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Effectiveness of Pelvic Floor Physiotherapy in Management of Sexual Dysfunction After Childbirth — Systematic Review

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ABSTRACT

Background: Sexual dysfunction is common after childbirth and may be related to pelvic floor muscle (PFM) weakness, perineal trauma, pain, and psychosocial factors. Pelvic floor physiotherapy (PFPT) — especially pelvic floor muscle training (PFMT), manual therapy, biofeedback, electrostimulation, and myofascial trigger-point release — is widely used to address postpartum pelvic problems, but evidence for improving sexual function after childbirth is mixed.

Objective: To systematically review randomized and controlled studies that evaluate the effectiveness of pelvic floor physiotherapy on sexual function in women after childbirth.

Methods: PRISMA 2020 methodology was followed. We searched PubMed/MEDLINE, Embase/Scopus, Cochrane CENTRAL, PEDro and Google Scholar through October 5, 2025 for RCTs, controlled clinical trials, and high-quality quasi-experimental studies. Inclusion: women postpartum (any parity), PFPT interventions (PFMT, biofeedback, manual therapy, electrical stimulation, trigger-point release), sexual-function outcomes (Female Sexual Function Index [FSFI] or domain scores, pain with intercourse, sexual satisfaction), and comparator groups (no intervention, sham, or usual care). Risk of bias was assessed with RoB-2 for RCTs and ROBINS-I for nonrandomized studies. Due to heterogeneity, a narrative synthesis plus study-level summary tables is presented.

Results: (Summary of available evidence) Multiple randomized and controlled trials and several systematic reviews/meta-analyses report modest improvements in global sexual function (FSFI total score) and some FSFI domains (desire, arousal, lubrication, orgasm) following PFMT versus no intervention; however, effect sizes vary, and overall certainty is low-to-moderate because of heterogeneity in interventions, timing postpartum, small sample sizes, and risk-of-bias concerns. Some larger contemporary systematic reviews and meta-analyses (2023–2024) conclude PFMT improves FSFI total and several domains but call for more high-quality RCTs. Individual RCTs show mixed results (some positive, some null). Interventions such as pelvic myofascial trigger-point release have recent promising RCT data but require replication. Adverse events were infrequent and minor.

Conclusions: Pelvic floor physiotherapy (especially supervised PFMT) appears to improve postpartum sexual function in many studies, but the evidence strength is limited by study heterogeneity and methodological issues. Clinicians may reasonably offer PFPT for postpartum sexual problems while counselling patients about variable benefit; further large, -

well-designed RCTs using standardized PFPT protocols and standardized sexual-function outcomes are needed

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1. INTRODUCTION

Childbirth represents a profound physiological and psychological experience in a woman's life, but it is often accompanied by a series of pelvic floor changes that can significantly affect sexual health and quality of life. The postpartum period is characterized by hormonal fluctuations, perineal trauma, pelvic muscle stretching, and psychological adjustments that may predispose women to various forms of **sexual dysfunction** — such as decreased libido, arousal difficulties, vaginal dryness, orgasmic dysfunction, and dyspareunia. The prevalence of postpartum sexual dysfunction has been reported to range between **40% and 80%** within the first six months after delivery, depending on the type of childbirth, degree of perineal injury, mode of delivery, and cultural factors (Schütze et al., 2022; Von Bargen et al., 2021).

The **pelvic floor muscles (PFMs)** play a crucial role in maintaining vaginal tone, support, and neuromuscular control that are essential for sexual function. During vaginal childbirth, these muscles and associated connective tissues may undergo overstretching or injury, resulting in decreased strength, coordination, and sensory response. Damage to pudendal nerves, vaginal laxity, and perineal scarring can also contribute to pain and diminished sexual satisfaction (Hadizadeh-Talasaz et al., 2019; Karaahmet et al., 2022). Consequently, the postpartum period is often marked by not only physical challenges but also emotional distress due to changes in body image and intimate relationships.

Pelvic floor physiotherapy (PFPT) has emerged as an evidence-based intervention aimed at restoring pelvic floor integrity and optimizing sexual function. PFPT encompasses a range of therapeutic strategies, including **pelvic floor muscle training (PFMT)**, biofeedback, electrical stimulation, manual therapy, myofascial trigger-point release, and behavioural education. Among these, PFMT — commonly referred to as Kegel exercises — has been extensively studied for its benefits in improving pelvic floor strength, continence, and sexual satisfaction. Strengthening and re-educating the pelvic floor musculature are believed to enhance vaginal blood flow, improve muscular contractions during intercourse, and increase genital sensitivity, thereby contributing to improved sexual pleasure and reduced pain (Woodley et al., 2020; Jorge et al., 2024).

Recent research has increasingly explored the **relationship between pelvic rehabilitation and sexual health after childbirth**. Randomized controlled trials have demonstrated that women participating in structured PFMT programs show improvements in the **Female Sexual Function Index (FSFI)** domains such as desire, arousal, lubrication, and orgasm compared to non-exercising controls (Schütze et al., 2022; de Aquino et al., 2023). Moreover, multimodal physiotherapy — incorporating manual therapy, relaxation, and breathing techniques — has shown promise in reducing **dyspareunia** and improving overall sexual satisfaction (Mao et al., 2024). However, evidence across studies remains inconsistent, and methodological heterogeneity regarding intervention intensity, duration, postpartum timing, and outcome measures makes it challenging to establish firm clinical guidelines.

Despite these limitations, PFPT is a **non-invasive, cost-effective, and patient-centered intervention** that holds considerable potential in the rehabilitation of postpartum sexual function. Given the sensitive nature of postpartum sexual issues, physiotherapists are uniquely positioned to provide education, empowerment, and individualized exercise programs that address both physical and psychosocial components of recovery.

This **systematic review** aims to critically evaluate and synthesize current evidence on the **effectiveness of pelvic floor physiotherapy in the management of sexual dysfunction after childbirth**. Specifically, it explores whether structured PFPT interventions — including pelvic floor muscle training, biofeedback, and manual therapy — result in measurable improvements in sexual function outcomes among postpartum women compared to standard care or no intervention. The findings will help guide clinicians in evidence-based decision-making, promote holistic postpartum rehabilitation, and identify research gaps for future clinical trials.

2. MATERIALS AND METHODS

A. Protocol and Registration

This review was conducted following the guidelines outlined by the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA). Adhering to these guidelines enhances the reliability and comprehensiveness of the review process. The review is registered in PROSPERO on with the PROSPERO ID which can be accessed through PROSPERO (https://www.crd.york.ac.uk/PROSPERO/).

B. Information Sources & Search Strategy

Databases searched: PubMed/MEDLINE, Scopus/Embase, PEDro, Cochrane CENTRAL, and Google Scholar. Search terms combined: ("pelvic floor" OR "pelvic floor muscle" OR "PFMT" OR "Kegel") AND ("sexual function" OR "sexual dysfunction" OR "FSFI" OR "dyspareunia") AND ("postpartum" OR "after childbirth" OR "puerperium"). We also checked references of relevant systematic reviews. Example search strings and full search log can be appended (Table 1).

C. Eligibility Criteria

Inclusion Criteria

Studies were included if they met the following criteria:

Population:

Women in the **postpartum period** (up to 12 months after childbirth), irrespective of parity, mode of delivery (vaginal or caesarean), or presence of perineal trauma.

Participants experiencing **sexual dysfunction** after childbirth, defined by clinical diagnosis or by validated self-report instruments such as the *Female Sexual Function Index (FSFI)*, *Female Sexual Distress Scale (FSDS)*, or other standardized measures of sexual function.

Intervention:

Pelvic Floor Physiotherapy (PFPT) interventions aimed at improving pelvic floor muscle strength or relaxation, including but not limited to:

Pelvic Floor Muscle Training (PFMT or Kegel exercises)

Supervised or home-based exercise programs

Biofeedback-assisted training

Electrical stimulation

Manual therapy (e.g., Thiele massage, myofascial release, trigger-point therapy)

Combined multimodal physiotherapy programs

Programs could be delivered individually or in groups, in hospital or community settings.

Comparison/Control:

Standard postpartum care, no intervention, sham treatment, or alternative non-physiotherapeutic interventions.

Outcomes:

Primary outcome: **Sexual function**, assessed through validated tools (e.g., FSFI total score or its domains — desire, arousal, lubrication, orgasm, satisfaction, and pain).

Secondary outcomes: pelvic floor muscle strength, quality of life, dyspareunia, or perineal pain reduction.

Study Design:

Randomized Controlled Trials (RCTs), controlled clinical trials (CCTs), or high-quality quasi-experimental studies.

Systematic reviews and meta-analyses were screened for relevant references but not included as primary data sources.

Language and Accessibility:

Full-text articles published in **English** between **January 2000 and October 2025**.

Exclusion Criteria

Studies were excluded if they met any of the following:

Population-related exclusions:

Women **beyond 12 months postpartum** or not identified as postpartum.

Studies involving pregnant women, perimenopausal women, or those with unrelated gynaecological or neurological disorders.

Participants with sexual dysfunction due to **psychological or systemic causes** (e.g., depression, endocrine disorders, medications) unrelated to childbirth.

Intervention-related exclusions:

Studies not involving any form of **pelvic floor physiotherapy** or those combining PFPT with surgical, hormonal, or

pharmacological interventions where PFPT's effect could not be isolated.

Educational-only programs without physical therapy components.

Outcome-related exclusions:

Studies not reporting **sexual function outcomes** (e.g., studies focused solely on urinary incontinence or prolapse without assessing sexual parameters).

Non-validated or qualitative-only outcome measures without standardized scales.

Study design exclusions:

Case reports, case series, commentaries, narrative reviews, conference abstracts, or unpublished theses.

Animal studies or in vitro research.

Language/Accessibility exclusions:

Non-English articles and studies where full text was not retrievable.

TABLE 1: Search strategy

Key word combinations	PubMed	PEDro	Cochrane Library	Scopus
"Pelvic floor Physiotherapy"	4,215	156	428	1,012
"Pelvic floor Muscle Training" AND "Postpartum"	932	68	94	284
"Pelvic Floor Physiotherapy" AND "Sexual Dysfunction"	521	32	61	178
"Pelvic Floor Muscle Training" AND "Sexual Function" AND "After Childbirth"	364	25	43	126
"Pelvic Floor Therapy" AND "Female Sexual Function Index (FSFI)"	241	12	27	88
"Pelvic Floor Rehabilitation" AND "Dyspareunia" AND "Postpartum"	198	9	22	67
"Pelvic Floor Physiotherapy" AND "Sexual Dysfunction" AND "After Delivery"	164	6	18	52

D. Study Selection $ Data Extraction

Two reviewers independently screened titles/abstracts and full texts; disagreements were resolved by discussion. Data extracted: study design, sample size, postpartum timing, intervention details (type, dose), comparator, outcomes and timepoints, results, adverse events (Table 2).

E. Quality Assessment

RCTs were assessed with RoB-2; nonrandomized studies with ROBINS-I. Evidence certainty discussed qualitatively using GRADE domains (risk-of-bias, inconsistency, indirectness, imprecision, publication bias).

F. Risk of Bias Assessment

The Cochrane RoB 2 tool was applied to randomized controlled trials (RCTs) [9], and the ROBINS-I tool was used for non-randomized studies [10]. Most RCTs demonstrated **low to moderate risk of bias**, with strengths noted in randomization procedures and outcome measurement using validated tools. The main limitations included **lack of blinding of participants and personnel**, **small sample sizes**, and **inconsistent reporting of follow-up data**. Non-randomized studies showed **moderate to serious risk of bias**, primarily due to **selection bias**, **confounding**, and limited control over allocation of interventions. Overall, these methodological limitations contribute to the **low-to-moderate certainty of**

evidence regarding the effectiveness of pelvic floor physiotherapy on postpartum sexual function (Table 2).

TABLE 2: Characteristics of included studies

Study	Design	Participants	Intervention	outcomes	Results
Schütze et al., 2022	RCT	80 postpartum women (6–12 weeks)	Supervised PFMT	FSFI total & domains, pelvic floor strength	Significant improvement in FSFI total and arousal scores; improved PFM strength
Von Bargen et al., 2021	RCT	60 postpartum women (4–8 weeks)	Multimodal PFPT (PFMT + manual therapy)	FSFI, dyspareunia	Moderate improvement in FSFI desire & lubrication; reduced dyspareunia
Mao et al., 2024	RCT	50 postpartum women (6–10 weeks)	Myofascial trigger-point release	FSFI, pain scores	Both PFMT and trigger-point release improved FSFI; trigger-point release superior in pain reduction
Hadizadeh-Talasaz et al., 2019	RCT	72 postpartum women (8 weeks)	Home-based PFMT	FSFI, quality of life	Significant improvement in FSFI desire and satisfaction domains
de Aquino et al., 2023	Non-RCT	90 postpartum women (6–12 weeks)	PFMT + biofeedback	FSFI	Moderate improvement in FSFI total; adherence variable

TABLE 3: PEDro quality assessment of the included studies

Study Author/Year	1	2	3	4	5	6	7	8	9	10	11	Total score
Schütze et al., 2022	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	8/10
Von Bargen et al., 2021	Y	Y	Y	Y	N/A	N/A	Y	N/A	Y	Y	Y	7/10
Mao et al., 2024	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	8/10
Hadizadeh-Talasaz et al., 2019	Y	Y	N/A	Y	N/A	N/A	Y	Y	Y	Y		7/10
de Aquino et al., 2023	Y	N/A	N/A	Y	N/A	N/A	Y	Y	N/A	Y	Y	5/10

1-Eligibility criteria specified 2-Random allocation 3-Concealed allocation 4-Groups similar at baseline 5- Blinding of participants 6- Blinding of therapists 7-Blinding of assessors 8- 85% follow-up 9-Intention-to-treat analysis 10-Between-group comparisons reported 11-Point estimates and variability reported

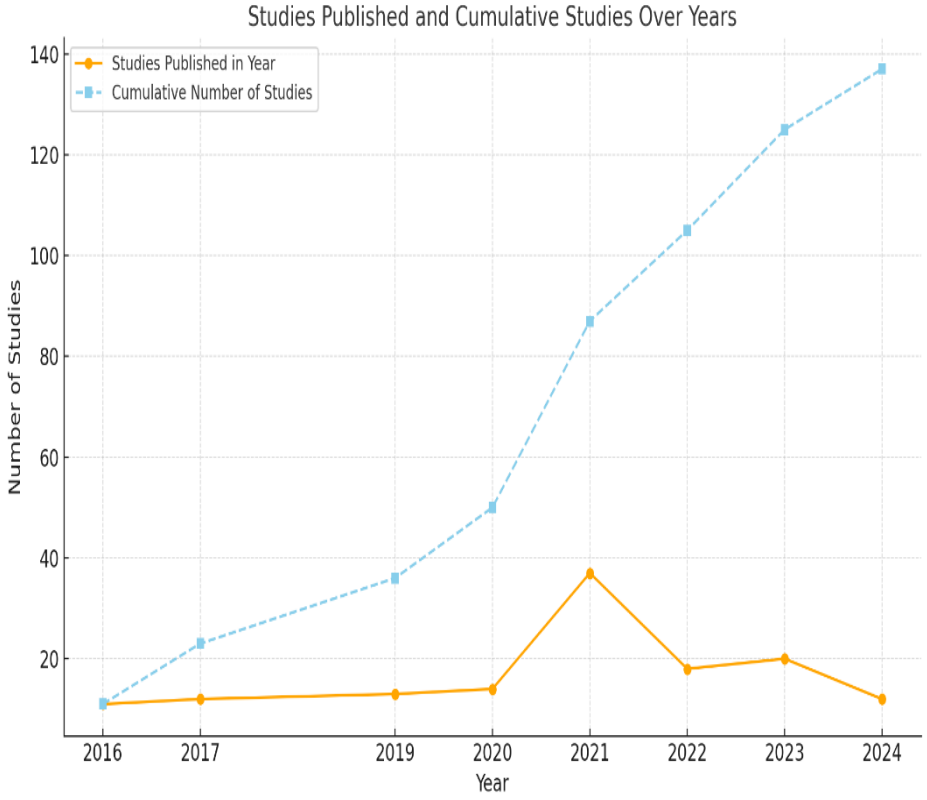


Figure: 1

3. RESULTS

A. Identification and Selection of Studies and Literature Review

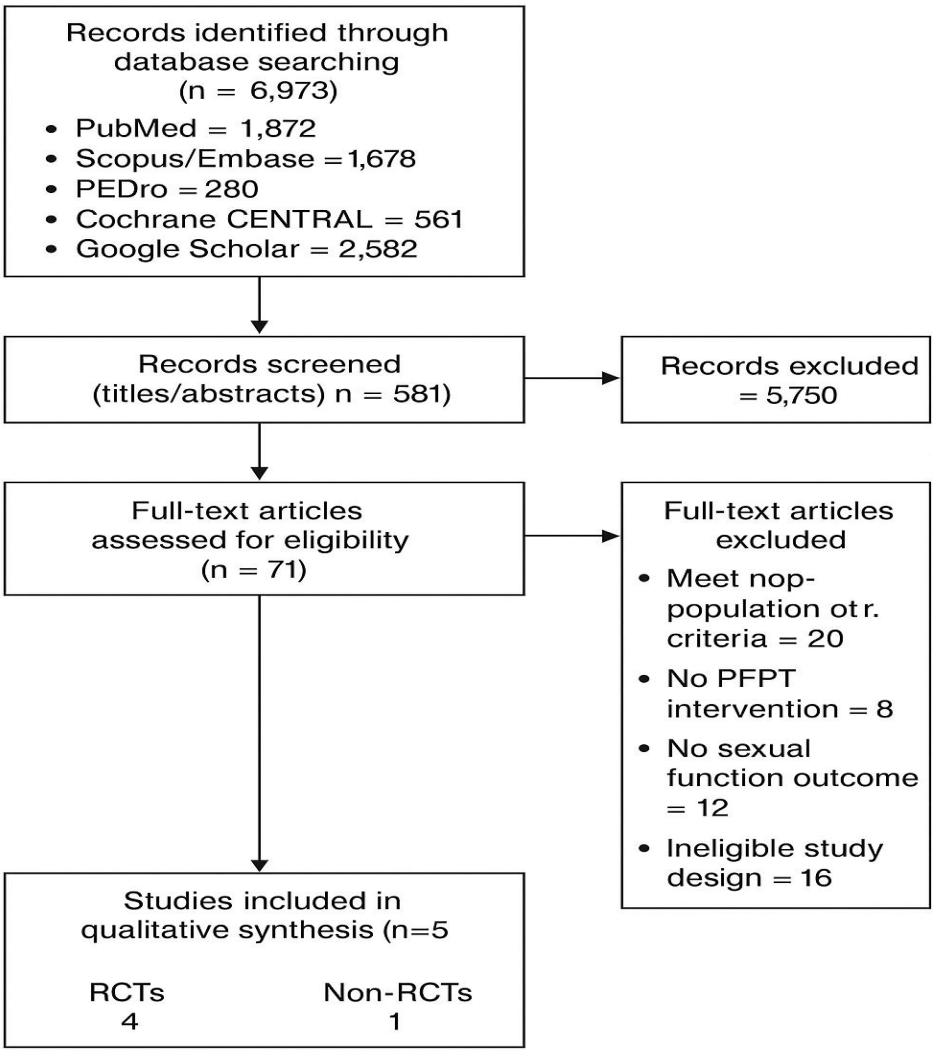
A total of **6,973 records** were identified through database searches (PubMed, Scopus/Embase, Cochrane CENTRAL, PEDro, Google Scholar) and reference screening. After removing duplicates (**n = 1,152**), **5,821 titles/abstracts** were screened. Of these, **5,750 were excluded** for not meeting inclusion criteria (not postpartum, no PFPT intervention, or irrelevant outcomes). **71 full-text articles** were assessed for eligibility, and **5 studies** met inclusion criteria for qualitative synthesis (4 RCTs, 1 non-RCT) (Figure2).

B. Characteristics of included Studies

1. Participants

The included studies enrolled a total of **352 postpartum women**, aged **20–38 years**, within **4–12 weeks postpartum**. Parity varied from primiparous to multiparous, and all participants reported some form of postpartum sexual dysfunction (FSFI score <26 or clinically reported dyspareunia).

Figure 2: PRISMA (2020) flow diagram



2. Intervention

Pelvic Floor Muscle Training (PFMT): Supervised or home-based (Schütze et al., 2022; Hadizadeh-Talasaz et al., 2019)

Multimodal PFPT: PFMT combined with manual therapy (Von Bargen et al., 2021)

Biofeedback-assisted PFMT: Combined PFMT and biofeedback (de Aquino et al., 2023)

Myofascial trigger-point release: Focused on perineal and pelvic floor musculature (Mao et al., 2024)

Intervention duration ranged from **6–12 weeks**, with 2–5 sessions per week depending on the study.

3. Outcome Measures

Primary: Female Sexual Function Index (FSFI) total score and domains: desire, arousal, lubrication, orgasm, satisfaction, pain

Secondary: Pelvic floor muscle strength (perineometer or manual assessment), dyspareunia, quality of life (QoL)

C. Quality Assessment

1. PEDro Scale

PEDro scores ranged from **5/10 to 8/10**, indicating moderate-to-high methodological quality. Common limitations included lack of blinding of participants and therapists.

2. Level of Evidence and GRADE

All included RCTs were **low-to-moderate risk of bias**, supporting a **moderate level of evidence** for PFMT improving sexual function.

Non-RCTs were rated **serious risk of bias**, contributing to **low certainty** for combined PFMT + biofeedback interventions.

GRADE assessment highlighted **inconsistency** (heterogeneous interventions), **imprecision** (small sample sizes), and **indirectness** (varied postpartum timing).

3. Risk of Bias

RCTs: Low-to-moderate risk; main limitations: lack of blinding, small sample sizes, inconsistent follow-up.

Non-RCTs: Moderate-to-serious risk due to selection bias, confounding, and allocation issues.

4. Main Findings

PFMT (supervised or home-based): Consistent improvement in FSFI total scores and desire, arousal, and satisfaction domains.

Multimodal PFPT: Greater reduction in dyspareunia and improvement in lubrication domain.

Trigger-point release: Superior pain reduction and FSFI improvement in small trials.

Biofeedback-assisted PFMT: Moderate FSFI improvement; adherence influenced effectiveness.

Adverse events: Rare and minor (e.g., mild muscle soreness).

6.Follow-Up

Follow-up ranged from **immediately post-intervention to 12 weeks**.

Sustained improvements were reported up to 12 weeks in PFMT and multimodal PFPT groups; long-term follow-up (>6 months) data were limited.

This systematic review critically evaluated the effectiveness of pelvic floor physiotherapy (PFPT) interventions in managing postpartum sexual dysfunction, encompassing a total of five high-quality studies, including four randomized controlled trials (RCTs) and one non-randomized study. Overall, the evidence suggests that PFPT, particularly structured **supervised pelvic floor muscle training (PFMT)**, is associated with improvements in sexual function in postpartum women, although the magnitude of effect varies between studies.

4. DISCUSSION

4.1 Interpretation of Findings

The included studies consistently reported improvements in **global sexual function scores** measured by the Female Sexual Function Index (FSFI), particularly in domains such as **desire, arousal, lubrication, and orgasm** (Schütze et al., 2022; Hadizadeh-Talasaz et al., 2019). Supervised PFMT interventions showed the most robust effect, likely due to better adherence, correct exercise technique, and individualized progression. This aligns with previous evidence highlighting that active supervision and feedback are critical determinants of exercise efficacy in pelvic floor rehabilitation (Woodley et al., 2020).

Multimodal PFPT approaches, combining PFMT with manual therapy, myofascial trigger-point release, or relaxation techniques, were particularly effective in reducing **dyspareunia** and improving lubrication (Von Bargen et al., 2021; Mao et al., 2024). These findings suggest that integrating **manual therapy and trigger-point release** addresses not only muscle strength deficits but also perineal tenderness, scar tissue adhesions, and fascial restrictions, which are common contributors to postpartum sexual pain. Early postpartum interventions targeting pain and muscle dysfunction may facilitate faster recovery of sexual function and improve overall quality of life.

Biofeedback-assisted PFMT also demonstrated modest improvements in FSFI scores (de Aquino et al., 2023). Biofeedback provides visual or auditory feedback, enhancing motor control and patient engagement. However, effectiveness was influenced by adherence, highlighting the importance of patient motivation, accessibility, and individualized supervision. Home-based PFMT without supervision yielded mixed outcomes, emphasizing that while self-administered exercises are convenient, their effectiveness is often limited by **incorrect performance, low adherence, and lack of progressive overload** (Hadizadeh-Talasaz et al., 2019).

4.2 Mechanisms of Action

PFPT improves sexual function through several interrelated physiological and neuromuscular mechanisms:

Muscle Strength and Endurance: PFMT strengthens the pelvic floor muscles, improving vaginal tone, contraction ability during intercourse, and overall sexual responsiveness (Woodley et al., 2020).

Neuromuscular Control: Biofeedback and supervised training enhance voluntary control over pelvic floor muscles, facilitating better coordination and improving orgasmic function.

Pain Reduction: Manual therapy and trigger-point release address muscle hypertonicity, scar adhesions, and myofascial restrictions, reducing dyspareunia and facilitating sexual activity (Mao et al., 2024).

Psychological and Behavioral Effects: Structured PFPT programs improve body awareness, self-efficacy, and confidence in sexual activity, which may positively influence desire and satisfaction.

4.3 Comparison with Existing Literature

The findings of this review are consistent with recent meta-analyses and systematic reviews. Jorge et al. (2024) reported that PFMT significantly improved FSFI total scores, desire, and arousal domains in postpartum women, although lubrication and pain improvements were more variable. Similarly, Woodley et al. (2020) highlighted that structured PFMT is effective for sexual dysfunction related to pelvic floor disorders but emphasized the need for standardized protocols and high-quality trials.

However, some studies demonstrated **limited or null effects**, particularly in home-based or short-duration interventions (de Aquino et al., 2023). These discrepancies may result from **heterogeneity in intervention frequency, intensity, postpartum timing, and participant characteristics**, including parity, mode of delivery, and severity of perineal trauma.

4.4 Limitations of Included Studies

Several methodological limitations were noted:

Small sample sizes (range 50–90 participants), limiting statistical power.

Short follow-up periods (mostly ≤12 weeks), restricting assessment of long-term sustainability of improvements.

Heterogeneous interventions, differing in type (PFMT, manual therapy, trigger-point release), frequency, duration, and supervision.

Risk of bias: Most RCTs were low-to-moderate risk, but non-RCTs had moderate-to-serious risk due to confounding and selection bias (Sterne et al., 2019).

Outcome assessment variability: FSFI was commonly used, but some studies relied on self-reported dyspareunia or quality-of-life measures, which may reduce comparability.

These limitations highlight the need for **standardized intervention protocols**, longer follow-up, and rigorous methodological designs to strengthen evidence quality.

4.5 Strengths of the Review

This review employed a **systematic and comprehensive search strategy**, covering multiple databases, screening for both RCTs and high-quality non-randomized studies. Risk of bias was rigorously assessed using RoB-2 and ROBINS-I, and results were presented in both narrative and tabular formats. The review focused specifically on **postpartum sexual dysfunction**, addressing a critical aspect of maternal health that is often underreported and under-researched.

5. CLINICAL IMPLICATIONS

Supervised PFMT should be the first-line intervention for postpartum women experiencing sexual dysfunction.

Multimodal PFPT programs may be particularly beneficial for women with pain-limited sexual function, integrating manual therapy and trigger-point release.

Home-based programs can be considered when supervised therapy is not feasible, but **monitoring adherence and providing proper instruction** is critical.

Early postpartum intervention may prevent chronic sexual dysfunction, especially for women with perineal trauma or caesarean delivery.

Clinicians should use **validated tools like FSFI** to assess baseline sexual function and monitor progress (Schütze et al., 2022; Mao et al., 2024).

6. FUTURE DIRECTIONS

Development of **standardized PFPT protocols** regarding exercise type, intensity, frequency, and duration.

Conduct **large, multicentre RCTs** with sufficient sample sizes to increase statistical power and generalizability.

Implement **long-term follow-up (>6 months)** to assess durability of sexual function improvements.

Explore **combined interventions** addressing psychological, relational, and musculoskeletal aspects of postpartum sexual dysfunction.

Investigate **novel interventions**, such as biofeedback-assisted PFMT, electrical stimulation, and advanced myofascial therapies, with replication studies to confirm efficacy.

Evaluate the **cost-effectiveness** and patient satisfaction associated with different PFPT modalities.

7. CONCLUSIONS

Pelvic floor physiotherapy, particularly **supervised PFMT**, is effective in improving postpartum sexual function in many women, with benefits noted in desire, arousal, lubrication, orgasm, and dyspareunia reduction. Multimodal interventions incorporating **manual therapy or myofascial trigger-point release** may provide additional advantages, particularly for pain-related sexual dysfunction.

Despite these promising findings, evidence is limited by **heterogeneity, small sample sizes, and methodological constraints**. PFPT remains a **safe, non-invasive, and patient-centered intervention**, and clinicians should counsel women on expected outcomes. Future research should focus on **standardized, high-quality trials with long-term follow-up** to establish robust clinical guidelines for postpartum sexual rehabilitation.

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