

SYSTEMATIC REVIEW

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Women's perceptions of urinary incontinence during the postpartum period: systematic review of qualitative evidence

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Abstract

Background Urinary incontinence is a common condition in the postpartum period, although most women do not seek help because they believe that their problems resolve spontaneously. Urinary incontinence has been associated with feelings of distress, shame, anxiety, depression, and social isolation. This systematic review of qualitative studies aimed to enhance the knowledge of postpartum women's perceptions of urinary incontinence, particularly their feelings and problems in their daily lives.

Methods This qualitative evidence review was registered in PROSPERO (CRD42024596647) and conducted in accordance with the ENTREQ reporting guidelines. From inception until 19th December 2025, a comprehensive search of qualitative findings was conducted across the MEDLINE, EMBASE, Web of Science, PsycINFO and CINAHL databases, and grey literature sources (the ProQuest Dissertations & Theses, OpenGrey, Google Scholar, and the Zenodo repository). Additionally, reference lists of the included studies were also screened. Studies reporting a qualitative analysis of the perceptions associated with urinary incontinence in postpartum women were included. The Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research was used to assess study quality. A thematic synthesis approach was applied to generate codes and themes through inductive, data-driven analysis. The GRADE-CERQual approach was used to assess confidence in each synthesized finding.

Results The review included 15 studies comprising 712 postpartum women (20–45 years old) who had delivered vaginally, by cesarean section, or via both modes. The postpartum period was defined as the first 12 months after childbirth. The review included studies from various countries, including Turkey, the Netherlands, Canada, the United Kingdom, Australia, China, Ireland and the United States, conducted between 1999 and 2025. Three analytical themes emerged: the perception of urinary incontinence as not a problem, the feelings associated with urinary incontinence, and problems in daily life. The GRADE-CERQual appraisal indicated high confidence in all synthesized findings.

Conclusions This meta-synthesis highlights the impact of postpartum urinary incontinence on women's well-being, causing discomfort, anxiety, and sadness despite its normalization. The findings emphasize the need for better

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education, healthcare, and support, with health professionals encouraged to provide early interventions to improve postpartum well-being.

Keywords Feelings, Meta-synthesis, Thematic synthesis, Pelvic floor disorders, After delivery, Women's health

Introduction

Urinary incontinence (UI) has been defined as an involuntary loss of urine [1] that represents a social and hygienic problem for those who suffer from it [2], and is a common condition among women that may affect their quality of life [3]. Pregnancy and childbirth are major risk factors as they can contribute to a weakening and injury of the perineal area and pelvic floor [4]. Furthermore, biomechanical and endocrinological changes occurring during pregnancy, childbirth, and the early postpartum period facilitate the onset of postpartum UI [5]. In addition to these physical mechanisms, the postpartum period is also characterized by profound emotional and social changes, with UI being one of the most disruptive conditions, often interfering with daily activities and overall well-being [6].

These consequences are closely linked to women's responses to their condition and their interactions with healthcare services. Despite the high prevalence of UI during the postpartum period, with an estimated incidence ranging from 15 to 30% in the first year [6], and from 24 to 32% at 6 weeks and 12 months postpartum [7], few women seek assistance because they believe that the problem will resolve spontaneously or over time [7]. Moreover, the clinical assessment and management of UI frequently focus on physical symptoms alone and fail to consider its wider psychosocial implications. As a result, the true burden of the condition may be underestimated, as UI can be associated with feelings of suffering, shame, anxiety, depression, and social isolation, which can significantly affect women during this period [8, 9].

To better understand these subjective experiences that cannot be captured by quantitative data, previous qualitative evidence has explored different aspects of UI in various contexts, including its psychological and social impact, the barriers to seeking care, and the experiences of affected individuals across different populations ranging from family caregivers to older people [10–15]. However, these findings remain fragmented across studies, settings, and cultural contexts, and have not been systematically synthesized for the postpartum population. A qualitative systematic review is therefore needed at this time to consolidate existing evidence, identify common patterns and divergences in women's experiences, and explore how contextual and cultural factors may shape postpartum UI experiences. In addition, women should be informed about postpartum care and support health-care professionals in addressing their psychosocial needs. Therefore, the aim of this systematic review of qualitative

evidence is to obtain an in-depth understanding of postpartum women's perceptions of UI, particularly their feelings and problems in daily life.

Methods

This systematic review of qualitative evidence was registered in PROSPERO (CRD42024596647) and was developed according to the Enhanced Transparency in Reporting Qualitative Research Synthesis (ENTREQ) Statement [16] (Table S1) and the eMERGe reporting guidelines for meta-ethnography with the methodological guidance of the Cochrane Qualitative & Implementation Methods Group [17].

Search strategy

Two reviewers (CG-G and HM-M) independently searched the MEDLINE (via PubMed), EMBASE (via Scopus), Web of Science, PsycINFO, and CINAHL databases, as well as grey literature sources (the ProQuest Dissertations & Theses, OpenGrey, Google Scholar, and the Zenodo repository). Additionally, the reference lists of the included studies were also screened from inception to December 19th, 2025. The search strategy was developed following the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, and Research type) tool [18], which incorporates the terms "urinary incontinence", "postpartum", "perception" and their variations (Table S2). Additionally, the reference lists of the included studies were examined to identify further relevant publications. Studies that assessed perceptions of UI in postpartum women, defined as up to 12 months after delivery were selected. The postpartum period was determined as up to 12 months after childbirth, in line with maternal health frameworks that consider the first year postpartum a critical period for physical and psychosocial recovery [19]. No language restrictions were applied, and no filters were used. Data had to be collected via qualitative methods such as semistructured interviews, focus groups, or alternative approaches. In studies employing mixed methods, only the qualitative components that were explicitly analysed were considered. The Rayyan.ai citation manager [20] was used to find duplicates, and a third reviewer peer-reviewed the search process (AT-C).

Data extraction

The extracted information included the author, year of publication, country, data collection methods, data analysis software, analytical approach, participant characteristics (sample size, age, time from delivery, delivery

type, parity and education level), location, and method of recruitment. A standardized document was used for data extraction, and a pilot test of the extraction template was conducted to identify and select variables relevant to postpartum UI. Quotations were extracted mechanically. The search for information and the entire literature review process were carried out by two independent reviewers (CG-G and HM-M).

The risk of bias was assessed independently by two reviewers (concordance agreement by weighted kappa statistics 0.6) and inconsistencies were resolved by consensus or discussion with a third researcher.

Quality appraisal

The methodological quality of the included studies was rated via the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research [21]. This instrument comprises 10 items that assess potential sources of bias in study design, conduct, and analysis (Table S3). Two authors (CG-G and HM-M) independently applied the checklist, and disagreements were resolved by consensus. The assessment did not influence the inclusion/exclusion of studies, only the rating of confidence.

Data and thematic synthesis

Following the thematic synthesis approach described by Thomas and Harden [22], two reviewers (CG-G and HM-M) independently conducted line-by-line coding of the findings and quotations from the included studies. This independent process was used to generate initial codes, which were then compared and grouped into descriptive themes through a collaborative, iterative process designed to minimize potential bias.

The codes generated by each reviewer were systematically compared and merged through regular consensus meetings. Any discrepancies in coding or theme categorization were resolved through discussion until a total consensus was achieved. A third reviewer (AT-C) was available for adjudication if necessary. The synthesis process and the organization of quotations by themes and subthemes were managed via Microsoft Excel to facilitate data classification and maintain a clear audit trail of the analytical process.

Confidence of evidence

The confidence of evidence for each synthesized finding was assessed by via the Grading of Recommendations Assessment, Development, and Evaluation–Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual) approach, classifying it as high, moderate, low, or very low. This evaluation was based on four key components: methodological limitations, coherence, data adequacy, and relevance [23–28]. (Table S4).

Data extraction, thematic synthesis and quality assessment were conducted by 2 reviewers (CG-G and HM-M), and any discrepancies were resolved through consensus or involving a third researcher (AT-C).

The methodological limitations domain of the GRADE-CERQual assessment was directly informed by the results of the JBI quality appraisal. This approach ensured that any biases identified in the design or conduct of the primary studies were systematically reflected in the overall confidence rating for each synthesized finding.

Results

Study selection

The electronic search retrieved 5745 records. After removing duplicates, 4566 studies were screened by title and abstract, and 31 papers were included for full-text review to assess eligibility. Finally, 15 studies were included (Fig. 1).

One study was conducted in Turkey [29], two in the Netherlands [7, 30], one in Canada [31], six in the United Kingdom [32–36], one in Australia [37], two in China [38, 39], one in Ireland [40], and two in the United States [41, 42]. All studies used primarily qualitative methods. The data collection methods included semistructured interviews in twelve studies [7, 29–32, 34, 35, 38–42], in depth face to face interviews in one study [37], and open-ended interviews in two studies [33, 36] (Table 1).

The mean interrater agreement for the inclusion of eligible articles was 85%.

Characteristics of the included studies

Our analysis included a total of 712 postpartum women aged between 20 and 45 years. The postpartum period was determined as up to 12 months after childbirth. The type of delivery was vaginal in four studies [30, 32, 35, 38], caesarean in one study [37], women with both vaginal delivery and caesarean delivery were included in five studies [29, 34, 39, 41, 42], and five studies did not report these data [7, 31, 33, 36, 40]. A total of 7% of the included studies were conducted with only multiparous women, 7% with only primiparous women, 80% with both primiparous and multiparous women, and 7% of the studies did not report this information. Educational level was reported in 53% of the articles including women from elementary to university education. The studies were published between 1999 and 2025.

Risk of bias and included studies and confidence of evidence

The GRADE-CERQual assessment yielded high confidence ratings for all three analytical themes. While two studies [33, 36] were identified as having moderate methodological limitations because they used open-ended survey questions rather than in-depth interviews, this

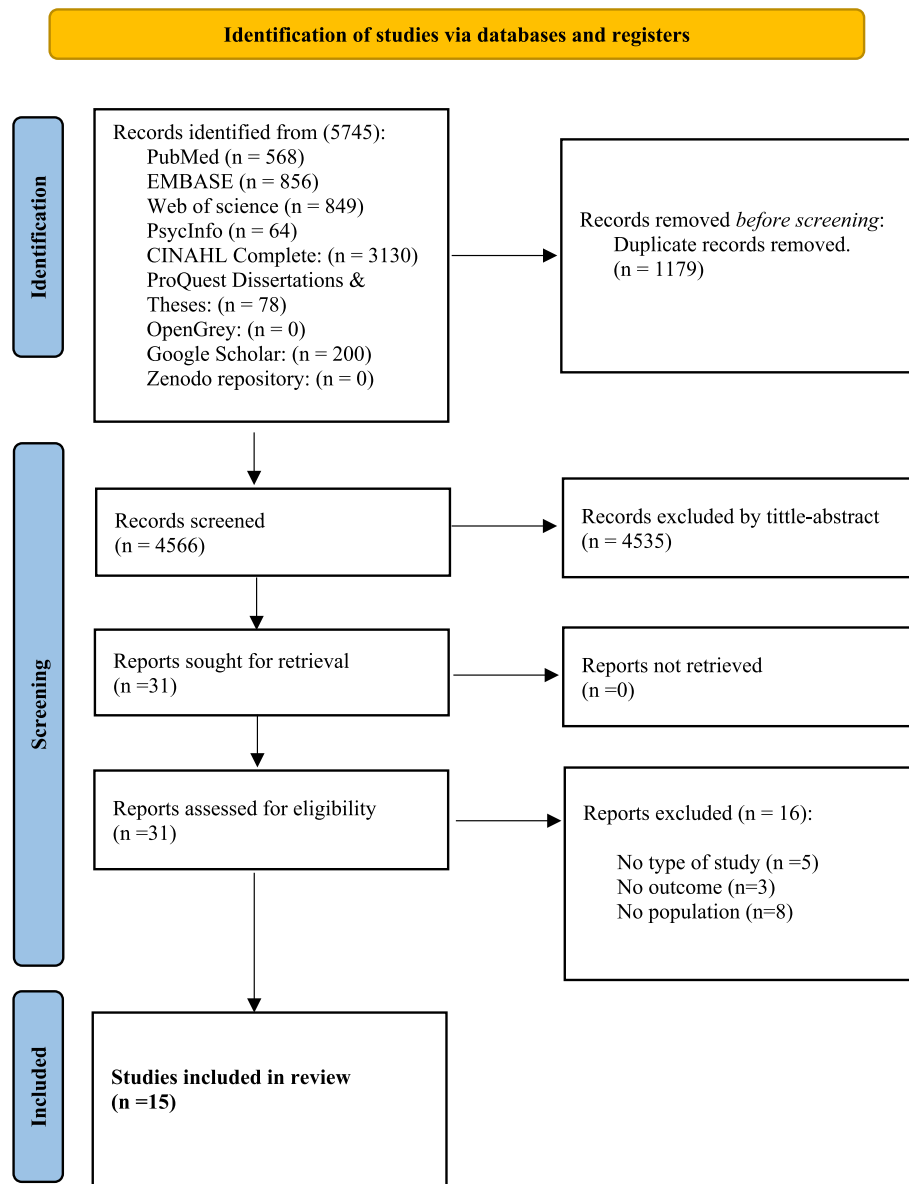


Fig. 1 Flow diagram

did not lead to the findings being downgraded. The high coherence and richness of the data across the 15 studies ensured that confidence in the results remained high (Table S4).

The risk of bias was assessed independently by two reviewers (concordance agreement by weighted kappa statistics 0.6) and inconsistencies were resolved by consensus or discussion with a third researcher.

Synthesis of the results

The analysis distinguishes between the affective and procedural aspects of women's experiences. In this sense, the thematic synthesis revealed three main themes: (1) the perception of UI as not a problem; (2) feelings associated

with UI; and (3) problems in daily life. Each theme consists of different subthemes supported by relevant quotations (Fig. 2). All the quotations, organized by themes and subthemes, are presented in Table S5.

Theme 1: perception of UI as not a problem

This theme is supported by 11 of the 15 studies included in this review.

Surrounding environment [7, 32, 39–41]

Many women report feeling inadequately informed about the changes and challenges they may encounter during the postpartum period, particularly with respect to UI. Consequently, they often express uncertainty and

Table 1 Characteristics of the included studies

Author, year and country	Methodology of data collection	Methodology of analysis (software); paradigmatic approach	Participant characteristics	Setting and method of recruitment
Aksoy et al. 2021 [29], Turkey	semi-structured interviews, face-to-face interviews with 2 sections: a personal information section and a section with semi-structured open-ended questions	Thematic groups and content analysis (MAXQDA 11); NR	n: 51 Age: 32.50 ± 5.39 Time from delivery: 12 months Delivery type: vaginal birth = 90.2%; cesarean delivery = 9.8% Parity: primiparous = 17.6%; multiparous = 82.4% Education level: year 4 or below 25 = 49.1%; between year 5 and 12 = 39.2%; bachelor or postgraduate = 11.8%	Purposive sampling (family health centres)
Buurman et al. 2013 [30], Netherlands	semi-structured face-to-face interviews	Content analysis using the technique of constant comparative analysis (NR); NR	n: 26 Age: 20–24 = 11.53%; 25–29 = 23.07%; 30–35 = 38.46%; 36–40 = 26.92% Time from delivery: 1 month to 1 year Delivery type: all vaginal delivery Parity: primiparous = 53.85%; multiparous = 46.15% Education level: secondary school = 19.2%; intermediate vocational education = 23.07%; higher vocational education = 23.07%; university = 34.61%	Purposive sampling (general practitioner populations)
Cox 2025 [31], Canada	Semi-structured interviews	inductive content analysis (NVivo); qualitative descriptive approach	n: 15 Age: 32.7 ± 3.8 Time from delivery: 22.5 ± 15.9 weeks Delivery type: NR Parity: all primiparous Education level: Bachelor's degrees = 53%; College diplomas = 27%; Graduate degrees = 20%	Purposive sampling (PP-specific patient groups, community groups for new mothers and hospital)
Gutiérrez et al. 2019 [32], United Kingdom	in-depth semi-structured interviews	Framework analysis (NR); descriptive qualitative approach	n: 9 Age: NR Time from delivery: from 6 weeks to 6 months Delivery type: all vaginal birth Parity: primiparous = 60%; multiparous = 40% Education level: NR	Purposive sampling (hospital, maternity care, and associated birth centres)
Kealy et al. 2010 [37], Australia	in-depth face-to-face interview with each woman at a time and place of her choice	Thematic analysis, theoretical framework (NR); NR	n: 32 Age: 20–24 = 3.12%; 25–34 = 68.75%; 35–39 = 18.75%; 40–42 = 6.25% Time from delivery: NR Delivery type: all caesarean birth Parity: primiparous = 71.87%; multiparous = 28.12% Education level: Secondary = 43.75%; Further education, incl. tertiary studies = 56.25%	Purposive sampling (major tertiary hospital)
Li et al. 2023 [38], China	semi-structured face-to-face interviews	Thematic analysis (NVivo software);	n: 22 Age: 25–38 Time from delivery: between 6 weeks and 1 year Delivery type: all vaginal birth Parity: primiparous = 54.54%; multiparous = 45.45% Education level: Speciality = 22.72%; Master's = 18.18%; Higher school education = 13.63%; Undergraduate college = 45.45%	Purposive sampling
Li et al., 2025 [39], China	semi-structured face-to-face interviews	Thematic analysis (NVivo v.15 software); Colaizzi's phenomenological approach	n: 22 Age: 32.4 ± 3.5 years Time from delivery: between 3 months and 1 year Delivery type: vaginal birth = 77.3%; caesarean birth = 22.7% Parity: primiparous = 63.6%; multiparous = 36.4% Education level: Junior College = 13.6%; Undergraduate college = 63.6%; Master = 18.2%; Doctor = 4.5%	Purposive sampling (tertiary hospital)
Mason et al. 1999 [36], United Kingdom	open-ended interviews	Framework analysis (NR); NR	n: 50 Age: 31.38 ± 5.43 Time from delivery: 8 weeks and 1 year Delivery type: NR Parity: 1–7 (8 weeks PP) Education level: NR	Purposive sampling (from a wider study)
Mason et al. 2001 [33], United Kingdom	open-ended interviews	Framework analysis (NR); NR	n: 50 Age: 31.38 ± 5.43 Time from delivery: 8 weeks and 1 year Delivery type: NR Parity: 1–7 (8 weeks PP) Education level: NR	Purposive sampling (from a clinical trial)
Moossdorff-Steinhausser et al. 2023 [7], The Netherlands	semi-structured face-to-face interviews	Thematic analysis (NVIVO 12); qualitative approach	n: 7 Age: 25–38 Time from delivery: 2–10 months PP Delivery type: NR Parity: primiparous = 71.42%; multiparous = 28.57% Education level: Secondary = 85.71%; Tertiary = 14.28%	Purposive sampling (from Facebook page)

Table 1 (continued)

Author, year and country	Methodology of data collection	Methodology of analysis (software); paradigmatic approach	Participant characteristics	Setting and method of recruitment
Reynolds et al. 2019 [40], Ireland	semistructured interviews	Thematic analysis; In Vivo coding strategy	n: 6 Age: 32–45 Time from delivery: ≥ 6 months Delivery type: NR Parity: all multiparous Education level: NR	Purposive sampling (private clinic, through other participants, and posters)
VanWiel et al. 2025 [42], United States	semi-structured in-depth interviews	Thematic analysis with a phenomenological lens (Dedoose qualitative software);	n: 30 Age: 34.6 ± 3.91 Time from delivery: between 3–12 months Delivery type: vaginal birth = 80%; cesarean delivery = 20% Parity: primiparous = 43.3%; multiparous = 56.7% Education level: Less than college = 10%; Baccalaureate degree = 20%; Graduate degree = 70%	Purposive sampling (universities)
Wagg et al. 2017 [34], United Kingdom	Semi-structured individual interviews	Grounded theory: hybrid model demonstrated by Charmaz (2006) (manual analysis); inductive approach	n: 15 Age: 23–41 Time from delivery: ≥ 12 weeks Delivery type: vaginal birth = 93.3%; cesarean delivery = 6.66% Parity: primiparous = 53.33%; multiparous = 46.66% Education level: NR	Theoretical sampling (recruiting by convenience initially and then in relation to emerging themes: general practice by letter or personal invitation)
Whapples et al. 2014 [35], United Kingdom	semistructured open-ended interviews	Thematic analysis (NR); multifaceted approach	n: 9 Age: NR Time from delivery: 3–6 months PP Delivery type: all vaginal birth Parity: NR Education level: NR	Purposive and convenience sampling (centres with postnatal groups)
Yount-Tavener et al. 2024 [41], United States	semistructured open-ended interviews	Thematic analysis (NR); inductive approach	n: 368 Age: 31.35 ± 0.45 Time from delivery: NR Delivery type: vaginal birth = 75.8%; cesarean delivery = 24.2% Parity: primiparous = 42.8%; multiparous = 57.2% Education level: NR	Convenience sampling (birth centers and hospitals)

NR Not reported, PP Postpartum

skepticism about the reliability and completeness of the information received from various sources, including healthcare professionals, family members, other mothers, and written or verbal information:

"I remember after having my second (child) a friend came in and she was laughing, and she said to me 'oh you'll never laugh the same again!' I said, 'what do you mean?' and she said, 'you'll always leak!..... oh yeah, never the same!'"

"Nobody really talks about all the things that happen during pregnancy and afterwards...unless you have a really good group of friends."

"My friends, honestly, it's a bond. We joke about it, like, who wet their pants today?"

"I'm actually pretty close to my mom, so she also had tearing when she gave birth to me. So that's why I was, like, you know, kind of asking her all these things, because she has been sharing all this stuff and it brought us closer together."

In addition, cultural and racial contexts shaped how women experienced stigma related to UI during the postpartum period. Women from racialized backgrounds

reported greater difficulty in discussing their symptoms and accessing support.

"In South Korea, communication around postpartum changes remains limited, saying 'our people don't want to talk about the changes after birth'."

"I feel like I have the confidence as a Canadian, White woman to talk about my urinary incontinence, whereas, like, other cultures and backgrounds are probably not that open about it, right?"

Resignation and normalization [7, 30, 32–36, 40]

This subtheme represents the cognitive process through which women minimize the clinical relevance of their symptoms. Most women perceive UI as an inherent aspect of pregnancy and the postpartum period, attributing little importance to it and often assuming that it will resolve spontaneously. This perception is further reinforced by observing other women who have experienced similar symptoms, leading them to normalize the condition as a natural occurrence associated with childbirth. As a result, many women have resigned to living with it:

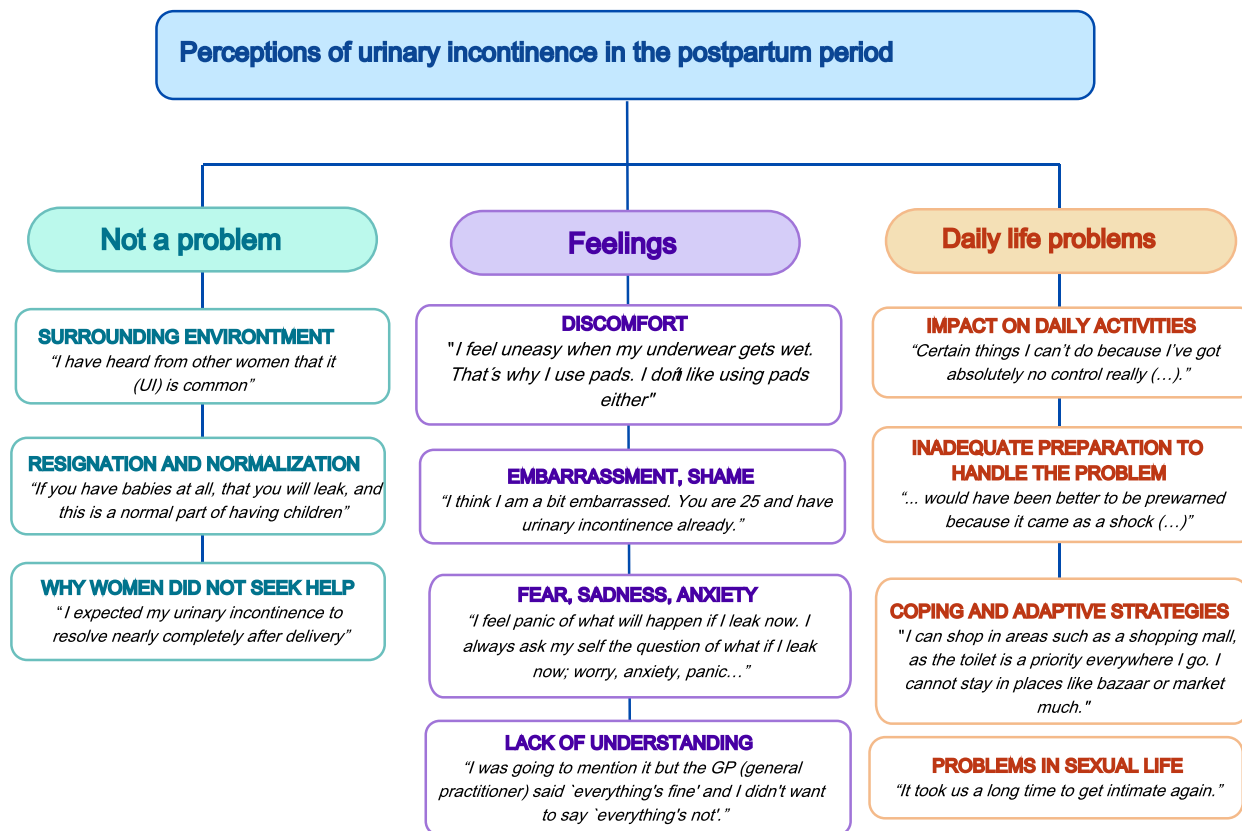


Fig. 2 Graphical themes and subthemes

"Well, because several women told me they lose a little urine sometimes. So, I feel I'm not the only one and that this is quite normal".

Why women did not seek help [7, 30, 31, 33, 39, 40]

Despite taking the initiative to seek professional help, some women reported that their relatives minimized the problem by assuring them that UI was a common condition that would naturally improve or resolve over time. This reassurance led them to underestimate the seriousness and potential persistence of their symptoms, causing them to regard the condition as temporary and consequently consider further healthcare intervention unnecessary:

"No, I didn't call in medical help because my relatives, especially my mum and my gran, said that it would just pass off. So, I was like if my mum and my gran say so, it'll be all right".

Theme 2: feelings associated with UI

This theme is supported by the 15 studies included in this review.

Discomfort [29, 31, 35–37, 41]

Many women experience considerable concern and discomfort in relation to UI, expressing uncertainty regarding its resolution and how best to manage its associated challenges, such as odor, persistent wetness, and the need for the continuous use of sanitary pads:

"In fact, it is very tiring. The person does not want to have such a problem after birth...it may smell badly..."

Embarrassment, shame [7, 29–32, 34, 35, 38]

Women frequently experience embarrassment regarding the problems associated with UI. Consequently, they attempt to conceal their condition, often planning outings around access to toilets and expressing shame or anxiety about potential leakage, unpleasant odor, the need to use sanitary pads, and the possibility of being ridiculed by others:

"I only just make it sometimes, bit embarrassing... often my pants smell a bit of urine as well which isn't very pleasant. That makes me feel really self-conscious".

Fear, sadness, anxiety [29, 31, 34–36, 38, 39, 42]

Some women described experiencing significant psychological and emotional distress as a consequence of UI, including fear of urine leakage during activities such as coughing or laughing, as well as apprehension regarding the possibility of requiring surgical intervention. Collectively, these factors may contribute to feelings of sadness, anxiety, and even fear or panic, with potential detrimental effects on their mental health:

"This process is bad for me, I feel psychologically worn out, I feel like an incomplete mother, a missing woman, I think it is a sad situation".

Lack of understanding [30, 31, 33, 35, 40]

Women explain their emotional experiences of social isolation and their perceptions of a lack of empathy from their partners and other professionals. This perceived lack of understanding contributes to their feelings of being misunderstood and unsupported by those around them:

"Angry that after 6 weeks or so if things seem all right, you're left high and dry to get on with it. If you just had a bit of time with health visitor or doctor or someone you can relate to. Just that aftercare that annoys me. You get left".

Theme 3: daily life problems

This theme is supported by the 15 studies included in this review.

Impact on daily activities [29, 31, 34–36, 38, 39, 42]

Some women express concern that UI may hinder their ability to care for and breastfeed their babies effectively. Many reported feeling overwhelmed by the limitations imposed by their condition, as they are no longer able to engage in the activities they performed prior to childbirth, including sports and routine daily tasks such as shopping, swimming, or spending time outdoors. In addition, fear of urine leakage, particularly during laughing or coughing, leads many women to rely on sanitary pads or panty liners for reassurance and practical management of their symptoms:

"I used to do step aerobics—can't do that at the moment. Won't go swimming, dad has to take the children. I need protection if I go shopping or go out for the day (...)"

Inadequate preparation to handle the problem [31–35, 37, 40, 41]

Women refer to the structural and educational failure of healthcare systems to provide timely clinical information.

They report receiving insufficient guidance on potential postpartum complications, such as UI, during childbirth preparation, and describe a continued lack of care and support once the condition develops. Many believe that they should have been adequately informed about the potential onset of these problems and note that their experience of UI was unexpected and came as a shock:

"I do recall getting a leaflet, but I don't, it was more there's some paperwork have a look at it not in like do you understand the importance of this".

Coping and adaptive strategies [7, 29, 31, 35, 36, 38, 42]

Women adopt various strategies to manage their symptoms, such as using sanitary pads, limiting their activities to environments with easily accessible toilets, and reducing their fluid intake when away from home. Some women also consult with healthcare professionals and engage in pelvic floor exercises to strengthen the pelvic musculature and prevent urine leakage:

"Whenever I needed toilet during the day, wherever I am, I need to find a toilet urgently, this situation makes me difficult, and the fear of urinary incontinence disturbs".

Problems in sexual life [29, 30, 35, 36, 39]

Some women have difficulty enjoying sexual relationships because of concerns about involuntary urination during intercourse. Consequently, they may avoid sexual activity, which can contribute to relationship problems and other interpersonal issues:

"It's a constant worry It affects my whole life. My biggest fear is having a leak when my husband and I are making love. It overshadows the proceedings".

Discussion

Overall, women's health during the postpartum period is an important but often underestimated issue because of the emphasis placed on caring for the baby, and the tendency to normalize all the problems that arise after childbirth, particularly UI. To our knowledge, this is the first study to perform a systematic review to gain an understanding of women's perceptions of postpartum UI by analysing the available qualitative research on this topic. Three key themes emerged from our analysis with a high level of confidence in the GRADE-CERQual assessment: the perception of UI as not a problem, the feelings associated with UI, and problems in daily life. This high level of confidence reinforces the strength of our conclusions and highlights the importance of healthcare professionals implementing early interventions to address the normalization of postpartum UI symptoms.

Perception of UI as not a problem

Approximately 30–40% of pregnant women suffer from postpartum UI, which has been linked to reduced quality of life and negative effects on maternal mental health [43]. However, women tend to normalize UI as part of the natural postpartum process, seeing it as a typical part of life rather than recognizing it as a medical problem or treatable illness. This perception is reinforced by their environment, such as family, health workers, or other women resulting in low motivation to notify and seek help. As a result, they experience a lack of access to adequate information, which has left them unaware of the available resources and support systems and admitting that they are struggling and uncertain about how to deal with the situation could be difficult, leading to hesitation or avoidance [32]. Our data suggest that the normalization of UI as a common postpartum issue is influenced by broader sociocultural expectations, as well as by family, peers and healthcare professionals. These findings emphasize that postpartum UI is not only a health condition, but also a socially mediated experience. This highlights the need for education and communication strategies that empower women to recognize and address this condition. Similar findings have been reported in previous studies on postpartum UI and in other populations [44, 45].

Feelings associated with UI

Not surprisingly, persistent feelings of discomfort, as well as embarrassment and shyness, were described in most of the included studies. This occurs mainly in social settings, especially at times involving actions such as laughing, coughing or sneezing, sometimes together with the need to use hygiene products that reinforce the feeling of insecurity, related to odor or signs of urine leakage. Over time, women reported that these experiences may contribute to feelings of isolation. They may be reluctant to express their concerns or seek help because they are afraid of being ignored or misunderstood by others or healthcare professionals [46]. These findings suggest that when communication is limited or ineffective, women may normalize their symptoms and accept the persistent burden in silence. This can act as a barrier to seeking help and may reduce their perceived ability to manage their condition [34] and mental health issues such as depression, which are widely recognized in the postpartum period [9].

Problems in daily life

UI affects women's quality of life in the postpartum period [47, 48], but the focus of this review was to understand the impact of postpartum UI on daily life. In this sense, the difficulties they face go beyond physical discomfort, as they affect their ability to care for their baby,

or interfere with other daily activities, such as exercise, shopping or even simple, involuntary actions such as coughing or sneezing. Our analyses revealed that some women felt unprepared and lacked sufficient resources to manage the problem effectively, because they were unaware of the possibility of such complications due to a lack of adequate education and information on the issue [49]. However, it is important for women to understand the causes of their postpartum UI, and to know that it is a treatable condition [50]. Increasing awareness and providing more accessible treatments could help reduce the associated stigma. This is partly due to the lack of information provided by health professionals about UI in preventive encounters, such as during antenatal care or postpartum but also because UI remains a sensitive and stigmatized topic for many women [15].

Women adopt different coping strategies to mitigate the impact of UI and seek treatment options. There is much previous evidence that pelvic floor muscle training is the first treatment option in the guidelines for UI [51]. However, few women have access to these interventions and more women report lifestyle changes to manage their symptoms, reduce their water intake to minimize the frequency of urinary urgency, and always know the nearest toilets when they are away from home. These proactive measures enabled them to consider their daily routines with greater confidence and a sense of control, despite the difficulties caused by UI [52].

Another theme that emerged from this study, problems in sexual life, highlighted the importance of this aspect at this time. Women expressed fear of leaking urine during intercourse. This situation often makes them anxious and self-conscious, making them reluctant or even unwilling to engage in sexual intercourse. This emotional discomfort not only affects their self-esteem, but also has a significant effect on their relationship with their partner, and can lead to feelings of distance, frustration or lack of emotional connection [53, 54].

Importantly, women's perceptions of postpartum UI may be shaped by the cultural and healthcare contexts in which they live [43]. Our data show differences across countries and cultures suggesting variations in openness to discussing UI, access to postpartum care, and societal norms regarding women's health. These contextual variations highlight that experiences and coping strategies may not be directly comparable across countries, and future research should examine how cultural beliefs and healthcare system structures influence UI women's experiences during the postpartum period and their help-seeking behaviors.

Strengths and limitations

The main strength of the current meta-synthesis was that studies involving women from different countries,

cultural contexts, age groups, and parity statuses from different countries and cultures were included. Thus, consistencies were identified in themes across the studies, suggesting a potential universality to the experiences and perceptions of UI during the postpartum period. While this diversity provides a broad perspective, it also results in a heterogeneous sample, which may influence the comparability of experiences and knowledge gained from different populations. Differences in sociocultural norms and health systems across regions could further influence the interpretation and applicability of the results. In addition, other limitations should be acknowledged. First, there is also heterogeneity in the methods of data collection and interpretation, and in the sampling strategies used. While the results are representative of all the data, some studies lack key participant characteristics (e.g. mode of delivery, parity or socioeconomic status). This may have affected the synthesis, meaning that some issues are discussed in more depth than others due to the methodology. Second, to facilitate behavior change, it may be important to understand the contextual details of the management of UI, not only from the perspective of women experiencing UI in the postpartum period, but also from the perspective of health professionals. Third, psychological determinants have emerged as key factors closely associated with the experience of UI in postpartum women. Emotional and psychological aspects have been shown to play crucial roles in the perception and coping of this condition by women and should be strongly considered in future research. Finally, a potential limitation for the robustness of the synthesis of findings could be that, although certain studies used less intensive data collection methods, their results regarding normalization and barriers to seeking help were entirely consistent with the findings of studies that used robust in-depth interviews.

Conclusion

This meta-synthesis highlights the impact of postpartum UI from a woman's perspective. During this period, UI is often normalized, although women may experience feelings of discomfort, worry, anxiety, or sadness that have a significant impact on their daily lives. They often feel misunderstood and unprepared to deal with the problem. Addressing these issues requires educational interventions that provide clear, accessible information about postpartum UI, its management options, and strategies to reduce stigma. Health professionals should proactively screen for UI, validate women's experiences, provide personalized counselling, and offer early interventions to support both physical and mental well-being. At the healthcare system level, integrating postpartum UI management into routine care, training providers, and promoting public awareness can improve quality

of life, ensure equitable access, and empower women to seek help. Finally, future research should evaluate the effectiveness and acceptability of educational and clinical interventions from women's and health professionals' perspectives so that they can be effectively integrated into routine postnatal services.

Abbreviations

UI Urinary incontinence
JBI Joanna Briggs Institute

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

CG-G: Data curation, Writing- Original draft preparation. HM-M: Conceptualization, Methodology, Software. VM-M: Visualization and Supervision. CQ-B, SM-B and JB-L: Software, Validation. AF-M and AT-C: Writing- Reviewing and editing. All the authors read and approved the final manuscript.

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Data availability

The data that support the findings of this study are available in the Supporting Information for this article.

Declarations

Ethics approval and consent to participate

Ethical approval was not required due to the nature of the work being a qualitative evidence synthesis.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. Abrams P, Cardozo L, Fall M, Griffiths D, Rosier P, Ulmsten U, et al. The standardisation of terminology of lower urinary tract function: report from the standardisation sub-committee of the International Continence Society. *Neurourol Urodyn*. 2002;21(2):167–78.
2. Diz-Teixeira P, Alonso-Calvete A, Justo-Cousiño LA, González-González Y, Cuña-Carrera ID. Update on Physiotherapy in Postpartum Urinary Incontinence A systematic review. *Arch Esp Urol*. 2023;76(1):29–39.
3. Koomson G, Mgozoli SE, Mshunqane N. Prevalence of urinary incontinence in postpartum women and physiotherapy interventions applied: An integrative review. *International Journal of Gynecology & Obstetrics*. Disponible en: <https://onlinelibrary.wiley.com/doi/abs/10.1002/ijgo.15950>. Citado 2 de enero de 2025.
4. Morkved S, Bo K. Effect of pelvic floor muscle training during pregnancy and after childbirth on prevention and treatment of urinary incontinence: a systematic review [with consumer summary]. *Br J Sports Med*. 2014;48(4):299–310.
5. Suar G, Cevik F, SimalYavuz N, Ozerdogan N. Urinary incontinence in the postpartum 1-year period: its prevalence and effect on psychosocial status of women. *LUTS: Lower Urinary Tract Symptoms*. 2023;15(5):191–9.
6. Dai S, Chen H, Luo T. Prevalence and factors of urinary incontinence among postpartum: systematic review and meta-analysis. *BMC Pregnancy Childbirth*. 2023;23(1):761.
7. Moosssdorff-Steinhauser HFA, Houkes I, Berghmans BCM, Spaanderman MEA, Bols EMJ. Experiences of peri-partum urinary incontinence from a women's and health care perspective: a qualitative study. *Matern Child Health J*. 2023;27(7):1199–207.
8. Xu P, Jin Y, Guo P, Xu X, Wang X, Zhang W, et al. Barriers and enablers of pelvic floor rehabilitation behaviours in pregnant women with stress urinary incontinence: a qualitative analysis using the theoretical domains framework. *BMC Pregnancy Childbirth*. 2023;23(1):300.
9. Gallego-Gómez C, Rodríguez-Gutiérrez E, Torres-Costoso A, Martínez-Vizcaino V, Martínez-Bustelo S, Quezada-Bascuñán CA, et al. Urinary incontinence increases risk of postpartum depression: systematic review and meta-analysis. *Am J Obstet Gynecol*. 2024;S0002–9378(24):00419–28.
10. Talley KMC, Davis NJ, Peden-McAlpine C, Martin CL, Weinfurter EV, Wyman JF. Navigating through incontinence: a qualitative systematic review and meta-aggregation of the experiences of family caregivers. *Int J Nurs Stud*. 2021;123:104062.
11. Yan F, Xiao LD, Zhou K, Li Z, Tang S. Perceptions and help-seeking behaviours among community-dwelling older people with urinary incontinence: a systematic integrative review. *J Adv Nurs*. 2022;78(6):1574–87.
12. Rada MP, Jones S, Betschart C, Falconi G, Haddad JM, Doumouchtsis SK. A meta-synthesis of qualitative studies on stress urinary incontinence in women for the development of a core outcome set: a systematic review. *Int J Gynaecol Obstet*. 2022;158(1):3–12.
13. Murphy C, Avery M, Macaulay M, Fader M. Experiences and impact of living with incontinence associated stigma: a protocol for a systematic review and narrative synthesis of qualitative studies. *PLoS ONE*. 2022;17(7):e0270885.
14. Ackenbom MF, Carter-Brooks CM, Soyemi SA, Everstine CK, Butters MA, Davis EM. Barriers to urogynecologic care for racial and ethnic minority women: a qualitative systematic review. *Urogynecology*. 2023;29(2):89–103.
15. Toye F, Barker KL. A meta-ethnography to understand the experience of living with urinary incontinence: «is it just part and parcel of life?». *BMC Urol*. 2020;20(1):1.
16. Tong A, Flemming K, McInnes E, Oliver S, Craig J. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Med Res Methodol*. 2012;12:181.
17. Cochrane Handbook for Systematic Reviews of Interventions. Disponible en: <https://training.cochrane.org/handbook>. Citado 21 de mayo de 2024.
18. Cooke A, Smith D, Booth A. Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qual Health Res*. 2012;22(10):1435–43.
19. Kumarasinghe M, Herath MP, Hills AP, Ahuja KDK. Postpartum versus postnatal period: do the name and duration matter? *PLoS ONE*. 2024;19(4):e0300118.
20. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan-a web and mobile app for systematic reviews. *Syst Rev*. 2016;5(1):210.
21. Lockwood C, Munn Z, Porritt K. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *Int J Evid Based Healthc*. 2015;13(3):179–87.
22. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol*. 2008;8:45.
23. Lewin S, Booth A, Glenton C, Munthe-Kaas H, Rashidian A, Wainwright M, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci*. 2018;13(Suppl 1):2.
24. Lewin S, Bohren M, Rashidian A, Munthe-Kaas H, Glenton C, Colvin CJ, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 2: how to make an overall CERQual assessment of confidence and create a summary of qualitative findings table. *Implement Sci*. 2018;13(Suppl 1):10.
25. Munthe-Kaas H, Bohren MA, Glenton C, Lewin S, Noyes J, Tunçalp Ö, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 3: how to assess methodological limitations. *Implement Sci*. 2018;13(Suppl 1):9.
26. Colvin CJ, Garside R, Wainwright M, Munthe-Kaas H, Glenton C, Bohren MA, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 4: how to assess coherence. *Implement Sci*. 2018;13(Suppl 1):13.
27. Glenton C, Carlsen B, Lewin S, Munthe-Kaas H, Colvin CJ, Tunçalp Ö, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 5: how to assess adequacy of data. *Implement Sci*. 2018;13(Suppl 1):14.
28. Noyes J, Booth A, Lewin S, Carlsen B, Glenton C, Colvin CJ, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings-paper 6: how to assess relevance of the data. *Implement Sci*. 2018;13(Suppl 1):4.
29. Aksoy YE, Akin B, Dereli Yilmaz S. Postpartum urinary incontinence: a qualitative study on sexuality and life experiences of Muslim Turkish women. *Female Pelvic Med Reconstr Surg*. 2021;27(8):514–20.
30. Buurman MBR, Lagro-Janssen ALM. Women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour: a qualitative interview study. *Scand J Caring Sci*. 2013;27(2):406–13.
31. Cox JM. How does stigma associated with postpartum urinary incontinence affect health-seeking behaviours? 2025. <https://ualberta.scholaris.ca>.
32. Gutiérrez VB, Fader M, Monga A, Kitson-Reynolds E. Lack of care? Women's experiences of maternity bladder management. *Br J Midwifery*. 2019;27(1):15–25.
33. Mason L, Glenn S, Walton I, Hughes C. Women's reluctance to seek help for stress incontinence during pregnancy and following childbirth. *Midwifery*. 2001;17(3):212–21.
34. Wagg AR, Kendall S, Bunn F. Women's experiences, beliefs and knowledge of urinary symptoms in the postpartum period and the perceptions of health professionals: a grounded theory study. *Prim Health Care Res Dev*. 2017;18(5):448–62.
35. Whapples E. Do women who have encountered vaginal childbirth experience long term incontinence or perineal pain? *Br J Midwifery*. 2014;22(10):706–15.
36. Mason L, Glenn S, Walton I, Appleton C. The experience of stress incontinence after childbirth. *Birth*. 1999;26(3):164–71.
37. Kealy MA, Small RE, Liampittong P. Recovery after caesarean birth: a qualitative study of women's accounts in Victoria, Australia. *BMC Pregnancy Childbirth*. 2010;10:47.
38. Li J, Li T, Huang S, Chen L, Cai W. Motivations, psychosocial burdens, and decision-making modes of post-partum women with stress urinary incontinence engaging in pelvic floor physical therapy: a qualitative research. *Int Urogynecol J*. 2023;34(8):1803–13.
39. Li S, Xu J, Zhong Z, Li J, Tang W, Cai W. Motivations, challenges, and practices of pelvic floor rehabilitation in postpartum women with urinary incontinence under China's proactive health framework: a qualitative research. *Midwifery*. 2025;150:104605.
40. Reynolds N, Wilson IM. «There was no real importance put on them». Experiences of multiparous women and pelvic floor muscle exercise (PFME) prescription. a qualitative study. *Physiotherapy Practice and Research: The Official Journal of The Irish Society of Chartered Physiotherapists*. 2019;40(2):135–43.
41. Yount-Tavener SM, Fay RA. Maintaining a long-term practice of daily pelvic floor muscle exercises: what do childbearing women think? *J Midwifery Womens Health*. 2024;69(4):567–76. <https://doi.org/10.1111/jmwh.13626>.
42. VanWiel L, Butler O, Carr LJ, Gorzelitz J, Story WT, Whitaker KM. A qualitative analysis of postpartum women's experiences with urinary incontinence and physical activity. *Midwifery*. 2025;150:104591.
43. Cox JM, Sánchez-Polán M, Mota P, Barakat R, Nagpal TS. A scoping review exploring stigma associated with postpartum urinary incontinence. *Int Urogynecol J*. 2023;34(9):1997–2005.
44. Ruiz de Vinaspre Hernandez R. Efficacy of hypopressive abdominal gymnastics in rehabilitating the pelvic floor of women: a systematic review. *Actas Urol Esp*. 2018;42(9):557–66.
45. Koch LH. Help-seeking behaviors of women with urinary incontinence: an integrative literature review. *J Midwifery Women's Health*. 2006;51(6):e39–44.

46. Howell EA. Lack of patient preparation for the postpartum period and patients' satisfaction with their obstetric clinicians. *Obstet Gynecol*. 2010;115(2 Pt 1):284–9.
47. Wuytack F, Moran P, Daly D, Begley C. Is there an association between parity and urinary incontinence in women during pregnancy and the first year postpartum? A systematic review and meta-analysis. *Neurourol Urodyn*. 2022;41(1):54–90.
48. Liang Y, Chen Y, Yu X, Li X. Quality of life among women with postpartum urinary incontinence: a cross-sectional study. *Gynecol Obstet Clin Med*. 2021;1(3):164–8.
49. Wagg A. Women's experiences, beliefs and knowledge of urinary symptoms in the postpartum period and the perceptions of health professionals. 2010. <https://doi.org/10.1017/S1463423617000366>. (Doctoral dissertation).
50. Effects of Training Interventions to Treat Postpartum Urinary Incontinence: A Meta-Analysis - Gallego-Gómez - 2026 - BJOG: An International Journal of Obstetrics & Gynaecology - Wiley Online Library. Disponible en: <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.70014>. Citado 28 de diciembre de 2025.
51. Health NI for, Excellence C. Urinary incontinence in women. National institute for health and care excellence. 2015. <https://www.ncbi.nlm.nih.gov/books/NBK247723/>.
52. Yilmaz SD, Erkal Aksoy Y. Urinary incontinence in Turkish women: a qualitative study on daily life and sexual health. *J Wound Ostomy Continence Nurs*. 2023;50(1):66.
53. Seshan V, Muliira JK. Dimensions of the impact of urinary incontinence on quality of life of affected women: a review of the English literature. *Int J Urol Nurs*. 2014;8(2):62–70.
54. Woodley SJ, Hay-Smith EJC. Narrative review of pelvic floor muscle training for childbearing women-why, when, what, and how. *Int Urogynecol J*. 2021;32(7):1977–88.

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