the results in the Internet group. Domain 3: Missing outcome data: low risk Domain 4: Measurement of the outcome: some concerns There was no 'blinding' of group allocation to study participants, healthcare providers, or researchers. Domain 5: Selection of the reported result: low risk Domain 6: Overall judgement of bias: some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
County Council (ALF), and Visare Norr, Northern County Councils, Sweden					

BMI: body mass index; DA: decision aid; DCS: decision conflict scale; GP: general practitioner; HADS: Hospital Anxiety and Depression Scale; ICIQ: International Consultation on Incontinence; ICS: International continence society; IIQ: International incontinence questionnaire; IQR: interquartile range; IUSS: indevus urgency severity scale; LUTS: lower urinary tract symptoms; MOS: modified oxford scale; OAB: overactive bladder; PERFECT: Power, endurance, repetitions, fast contractions, elevation, co-contraction and timing; PFD: pelvic floor dysfunction; PFM: pelvic floor muscle; PFMT: pelvic floor muscle training; PFPT: pelvic floor physiotherapy; POP: pelvic organ prolapse; POP-Q: Pelvic organ prolapse quantification; P-QOL: Prolapse quality of life; QoL: Quality of Life; QUID: The Questionnaire for Urinary Incontinence Diagnosis; RCT: randomised controlled trial; SC: standard counselling; SD: standard deviation; SF: short form; SF-12v2; short form general health survey; SUI: stress urinary incontinence; TCP: telemedicine continence programme; UDI-6: Urinary Distress Inventory 6; UI: urinary incontinence; UUI: urge urinary incontinence; UTI: urinary tract infection

10 Appendix E – Forest plots

11 Forest plots for review question: What information provision strategies are 12 effective for women with symptoms associated with pelvic floor dysfunction?

13 No meta-analysis was conducted for this review question and so there are no forest plots.

1 Appendix F – GRADE tables

2 GRADE tables for review question: What information provision strategies are effective for women with symptoms associated 3 with pelvic floor dysfunction?

4 Table 5: Clinical evidence profile for written versus digital information

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Written	Digital	Relative (95% CI)	Absolute	Quality	Importance
Touch screen vs leaflet for OAB - Satisfaction with info tool/care (follow-up 1 month)												
Bulmer 2001	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	20/20 (100%)	20/20 (100%)	RR 1.00 (0.91 to 1.10)	0 fewer per 1000 (from 90 fewer to 100 more)	MODERATE	CRITICAL
Internet vs written treatment programme for UI - Satisfaction with info tool/care (follow-up 4 months)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	71/113 (62.8 %)	89/107 (83.2%)	RR 0.76 (0.64 to 0.89)	200 fewer per 1000 (from 299 fewer to 91 fewer)	LOW	CRITICAL
Internet vs written treatment programme for UI - Satisfaction with info tool/care (follow-up 1 year)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	46/76 (60.5 %)	60/86 (69.8%)	RR 0.87 (0.69 to 1.09)	91 fewer per 1000 (from 216 fewer to 63 more)	LOW	CRITICAL
Touch screen vs leaflet for OAB - Knowledge (follow-up immediate post-intervention; measured with: change from baseline; range of scores: 0-11; Better indicated by higher values)												
Bulmer 2001	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [3]	none	40	40	-	MD 0.8 lower (3.21 lower to 1.61 higher)	LOW	CRITICAL
Mobile app vs written info for PFMT - Adherence to treatment (follow-up 2 months; measured with: Number of PFMT protocol repetitions; Better indicated by higher values)												
Araujo 2020	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	14	-	MD 16.2 lower (23.59 to 8.81 lower)	MODERATE	CRITICAL
Mobile app vs written info for PFMT - Change in symptoms (follow-up 3 months; measured with: ICIQ-UI SF (reduction from baseline); range of scores: 0-21; Better indicated by higher values)												
Araujo 2020	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious imprecision [4]	none	9	12	-	MD 0.6 lower (6.30 lower to 5.10 higher)	VERY LOW	CRITICAL
Internet vs written treatment programme for UI - Change in symptoms (follow-up 4 months; measured with: ICIQ-UI SF (reduction from baseline); range of scores: 0-21; Better indicated by higher values)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	113	107	-	MD 0.5 lower (1.36 lower to 0.36 higher)	MODERATE	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Written	Digital	Relative (95% CI)	Absolute	Quality	Importance
Internet vs written treatment programme for UI - Change in symptoms (follow-up 1 year; measured with: ICIQ-UI SF (reduction from baseline); range of scores: 0-21; Better indicated by higher values)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	81	88	-	MD 0.5 lower (1.51 lower to 0.51 higher)	MODERATE	CRITICAL
Mobile app vs written info for PFMT - Quality of life (follow-up 3 months; measured with: ICIQ-VS QOL; Range 0 to 10; Better indicated by lower values)												
Araujo 2020	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	9	12	-	MD 4.30 lower (7.38 lower to 1.22 lower)	LOW	IMPORTANT
Internet vs written treatment programme for UI - Quality of life (follow-up 4 months; measured with: EQ5D increase from baseline; Range 0 to 100; Better indicated by higher values)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	122	119	-	MD 1.80 lower (4.96 lower to 1.36 higher)	MODERATE	IMPORTANT
Internet vs written treatment programme for UI - Quality of life (follow-up 1 year; measured with EQ5D increase from baseline; Range 0 to 100; Better indicated by higher values)												
Sjöström 2013	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	81	88	-	MD 0.80 lower (2.76 lower to 1.16 higher)	MODERATE	IMPORTANT

CI: confidence interval; EQ5D: EuroQol-5D; ICIQ-UI SF: International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form; ICIQ-VS QOL: International Consultation on Incontinency Questionnaire-Vaginal symptoms quality of life; MD: mean difference; OAB: overactive bladder; PFMT: pelvic floor muscle training; RR: relative risk; UI: urinary incontinence

1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2

2 95% CI crosses 1 MID (0.8 or 1.25)

3 95% CI crosses 1 MID (0.5x control group SD, for knowledge = 2)

4 95% CI crosses 1 MID (0.5x control group SD, for ICIQ-UI SF = 2.3)

5 95% CI crosses 1 MID (0.5x control group SD, for ICIQ-VS QOL = 2.3)

Table 6: Clinical evidence profile for written ± verbal instructions versus verbal instructions alone

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Written ± verbal	Verbal	Relative (95% CI)	Absolute	Quality	Importance
Leaflet versus verbal instructions. Symptoms (follow-up 2 months; measured with: IIQ-7; Range 0 to 100; Better indicated by lower values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15 (median 23.8,	15 (median 19.0, range 0 to 38.1)	-	Median 4.8% better with verbal (no sig. difference)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Written ± verbal	Verbal	Relative (95% CI)	Absolute		
							range 0 to 47.6)					
Leaflet plus verbal instructions versus verbal instructions alone. Symptoms (follow-up 2 months; measured with: IIQ-7; Range 0 to 100; Better indicated by lower values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15 (median 0, range 0 to 4.7)	15 (median 19.0, range 0 to 38.1)	-	Median 19% better with leaflet plus verbal (P<0.001)	LOW	CRITICAL
Leaflet versus verbal instructions. Symptoms (follow-up 2 months; measured with: UDI-6; Range 0 to 100; Better indicated by lower values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15 (median 27.7, range 11.1 to 50)	15 (median 22.2, range 11.1 to 38.8)	-	Median 5.5% better with verbal (no sig. difference)	LOW	CRITICAL
Leaflet plus verbal instructions versus verbal instructions alone. Symptoms (follow-up 2 months; measured with: UDI-6; Range 0 to 100; Better indicated by lower values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	15 (median 5.5, range 0 to 11.1)	15 (median 22.2, range 11.1 to 38.8)	-	Median 16.7% better with leaflet plus verbal (P<0.001)	LOW	CRITICAL
Leaflet versus verbal instructions. Quality of life (follow-up 2 months; measured with: I-QOL; Range 0 to 100; Better indicated by higher values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	15 (median 80.9, range 63.6 to 99.1)	15 (median 79.1, range 56.3 to 98.1)	-	Median 1.8% better with leaflet (no sig. difference)	LOW	IMPORTANT
Leaflet plus verbal instructions versus verbal instructions alone. Quality of life (follow-up 2 months; measured with: I-QOL; Range 0 to 100; Better indicated by higher values)												
Gezginci 2018	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15 (median 98.1, range 94.5 to 99.1)	15 (median 79.1, range 56.3 to 98.1)	-	Median 19% better with leaflet plus verbal (P<0.001)	LOW	IMPORTANT

1 *CI: confidence interval; IIQ-7: Incontinence Impact Questionnaire (7-item shortened version); I-QOL: Urinary Incontinence Quality of Life Instrument; UDI-6: Urogenital Distress*
2 *Inventory (6-item shortened version)*
3 *1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2*

2 Results reported as medians & ranges only; downgraded by 1 level

Table 7: Clinical evidence profile for video versus in-person class

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Video**	**In-person class**	**Relative (95% CI)**	**Absolute**		
Change in symptoms (follow-up 2 years; measured with: ICIQ-SF; Better indicated by higher values)												
Sampselle 2017	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	276	268	-	MD 0.32 higher (0.44 lower to 1.08 higher)	MODERATE	CRITICAL
Change in symptoms (measured with: IUSS; Better indicated by lower values)												
Sampselle 2017	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	276	268	-	MD 0.13 higher (0.05 lower to 0.31 higher)	MODERATE	CRITICAL

CI: confidence interval; ICIQ-SF: International Consultation on Incontinence Short Form; IUSS: Indevus Urgency Severity Scale; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 8: Clinical evidence profile for video-conference continence program versus in-person continence program

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Video-conference**	**In-person**	**Relative (95% CI)**	**Absolute**		
Symptoms (follow-up 2 months; measured with: urinary symptom severity index; Range 0 to 3; Better indicated by lower values)												
Hui 2006	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	27	31	-	MD 0.2 higher (0.14 lower to 0.54 higher)	LOW	CRITICAL

CI: confidence interval; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (0.5x control group SD, for severity index = 0.4)

Table 9: Clinical evidence profile for standard counselling versus standard counselling plus additional information aid

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Standard counselling	Standard counselling plus additional information aid	Relative (95% CI)	Absolute	Quality	Importance
Satisfaction with info tool/care (SC vs SC + web-based tool in POP) (follow-up immediately after intervention; assessed with: Satisfaction with counselling method)												
Myers 2014	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	43/44 (97.7%)	46/46 (100%)	RR 0.98 (0.92 to 1.04)	20 fewer per 1000 (from 80 fewer to 40 more)	MODERATE	CRITICAL
Self-efficacy/empowerment (SC vs SC + decision aid in POP) (follow-up immediately after intervention; measured with: decisional conflict scale - overall score; range of scores: 0-100; Better indicated by lower values)												
Brazell 2015	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	72	71	-	MD 1.7 lower (6.63 lower to 3.23 higher)	MODERATE	CRITICAL
Knowledge (SC versus SC+ web based tool in POP) (follow-up immediately after intervention; assessed with: Satisfaction with anatomy knowledge)												
Myers 2014	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	42/44 (95.5%)	45/46 (97.8%)	RR 0.98 (0.90 to 1.05)	20 fewer per 1000 (from 98 fewer to 49 more)	MODERATE	CRITICAL
Knowledge (SC vs SC + written leaflet in OAB) (follow-up 2 weeks; measured with: Recall of OAB treatment strategies; range of scores: 0-6; Better indicated by higher values)												
Shirreff 2020	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	31	31	-	MD 0.1 higher (0.57 lower to 0.77 higher)	VERY LOW	CRITICAL
Adherence to treatment (SC vs SC + video in PFD) (follow-up 1 months; assessed with: Attendance of at least 50% of PFPT)												
Shannon 2018	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	50/68 (73.5%)	47/58 (81%)	RR 0.91 (0.75 to 1.1)	73 fewer per 1000 (from 203 fewer to 81 more)	LOW	CRITICAL
Change in symptoms (SC vs SC + flip-chart in POP) (follow-up 6 months; assessed with: Reported feeling of a bulge/lump from or in the vagina)												
Caagbay 2020	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	67[4]	69[4]	RR 0.38 (0.16 to 0.90)	-	LOW	CRITICAL
Change in symptoms (SC vs SC + video in PFD) (follow-up 1 months; measured with: Change in UDI-6 score from baseline; range of scores: 0-100; Better indicated by higher values)												
Shannon 2018	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	100	100	-	MD 4.45 lower (11.03 lower to 2.13 higher)	MODERATE	CRITICAL
Anxiety and depression (SC vs SC + web-based tool in POP) (follow-up immediately after intervention; assessed with: Self rated moderate to extreme anxiety)												

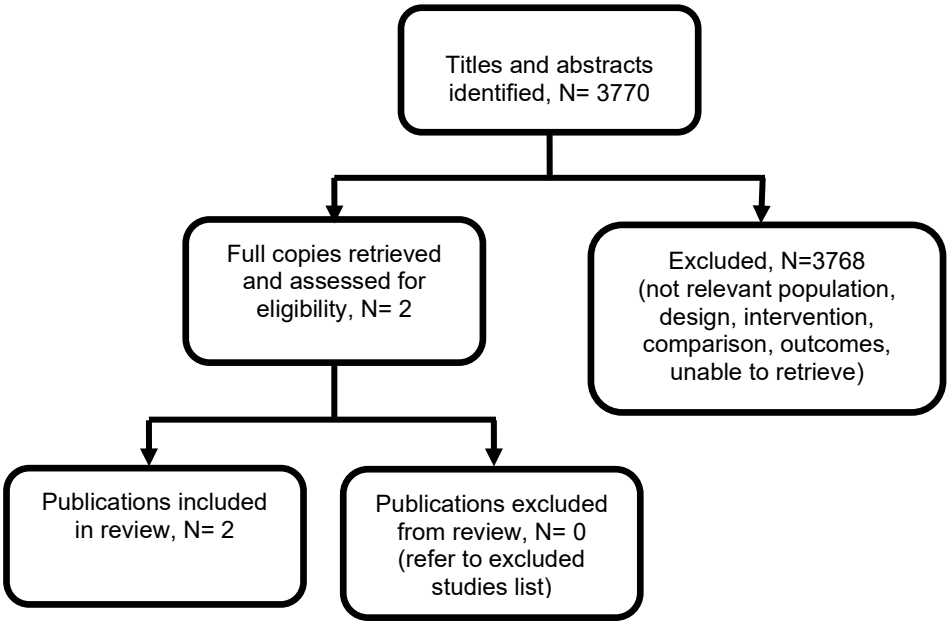
Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Standard counselling**	**Standard counselling plus additional information aid**	**Relative (95% CI)**	**Absolute**		
Myers 2014	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	21/34 (61.8%)	15/29 (51.7%)	RR 1.19 (0.77 to 1.85)	98 more per 1000 (from 119 fewer to 440 more)	VERY LOW	IMPORTANT
Quality of life (SC vs SC + flip-chart in POP) (follow-up 6 months; measured with: POP-Q prolapse impact score - change from baseline; range of scores: 0-100; Better indicated by lower values)												
Caagbay 2020	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	54	48	-	MD 12.52 higher (4.84 to 20.2 higher)	LOW	IMPORTANT

CI: confidence interval; MD: mean difference; PFD: pelvic floor dysfunction; PFPT: pelvic floor physiotherapy; POP: pelvic organ prolapse; POP-Q: pelvic organ prolapse quantification; RR: Relative risk; SC: standard counselling;
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (0.5x control group SD=-0.5,0.5)
3 95% CI crosses 1 MID
4 Event rates not reported
5 95% CI crosses 2 MIDs (0.8, 1.25)

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

Figure 2: Study selection flow chart



1 Appendix H – Economic evidence tables

2 Economic evidence tables for review question: What information provision strategies are effective for women with 3 symptoms associated with pelvic floor dysfunction?

4 **Table 10: Economic evidence tables for virtual clinic vs usual care**

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
Jones, G., Brennan, V., Jacques, R., Wood, H., Dixon, S., Radley, S., Evaluating the impact of a 'virtual clinic' on patient experience, personal and provider costs of care in urinary incontinence: A randomised controlled trial, PLoS ONE, 13 (1) (no pagination), 2018: UK Type of economic analysis: cost utility Source of funding: Sheffield Hospitals Charity	Intervention: Virtual care. Posted details on how to access and use a website. Comparator: Usual care. Posted appointment details to attend the urogynaecology clinic	Women aged 18 or older Based alongside an RCT Source of baseline data: Based alongside an RCT Source of effectiveness data: Based alongside an RCT Source of cost data: Based alongside an RCT Source of unit cost data: Pay and prices index	Costs (type): Staff time, computers, software, overheads Mean cost per participant: Intervention: £640.77 Control: £532.41 Difference: £108.37 Primary measure of outcome (for instance if remission how defined; if based on scale, what that scale is; if QALYs method of eliciting health valuations): QALYs using SF-36 Mean outcome per participant: Intervention: -0.0076 Control:0.0019 Difference: -0.0095	ICERs: Control dominates Probability of being cost effective: Probability of intervention being cost effective is 35% Sensitivity analysis:	Currency: GBP Cost year: 2011 Time horizon: 6 months Discounting: N/A Applicability: Directly Limitations: Minor

Table 7: Economic evidence tables for Internet based treatment vs postal based treatment

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
Sjöström, M., Umefjord, G., Lindholm, L., Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015 Sweden Type of economic analysis: cost effectiveness Source of funding: Swedish Council for Working Life and Social Research, Jämtland County Council, Västerbotten County Council, Visare Norr	Intervention: Internet based treatment, based on Pelvic Floor Muscle training and urinary incontinence information Comparator: Postal based treatment, based on Pelvic Floor Muscle training and urinary incontinence information	Women aged 18 to 70 with stress urinary incontinence at least once a week Based alongside an RCT Source of baseline data: Based alongside an RCT Source of effectiveness data: Based alongside an RCT Source of cost data: Based alongside an RCT Source of unit cost data: Payroll taxes, pharmacy website	Costs (type): Staff time, incontinence aids Mean cost per participant: Intervention: €53.10 Control: €21.50 Difference: €31.60 Primary measure of outcome (for instance if remission how defined; if based on scale, what that scale is; if QALYs method of eliciting health valuations): QALYs using ICIQ-SF Mean outcome per participant: Intervention: 0.010 Control:0.009 Difference: 0.001	ICERs: €31,600	Currency: Euro Cost year: 2010 Time horizon: 1 year Discounting: N/A Applicability: Partially Limitations: Potentially serious

Table 8: Economic evidence tables for postal based treatment vs no treatment

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
Sjöström, M., Umefjord, G., Lindholm, L.,	Intervention: Postal based treatment, based on Pelvic Floor Muscle	Women aged 18 to 70 with stress urinary	Costs (type): Staff time, incontinence aids	ICERs: €2,388.89	Currency: Euro Cost year: 2010

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015 Sweden Type of economic analysis: cost effectiveness Source of funding: Swedish Council for Working Life and Social Research, Jämtland County Council, Västerbotten County Council, Visare Norr	training and urinary incontinence information Comparator: No treatment	incontinence at least once a week Based alongside an RCT Source of baseline data: Based alongside an RCT Source of effectiveness data: Based alongside an RCT Source of cost data: Based alongside an RCT Source of unit cost data: Payroll taxes, pharmacy website	Mean cost per participant: Intervention: €21.50 Control: €0.00 Difference: €21.50 Primary measure of outcome (for instance if remission how defined; if based on scale, what that scale is; if QALYs method of eliciting health valuations): QALYs using ICIQ-SF Mean outcome per participant: Intervention: 0.009 Control:0.000 Difference: 0.009		Time horizon: 1 year Discounting: N/A Applicability: Partially Limitations: Potentially serious

1 **Table 9: Economic evidence tables for Internet based treatment vs no treatment**

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
Sjöström, M., Umefjord, G., Lindholm, L., Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for	Intervention: Internet based treatment, based on Pelvic Floor Muscle training and urinary incontinence information	Women aged 18 to 70 with stress urinary incontinence at least once a week	Costs (type): Staff time, incontinence aids Mean cost per participant: Intervention: €53.10	ICERs: €5,310	Currency: Euro Cost year: 2010 Time horizon: 1 year Discounting: N/A Applicability: Partially

Study country and type	Intervention and comparator	Study population, design and data sources	Costs and outcomes (descriptions and values)	Results	Comments
stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015 Sweden Type of economic analysis: cost effectiveness Source of funding: Swedish Council for Working Life and Social Research, Jämtland County Council, Västerbotten County Council, Visare Norr	Comparator: No treatment	Based alongside an RCT Source of baseline data: Based alongside an RCT Source of effectiveness data: Based alongside an RCT Source of cost data: Based alongside an RCT Source of unit cost data: Payroll taxes, pharmacy website	Control: €0.00 Difference: €53.10 Primary measure of outcome (for instance if remission how defined; if based on scale, what that scale is; if QALYs method of eliciting health valuations): QALYs using ICIQ-SF Mean outcome per participant: Intervention: 0.010 Control:0.000 Difference: 0.010		Limitations: Potentially serious

1
2

1 Appendix I – Economic evidence profiles

2 Economic evidence profiles for review question: What information provision strategies are effective for women with 3 symptoms associated with pelvic floor dysfunction?

4 **Table 10: Economic evidence profiles for virtual clinic vs usual care**

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Jones, G., Brennan, V., Jacques, R., Wood, H., Dixon, S., Radley, S., Evaluating the impact of a 'virtual clinic' on patient experience, personal and provider costs of care in urinary incontinence: A randomised controlled trial, PLoS ONE, 13 (1) (no pagination), 2018: UK	Minor limitations[1]	Directly applicable[2]	Type of economic analysis: Cost utility Time horizon: 6 months Primary measure of outcome: QALYs	Intervention: £640.77 Control: £532.41 Difference: £108.37	Intervention: -0.0076 QALYs Control: 0.0019 QALYs Difference: 0.0095	Control dominates	PSA: 35% likely for intervention to be cost effective

5 1. *Short time horizon*
6 2. *UK women 18+*

Table 11: Economic evidence profiles for Internet based treatment vs postal based treatment (control)

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Sjöström, M., Umefjord, G., Lindholm, L., Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015 Sweden	Potentially serious limitations[1]	Partially applicable[2]	Type of economic analysis: Cost effectiveness Time horizon: 1 Year Primary measure of outcome: QALYs	Intervention: €53.10 Control: €21.50 Difference: €31.60	Intervention: 0.010 QALYs Control: 0.009 QALYs Difference: 0.001 QALYs	€31,600	No probabilistic sensitivity analysis undertaken to quantify uncertainty with respect to base case estimates. One-way and multi-way sensitivity analysis only undertaken for societal perspective

1. *No quantification of uncertainty around base case estimates and no sensitivity analysis from healthcare perspective*
2. *Swedish healthcare setting*

Table 12: Economic evidence profiles for postal based treatment vs no treatment (control)

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Sjöström, M., Umefjord, G., Lindholm, L., Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology &	Potentially serious limitations[1]	Partially applicable[2]	Type of economic analysis: Cost effectiveness Time horizon: 1 Year Primary measure of outcome: QALYs	Intervention: €21.50 Control: €0.00 Difference: €21.50	Intervention: 0.009 QALYs Control: 0.000 QALYs Difference: 0.009 QALYs	€2,388.89	No probabilistic sensitivity analysis undertaken to quantify uncertainty with respect to base case estimates. One-way and multi-way sensitivity analysis only undertaken for

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Urodynamics, 34, 244-50, 2015 Sweden							societal perspective

1. *No quantification of uncertainty around base case estimates and no sensitivity analysis from healthcare perspective*
2. *Swedish healthcare setting*

Table 13: Economic evidence profiles for Internet based treatment vs no treatment (control)

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Sjöström, M., Umefjord, G., Lindholm, L., Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015 Sweden	Potentially serious limitations[1]	Partially applicable[2]	Type of economic analysis: Cost effectiveness Time horizon: 1 Year Primary measure of outcome: QALYs	Intervention: €53.10 Control: €0.00 Difference: €53.10	Intervention: 0.010 QALYs Control: 0.000 QALYs Difference: 0.010 QALYs	€5,310	No probabilistic sensitivity analysis undertaken to quantify uncertainty with respect to base case estimates. One-way and multi-way sensitivity analysis only undertaken for societal perspective

1. *No quantification of uncertainty around base case estimates and no sensitivity analysis from health care perspective*
2. *Swedish healthcare setting*

Appendix J – Economic analysis

Economic evidence analysis for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

Clinical studies

Table 14: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Agnew, R, Van Den Heuvel, E, Tannenbaum, C., Comparative impact of continence promotion interventions targeting older women reluctant to seek care for urinary incontinence, Journal of the American Geriatrics Society, 60, S81, 2012	Abstract
Andrade, A. D., Anam, R., Karanam, C., Downey, P., Ruiz, J. G., An overactive bladder online self-management program with embedded avatars: a randomized controlled trial of efficacy, Urology, 85, 561-7, 2015	Comparison not relevant
Anger, J. T, Khan, A, Smith, A. L, Nissim, H. A, Le, T. X, Sarkisian, C. A, Maliski, S. L, Litwin, M. S, Raz, S, Rodriguez, L. V., Misconceptions and miscommunication among aging women with OAB, Journal of Urology, 181, 565, 2009	Abstract
Ben Ami, Noa, Dar, Gali, What is the most effective verbal instruction for correctly contracting the pelvic floor muscles?, Neurourology and Urodynamics, 37, 2904-2910, 2018	Compares different verbal instructions
Bernard, S, Boucher, S, McLean, L, Moffet, H., Mobile technologies for the conservative self-management of urinary incontinence: a systematic scoping review, International Urogynecology Journal., 2019	Systematic Review - included studies checked for relevance and no new studies identified
Bokne, Kajsa, Sjostrom, Malin, Samuelsson, Eva, Self-management of stress urinary incontinence: effectiveness of two treatment programmes focused on pelvic floor muscle training, one booklet and one Internet-based, Scandinavian journal of primary health care, 37, 380-387, 2019	Not an RCT
Boone, A, Hoover, K., 106. Prevalence and Awareness of Pelvic Floor Disorders in Adolescent Females with Chronic Cough Relative to Healthy Controls, Journal of Pediatric and Adolescent Gynecology, 33, 227, 2020	Abstract
Boyington, Alice R, Dougherty, Molly C, Phetrasuwan, Supapak, Effectiveness of a computer-based system to deliver a continence health promotion intervention, Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society, 32, 246-54, 2005	Control group did not receive info on PFD treatment
Byrne, C. M, Solomon, M. J, Rex, J, Young, J. M, Heggie, D, Merlino, C., Telephone vs. face-to-face biofeedback for fecal incontinence: Comparison of two techniques in 239 patients, Diseases of the Colon and Rectum, 48, 2281-2288, 2005	Not an RCT
Chaudhry, Z, Cohen, S. A, Kim, J, Tarnay, C., Does internet use prior to evaluation for pelvic floor disorders improve patient knowledge about pelvic floor dysfunction?, Female Pelvic Medicine and Reconstructive Surgery, 21, S94, 2015	Abstract
Cheskin, L. J, Burnett, A. L., A behavioural weight-loss programme was better than an education programme for urinary incontinence in overweight and obese women, Evidence-Based Medicine, 14, 118, 2009	Abstract
Chhatre, Sumedha, Newman, Diane K, Wein, Alan J, Jefferson, Ashlie E, Schwartz, J. Sanford, Jayadevappa, Ravishankar, Knowledge and attitude	Not a proper systematic review or qualitative study

Study	Reason for Exclusion
for overactive bladder care among women: development and measurement, BMC Urology, 18, 56, 2018	
Chou, E. C. L, Hsieh, P. F, Chang, C. H, Wu, H. C., Remote monitoring of videourodynamics using smart phone and free instant messaging software, Journal of Urology, 189, e935-e936, 2013	Abstract
de Assis, L. C, Bernardes, J. M, Barbosa, A. M, Santini, A. C, Vianna, L. S, Dias, A., Effectiveness of an illustrated home exercise guide on promoting urinary continence during pregnancy: a pragmatic randomized clinical trial, Revista Brasileira de Ginecologia e Obstetricia Rev, 37, 460-466, 2015	Language not English
Dumoulin, C, Morin, M, Mayrand, M. H, Tousignant, M, Abrahamowicz, M., Group physiotherapy compared to individual physiotherapy to treat urinary incontinence in aging women: Study protocol for a randomized controlled trial, Trials, 18 (1) (no pagination), 2017	Protocol
Ferreira, C. H. J, Pitanguy, M, Vasconcelos, E. C. L. M, Antonio, F. I., Evaluation of urinary incontinence reports and pelvic floor muscle knowledge among women participating in a pelvic floor educational group, Physiotherapy (United Kingdom), 97, eS337-eS338, 2011	Abstract
Ferreira, L. A, Gimenez, M. M, Matias, M. M, Fitz, F. F, Bortolini, M, Castro, R. A., Does educational program of pelvic floor muscle with vaginal palpation improve the motor control of the pelvic floor muscle of women with urinary incontinence? A randomized controlled trial, International Urogynecology Journal, 30, S319, 2019	Abstract
Gaj, F, Bellucci, M, Biviano, I., iProcto: new digital technology in Proctology. A randomized study, La Clinica terapeutica, 168, e186-e191, 2017	Population includes males
Gallo, M. L, Staskin, D. R., Cues to action: Pelvic floor muscle exercise compliance in women with stress urinary incontinence, Neurourology and Urodynamics, 16, 167-177, 1997	Probably not RCT. Allocation appears to have been alternating assignment.
Giroux, M, Funk, S, Bhargava, R, Kamencic, H, Karreman, E., A randomized comparison of hands-on versus video-based training program designed to enhance pelvic floor examination in patients presenting with chronic pelvic pain, International Urogynecology Journal, 30, S52, 2019	Abstract
Hagen, S, Glazener, C, McClurg, D, Macarthur, C, Elders, A, Herbison, P, Wilson, D, Toozs-Hobson, P, Hemming, C, Hay-Smith, J, Collins, M, Dickson, S, Logan, J., Pelvic floor muscle training for secondary prevention of pelvic organ prolapse (PREVPROL): a multicentre randomised controlled trial, LancetLancet, 389, 393-402, 2017	Comparison not relevant: compares supervised PFMT with information leaflet.
Hamilton, B., Continence. Education for continence, Nursing times, 84, 78-82, 1988	Review article
Hedman, Erik, Ljotsson, Brjann, Lindefors, Nils, Cognitive behavior therapy via the Internet: a systematic review of applications, clinical efficacy and cost-effectiveness, Expert Review of Pharmacoeconomics & Outcomes ResearchExpert rev, 12, 745-64, 2012	Systematic Review - included studies checked for relevance and no new studies identified
Herschorn, S, Becker, D, Miller, E, Thompson, M, Forte, L., Impact of a health education intervention in overactive bladder patients, Canadian Journal of UrologyCan J Urol, 11, 2430-2437, 2004	Population includes males and does not report outcomes for each sex
Heymen, S, Palsson, O. S, Kim, S. M, Twist, S, Whitehead, W. E., Patient preference for defining success in fecal incontinence treatment trials, Gastroenterology, 146, S-121, 2014	Abstract
Hougardy, Veronique, Vandeweerd, Jean-Michel, Reda, Ayalu A, Foidart, Jean-Michel, The impact of detailed explanatory leaflets on patient satisfaction with urodynamic consultation: a double-blind randomized controlled trial, Neurourology and Urodynamics, 28, 374-9, 2009	Control group did not receive info on PFD treatment

Study	Reason for Exclusion
Hsieh, Po-Fan, Chang, Chao-Hsiang, Lien, Chi-Shun, Wu, Hsi-Chin, Hsiao, Po-Jen, Chou, Eric Chieh-Lung, Remote monitoring of videourodynamics using smart phone and free instant messaging software, Neurourology and Urodynamics, 32, 1064-7, 2013	Not an RCT
Jacomo, R. H, Alves, A. T, Dos Santos Bontempo, A. P, Botelho, T. L, Teixeira, F. A, De Sousa, J. B., Effect of increasing awareness of genital anatomy on pelvic floor muscle strength in postmenopausal women: A randomized controlled trial, Topics in Geriatric Rehabilitation, 32, 274-279, 2016	Control group did not receive info on PFD treatment
Jeffries, S. A, Robinson, J. W, Craighead, P. S, Keats, M. R., An effective group psychoeducational intervention for improving compliance with vaginal dilation: A randomized controlled trial, International Journal of Radiation Oncology Biology Physics, 65, 404-411, 2006	Population not PFD
Jeppson, P. C, Clark, M. A, Shanley, K. E, Raker, C. A, Sung, V. W., Development and assessment of a patient-based educationalvideo for sacral nerve stimulation for overactive bladder, Female Pelvic Medicine and Reconstructive Surgery, 18, S92, 2012	Abstract
Jeppson, Peter Clegg, Clark, Melissa A, Hampton, Brittany Star, Raker, Christina A, Sung, Vivian W., Improving patient knowledge about sacral nerve stimulation using a patient based educational video, The Journal of urology, 190, 1300-5, 2013	Both groups received a video
Jones, L. M, McCabe, M. P., The effectiveness of an Internet-based psychological treatment program for female sexual dysfunction, Journal of Sexual Medicine, 8, 2781-92, 2011	Control group did not receive info on PFD treatment
Juliato, C, Araujo, C, Marques, A., Mobile App increases the adherence of pelvic floor muscles training for women with urinary incontinence, International Urogynecology Journal, 29, S49, 2018	Abstract
Kinouchi, K, Ohashi, K., Smartphone-based reminder system to promote pelvic floor muscle training for the management of postnatal urinary incontinence: historical control study with propensity score-matched analysis, PeerJPeerj, 6, e4372, 2018	Not an RCT
Konstantinidou,E, Apostolidis,A, Kondelidis,N, Tsimtsiou,Z, Hatzichristou,D, Ioannides,E., Short-term efficacy of group pelvic floor training under intensive supervision versus unsupervised home training for female stress urinary incontinence: a randomized pilot study, Neurourology and Urodynamics, 26, 486-491, 2007	Compares supervised/group PFMT with unsupervised individual PFMT. This is covered in another evidence review
Kuhlmann, P. K, Gonzalez, G, Zektser, Y, Arnold, C. K, Almario, C. V, Spiegel, B. M. R, Anger, J. T., Is digital ethnography the focus group of the future? Focus groups vs. social media analysis of women's experience with overactive bladder (OAB), International Urogynecology Journal, 30, S55, 2019	Abstract
Leme Nagib, A. B, Riccetto, C, Martinho, N. M, Camargos Pennisi, P. R, Blumenberg, C, Paranhos, L. R, Botelho, S., Use of mobile apps for controlling of the urinary incontinence: A systematic review, Neurourology and Urodynamics, 39, 1036-1048, 2020	Systematic review - included studies checked for relevance and no new studies identified
Leong, B. S, Mok, Nicola W., Effectiveness of a new standardised Urinary Continence Physiotherapy Programme for community-dwelling older women in Hong Kong, Hong Kong medical journal = Xianggang yi xue za zhi, 21, 30-Jul, 2015	Comparison not relevant
Madsen, A. M, Dunivan, G. C, Rogers, R. G, Parrillo, A. M, Sung, V. W., Patient-important critical contentand the role of peer support for women	Abstract

Study	Reason for Exclusion
undergoing surgery for pelvic floor disorders, Female Pelvic Medicine and Reconstructive Surgery, 23, S70, 2017	
McCabe, M. P, Jones, L. M., Attrition from an Internet-based treatment program for female sexual dysfunction: who is best treated with this approach?, Psychology, health & medicine, 18, 612-618, 2013	Control group did not receive info on PFD treatment
Meisler,J.G, Newman,D.K., Pamphlets for your patients: Urinary incontinence, Journal of Women's Health, 7, 415-426, 1998	Review
Milne, J., The impact of information on health behaviors of older adults with urinary incontinence, Clinical nursing research, 9, 161-176, 2000	Population includes men
Nazarpour, S, Simbar, M, Ramezani Tehrani, F, Alavi Majd, H., The impact of a sexual enhancement program on the sexual function of postmenopausal women, Climacteric, 19, 506-511, 2016	Population not PFD
Ntr,, The effectiveness of internetbased therapy on female sexual dysfunctioning, http://www.who.int/trialsearch/Trial2.aspx?TrialID=NTR1889, 2009	Clinical trial - no data
R. B. R. b2g2y, Different semantic frequencies of pelvic floor muscle training for women with stress urinary incontinence, http://www.who.int/trialsearch/Trial2.aspx?TrialID=RBR-3b2g2y, 2019	Clinical trial - no data
Rigby, D., Continence. Face to face support, Nursing Times, 92, 84, 1996	Review article
Sjostrom, M, Umefjord, G, Lindholm, L, Samuelsson, E., Cost-effectiveness of an Internet-based treatment program for stress urinary incontinence, Neurourology & Urodynamics, 34, 244-50, 2015	Economic paper
Sugaya, Kimio, Owan, Tomoko, Hatano, Tadashi, Nishijima, Saori, Miyazato, Minoru, Mukouyama, Hideki, Shiroma, Kazuo, Soejima, Kyoko, Masaki, Zenjiro, Ogawa, Yoshihide, Device to promote pelvic floor muscle training for stress incontinence, International journal of urology : official journal of the Japanese Urological Association, 10, 416-22, 2003	Not an RCT
Tak, Erwin C. P. M, van Hespen, Ariette, van Dommelen, Paula, Hopman-Rock, Marijke, Does improved functional performance help to reduce urinary incontinence in institutionalized older women? A multicenter randomized clinical trial, BMC geriatrics, 12, 51, 2012	Control group did not receive info on PFD treatment
Tannenbaum, C, Agnew, R, Benedetti, A, Thomas, D, Van Den Heuvel, E., Effectiveness of continence promotion for older women via community organisations: A cluster randomised trial, BMJ open, 3 (12) (no pagination), 2013	All group education
Tannenbaum, C, Fritel, X, Halme, A, Van Den Heuvel, E, Jutai, J, Wagg, A., Long-term effect of community-based continence promotion on urinary symptoms, falls and healthy active life expectancy among older women: Cluster randomised trial, Age and ageing, 48, 526-532, 2019	Control group did not receive info on PFD treatment
Tsai, Yueh-Chi, Liu, Chieh-Hsing, The effectiveness of pelvic floor exercises, digital vaginal palpation and interpersonal support on stress urinary incontinence: An experimental study, International Journal of Nursing Studies, 46, 1181-1186, 2009	No relevant outcomes
Wu, Q, Xu, C, Huang, C, Qiu, Y, Feng, J., The application of online pelvic floor training during the rehabilitation of postpartum pelvic floor, International Urogynecology Journal, 29, S84-S85, 2018	Abstract
Yildiz, T, Yazici, C. M, Dogan, C, Cetintas, M, Malak, A., Does patient education increase antimuscarinic treatment persistence in overactive bladder syndrome?, International Journal of Urological Nursing, 9, 84-91, 2015	Comparing information provider
Zarski, A. C, Berking, M, Fackiner, C, Rosenau, C, Ebert, D. D., Internet-Based Guided Self-Help for Vaginal Penetration Difficulties: Results of a Randomized Controlled Pilot Trial, Journal of Sexual Medicine, 14, 238-254, 2017	Control group did not receive info on PFD treatment

PFD: pelvic floor dysfunction; PFMT: pelvic floor muscle training; RCT: randomised controlled trial

Economic studies

No economic evidence was excluded for this review.

Appendix L – Research recommendations

Research recommendations for review question: What information provision strategies are effective for women with symptoms associated with pelvic floor dysfunction?

No research recommendations were made for this review question.