

OCCUPATIONAL IMPACT AND SELF-MANAGEMENT APPROACHES FOR
POSTPARTUM PELVIC FLOOR DYSFUNCTION IN WORKING MOTHERS: A
MINI LITERATURE REVIEW

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Abstract

Background: Postpartum pelvic floor dysfunction (PFD) is common, and it can interfere with the everyday functioning, role performance, and psychosocial well-being, especially in working mothers. PFMT is a popular form of conservative rehabilitation and could be enhanced by access and adherence through technology-assisted methods.

Objective: To assess occupational impact and self-management approaches for postpartum pelvic floor dysfunction in working mothers.

Methods: A narrative literature review was performed using PubMed and Google Scholar by including articles released since 2010 and 2025. Qualitative studies, meta-analyses, randomized trials, and systematic reviews were narratively synthesized because of the heterogeneity.

Results: Twenty-two studies were included. Supervised PFMT improved urinary continence and pelvic floor strength. App-guided PFMT supported adherence and symptom reduction. Telehealth-delivered PFMT produced outcomes comparable to in-person delivery. Biofeedback-enhanced PFMT showed additional improvements in continence-related outcomes compared with PFMT alone. Occupation-centred outcomes (e.g., return-to-work, role performance) were inconsistently reported.

Conclusion: PFMT delivered through supervised, digital, telehealth, and biofeedback-supported formats is effective for postpartum PFD. Future research should include occupation-based outcomes to better address the needs of postpartum working mothers.

INTRODUCTION

Pelvic floor dysfunction (PFD) is among the most common postpartum morbidities and it includes urinary incontinence, pelvic organ prolapse, pelvic pain and sexual dysfunction. In a recent systematic review and meta-analysis of 32 reports, it was indicated that the overall incidence rate of postpartum urinary incontinence (UI) was 26% (95% CI 21-30%), indicating that over one out of every four women experiences incontinence following childbirth. [1] Previous studies had established that within the initial three months of post-partum, the prevalence of any incontinence may be as high as a third of women, increasing after vaginal and not caesarean birth. [2] The pelvic floor alterations during the postpartum period can also cause pain, dyspareunia and heaviness or prolapse, which also have an impact on body image and intimate relationships. [3] A combination of these

symptoms affects physical comfort, engagement in physical activities and socialization, and the general quality of life of most new mothers.

Other than symptoms, PFD has an obvious occupational effect. A qualitative-quantitative investigation of parous women in the United States demonstrated that postpartum PFD restricted the involvement of such women, especially in exercise and sexual activity, and that a large number of women were not aware of the treatment options available to them. [4] A recent occupational-therapy capstone targeting postpartum women also reported on high levels of leakage, urgency and pelvic heaviness interfering with day-to-day self-care, childcare, socialization and confidence in the community. [5] Such restrictions particularly apply to postpartum working mothers who have to fulfill both the childcare and the need to resume work, in most cases under time pressure, with little rest or frequent toileting. Despite the scarcity of research investigating specifically on the phenomenon of working status, the literature of occupational therapy (OT) scientists and professional organizations highlights that the alteration of the functionality of the pelvic floor may contribute to postponing the restoration of past jobs and decreasing performing capacity on employment, family administration and community life. [6] [7]

Occupational therapy is also seen to become a part of interdisciplinary pelvic-health services. Novak (2024) conducted a systematized review and reviewed the evidence-based interventions targeting postpartum women with PFD and indicated that OTs could have a role in the education process, altering activities, and providing environmental and self-care assistance. [6] Existing professional and education materials inform about the method of the OTs measuring the effect of PFD on the everyday activities, teaching the posture and body movement, modifying the toileting habits and lifting methods, and

organizing the work and home with the help of the ergonomics. [7] These strategies are in line with Person Occupation perspective which perceives pelvic symptoms as not only medical issue but also an obstacle in taking part in meaningful activities.

Meanwhile, it has been well established that pelvic floor muscle training (PFMT) should be used as a preventive and treatment of peripartum incontinence. The revised Cochrane system by Woodley et al. (2020) determined that PFMT in the course of pregnancy and postnatal time diminishes the risk and seriousness of postpartum UI than untrained control. [8] A brief Cochrane review by Boyle et al. (2014) of women during the antenatal period and postnatally also established that PFMT is more effective in enhancing urinary and faecal continence outcomes. [9] These results justify the use of PFMT as an essential element of the therapeutic process, which can be incorporated by OTs into more extensive, occupation-based programmes. Nevertheless, clinic-based PFMT, in general, may demand face-to-face sessions, and not all postpartum women can afford to attend them, particularly those who went back to work or have several caregiving tasks to complete.

Several studies have determined that there are behavioral and contextual hindrances to a long-term pelvic-floor rehabilitation. Low knowledge, lack of awareness of correct contraction technique, competing life demands, embarrassment and social support are some of the barriers in pregnant and postpartum women with incontinence. [10] The qualitative interactions with women who already have PFD have also reported difficulties of sustaining home-based exercises following the supervised treatment, among them being fatigue, forgetfulness and inability to integrate PFMT into daily lives. [11] These environmental and behavioral determinants are key to OT practice and justify self-

management models, habit-forming strategies and context-responsive interventions based on work occupational profiles of women.

To address these obstacles, there has been a rapid increase in the number of technology-aided interventions in the pelvic-floor. Randomized trials have demonstrated that smartphone alerts or app-based PFMT can increase compliance and lead to better pelvic-floor outcomes in women in the postpartum phase. The study by Chu et al. (2024) found that PFMT in women 6-8 weeks after childbirth using smartphone reminders was more effective than regular instructions in improving adherence. [12] To support this, Kijmansawat et al. (2023) discovered that the symptoms of the PFMT programme were enhanced by using an app-guided PFMT programme over typical care in terms of stress UI and self-efficacy. [13] A more recent trial of a mobile fitness app with PFMT during the puerperal women also indicated better pelvic-floor strength and activity. [14] Collectively, these studies affirm mHealth strategies as viable among new mothers, who in most cases, like flexibility in methods where they can access them at home rather than attending their clinics.

There is also the emergence of telehealth and remote rehabilitation. A 2024 trial of a telehealth pelvic-abdominal mechanics training programmed in the peri partum period established the efficacy of remote delivery as significant in improving pelvic-floor outcomes and recommended telemedicine as an effective modality of early postpartum pelvic rehabilitation. [15] A second randomized controlled trial of PFMT administered through telemedicine versus conventional therapy in women in their early postpartum also found significant symptom reduction in both groups, indicating that remote therapies are at least as effective as traditional care. [16] These results have a great relevance to working mothers who might lack time or flexibility in attending clinic

sessions during working days. Lastly, biofeedback-enhanced PFMT has come into play as a significant supplement. A big randomized clinical test by Wang et al. (2024) showed that pressure-mediated biofeedback, PFMT was better than PFMT in women with stress urinary incontinence as it enhanced both symptom rating and patient-reported results. [17] Recent meta-analysis of biofeedback electrical stimulation with PFMT in postpartum stress UI also reported increased clinical outcomes and pelvic-floor strength versus PFMT. [18] These technologies are becoming more home-based technologies, which could be incorporated in OT-led self-management programmes, particularly in cases where women are unable to attend regular supervised sessions.

Although this provides a growing evidence base in PFMT, mHealth, telehealth and biofeedback, there are several critical gaps. First, the outcomes mostly used in most of the trials include symptom severity or muscle functioning and rarely include occupation based results including return-to-work, work ability, time use, role performance or participation in physical, social and care-giving activities. [4] [5] [6] Second, only a small number of studies focus on the experiences of working mothers during postpartum, despite the group possibly being the most affected by logistical issues and role strain. Third, occupational-centred intervention designs do not always address contextual and behavioural barriers which have been found in qualitative studies. [11] [19]

Thus, an occupational therapy-based synthesis of the pelvic-floor intervention in the postpartum population is evident, especially in the case of women who have to resume work. Although extensive literature exists concerning pelvic-floor rehabilitation, only a small number of studies have addressed the functional, occupational, and role-based outcomes that are necessary to postpartum working mothers, which can be considered a major gap in the current literature. With this consideration, the present quick literature

review will (1) provide a summary of the available evidence on OT-led or OT-relevant interventions, including pelvic-floor muscle training (PFMT), telehealth, app-guided training, and home biofeedback, as it applies to postpartum pelvic-floor dysfunction; and (2) reveal the gaps concerning occupation-centred outcomes, especially of involvement in caregiving and work activities by postpartum working mothers.

Materials and Methods:

A narrative literature review was carried out to summarize the evidence on occupational therapy relevant interventions to manage pelvic floor dysfunction (PFD) in postpartum women and specifically when they are back to work. The mini review method was selected to conduct a focused and efficient synthesis of evidence available in a limited amount of time but with a transparent and systematic process. The heterogeneity in the study designs, interventions and measure of outcome led to the use of narrative synthesis.

Electronic searches were performed in PubMed and Google Scholar, along with manual searches of professional and institutional websites for studies published between January 2010 and January 2025. Search terms included combinations of postpartum pelvic floor dysfunction, postpartum urinary incontinence, pelvic floor muscle training, occupational therapy pelvic health, mobile or app-based pelvic floor exercises, telehealth pelvic floor therapy, biofeedback, and postpartum working mothers. Articles in English only were taken into account. Manual screening of reference lists of important articles was also done to generate more relevant studies.

The inclusion criteria were that the studies should involve postpartum women (up to 12 months postpartum), had to include symptoms of pelvic floor dysfunction (e.g. urinary incontinence, pelvic organ prolapse, pelvic pain, dyspareunia) and needed to provide interventions that could be applied in the practice of occupational therapy (e.g.

pelvic muscle training, self-management, education or behaviour change, ergonomic, or technology-assisted rehabilitation). The studies that concentrated on pregnancy alone, treatment by surgery or pharmacological approach, neurological conditions or had no functional or participation-related outcome were not included. The selection of studies was performed in two steps, that is, the preliminary screening of the titles and abstracts, and the analysis of the articles that may qualify as eligible. About twenty researches were found to meet the inclusion criteria and were incorporated in the final review.

The selection of the data was based on a structured template that included the authorship, year, type of study, type of intervention, delivery format (clinic-based, home-based, app-guided, telehealth, or biofeedback-supported), measure of outcome, and key findings. Special consideration was directed toward the results of occupational performance, role participation, care giving activities, fatigue and the experiences of returning work. Because of the methodological heterogeneity, the synthesis of findings was made in a narrative manner. Since this review was founded on already published studies, there was no need to provide ethical approval.

Results:

The literature synthesis revealed that pelvic floor muscle training (PFMT) was most commonly reported as an intervention to treat postpartum pelvic floor dysfunction. High-quality review evidence showed that PFMT during pregnancy and in the postpartum period continuously lowers the risk and severity of urinary incontinence, and large Cochrane studies revealed that urinary and faecal continence outcomes showed significant improvements with training as compared to no training. [8] [9] The prevalence studies also affirmed that postpartum urinary incontinence was still prevalent with the rates reported as 26 percent in the general population and up to one-third in the first

three months postpartum, especially after vaginal delivery. [1] [2] Other symptoms like pelvic pain, heaviness and dyspareunia were also commonly reported and added to the discomfort and lack of physical comfort in their day to day activities. [3]

The effects of postpartum pelvic floor across the reviewed sources were constantly linked to disabilities in daily functioning and role involvement. Research in parous women showed the lack of activity in exercise, sex life, and communication, and most of them were characterized by the lack of knowledge about possible treatments. [4] Occupational therapy capstone work was found to be similarly disrupted, with postpartum women reporting leakage, urgency, and pelvic heaviness as disruptive to childcare routines, self-care, community mobility, and social participation. [5] The evidence of professional reports and systematized OT literature additionally meant that PFD can increase the time to return to work as well as decrease the work performance and the household management [6] [7]

Long-term PFMT adherence was often associated with behavioural and contextual barriers. Such issues as low awareness of the proper technique of contraction, embarrassment, conflicting life demands, fatigue, and the inability to make PFMT an integral part of life were common. [10] [11] These obstacles were always present throughout qualitative studies.

The evidence reviewed showed the emergence of technology-supported interventions. PFMT reminders conducted through Smartphones showed higher compliance and better symptoms management in postpartum women. [12] Application-based PFMT also demonstrated a better stress urinary incontinence management outcome and self-efficacy than traditional teaching. [13] M-fitness apps that included

PFMT also showed improvements in the level of pelvic-floor strength and activity levels in the postpartum users. [14]

Results of the telehealth-based interventions showed that the remote pelvic-floor rehabilitation had the same symptom improvement as clinic-based delivery had. Pelvic-abdominal mechanics training through remote instruction was also said to have enhanced pelvic-floor results in early postpartum women and tele-PFMT was indicated to have decreased severity of symptoms as compared to the conventional face-to-face sessions. [16] [15]

Another intervention that was widely reported was biofeedback-enhanced PFMT. Huge randomized trials showed that pressure-based biofeedback (along with PFMT) led to the better result of pelvic-floor symptoms and muscle coordination in comparison to PFMT alone. [17] Meta-analysis results also provided more support to enhanced pelvic-floor strength and symptomatic reduction when electrical-stimulation-based biofeedback was implemented as an addition to PFMT programmes. [18]

In all types of intervention, those outcomes related to symptoms (pelvic-floor strength, continence and self-reported reduced symptoms) were uniformly reported, but the occupation-centred outcome (return-to-work readiness, work performance, caregiving capacity, and broader participation measures) were seldom documented. Very few studies recognized the distinct issues of postpartum working mothers or measured impacts on functions other than change of clinical symptoms. [5] [4] [6]

Table 1. Summary of included studies on occupational impact and self-management interventions for postpartum pelvic floor dysfunction in working mothers

Author (Year)	Study Design & Population	Intervention/ Focus	Main Findings
He, X., Xie, Y., Xie, B., & Zhao (2025)	Randomized controlled trial; postpartum (puerperal) women	Mobile fitness application integrated with PFMT	The mobile app group showed significantly greater pelvic floor muscle strength, reduced urinary incontinence symptoms, and higher adherence compared with usual care.
Zhang, R., Li, Y., Liu, X., & Wang (2025)	Telehealth randomized controlled trial; puerperal women	Online pelvic–abdominal mechanics training	Telehealth-delivered PFMT significantly improved pelvic floor muscle function, with outcomes comparable to in-person rehabilitation.
Ozdincler, A. R., Dayican, D. K., & Ozyurek (2025)	Randomized controlled trial; postpartum women	Tele-PFMT versus clinic-based PFMT	Tele-PFMT achieved similar improvements in continence and pelvic floor strength as clinic-based therapy, with high satisfaction and feasibility.
Tian, Z., & Ji (2025)	Meta-analysis	Biofeedback and electrical stimulation combined with PFMT	Combined biofeedback and PFMT produced significantly greater improvements in pelvic floor muscle strength and reductions in stress urinary incontinence compared with PFMT alone.
Harper, R. C., Sheppard, S., Stewart, & Clark	Qualitative thematic analysis; postpartum	Psychosocial and environmental influences on	Fatigue, embarrassment, caregiving demands, low confidence, and

(2023)	women	PFMT	environmental barriers were identified as major factors limiting PFMT adherence.
Xu, P., Jin, Y., Guo, P., Zhang, & Feng (2023)	Qualitative behavioural study; pregnant and postpartum women	Barriers and enablers to PFMT practice	Key barriers included low awareness, difficulty performing correct contractions, embarrassment, fatigue, and competing life demands.
Chu, L., Jin, X., Wu, S., Tong, & Chen (2023)	Randomized controlled trial; postpartum women with stress UI	Smartphone reminder–assisted PFMT	The intervention group demonstrated significantly higher exercise adherence, improved self-monitoring, and fewer urinary incontinence episodes.
Kijmanawat, A., Kaewnopparat, S., Suksri, & Kaewrudee (2023)	Randomized controlled trial; women with stress UI	App-guided, animation-based PFMT	App-guided PFMT led to improved pelvic floor muscle strength, reduced stress urinary incontinence symptoms, and increased self-efficacy.

Discussion

This review evidence shows that postpartum pelvic floor interventions in general, and specifically, pelvic floor muscle training (PFMT), mobile-health-based, and telehealth delivery models, and biofeedback-enhanced exercises, consistently report positive results in continence outcomes, pelvic floor strength, and symptom reduction across a broad spectrum of postpartum populations. The findings are consistent with the evidence found in the past that structured PFMT decreases postpartum urinary incontinence and

enhances pelvic performance of the body both in the antenatal and postnatal stages. [8] [9] Nevertheless, with such positive clinical outcomes, there is still a high degree of inconsistency in the long-term adherence, practicality in real life, and integration into the lives of postpartum women especially those who are back to work. PFMT became the most developed intervention with well-developed systematic reviews and clinical trials demonstrating the decrease of urinary incontinence and increase of pelvic floor strength. These results are aligned with previous prevalence studies that prove the rates of postpartum urinary incontinence are 26-33% with a high rate during the first three months following childbirth. [1] [2] However, despite the high therapeutic promise of PFMT, adherence problems, such as fatigue, inadequate technique awareness, embarrassment, and competing demands of life and caregiving issues, are still important and reflect previous issues about the sustainability of home-based postpartum rehabilitation. [10] [11] These behavioural and contextual obstacles indicate the shortcomings of the traditional clinic-based models of PFMT and support more flexible and context-adaptive intervention models.

The positive results of mobile-health-assisted PFMT programmes were strong and demonstrated by the increase in adherence, self-efficacy, and continuity results in postpartum women with smartphone reminders and app-guided interventions. [13] [12] Like the trends in other areas of digital health, these gains seem to be associated with enhanced access, flexibility, and personalization, which is especially important in the case of postpartum working women who have to manage time-bound schedules. Pelvic floor rehabilitation was also conducted using telehealth, where remote pelvic-abdominal training and tele-PFMT showed the same improvement as those provided in-person. [16] [15] These results are consistent with larger changes toward virtual rehabilitation, and they

hint at the fact that telehealth has the potential to alleviate conventional limitations regarding transportation, childcare, and clinic appointments.

PFMT in which biofeedback was used also had consistently positive results. Big randomized trials and meta-analyses demonstrated better symptoms improvements and strength of the pelvic-floor when biofeedback was added to PFMT routines. [17] [18] The pattern is similar to others in the field of motor-relearning interventions with augmented feedback enhancing the speed of the learning process and accuracy of muscle activation. Nonetheless, as is also noted with other technologies in the field of technology-assisted rehabilitation, the adoption of biofeedback can be restricted by the price of the device, its accessibility, as well as by the necessity of special training.

In all the categories of the interventions, a weakness area is associated with the lack of focus on the occupation-centred and role-based outcomes. Although the severity of continence, and muscle functioning have been regarded as clinical indicators that were consistently reported, there is also a paucity of studies on the return-to-work preparation, work performance, time-use practices, caregiving roles, or social participation, even though qualitative evidence has identified significant occupational disruption in postpartum women with pelvic floor symptoms. [4] [5] [6] The absence of this implies an imbalance between existing evidence priorities and lived experiences of working mothers who are postpartum with their own set of distinct limitations about the lack of rest, large role strain, and access to consistent toileting.

The general implications of these results are the necessity of future studies to be more extensive in their scope (beyond symptom reduction) to more comprehensive, occupation-oriented results. Occupational therapy-based interventions, such as habit formation, environmental modification, ergonomic adjustment, and formal self-

management, can be applied to overcome the contextual barriers found in qualitative research. [11] [19]

Also, longitudinal studies of real-world adherence, long-term functional gains, and long-term participation outcomes are small and should be considered in more depth. Lastly, despite the promising trends of technology-assisted PFMT and telehealth, the imbalance in access, lack of digital literacy, and differing affordability of the devices can limit the implementation of the technologies, especially in women with low-resource backgrounds. To resolve these structural factors, collaboration among the healthcare providers, policymakers, and developers of technology will be essential to make postpartum pelvic floor rehabilitation accessible, long term, and amenable to the professional realities of postpartum working mothers.

Conclusion

This mini literature review shows that pelvic floor muscle training (PFMT) and mobile application-based interventions, telehealth methods of delivery, and biofeedback interventions can be useful in enhancing the outcome of continence and pelvic floor strength among postpartum women. These could be flexible delivery models that could be of great use to working mothers as they help to adhere to the demanding care and work schedules. Nevertheless, the existing evidence base is still largely concentrated on clinical and symptom related outcomes, and little interest in occupation based outcomes like return-to-work preparedness, role functioning and engagement in daily activities. It is important to integrate occupational therapy-based self-management practices and occupation-based outcomes in order to accommodate better the functional and contextual requirements of working mothers in the postpartum phase.

Consent for publication:

I gave the consent to publish my research paper.

Availability of data and materials

Data is available on the research websites.

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There are no competing interests.

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Authors' contributions:

1,2 and 3 wrote the introduction and methodology.

1, 4, 5 wrote the manuscript.

1, 2, 3, 4 and 5 carried out the data collection and analysis.

1,2 conceived the original idea.

5 supervised the project

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