# The public health case for investing in low-cost, preventative pelvic health support for women

**Based on findings from the Medway MUTU pilot**

## Introduction

This extract from the report *Improving pelvic health pathways in primary and community care* makes the public health case for investing in low-cost pelvic health support as an early intervention for women experiencing preventable need, unequal access and avoidable deterioration. It is intended for public health, ICB, women's health hub and prevention leads considering how to reduce inequalities, improve population health outcomes and shift support closer to home.

## The public health problem

Pelvic health symptoms should be understood as a population health and inequalities issue, not only an individual clinical problem. Symptoms such as urinary leakage, prolapse and reduced core function can affect physical activity, mental wellbeing, employment, caring responsibilities and social participation. Yet symptoms are often normalised, hidden or managed privately, which means need is least visible among women who face the greatest barriers to accessing support.

Inequalities arise when earlier support depends on confidence, health literacy, digital access, cultural acceptability, time, ability to pay or persistence in navigating services. Women who can pay privately may act early, while women relying on inconsistent NHS provision may continue with symptoms until they worsen or affect wider wellbeing. The Medway pilot is therefore important because it was delivered through Reach Healthcare, serving a population with higher deprivation than the national average, and showed clear unmet need: 100 women signed up against 50 funded licences, 96 completed a baseline survey, 57% reported urine leakage, 18% reported prolapse, 18% reported diastasis recti, and only 12% had ever been offered NHS treatment or physiotherapy.

## Why public health and ICB leadership is needed

This is a prevention opportunity. Earlier pelvic health support can help women manage symptoms before they escalate, reduce embarrassment and isolation, improve confidence, support physical activity and contribute to better mental wellbeing. It is aligned with public health priorities around prevention, reducing inequalities, improving healthy life chances, supporting maternal and women's health, and shifting care from treatment to earlier community-based support.

ICB and public health leadership is needed because existing commissioning routes do not consistently surface or fund this need. Pelvic health symptoms are not always coded, women may not present because symptoms are normalised or embarrassing, and benefits such as quality of life, confidence, social participation and prevention of deterioration are not easily captured in short-term financial business cases. Without a dedicated equity lens, women with the greatest unmet need may remain least likely to receive early support.

# Public health commissioning requests

1. **Fund early intervention for women least able to pay privately.** Public health and ICB partners should consider funding access to low-cost pelvic health support such as MUTU for women with unmet need, alongside community physiotherapy and women's health hub pathways.
2. **Target the offer using an inequalities lens.** Priority cohorts should include women in more deprived communities, women up to four years postpartum, women with continence symptoms, mild prolapse, diastasis recti, low confidence, poorer access to private care, or those waiting for physiotherapy.
3. **Resource trusted community delivery.** Recruitment and onboarding should be led through GP practices, women's health hubs or other trusted NHS routes. This work should be funded because identifying cohorts, sending communications, supporting uptake and follow-up are essential implementation activities, not optional extras.
4. **Design for inclusion from the start.** Digital support should be one route within a wider pathway. Public health partners should consider language, literacy, cultural acceptability, digital confidence, caring responsibilities and time barriers when designing access and follow-up.
5. **Measure prevention and inequalities outcomes.** Evaluation should capture uptake by cohort, symptom confidence, quality-of-life change, emotional wellbeing, activity, access barriers, previous NHS support and evidence of need that would otherwise remain hidden.
6. **Recognise wider social value.** Funding decisions should consider the potential impact on confidence, participation, mental wellbeing, activity, reduced deterioration and avoidable contacts, rather than relying only on short-term return on investment.

# Proposed call to action for Medway public health and ICB colleagues

1. **Convene a focused prevention discussion.** Bring together Medway public health, the ICB, Reach Healthcare and women's health hub leads to consider pelvic health as a preventable inequalities issue.
2. **Fund equitable access to low-cost support.** Public health and ICB partners should consider funding access to proven, low-cost pelvic health offers such as MUTU for women who are unlikely to pay privately, alongside community physiotherapy and women's health hub pathways.
3. **Agree the first equity cohort.** Identify which groups should receive funded access first, using deprivation, postpartum status, continence symptoms, physiotherapy waiting lists, maternal mental health links and women's health hub priorities.
4. **Develop a simple funded pathway.** Combine trusted NHS messaging, digital self-management, clear escalation routes, community physiotherapy links and non-digital alternatives for women who need them.
5. **Test sustainable prevention funding.** Explore public health, ICB and joint prevention funding options, including Better Care Fund routes where appropriate, to move beyond one-off pilot funding.
6. **Make hidden need visible.** Improve coding, reporting and outcome capture so pelvic health need, uptake, barriers and benefits are available for future commissioning decisions.
7. **Commit to moving from pilot to prevention pathway.** The next step should be to fund and evaluate an equitable, clinically owned pelvic health pathway that can be sustained beyond individual champions.

## Act now

Pelvic health support should not depend on a woman's ability to pay, confidence to seek help, or ability to navigate fragmented services. The Medway pilot shows that unmet need exists, that demand can be generated through trusted NHS routes, and that a low-cost preventative offer could help systems act earlier, reduce inequalities and improve women's quality of life.