

Original Research

Received 03 June 2026

Revised 18 July 2026

Accepted 01 Aug 2026

Natural Resources for Human
Health 2026, Vol. 6 (15s): 1589–1605

KEYWORDS:

Physical Therapy Modalities;
Obstetrics; Gynecology; Hospitals,
Public; Health Services
Accessibility

Physiotherapy Service Models in Obstetric and Gynaecological Care in Public Hospitals: A Scoping Review

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ABSTRACT: Physiotherapy addresses pelvic floor dysfunction, pregnancy-related musculoskeletal pain and recovery after childbirth and gynaecological surgery, yet in many public hospitals of low- and middle-income countries it is not organised as a defined service. This scoping review, conducted according to Joanna Briggs Institute guidance and reported against the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), mapped evidence and policy on physiotherapy roles, service models, referral arrangements, implementation determinants and equity in obstetric and gynaecological care in public-hospital and low-resource settings. An exploratory arm combined an academic search tool with grey-literature searches; a formal arm searched PubMed/MEDLINE, CINAHL Ultimate and Scopus (2010–2026, English). Screening used titles, abstracts and bibliographic records; a second reviewer checked every decision, and included sources were verified against publication records. Charted data were mapped to a five-tier stepped-care structure, to the Consolidated Framework for Implementation Research, to PROGRESS-Plus equity factors and to the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) dimensions. Of 35,237 records, 29 sources were included (26 empirical or review, three policy; 14 India-based). Stated awareness of physiotherapy consistently ran ahead of referral and uptake. Midwife-led task-shifting, primary-care-integrated outreach, quality-improvement referral redesign and telehealth were each demonstrated in single

studies; no low- or middle-income public-hospital example of specialist multidisciplinary care, no maintenance outcome and no parity- or digital-access-stratified finding emerged, and India's national maternal-health strategy does not name physiotherapy. The map supports a tiered, equity-informed service framework built on structured screening, a written referral pathway and task-appropriate delivery.

INTRODUCTION

Women's health needs during pregnancy, childbirth, the postnatal period and recovery from gynaecological surgery extend well beyond survival. Pelvic floor dysfunction, urinary and faecal incontinence, pelvic girdle and low back pain, diastasis recti, post-caesarean and postoperative deconditioning, and sexual dysfunction affect continence, mobility, work, caregiving and quality of life. Physiotherapy holds an established place in preventing, detecting and conservatively managing these problems, and in supporting rehabilitation after gynaecological surgery, including oncological surgery.

International policy now treats rehabilitation as a component of universal health coverage rather than an optional extra. The World Health Organization's Rehabilitation 2030 initiative describes rehabilitation as an integral and currently under-resourced element of health systems (World Health Organization, 2017), and the profession's global body has called for rehabilitation workforce planning and the integration of physiotherapy into universal health coverage strategies (World Physiotherapy, 2023). India's national maternal-health programme sets continuum-of-care standards spanning antenatal, intranatal and postnatal services, with defined referral-transport provisions; the published strategy, however, does not name physiotherapy as a distinct service component at any point (National Health Mission, n.d.).

Between the policy commitment and the clinic lies an organisational question that has received little systematic attention: how, if at all, are physiotherapy services for obstetric and gynaecological (OBG) care structured in public hospitals, particularly where resources are constrained? Individual interventions such as pelvic floor muscle training carry a substantial trial literature, but a service must also solve problems of referral, workforce roles, privacy, documentation and follow-up before any intervention reaches the women who need it. No prior review known to the authors has mapped this service-model literature for public-hospital and low-resource contexts.

The review reported here forms the evidence-mapping phase of a larger, ethics-approved framework-development study for a public tertiary hospital in South India, in which this map informs stakeholder interviews, participatory co-design and consensus validation of a tiered OBG physiotherapy service framework; the hospital is not named, in keeping with the parent protocol's confidentiality provisions. Two questions guided the work: what physiotherapy roles, service models and referral arrangements in OBG care have been described in public-hospital and low-resource settings, and what implementation determinants, equity considerations and outcomes have been reported for those services?

MATERIALS AND METHODS

Design and reporting

We conducted a scoping review oriented to the Joanna Briggs Institute approach to evidence mapping (Peters et al., 2020) and reported with reference to the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The review was conducted under the protocol of the ethics-approved parent study and was not registered separately; departures from that protocol are reported under Strengths and limitations, and a completed PRISMA-ScR checklist is provided as Supplementary Material 1. Consistent with scoping methodology, sources were not critically appraised and no effect estimates were pooled.

Eligibility criteria

Eligibility followed a population–concept–context structure. The population comprised women receiving obstetric, postnatal, pelvic health, gynaecological, urogynaecological, oncological or perioperative care, together with the clinicians, services and health systems providing that care. The concept comprised physiotherapy roles, interventions, service models, referral pathways, workforce competencies, implementation strategies, documentation, governance and service indicators. The context comprised hospital-based, hospital-linked, public-hospital, low-resource, low- and middle-income-country or South Asian settings, with high-income sources retained where they described service structures of comparative value. Empirical studies of any design,

reviews and policy or grey-literature documents were eligible. In the formal database arm, records were limited to 2010–2026 and to English. Records were excluded when they contained no physiotherapy or rehabilitation concept, addressed populations outside OBG care, described general rehabilitation without an OBG-specific focus, or could not be verified against any publication record.

Information sources and search

Searching proceeded in two arms, both documented query-by-query in a search log (Supplementary Material 2). In the exploratory arm (13 August 2026), seven topic searches were run through Consensus, an academic search tool that indexes PubMed/MEDLINE-, Scopus- and Semantic Scholar-indexed records, with ten records screened per query (70 records), and two targeted grey-literature web searches were run for World Health Organization and World Physiotherapy policy sources (seven records) and Indian Ministry of Health and Family Welfare/National Health Mission sources (six records). In the formal arm (16 August 2026), a single Boolean string was run in PubMed/MEDLINE, CINAHL Ultimate (EBSCOhost) and Scopus, limited to 2010–2026 and English:

(Physiotherap OR “physical therap*” OR rehabilitat*) AND (Obstetric* OR gynaecolog* OR gynecolog* OR pregnan* OR postnatal OR postpartum OR maternal OR “pelvic floor” OR urogynaecolog* OR antenatal OR prenatal) AND (“public hospital*” OR “low resource*” OR LMIC OR “developing countr*” OR India OR Pakistan OR Nepal OR Bangladesh OR “South Asia”)*

The PubMed/MEDLINE and CINAHL exports reached the platforms’ export caps at 10,000 and 25,000 records respectively, with database hits exceeding the exported records; the Scopus result set (154 records) was exported in full. The reference lists of the included sources were also hand-searched for additional eligible records; no further sources meeting the eligibility criteria were identified. Four sources named in the parent protocol – PEDro, the Cochrane Library, Web of Science and Google Scholar – were not separately searched in this cycle; this deviation is examined under Strengths and limitations.

Source selection

Two cross-database duplicates were removed before screening. Because the capped PubMed/MEDLINE and CINAHL exports were too large for manual screening, a disclosed automated co-occurrence rule was applied to those two exports: a record was retained only if its title or abstract contained both a physiotherapy or rehabilitation term and an obstetric or gynaecological term. This rule excluded 35,089 records. All remaining formal-arm records and every exploratory and grey-literature record were screened manually on title and abstract, with each decision and exclusion reason entered in a line-by-line screening register; 53 records were excluded at this step. The 93 records that remained were assessed for eligibility on their titles, abstracts and bibliographic records. Full texts were not retrieved at this stage, a departure from conventional practice that is stated here plainly and revisited under Strengths and limitations. Of the 93, 52 were excluded for wrong population or concept, ten as background-only sources without an OBG-specific physiotherapy focus, and two because no corresponding publication record could be located. A verification pass by the second reviewer on 21 August 2026 checked the included set against publication records, corrected charted details for six sources, replaced one record that could not be matched to a publication with the verified source it evidently referred to (Munawar et al., 2013), and excluded the two unverifiable records. Twenty-nine sources were included.

A second, bibliographic verification pass on 23 August 2026 checked every included record against publication databases and publisher records. Fifteen records, including every source contributing a quantitative finding to this review, were confirmed in full, and their citations completed or corrected in the process: the publication year of the Ethiopian trial was confirmed against its journal record, and the full author lists and identifiers of the two most recent sources were established (Boulanger et al., 2026; Chun et al., 2026). Ten records from regional journals, whose full bibliographic details were already charted, could not be independently relocated through the indexes searched in that pass; the review team retrieved and confirmed each of them at full-text follow-up, completed on 25 August 2026. One record could not initially be located in any index searched; at the same full-text follow-up the review team located the publication and corrected its charted year (Sushil et al., 2023). On 24 August 2026, the published records of all sources contributing quantitative findings were retrieved in full and each such finding was checked against its source; one finding removed at the previous pass as unconfirmed, the shorter time to starting chemotherapy after prehabilitation, was confirmed against the published results (median 25 versus 35 days) and reinstated. Screening and charting were initially compiled by one reviewer in a structured register, after which a second reviewer checked every screening

decision and charted entry; the corrections of 21 August 2026 record the outcome of that check. Fully independent duplicate screening, with both reviewers screening records in parallel as envisaged in the parent protocol, is planned for the full-text stage.

Data charting

A fourteen-field charting instrument aligned to the parent protocol (Supplementary Material 3) was applied to every included source: serial number; author or organisation and year; country or region; source type; population; clinical area; care tier; key contribution or finding; Consolidated Framework for Implementation Research (CFIR) domain engaged; PROGRESS-Plus factor; RE-AIM dimension; low-resource relevance; limitations; and applicability to the South Indian public-hospital context. Where a specific figure or study detail could not be confirmed from the bibliographic record alone, it was charted with an explicit flag for confirmation at full-text retrieval.

Synthesis

Charted data were summarised numerically and mapped in four ways: to a five-tier stepped-care structure (Tier 1, universal antenatal education; Tier 2, targeted screening; Tier 3, basic rehabilitation; Tier 4, specialist multidisciplinary care; Tier 5, onward referral); to the five domains of the CFIR (Damschroder et al., 2022); to PROGRESS-Plus equity factors (O'Neill et al., 2014); and to the five RE-AIM dimensions of reach, effectiveness, adoption, implementation and maintenance (Glasgow et al., 1999). Evidence gaps were recorded wherever a cell of these maps remained empty.

RESULTS

Source selection

The two search arms identified 35,237 records: 10,000 from the capped PubMed/MEDLINE export, 25,000 from the capped CINAHL Ultimate export, 154 from Scopus, 70 from the exploratory searches and 13 from the grey-literature searches. After removal of two duplicates, 35,235 records were screened; the automated co-occurrence rule excluded 35,089 and manual title-and-abstract screening excluded a further 53. Of the 93 records assessed for eligibility on title, abstract and bibliographic record, 64 were excluded (52 wrong population or concept; ten background-only; two unverifiable), leaving 29 included sources: 26 empirical or review sources and three policy or grey-literature documents (Figure 1). Hand-searching of the included sources' reference lists identified no additional eligible records.

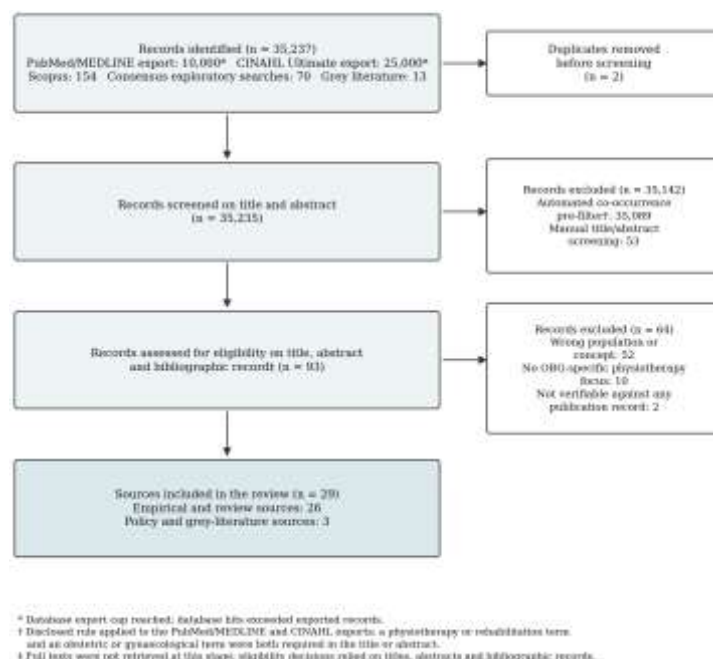


Figure 1. Flow of sources through the review, adapted from the PRISMA-ScR template. Footnotes mark the export caps, the disclosed automated pre-filter and the absence of full-text retrieval at the eligibility step.

Characteristics of included sources

The 29 included sources are summarised in Table 1. Twenty-eight carried a publication year, spanning 2013 to 2026; 25 of the 28 dated sources were published in 2019 or later and 18 in 2022 or later. Fourteen sources were India-based, comprising thirteen empirical or review sources and the national maternal-health strategy; two came from Pakistan; Ghana, Nigeria, Ethiopia, Belize, Singapore, Spain, the United Kingdom, the United States and Canada contributed one source each; two were multi-country reviews (one on Asian postpartum traditions, one on maternal referral in sub-Saharan Africa); and two were global policy documents. Twenty-two sources concerned low- and middle-income or low-resource multi-country settings, five described single high-income settings retained for comparative value, and two were global. Designs comprised five cross-sectional surveys, four qualitative or ethnographic studies, two randomised trials (one cluster-randomised), four pilot or quality-improvement evaluations, three comparative studies, one observational study, one validation study, two case reports, four review or service-description sources and three policy or grey-literature documents. Low-resource relevance was charted as very high or high for 23 of the 29 sources. The principal charted tier concentrated at Tier 3, basic rehabilitation (ten sources), and Tier 5, onward referral (eight), with six sources at Tier 1, three at Tier 2 and two at Tier 4.

Table 1. Characteristics of the 29 included sources.

No.	Source (year)	Country/region	Design/type	Clinical area	Tier*	Key charted finding (condensed)
1	Koranteng et al. (2023)	Ghana	Cross-sectional survey	Antenatal; intrapartum; postnatal; gynae surgery	5	Referrer awareness 72.1–91.8% in obstetric care but 19.7–95.1% across gynaecological conditions; consultants more aware than residents
2	Naureen & Naseer (2019)	Pakistan	Narrative review	Antenatal; postnatal	1	Synthesises physiotherapy's perinatal contribution to posture, pain and continence care
3	Mullerpattan et al. (2022)	India (Maharashtra, rural)	Pilot service-delivery evaluation	Primary-care-integrated rehabilitation including women's health screening	2	Outreach model treated 1,800 rural patients over three years within existing primary care, including antenatal care for 1,629 pregnant women with musculoskeletal pain or stress urinary incontinence
4	Diaz-Feijoo et al. (2022)	Spain	Pilot before–after study	Gynae-oncology perioperative	4	Prehabilitation before ovarian cancer surgery: shorter median stay (5 vs 7 days), faster start of chemotherapy (median 25 vs 35 days) and 80% programme adherence
5	Onyekere et al. (2024)	Nigeria	Case report	Postnatal (obstetric palsy)	3 ^a	Early physiotherapy resolved pain and weakness after obstructed-labour palsy

No.	Source (year)	Country/region	Design/type	Clinical area	Tier*	Key charted finding (condensed)
6	Siyoun et al. (2025)	Ethiopia	Cluster-randomised controlled trial	Pelvic organ prolapse	3	Midwife-led pelvic floor muscle training improved prolapse symptoms and quality of life (187 women randomised)
7	Terry et al. (2020)	United Kingdom	Ethnographic study	Antenatal pelvic floor education	1	Midwives lacked confidence and no consistent pathway governed pelvic floor education
8	Hickman et al. (2020)	United States	Narrative service description	Peripartum pelvic floor	4	Describes subspecialty clinics pairing obstetric specialists with pelvic-floor physiotherapists
9	Mishra et al. (2020)	India (Gujarat)	Qualitative study	Urinary incontinence (community)	3	Silence, embarrassment and absent private space led rural women to decline physiotherapy
10	Sushil et al. (2023)	India (urban/semi-urban)	Qualitative study	Antenatal lumbopelvic pain	5	Non-adherence driven by unawareness that physiotherapy existed, and competing demands
11	Withers et al. (2018)	Asia (multi-country)	Narrative review	Perinatal cultural context	1	Confinement practices and humoral beliefs shape acceptability of biomedical rehabilitation
12	Boulanger et al. (2026)	Canada	Qualitative study	Pelvic-health access	5	Persistent lack of guidance on accessing pelvic physiotherapy; rural women worst affected
13	Ameyaw et al. (2020)	Sub-Saharan Africa (multi-country)	Systematic review	Maternal referral (general)	5	Poor documentation, absent escort protocols and transport delays undermined referral quality
14	Munawar et al. (2013)	Pakistan (Karachi)	Cross-sectional survey	Antenatal; postnatal referral behaviour	5	64.7% aware of antenatal physiotherapy but 18.7% referring; 68.0% vs 20.0% postnatally; 18.7% never advised it

No.	Source (year)	Country/region	Design/type	Clinical area	Tier*	Key charted finding (condensed)
15	Chun et al. (2026)	Singapore	Quality-improvement project	Pelvic floor screening to referral	2	Structured screening, training and a defined pathway raised referral uptake from 0% to 50% in six months
16	World Health Organization (2017)	Global	Policy report	Cross-cutting	5	Rehabilitation 2030 positions rehabilitation as integral and under-resourced within universal health coverage
17	World Physiotherapy (2023)	Global	Policy statement	Cross-cutting	5	Calls for rehabilitation workforce planning and integration into universal health coverage strategies
18	National Health Mission, MoHFW, India (n.d.)	India	Government strategy (grey)	Maternal continuum of care	1	Continuum-of-care standards defined; physiotherapy not named anywhere as a service component
19	Ramya et al. (2025)	India	Comparative study	Pelvic congestion syndrome	3	Compared targeted physiotherapy for pelvic congestion syndrome in an Indian cohort
20	Mahishale & Parikh (2025)	India	Observational study	Postpartum pelvic floor awareness	2	Low baseline knowledge of pelvic floor disorders and rehabilitation among postpartum women
21	Augustina et al. (2025)	India	Comparative study	Postnatal venous recovery	3	Soft-tissue manipulation compared with exercise for post-pregnancy venous insufficiency
22	Gracias et al. (2024)	India (Goa)	Cross-sectional survey	Antenatal exercise	1	Marked gap between awareness of antenatal exercise and its actual practice
23	Joshi & Rath (2024)	India (Maharashtra)	Validation study	Outcome measurement	3	Marathi translation and validation of the King's Health Questionnaire
24	Akilandeeswari et al. (2024)	India	Randomised controlled trial	Antenatal pelvic girdle pain	3	Home-based tele-Pilates improved pelvic girdle pain and lumbopelvic stability

No.	Source (year)	Country/region	Design/type	Clinical area	Tier*	Key charted finding (condensed)
25	Shinde & Jeevannavar (2023)	India (Maharashtra)	Cross-sectional survey	Antenatal physiotherapy awareness	1	Lower awareness among rural than urban respondents
26	Ramachandra (2022)	India	Case report	Antenatal telerehabilitation	3	Telerehabilitation for pelvic girdle dysfunction deployed rapidly during a lockdown
27	Kale & Bellare (2019)	India (Aurangabad)	Cross-sectional survey	Postnatal referral awareness	5	General awareness but limited working knowledge of postnatal physiotherapy indications among obstetricians
28	Sankarganesh & Lakshmi (2019)	India	Comparative study	Postnatal respiratory recovery	3	Physiotherapy improved peak expiratory flow rate after normal vaginal delivery
29	Rapp et al. (2024)	Belize	Pilot study	Urinary incontinence	3	Pilot pelvic-floor therapy programme feasible and acceptable in a low-resource setting

* Principal charted tier; several sources inform more than one tier (see Table 2). ^a In Table 2 this case report is grouped with Tier 4, because the complication it reports argues for specialist capacity. Sources are identified by author and year; full citations appear in the reference list.

Mapping to the stepped-care tiers

Table 2 maps the included sources to the five-tier structure. At Tier 1, sources documented awareness and delivery gaps in universal antenatal education – midwives without confidence or a governing pathway (Terry et al., 2020), women aware of antenatal exercise but not practising it (Gracias et al., 2024), rural–urban awareness differentials (Shinde & Jeevannavar, 2023) and cultural traditions shaping acceptability (Withers et al., 2018), alongside narrative syntheses of the profession’s perinatal contribution (Naureen & Naseer, 2019) – but no evaluated model of routine education delivery. At Tier 2, targeted screening proved workable within existing infrastructure in a rural outreach pilot (Mullerpatan et al., 2022) and a hospital quality-improvement project (Chun et al., 2026), with low postpartum awareness supplying the case for case-finding (Mahishale & Parikh, 2025); sustainability was untested in every instance. Tier 3 held the largest and most varied cluster: a cluster-randomised trial of midwife-led pelvic floor muscle training that improved prolapse symptoms and quality of life (Siyoun et al., 2025), a randomised trial of home-based tele-Pilates for pelvic girdle pain (Akilandeewari et al., 2024), rapidly deployed telerehabilitation (Ramachandra, 2022), a feasible low-resource pilot (Rapp et al., 2024), smaller Indian comparative studies of respiratory and vascular recovery (Augustina et al., 2025; Ramya et al., 2025; Sankarganesh & Lakshmi, 2019), an emerging regional-language measurement infrastructure (Joshi & Rathi, 2024) and clearly documented acceptability barriers (Mishra et al., 2020). Tier 4 was described only in high-income tertiary settings (Diaz-Feijoo et al., 2022; Hickman et al., 2020), with a Nigerian case report of obstetric palsy illustrating the complication burden such capacity would address (Onyekere et al., 2024); no example from a public hospital in a low- or middle-income country was identified. At Tier 5, referrer awareness varied widely across clinical areas and referral practice lagged stated awareness (Kale & Bellare, 2019; Koranteng et al., 2023; Munawar et al., 2013), women themselves lacked signposting (Boulanger et al., 2026; Sushil et al., 2023), general maternal-referral systems showed documentation and transport weaknesses transferable by analogy (Ameyaw et al., 2020), and policy sources supplied rationale without operational detail (World Health Organization, 2017; World Physiotherapy, 2023).

Table 2. Sources principally informing each stepped-care tier, with the evidence pattern observed.

Tier	Stepped-care tier	Sources principally informing the tier	Evidence pattern
1	Universal antenatal education	Terry et al. (2020); Gracias et al. (2024); Shinde & Jeevannavar (2023); Withers et al. (2018); Naureen & Naseer (2019); National Health Mission, MoHFW, India (n.d.)	Awareness and delivery gaps documented; no evaluated model of routine education delivery
2	Targeted screening	Mullerpatan et al. (2022); Chun et al. (2026); Mahishale & Parikh (2025)	Screening shown feasible within existing infrastructure; sustainability untested
3	Basic rehabilitation	Siyoun et al. (2025); Akilandeewari et al. (2024); Ramachandra (2022); Rapp et al. (2024); Mishra et al. (2020); Sankarganesh & Lakshmi (2019); Augustina et al. (2025); Ramya et al. (2025); Joshi & Rathi (2024)	Task-shifted, telehealth and pilot delivery each demonstrated singly; outcome-measure infrastructure emerging
4	Specialist multidisciplinary care	Hickman et al. (2020); Diaz-Feijoo et al. (2022); Onyekere et al. (2024)	Described in tertiary settings; no public-hospital example from a low- or middle-income country
5	Onward referral	Koranteng et al. (2023); Munawar et al. (2013); Kale & Bellare (2019); Ameyaw et al. (2020); Sushil et al. (2023); Boulanger et al. (2026); World Health Organization (2017); World Physiotherapy (2023)	Referrer awareness and referral quality are the weakest links in the pathway

Policy and cultural-context sources appear under the tier they speak to most directly; several bear on more than one tier.

Implementation determinants (CFIR)

Table 3 arranges the charted barriers, facilitators and tested strategies by CFIR domain. Barriers clustered in the outer setting – referrer awareness and attitude gaps, awareness–practice divergence and the national maternal-health strategy’s omission of physiotherapy – and among individuals, where midwife confidence gaps, patient shame and simple unawareness each appeared. Inner-setting barriers were the absence of a consistent clinical pathway governing pelvic floor education and weak inter-facility referral documentation. Facilitators concentrated in simple, structured designs: the task-shifted training protocol, structured antenatal screening, physician engagement during quality-improvement redesign and integration of outreach into existing primary-care infrastructure. Tested strategies were few: a cluster-randomised rollout of a task-shifted protocol, a two-cycle quality-improvement redesign and referral-documentation standardisation. Two cells of the map were empty and are recorded as gaps: no source described a barrier arising from the design of the physiotherapy service itself, and none evaluated the effectiveness of a training strategy aimed at individual clinicians.

Table 3. Barriers, facilitators and strategies mapped to CFIR domains.

CFIR domain	Barriers (n; examples)	Facilitators (n; examples)	Strategies suggested or tested (n; examples)
Innovation characteristics	0 – no innovation-level barrier specific to physiotherapy service design reported (gap)	2 – simplicity of the task-shifted pelvic-floor protocol (Siyoun et al., 2025); structured antenatal	1 – cluster-randomised rollout of a task-shifted, midwife-delivered protocol (Siyoun et al., 2025)

CFIR domain	Barriers (n; examples)	Facilitators (n; examples)	Strategies suggested or tested (n; examples)
		screening protocol (Chun et al., 2026)	
Outer setting	4 – referrer awareness and attitude gaps and awareness–practice divergence (Koranteng et al., 2023; Munawar et al., 2013; Kale & Bellare, 2019); policy silence on physiotherapy in the national maternal-health strategy (National Health Mission, n.d.)	1 – active physician engagement and counselling during quality-improvement redesign (Chun et al., 2026)	2 – referral-documentation and escort-protocol standardisation (Ameyaw et al., 2020); provider education to close awareness gaps (Koranteng et al., 2023; Munawar et al., 2013)
Inner setting	2 – no consistent guideline or pathway for who delivers pelvic floor education (Terry et al., 2020); poor inter-facility referral documentation (Ameyaw et al., 2020)	1 – integration of physiotherapy outreach into existing primary health centre infrastructure (Mullerpatan et al., 2022)	1 – twice-weekly outreach linked to existing primary-care infrastructure (Mullerpatan et al., 2022)
Individuals	3 – midwife confidence gaps in pelvic-floor teaching (Terry et al., 2020); patient shyness and silence (Mishra et al., 2020); unawareness that physiotherapy exists (Sushil et al., 2023)	1 – physician-led counselling normalising pelvic-floor discussion (Chun et al., 2026)	0 – no individual-level training strategy tested for effectiveness (gap)
Implementation process	1 – limited monitoring and evaluation capacity, by analogy from general maternal referral (Ameyaw et al., 2020)	2 – root-cause analysis with staged quality-improvement cycles (Chun et al., 2026); 80% adherence within a structured prehabilitation pathway (Diaz-Feijoo et al., 2022)	1 – two-cycle quality-improvement redesign adding physician counselling after cycle-one review (Chun et al., 2026)

Sources are identified by author and year; full citations appear in the reference list.

Equity dimensions (PROGRESS-Plus)

Place of residence was the best-evidenced equity factor (five sources): rural women faced reduced access and lower awareness, and primary-care-integrated outreach, community task-shifting and telehealth delivery were the demonstrated mitigation routes. Education and health literacy appeared in two sources, with unawareness that physiotherapy existed as an option the most consistently reported access barrier in the Indian qualitative literature identified. Language appeared once, through the Marathi validation of the King's Health Questionnaire, which begins to address regional-language outcome measurement. Income and socioeconomic status appeared twice: transport cost delayed referral in sub-Saharan Africa, and Pakistani public-sector patients received fewer referrals than private-sector patients. Travel burden appeared twice and mode of delivery once, through the obstructed-labour case. Two factors were entirely absent. No source stratified findings by parity. And although telehealth delivery itself was trialled, no source examined whether women's access to devices or connectivity conditioned who those services actually reached – so digital access as an equity stratifier remains unstudied (Table 4).

Reported outcomes (RE-AIM)

Reported outcomes were thin and uneven across RE-AIM dimensions (Table 4). Reach was quantified once, by the rural outreach pilot's 1,800 patients treated over three years. Effectiveness was the most populated dimension (six sources), spanning prehabilitation before gynae-oncology surgery, midwife-led pelvic floor training for prolapse, tele-Pilates for pelvic girdle pain and smaller Indian comparative studies of vascular and respiratory recovery. Adoption appeared in four sources, dominated by the divergence between provider awareness and referral behaviour and, on the positive side, by the quality-improvement project that raised referral uptake from 0% to 50% within six months. Implementation fidelity appeared twice. Maintenance was reported by no source at all: sustainability of any of the mapped service models beyond first implementation is unknown.

Table 4. Equity-relevant findings and reported outcomes, mapped to PROGRESS-Plus factors and RE-AIM dimensions.

Factor / dimension	Sources (n)	Summary of charted finding
PROGRESS-Plus equity factors		
Place of residence (rural/urban)	5 – Mullerpatan et al. (2022); Siyoum et al. (2025); Boulanger et al. (2026); Akilandeswari et al. (2024); Shinde & Jeevannavar (2023)	Rural women face reduced access and lower awareness; outreach, community task-shifting and telehealth are the demonstrated mitigation routes
Education / health literacy	2 – Mishra et al. (2020); Sushil et al. (2023)	Unawareness that physiotherapy exists as an option was the most consistently reported access barrier in the Indian qualitative literature identified
Language	1 – Joshi & Rathi (2024)	Marathi validation of the King's Health Questionnaire begins to address regional-language outcome measurement
Income / socioeconomic status	2 – Ameyaw et al. (2020); Munawar et al. (2013)	Transport cost delayed referral in sub-Saharan Africa; public-sector patients in Karachi received fewer referrals than private-sector patients
Parity	0	Gap – no source stratified findings by parity; first-time versus multiparous differences in uptake are unknown
Mode of delivery	1 – Onyekere et al. (2024)	Obstructed labour causing obstetric palsy was the sole charted mechanism; no comparative data across delivery modes
Travel burden	2 – Mullerpatan et al. (2022); Ameyaw et al. (2020)	Transport delays undermined referral completion; outreach visits reduced travel burden for rural women
Digital / technology access	0	Gap – telehealth delivery was trialled, but no source examined whether women's device or connectivity access conditioned who was reached
RE-AIM outcome dimensions		

Factor / dimension	Sources (n)	Summary of charted finding
Reach	1 – Mullerpatan et al. (2022)	Primary-care-integrated outreach treated 1,800 rural patients over three years
Effectiveness	6 – Diaz-Feijoo et al. (2022); Siyoum et al. (2025); Ramya et al. (2025); Augustina et al. (2025); Akilandeswari et al. (2024); Sankarganesh & Lakshmi (2019)	Prehabilitation improved the perioperative course; midwife-led pelvic floor training improved prolapse symptoms and quality of life; tele-Pilates improved pelvic girdle pain; smaller studies report vascular and respiratory benefits
Adoption	4 – Koranteng et al. (2023); Munawar et al. (2013); Chun et al. (2026); Kale & Bellare (2019)	Referral behaviour varied sharply by clinical area and lagged stated awareness; a structured screening-plus-education protocol raised referral uptake from 0% to 50% in six months
Implementation (fidelity / process)	2 – Diaz-Feijoo et al. (2022); Chun et al. (2026)	The prehabilitation pathway achieved 80% adherence; the quality-improvement project documented staff training and screening fidelity across two cycles
Maintenance	0	Gap – no source reported outcomes beyond the initial evaluation period; sustainability of any mapped model is unknown

Sources are identified by author and year; full citations appear in the reference list.

Policy context and evidence gaps

The most consequential host-country finding is negative: India's national maternal-health strategy defines continuum-of-care standards and referral-transport provisions without naming physiotherapy anywhere as a service component (National Health Mission, n.d.). Absence of a term from a published strategy is not proof of total absence in practice, but it does mean that a hospital establishing an OBG physiotherapy service currently does so without a national policy anchor. Beyond this, the mapping exposed five recurring empty cells: no evaluated model of routine antenatal education delivery; no public-hospital Tier 4 example from a low- or middle-income country; no maintenance outcomes for any service model; no parity-stratified findings; and no analysis of digital access as an equity condition on telehealth reach. Each is a candidate priority for primary research.

DISCUSSION

The clearest signal in this map is a gap between knowing and doing that recurs on both sides of the referral, across countries, decades of publication and study designs. Among providers, Ghanaian obstetricians and gynaecologists reported awareness of physiotherapy's obstetric role in the range of 72.1–91.8%, yet their awareness across gynaecological conditions ranged from 19.7% to 95.1% (Koranteng et al., 2023); in Karachi, 64.7% of specialists knew of antenatal physiotherapy sessions but 18.7% referred to them, 68.0% acknowledged postnatal sessions but 20.0% referred regularly, and 18.7% never advised physiotherapy at all (Munawar et al., 2013); in Aurangabad, general awareness coexisted with limited working knowledge of specific postnatal indications (Kale & Bellare, 2019). Among women, the same divergence appears as awareness without practice in Goa (Gracias et al., 2024), lower rural awareness in Maharashtra (Shinde & Jeevannavar, 2023), care declined for want of privacy and against a culture of silence in Gujarat (Mishra et al., 2020) and non-adherence rooted in not knowing physiotherapy existed (Sushil et al., 2023). That the same pattern surfaces in a well-resourced universal system (Boulanger et al., 2026) suggests the problem is structural – an unbuilt bridge between maternity care and rehabilitation – rather than a simple artefact of poverty.

Against this, the map offers a small set of delivery models, each demonstrated once. A structured quality-improvement redesign moved referral uptake from 0% to 50% in six months using screening, staff training and a written pathway rather than new resources (Chun et al., 2026). Task-shifted, midwife-led pelvic floor training improved outcomes in a cluster-randomised trial

where physiotherapists were scarce (Siyoun et al., 2025). Outreach integrated into existing primary-care infrastructure reached 1,800 rural patients over three years (Mullerpatan et al., 2022). Telehealth improved pelvic girdle pain in a randomised trial and proved deployable at speed (Akilandeewari et al., 2024; Ramachandra, 2022), and a pilot in Belize demonstrated that pelvic-floor therapy can be delivered, and accepted by the women receiving it, in a low-resource setting (Rapp et al., 2024). Single demonstrations are thin evidence, but they are directionally consistent: referral pathways are modifiable at low cost, tasks can be shifted where the workforce is thin, and existing infrastructure can carry new screening functions.

For the framework-development study this review serves, the implications are concrete. Tier 5 problems come first: provider education, a written referral pathway with a standard form, and documentation standards address the best-evidenced weak link, and the referral-quality failures described for general maternal care – poor documentation, no escort protocol, transport delay – supply a transferable checklist of what the pathway must specify (Ameyaw et al., 2020). Screening belongs where women already are, on the precedent of the outreach and quality-improvement models. Basic rehabilitation can be planned around protocolised, teachable interventions with telehealth as a reach extension. Acceptability must be designed in rather than assumed: private assessment space, attention to modesty and confinement traditions, and regional-language materials and outcome measures, for which the Marathi King's Health Questionnaire validation offers a template that a Tamil-speaking setting would need to replicate (Joshi & Rathi, 2024; Mishra et al., 2020; Withers et al., 2018). Specialist multidisciplinary capacity is aspirational for now; no low- or middle-income public-hospital example exists to copy, which argues for building the lower tiers first and defining upward referral criteria.

The gaps matter as much as the findings. Nothing is known about whether any of these models lasts: maintenance was unreported everywhere. Nothing is known about parity, although first-time and multiparous women plausibly differ in both need and ability to attend. Telehealth was tested as a delivery route but never examined as an equity risk, despite depending entirely on device access and connectivity. And the national policy silence means local service-building currently proceeds without a programmatic hook – itself a finding worth carrying to policy audiences.

Strengths and limitations

The review's strengths are its transparency and its structure: a query-by-query search log, a line-by-line screening register with reasons for every exclusion, a fourteen-field charting instrument aligned to a pre-existing protocol, mapping to four established frameworks, checking of every screening decision and charted entry by a second reviewer, and successive verification passes (21–25 August 2026) that corrected charted entries, completed citations against publication records and removed every record that could not be matched to a publication.

The limitations are material and are stated without qualification. First, eligibility decisions and data charting relied on titles, abstracts and bibliographic records rather than full texts; the bibliographic verification pass of 23 August 2026 confirmed fifteen records in full, on 24 August 2026 the published results of every quantitatively cited source were retrieved and each such finding checked against them, and the remaining records were retrieved and bibliographically confirmed by the review team at full-text follow-up on 25 August 2026. Second, the PubMed/MEDLINE and CINAHL exports were truncated at platform caps of 10,000 and 25,000 records while database hits exceeded those figures, so eligible records beyond the caps may have been missed. Third, the automated co-occurrence pre-filter, though fully disclosed, will have removed any relevant record whose title and abstract did not pair a physiotherapy term with an obstetric or gynaecological term. Fourth, records were screened by one reviewer and all decisions were then checked by a second reviewer, rather than being screened independently and in duplicate by both; fully independent duplicate screening is planned for the full-text stage. Fifth, part of the exploratory arm relied on an artificial-intelligence-linked academic search tool, and four protocol-specified sources (PEDro, the Cochrane Library, Web of Science and Google Scholar) were not separately searched. Sixth, two initially retrieved records proved unverifiable and were excluded, and a third was initially charted with an incorrect publication year and was located and corrected only at full-text follow-up (Sushil et al., 2023), and a further record's publication year and pagination were corrected against the journal's own archive during final reference verification (Munawar et al., 2013); these cases are a caution that tool-assisted retrieval demands bibliographic verification of every record. Seventh, grey-literature coverage was limited to two targeted searches, and the formal arm was restricted to English-language records from 2010 to 2026. The included set is therefore a structured, verified map of the readily retrievable literature rather than an exhaustive census.

CONCLUSION

Across 29 sources from fourteen countries and two global policy bodies, the literature on OBG physiotherapy in public-hospital and low-resource settings describes a service that women and clinicians know of more than they use, delivery models demonstrated singly but consistently in the direction of low-cost structural fixes, and a set of silences – on sustainability, parity, digital equity, specialist capacity in public hospitals and national policy recognition – that define the research and advocacy agenda. The map supports building a tiered, equity-informed service framework from the referral pathway upward, and it will next be tested against stakeholder experience in the parent study's interview and co-design phases.

Acknowledgments

The authors thank the clinical and administrative staff of the department hosting the parent framework-development study for their engagement with its design. The exploratory search arm used Consensus, an artificial-intelligence-linked academic search tool; a disclosed automated term co-occurrence rule was applied to two database exports as described in the Materials and Methods; manuscript drafting was assisted by a large language model working from the review's charting workbook and the parent study protocol; and a bibliographic verification pass on 23 August 2026 used the same academic search tool and general web searching to check every included record against publication records. All screening decisions, charted content and interpretations were verified by, and are the responsibility of, the authors.

Funding Source

This review received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors, and no funding source had any role in its design, conduct, analysis or reporting. The funding sources of the included studies were not extracted as a charted variable.

Author Contributions

Beulah Jebakani D: conceptualisation, review design, definition of intellectual content, manuscript preparation, manuscript editing and manuscript review; guarantor. Vijayakumar P: review design, definition of intellectual content, manuscript editing and manuscript review; guarantor and corresponding author. Jeyakumar S: review design, definition of intellectual content, manuscript editing and manuscript review. Sabitha P: clinical input, definition of intellectual content, manuscript editing and manuscript review. Anbupriya M: definition of intellectual content, literature search and manuscript review. Aarthi S: literature search and manuscript review. All authors have read and approved the final manuscript, meet the International Committee of Medical Journal Editors (ICMJE) criteria for authorship, and agree to be accountable for all aspects of the work.

Data Availability Statement

The complete search log, screening register, data-charting instrument and evidence maps are held in the review workbook and are available on request from the corresponding author; the completed PRISMA-ScR checklist, the query-by-query search documentation and the charting instrument accompany this article as Supplementary Materials 1–3.

Declarations

Conflicts of Interest/Competing Interests

The authors declare that they have no conflict of interest.

Compliance with Ethical Standards

This review analysed published literature and public policy documents only; the authors declare that the results of the study do not involve human and/or animal rights, and no ethics approval was required for the review itself. The review forms the evidence-mapping phase of a larger framework-development study whose protocol was approved by an institutional ethics committee and which is conducted in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

REFERENCES

- [1] Akilandeewari, S., Sathya Prabha, B., & Ponmathi, P. (2024). Effect of home based tele pilates on pelvic girdle pain and lumbo pelvic stability among pregnant women: A randomized controlled trial. *Fizjoterapia Polska*, 24(4), 364-370.

- [2] Ameyaw, E. K., Njue, C., Tran, N. T., & Dawson, A. (2020). Quality and women's satisfaction with maternal referral practices in sub-Saharan African low and lower-middle income countries: A systematic review. *BMC Pregnancy and Childbirth*, 20, 682. <https://doi.org/10.1186/s12884-020-03339-3>
- [3] Augustina, S. J., Kamalakannan, M., Radhika, S., Dhanusia, S., & Ravichandran, B. (2025). Efficacy of soft tissue manipulation technique vs therapeutic exercise for an inadequate venous supply in women after pregnancy. *Fizjoterapia Polska*, 25(1), 67-70. <https://doi.org/10.56984/8ZG007DZPX0>
- [4] Boulanger, V., Morin, M., Bernard, S., Hudon, A., Chevalier, L., Gamache, K., Bourget, R.-M., Simard, C., Fortier, O., Gendron, A., Pépin, A., Morin, G., Girard, I., Gareau-Labelle, A.-K., Charbonneau, V., Levasseur, È., Déry-Rouleau, G., & Perreault, K. (2026). Women's perceptions regarding access to pelvic health physiotherapy: A qualitative study. *Disability and Rehabilitation*, advance online publication. <https://doi.org/10.1080/09638288.2026.2649663>
- [5] Chun, R. P. C., Goh, W. L., Kyaw Isabella, K. M. N., & Lim, J. S. K. (2026). Empowering women, strengthening support: A quality improvement project to enhance pelvic floor health awareness. *BMJ Open Quality*, 15, e003940. <https://doi.org/10.1136/bmjopen-2025-003940>
- [6] Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Science*, 17(1), 75. <https://doi.org/10.1186/s13012-022-01245-0>
- [7] Diaz-Feijoo, B., Agusti-Garcia, N., Sebio, R., et al. (2022). Feasibility of a multimodal prehabilitation programme in patients undergoing cytoreductive surgery for advanced ovarian cancer: A pilot study. *Cancers*, 14(7), 1635. <https://doi.org/10.3390/cancers14071635>
- [8] Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *American Journal of Public Health*, 89(9), 1322-1327. <https://doi.org/10.2105/AJPH.89.9.1322>
- [9] Gracias, A., Fernandes, E. N., & Dhuri, Y. J. (2024). Awareness, perception, and practice of antenatal exercise among females in Goa: A cross-sectional study. *Indian Journal of Physical Therapy and Research*, 6(2), 119-128. https://doi.org/10.4103/ijptr.ijptr_242_23
- [10] Hickman, L. C., Propst, K., Swenson, C. W., & Lewicky-Gaupp, C. (2020). Subspecialty care for peripartum pelvic floor disorders. *American Journal of Obstetrics and Gynecology*, 223, 709-714. <https://doi.org/10.1016/j.ajog.2020.08.015>
- [11] Joshi, R., & Rathi, M. (2024). Translation, cross-cultural adaptation, reliability, validation of King's Health Questionnaire in the Marathi language. *Indian Journal of Urology*, 40, 96-100. https://doi.org/10.4103/iju.iju_263_23
- [12] Kale, A., & Bellare, B. (2019). Awareness about exclusive role of postnatal physical therapy: A preliminary survey conducted on obstetricians at Aurangabad, Maharashtra. *Indian Journal of Physiotherapy and Occupational Therapy*, 13(3), 27-30. <https://doi.org/10.5958/0973-5674.2019.00086.8>
- [13] Koranteng, Y. B., Adu-Bonsaffoh, K., & Oppong-Yeboah, B. (2023). Physiotherapy practice in women's health: Awareness and attitudes of obstetricians and gynecologists in Ghana. *BMC Women's Health*, 23, 666. <https://doi.org/10.1186/s12905-023-02705-5>
- [14] Mahishale, A., & Parikh, Z. (2025). Knowledge and awareness of pelvic floor disorders and rehabilitation in postpartum women: An observational study. *Journal of Health and Allied Sciences NU*, 15, S52-S55. <https://doi.org/10.1055/s-0044-1788988>
- [15] Mishra, G. D., Kumar, D., Pathak, G. A., & Vaishnav, B. S. (2020). Challenges encountered in community-based physiotherapy interventions for urinary incontinence among women in rural areas of Anand District of Gujarat, India. *Indian Journal of Public Health*, 64, 17-21. https://doi.org/10.4103/ijph.IJPH_436_18
- [16] Mullerpatan, R., Waingankar, P., Parab, S., Agarwal, B., Nagrale, O., & Dalvi, S. (2022). Pilot implementation of rural rehabilitation services, India. *Bulletin of the World Health Organization*, 100, 662-668. <https://doi.org/10.2471/BLT.22.288168>

- [17] Munawar, H., Tasadduq, A., & Zehra, N. (2013). Awareness of obstetricians/gynecologists regarding the role of physiotherapy services in managing obstetric patients. *Pakistan Journal of Medicine and Dentistry*, 2(1), 17-23. <https://ojs.zu.edu.pk/pjmd/article/view/2945>
- [18] National Health Mission, Ministry of Health and Family Welfare, Government of India. (n.d.). Maternal health strategy. World Wide Web electronic publication (accessed 13 August 2026).
- [19] Naureen, A., & Naseer, R. (2019). Role of physiotherapy in obstetric care. *Pakistan Journal of Physical Therapy*, 2(4).
- [20] O'Neill, J., Tabish, H., Welch, V., Petticrew, M., Pottie, K., Clarke, M., et al. (2014). Applying an equity lens to interventions: Using PROGRESS ensures consideration of socially stratifying factors to illuminate inequities in health. *Journal of Clinical Epidemiology*, 67(1), 56-64. <https://doi.org/10.1016/j.jclinepi.2013.08.005>
- [21] Onyekere, C. P., Jonathan, B. N., & Igwesi-Chidobe, C. N. (2024). Case report: Physiotherapy management of maternal obstetric palsy in a Nigerian teaching hospital [version 1]. *F1000Research*, 13, 367. <https://doi.org/10.12688/f1000research.138647.1>
- [22] Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., et al. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBIC Evidence Synthesis*, 18(10), 2119-2126. <https://doi.org/10.11124/JBIES-20-00167>
- [23] Ramachandra, P. (2022). Telerehabilitation for pelvic girdle dysfunction in pregnancy during COVID-19 pandemic crisis: A case report. *Physiotherapy Theory and Practice*, 38, 2250-2256. <https://doi.org/10.1080/09593985.2021.1898706>
- [24] Ramya, S., Jeslin, G. N., Harini, P. S., Pooja, S., Lakshmanan, N., Jain, M., et al. (2025). Pelvic congestion syndrome management: A comparative study of targeted physiotherapy interventions. *Fizjoterapia Polska*, 25(3), 412-415. <https://doi.org/10.56984/8ZG7D19GXVH>
- [25] Rapp, D. E., Zilliox, J., Sun, F., Jones, M., Little, M., & Mitchell, J. (2024). Pelvic floor therapy program for the treatment of female urinary incontinence in Belize: A pilot study. *Frontiers in Global Women's Health*, 5, 1325259. <https://doi.org/10.3389/fgwh.2024.1325259>
- [26] Sankarganesh, A., & Lakshmi, M. (2019). Impact of physiotherapy care on peak expiratory flow rate among postnatal women with normal vaginal delivery. *Indian Journal of Physiotherapy and Occupational Therapy*, 13(3), 104-108.
- [27] Shinde, A. S., & Jeevanavar, J. S. (2023). Survey on awareness of antenatal physiotherapy among women from rural and urban populations of Maharashtra. *Indian Journal of Physiotherapy and Occupational Therapy*, 17(2), 15-18. <https://doi.org/10.37506/ijpot.v17i2.19227>
- [28] Siyoum, M., Nardos, R., Sirak, B., Spitznagle, T., Teklesilasie, W., & Astatkie, A. (2025). Effect of midwife-led pelvic floor muscle training on prolapse symptoms and quality of life in women with pelvic organ prolapse in Ethiopia: A cluster-randomized controlled trial. *PLOS Medicine*, 22, e1004468. <https://doi.org/10.1371/journal.pmed.1004468>
- [29] Sushil, P., Chawla, J. K., Kumar, P., & Duggal, T. (2023). Exploring Indian women's perception and care seeking behavior towards lumbopelvic pain: A qualitative study. *Journal of Human Behavior in the Social Environment*, 33, 685-697. <https://doi.org/10.1080/10911359.2022.2082621>
- [30] Terry, R., Jarvie, R., Hay-Smith, J., Salmon, V., Pearson, M., Boddy, K., et al. (2020). "Are you doing your pelvic floor?" An ethnographic exploration of the interaction between women and midwives about pelvic floor muscle exercises (PFME) during pregnancy. *Midwifery*, 83, 102647. <https://doi.org/10.1016/j.midw.2020.102647>
- [31] Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., et al. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*, 169(7), 467-473. <https://doi.org/10.7326/M18-0850>
- [32] Withers, M., Kharazmi, N., & Lim, E. (2018). Traditional beliefs and practices in pregnancy, childbirth and postpartum: A review of the evidence from Asian countries. *Midwifery*, 56, 158-170. <https://doi.org/10.1016/j.midw.2017.10.019>
- [33] World Health Organization. (2017). Rehabilitation 2030: A call for action. Geneva: World Health Organization.

[34] World Physiotherapy. (2023). Policy statement: Rehabilitation. London: World Physiotherapy.
<https://world.physio/policy/ps-rehabilitation> (accessed 13 August 2026).

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