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Iranian Women's Experiences of Physical Recovery from Perineal Injuries after Childbirth: A Qualitative Study

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ABSTRACT

Background & aim: The care plan of women with perineal injury during labor does not differ with women without perineal trauma in the health system of Iran, while they are encounter more physical problems after childbirth. The present study was designed to explore the experiences of Iranian postpartum women regarding physical recovery of perineal trauma after child birth.

Methods: This qualitative content analysis was conducted on 22 postnatal women with perineal trauma during childbirth delivered in Ommol-banin hospital, Mashhad, Iran, between 20th of April to 25th of December 2017. Participants were selected purposively until data saturation was achieved. To collect data face-to-face semi-structured interviews were conducted between 10 days to one year after childbirth. Data analysis was carried out using conventional content analysis recommended by Elo and Kyngas (2008) with MAXQDA software.

Results: Physical recovery after perineal trauma was conceptualized as a journey toward normalization of body function to reach physical recovery. Two generic categories emerged from the data including (1) experience of illness and (2) physical rehabilitation. In the first phase, participants confronted many complications such as mobile restrictions, sexual disorders and symptoms of illness. Recovery was achieved by alleviating of these disorders and getting better. Improving physical functions helped to restore emotional recovery as well, when participants recaptured pervious sense of self (normalization), and regained their daily activities.

Conclusion: Women, especially women with severe perineal trauma, in addition to the routine six-week post-partum care, need longer time of receiving care until completing the natural physical recovery process.

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Introduction

Perineal trauma is a serious health problem for women during their childbirth(1). more than 65% of women who experienced vaginal delivery also experienced some degree of perineal laceration(2). This state mother can be experience short- and long-term outcomes (3, 4). perineal trauma is often complicated by challenges due to infection ,persistent pain and sexual disorder, an increased risk for postpartum depression(2). Urinary incontinence and ultimately anal incontinence.(5, 6) ·However in postnatal clinic most focus is on physical problem, and women receive more physical care, but most concerns are more about long-term complications (7, 8). Most midwives and health care providers focus on routine care for early complications such as bleeding, infection, or preeclampsia while other late

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complications, such as urinary problems, anal incontinence are not well described, so there is little information about this also medical records, hospital discharge data are poor way to understand tragic conditions which can threaten the well-being of new mothers .Short- and long-term outcomes could have a long lasting effect on the woman's health and well-being. These outcomes mostly occurred in postpartum period or after it (9).Postpartum period (postnatal) begin immediately after birth until 6-8 weeks after and it is known as recovery period after birth which is associated with psychological, physical and social changes(4,). Majority studies focused on chronic pain, dyspareunia, infection and other physical problem (10). There are little study into account the views and experiences of women with perineal trauma during labor related to physical recovery. Baghirzada and et al(2018) have investigated a short time of recovery after child birth in women with low grade perineal trauma (11, 12). and Priddis and et al(2013) focused on coping and type of coping for their new life in women with sever perineal trauma (13). Woolhouse 's study(2013) compared physical problems during cesarean section and postpartum of normal delivery (15), None of mentioned studies have provided a clear definition of postpartum physical recovery in women with varying degrees of perineal trauma and also there is no definition for the concept of physical recovery.

Although the physical recovery is sometimes defined when the woman is ready to play the role of mother, her body will be retrograde so that the tremendous changes(15), but the question remains as to when the mother feels that her body is back to normal and also This time is not clear when women with perineal trauma feel physical improvement, because it is important to be aware of the maternal perception toward the physical recovery after birth, as they can identify areas for improvement maternal program in postnatal, and thus recommend actions to enhance the physical well-being, those are of great importance in understanding maternal health and evaluating health policies(16). Mothers' experiences by discovering the challenges of the care program can lead to better maternal policies in women with perineal injuries to improve the quality of maternal health(11, 17), Due to the impact of cultural differences on the definition of recovery and the impact of different perspectives(18), it is necessary to conduct a qualitative study. Qualitative study is useful to in- depth understanding of the human experiences (19). Postnatal women with perineal trauma during childbirth are in the best position to describe which factors influence their physical recovery and how they passé this journey and when they feel better. This study, therefore, aimed to explore the experiences of Iranian postpartum women regarding physical recovery of perineal trauma after child birth.

Materials and Methods

This qualitative study was conducted using a conventional content analysis. Research proposal of this study was approved by the Local Ethics Committee affiliated to the Mashhad University of Medical Sciences, Mashhad, Iran (IR.MUMS.REC.1395.568). All interviews were conducted during a time period between 10 days to one year after childbirth in Ommol-Banin Hospital, which is a specialized and educational hospital for women, between 20th April to 25th December 2017. Also it has the highest rate of normal childbirth. Participants included 22 Iranian women with obstetric perineal trauma during their recent vaginal birth, who were selected using purposive sampling. The main characteristics of the participants are shown in table 1.To recruit participants, the researcher needed to access the hospital information system (HIS). Finally eligible women were invited to participate in the study by the first author. For this purpose, the researcher introduced herself to the participants and explained completely the objectives of the study and made them assured that confidentiality and anonymity would be protected. If the participants announced their agreement, written consent was obtained. Out of 25postpartum women who were invited to participate in the study but 22 women accepted to be interviewed. Two participants refused to accept the invitation because of the illness of her mother, who did not have enough time to participate in the interview, and the other one who refused her husband's consent to participate in the study. An interview guide was developed with a focus on the participants'

experiences of the recovery after labor. Interviews included main questions such as: What occurred to you after birth? How do you perceive the physical recovery after birth? When did you feel you get back your health? A semi-structured face-to-face interview with each eligible woman was conducted. The interviews were carried out in Persian by the first author in a quiet place at the Gynecology clinic in this hospital. All interviews were audio-taped, except one, who did not allow and the researcher made note. All interviews lasted approximately 40-70 minutes. Four participants (2, 5, 6 and 22) requested to repeat the interviews because they intended to consult again with their family. Data saturation was achieved after 22 interviews. Maximum variation in sampling in terms of time period past from delivery and degree of perineal tear was considered during the recruitment of the participants. All of the interviews were recorded, transcribed verbatim and imported into the computer assisted qualitative data analysis software (MAXQDA).

Analysis was carried out using content analysis method suggested by Elo & Kings (2008) (20). Inductive content analysis was used for understanding of meaning of physical recovery after child birth with perineal tear because there was no previous studies dealing with the phenomenon. In the first phase of analysis, i.e. 'preparing phase' the transcriptions were read several times to obtain a general sense about the subject. Then the related parts to the study were determined and coded. The first author carried out the data analysis and the other authors supervised the analysis process. The researcher read through each transcript and coded words or sentences or paragraphs of the text related to the subject. Based on the basis of similarities and differences subcategories and then categories developed. For trustworthiness, according to Guba and Lincoln criteria(1989) were used credibility, transferability, dependability, and confirmability (21), Member checking and prolong engagement techniques and expert debriefing were used to provide the aim of credibility, for this purpose, the researcher asked the three participants to feedback after coding the transcript(Member checking), also the researcher had long-term spent a long time with participants for at least a year (prolong engagement) and also, the coded and analyzed texts were sent to third and fourth authors and their corrective opinions were used(expert debriefing). In order to keep dependability, the stages of the research process were described depth and completely until provide the possibility of assess the research steps by other researchers. To ensure confirmability, the decision trail of the study was evaluated through reviewing the process od data reduction and the emergence of subcategories and categories by other experienced qualitative researchers. To maintain transferability, employing maximum variation strategy in terms of parity, degree of perineal lacerations, demographic characteristics and type of delivery (vacuum, vaginal birth after cesarean, spontaneous delivery) as well as providing detail descriptions of the research process were considered.

Results

Out of 22 postnatal women with perineal trauma during childbirth, nine participants had mild degree of perineal injury (1st and 2nd degree tear) and 13 women experienced severe perineal injury (3rd and 4th degree tear). The basic characteristics of the participants are shown in table 1.

Through data analysis two generic categories and four subcategories emerged. The generic category of "experience of illness" consisted of two subcategories of "physical disorders" and "understanding symptoms of illness". Subcategories of the generic category of "physical rehabilitation" included "returning body function" and "subjective health perception (Table 2).

1- Experience of illness

Participants described that illness is a kind of disturbance in their body function after childbirth. They understood the symptoms of illnesses and were certain that they are ill. They experienced the illness through experiencing physical disorders and also understanding the symptoms of illness.

1-1-Physical disorders

Participants experienced physical disorders at this stage. Women with severe trauma experienced disorders which were more severe

and far from their expectations. The most common disorders were restricted movement, failure in wound healing, sexual dysfunction, digestive- defecation disorders and reduced lactation.

Table 1. Demographic and obstetric characteristic of participants

Variable	Mean/ % (N)
Mean age (year)	27.3±8.1
Educational level	
Secondary school and high school diploma	86.36(19)
Higher education	13.64(3)
Parity	
Primparous	63.64 (14)
Multiparous	36.36 (8)
Mode of birth	
Normal vaginal delivery	81.80(18)
Vacuum extraction	18.2(4)
Degree of laceration	
1st and 2nd degree lacerations (+Episiotomy)	40.90(13)
3rd and 4th degree lacerations (sever tears)	59.1(9)
Days since birth	
10-90	27.27 (6)
91-180	18.18 (4)
270-181	22.72 (5)
271-365	31.81(7)

Restricted movement was a common complain that most women with perineal trauma experienced especially women with sever lacerations. The main complain of these participants was difficulty in sitting, standing or walking. Continuing difficulty in movement two weeks after childbirth was not acceptable for most of them.

"It is around at least 60 days, 70 days after childbirth that I could not sit. It's not normal at all, because all women can sit one week after birth or a maximum of two weeks (P5, primiparous, normal vaginal delivery;, Ep+4thdegree).

Table 2. Emerged sub-sub categories, sub-categories, generic categories and main category

Sub-Sub categories	Sub-categories	Generic Categories	Main Category
Restricted movement	Physical disorders		
Failure in wound healing			
Sexual dysfunction			
Digestive-defecation disorder		Experience of illness	
Decreased lactation			
Unwarranted pain and disability	Understanding symptoms of illness		Normalization of body function
Requirement to long-term care assistance			
Healing of repair	Returning body functions		
Elimination of all barriers to the free movement			
Reduced digestive problem			
Enhanced intimacy in relationship		Physical rehabilitation	
Breastfeeding adequacy			
Return to the normal process of life	Subjective health perception		
Sense of healing			

Failure in wound healing was reported due to repair infection, suture opening, re-admission and secondary repair by participants who mostly had

grade 3 and 4 of tear during childbirth. The main complain of these women was lack of hospital follow-up of the patients until the full recovery as well as not being supported financially by the hospital for the cost of the treatment of complications subject to the injuries. Inappropriate repair and the need for secondary repair in the operating room was a problem which was occurred for one of the participants with tear grade 4 due to the disregard of the physician for antibiotic prescription at the time of discharge:

"I went home ... I saw that nothing has been prescribed for me, no acetaminophen, and no antibiotic. Then, on the eighth day, at the clinic, they said that the sutures are not repaired, they hospitalized me again…And then 4 days later, I went to the operating room" (P5, primiparous, normal vaginal delivery, Ep+4thdegree).

Another participant also reported secondary repair of perineum after childbirth and the carelessness of the medical team. She said:

"I realized something that they mistakenly sutured me. So, the doctor came and said to the students, why did you suture from the bottom? I thought that I cannot understand anything else, then they sutured the perineum again (P10, primiparous, vacuum delivery, Ep+4thdegree).

Sexual dysfunction was another complication experienced by the participants. A participant, who had her normal delivery three month after childbirth, complained of postpartum dyspareunia and had no information that it could be physiologic:

"I have sex with my husband, but I have pain, it was not so before ... I do not know whether it is normal or not, I didn't ask anyone" (P19, Normal vaginal delivery, 1st degree).

However, the participants who suffered from severe perineal trauma experienced more severe sexual problems which were never questioned by caregivers. A participant in the eleven month after childbirth reported that sexual frigidity was due to the stretch of the repairing site. She said:

"The stretching of sutures is a bad feeling, which means I'm not good, but I'm afraid of intercourse, I'm sexually cold, I'm screwed (P3, Multiparous ,Normal vaginal delivery, Ep+3rd degree).

Digestive-defecation disorder was another problem that the participants experienced. But one of the participants who was at the end of the first year after childbirth still experienced intermittent periods of constipation and diarrhea, and she gave up follow-up despite its chronic nature and while she still felt discomfort:

"I'm not well, I have constipation or I go toilet frequently, I'm not like before pregnancy, I go toilet frequently, but I didn't go to the doctor again (P2, primiparous, vacuum delivery, Ep+3rd degree).

A participant, who had anal sphincter laceration during childbirth, after six months of delivery, still considered constipation a problematic issue which caused hemorrhoid:

"I got constipation, then I got hemorrhoid, I did not have before it, doctors say that delivery had imposed pressure and you got so, I drink sulfate syrup" (P5, primiparous, Normal vaginal delivery;, Ep+4thdegree).

But the most important problem in women with perineal trauma was difficulty to control gas. One of the participants stated:

"After delivery, the problem that I have is not being able to control gas excretion. Obviously I'm so sad" (P13, primiparous, Vaginal birth after cesarean section; 3 rd degree).

Decreased lactation was another complication that caused by the consumption of medications and mother's illness and her inability to continuously breastfeed and cuddle her baby. One of the participants commented:

"I could not hug my baby well, I could not breast-feed well, I always eat drug and sleep, my baby also sleeps, so did not get any weight. If I was not ill, I hug my baby and I did breastfeeding, and the weight of my baby was not so low" (P2, primiparous, vacuum delivery, Ep+3rd degree).

1-2-Understanding Symptoms of Illness

All participants, when realized that their body functions are different with pre-pregnancy phase, compared their physical condition with others or even with their own previous delivery. The feeling of chronic pain and the feeling of the need for long-term care and treatment, disturbed them and somehow caused the feeling of being different with other normal population. They perceived illness symptoms through

unwarranted pain and disability as well as requirement to long term care assistance.

Unwarranted pain and disability

Most participants with severe perineal trauma considered their experienced physical problems, especially perineal and pelvic pain, as unacceptable and unusual. The participant who had the experience of one previous childbirth expressed that her sparkling pain is unacceptable:

"But this time I had more pain. I had a lot of sutures this time (second delivery). I didn't have the pain like the pain that I have now. At my first delivery, I stood up from the bed about the seven or eight day after birth, although I had sutures, but I did my works myself. I do not know why it has taken so long at this time" (P3, multiparous, normal vaginal delivery, Ep+3rd degree).

Requirement to long-term care assistance

Postpartum women elaborated long-term need to medical care as they required to receive care longer than usual, which is around ten days in Iranian culture:

"Now, I've seen somebody who had normal delivery, after 5 days, not 5 days, but 3 days, she does all of her works herself, but I still cannot do it, after ten day, I went to my mother-in-law house up to 45 days" (P8, primiparous, vacuum delivery, Ep+3rd degree).

2-Physical rehabilitation

In the rehabilitation phase, the participants experienced a way to release of physical disorders and return to their physical health like before pregnancy. Then, they felt that they have gained their lost health (feeling better). Relieving signs of illness affects women's acceptance and feelings. Indeed, they experienced physical rehabilitations through returning body functions and subjective health perception.

2-1-Returning Body Functions

At this stage, women with perineal trauma experienced normalization of their physical condition. The earliest symptom, which its improvement perceived by postpartum women was healing of sutures. They also experienced elimination of all barriers to the movement, reduced digestive problems, enhanced intimacy in relationship and breastfeeding adequacy.

Healing of repair

The participant after two month following childbirth reported that one of the causes of their recovery was timely sutures' absorption.

"I did not have any illness after birth. I was healthy ... my sutures absorbed timely at the second week, day 10 to 12 after childbirth (P22, primiparous, normal vaginal delivery+ EP).

Removal of all barriers to the free movement

Participants described the removal of movement barriers as an important sign of health because movement barriers limited their independency and ability to play a role. A participant in the fifteenth day after childbirth reported that the cause of their health was ability to move:

"I have no problem, I stand up, sit down, and take care of the baby myself." (P4, primiparous, normal vaginal delivery+ 1st degree).

Eliminatingor reducing digestive problems

Relieving digestive problems was another symptom that showed improvement and achievement of the health of women with perineal trauma.

"One month after childbirth, I had severe constipation. I went to the doctor. Three weeks later, she gave three to four pills and a syrup."I got better. I'm so much better. I had defecation" (P3, Multiparous, Normal vaginal delivery, Ep+3rd degree).

Enhanced intimacy in relationship

One participant stated that improving marital relationship was one of the signs of gradual improvement:

"I think that I'm getting better after two months, except that gas execration bother me. I have sexual relationship with my husband. Now, I have no marital problem like before. The pain has become less. For this I feel that I get better and better every day" (P14, primiparous, normal vaginal delivery, Ep+3rd degree).

Breastfeeding adequacy

Some participant believed that due to the medications they received for management of perineal tear, their breast milk secretion was impaired so that they have not adequate milk to breastfeed their children:

"At first, my breast milk reduced. I thought that medicine caused it reduction, then I got better, the drugs finished and my breast milk became enough" (P3, multiparous, normal vaginal delivery+ Ep large).

2-2- Subjective health perception

Participants also understood physical recovery achievement through comparison. Indeed, differences in body functions before and after childbirth turned into similarities. Similarity in physical functions and physical symptoms after childbirth and similarity in the rate of disability and need for care. Subjective health perception was experienced as returning to normal process of life and sense of healing.

Returning to the normal process of life

In the returning phase, participants experienced it as being on the returning process and adapting it to the road of health, as others passes. Most women, even women with severe trauma experienced being better from the second month. One participant said:

"After 25 days of childbirth that hemorrhage stopped, I said that I'm healthy like before (before pregnancy)."I was much better. My headache and backache was relieved. I had defecation. So I thaught I got well (P22, primiparous, normal vaginal delivery+ EP). Another participant stated: "But I'm feeling better. I do not see a problem with my health. The things which are normal and others have, I also have" (P1, prim parous, Normal vaginal delivery+ 2 nd degree).

Family support was the most important factor in facilitating the return to the normal process. One participant in this regard stated:

"They took care of me for 45 days when I got better. Then I myself did the works. It is about two months that I achieved to the first status" (P16, primiparous, vacuum delivery, Ep+3 rd degree).

Sense of healing was the opposite point of need for long-term care. Participants by reaching to ability and self-efficacy confirmed the sense of healing. At the end of one year, some of women with severe perineal trauma did not express this feeling. One of the participants in this relation declared:

"They still help me, whenever I want to go, they taking me, I still rest with their help to reduce my pain, I'm well when I do my works myself" (P3, multiparous, normal vaginal delivery, Ep+3rd degree).

Another participant who had normal delivery with tear grade 2 expressed her health as:

"It is needed to have two months of care, you are better when you can do your works" (P1, primiparous, normal vaginal delivery+ 2 nd degree).

Discussion

This is the first qualitative study in Iran that shows the experiences of women with perineal trauma during the first year after childbirth. The findings of this study include topics that indicate the real perception and experience of women with perineal trauma. The understanding of health recovery after childbirth from the viewpoint of these women involves the experience of a spectrum of changes in the physical dimensions being described as "moving from illness to the physical recovery".

Life after perineal trauma, especially severe trauma, is associated with numerous challenges in the physical dimensions. Movement barriers, failure in wound healing, digestive disorders, sexual dysfunction and decreased breast-feeding are among the complications that involve the life of these patients. Participants perceived the deviation from the normal process of physical recovery through continuous comparisons of themselves with others or sometimes with their previous experiences. The end of the physical recovery process was the opposite point of experiencing illness that arose in the form of physical recovery or returning of the bodily disrupted functions to primary healthy status as pre-pregnancy. In this study the return of women's body function was accompanied by enhanced intimacy of relationship with their spouses.

Removal of digestive-defecation problems, natural healing of sutures and removal of movement restrictions and ability of breastfeeding, all of which were symptoms of promoted women's health. But the sense of health in women was induced by constant comparison, and women compared their previous and current health, ability, and self-efficacy. They also compared themselves with others. A similar concept was developed for recovery after major orthopedic traumas in

England. In this study, the experience of 15 participants during the first 3 to 6 months of traumatic event was studied by phenomenological approach. The patients considered recovery as a journey from repair to rehabilitation. The researchers found recovery phases with three themes: "Getting back on their own feet", "Getting the right help to get there", "regaining a sense of normality"(22). Convergence of this concept with what we found in this study show that despite the difference in the phenomenon under study, societies as well as time, reflect the common nature of the trauma and its consequences on the lives of the patients. Another study also defined postpartum recovery as a range of experiences of physical and emotional disorders to reach the ability of doing daily activities. The main barriers to recovery are breastfeeding and its problems, labor pain, decreased movement, and wound compilations. These researchers have explained the ability of daily activity as a “new normal” (11). These findings are similar to our findings. But in our study, due to the participation of 13 women with severe perineal trauma, the experience of physical disorders was more sever, and the participants stated the alleviation of these symptoms as the first step in their physical recovery. The theme of “new normal” implies the ability to do things and the efforts of participants to reduce the postpartum complications, which in fact expresses the feeling of being healthy. This finding was congruent with our study findings too.

In other study, with a phenomenological approach two themes was extracted as "fearing intimacy" and "managing an unpredictable body". In this study ten women explained their experiences of trauma to pelvic floor during childbirth. Respecting the theme "fearing intimacy", participants pointed out that they afraid of having sexual intercourse with their husband due to confronting dyspareunia. In relation to the second theme, participants explained their inability to control urine or fecal and gas passing. Fear of having sexual relationship with spouse was one of the postpartum health problems (9, 23, 24). One of the main concerns of women with experience of grade 3 perineal tear and anal sphincter injury was the onset of sexual activity due to damage to the repairing site of perineum (25). As the results of this study show, some participants acknowledged it, but in somestudies, it has not been referred to as a barrier of physical recovery (11, 26).

Some of participants in this study stated postpartum dyspareunia, sexual frigidity that these disorders had reduced their marital relationship and they expressed their physical health lower than expected. Gutzeit and et al (2020) reported sexual function is important part of life and health that it does not go back to its baseline levels during the postpartum period and it can attributed to changes in body image, urinary stress, tension and lack of sleep, despite the significance of this issue, midwives or health providers often neglect sexual function during postpartum (27). In Baghirzada's study (2018) entitled "Recovery after childbirth" sexual dysfunction or the mother's need for long-term care or decreased lactation has not been reported, which is inconsistent with Baghirzada's study (11). These researcher examined 32 Canadian women who were mothers during the the first month after delivery and without severe perineal injuries, which could be the reason for this difference because these problems mainly become apparent in the following months.

Postpartum sexual problems were reported at about 43.5% had sexual dysfunction in State of Alagoas, Brazil three months of delivery (2014)(28). And in women with vacuum become more stable until 6 months after childbirth and the need for counseling during this period is necessary(2). Having no control on the body with respect to fecal and urinary incontinence in postpartum recovery in women with severe perineal trauma usually resulted in emotional changes and anxiety(7, 16). In the present study, participants stated their shame and concern from fecal incontinence, while they did not know about its eventual outcome, and some described that their digestive problems to be solved by passage of time.

A qualitative study by Kealy et al. (2010) participated 34 Australian women who had experienced cesarean section a maximum of one year. The researchers explored the themes of experiencing unexpected pain and limited mobility, wound complications and urinary

incontinence (29), while Kealy reported a definition similar to physical recovery similar to with the present study, these women did not expressed sexual dysfunction as a recovery problem

Differences in participants' cultural, emotional, and social supports may be possible reasons. So, further studies are suggested to clarify the issue. Participants and their effect on sexuality are some of the issues that need to be further clarified.

On the other hand, the lack of attention to postpartum problems by health professionals shows the care gaps in the healthcare service delivery. Because, some of the health problems of postpartum women is due to the neglect of the health team. Also there is difference between the views of caregivers and patients about recovery or regaining the health. As the participants' experiences in the present study showed, caregivers had less attention to the subtle feelings and changes that only patients can understand such as sense of healing. Achieving recovery is something that depends on woman's perception of their ability(11). So, regaining physical health from women's point of view takes longer than what caregivers assume. Although not receiving enough care for postpartum complains do not endanger the lives of women in a serious way, but reduce their quality of life and postpone regaining health. The strength of this study was adopting maximum variation strategy in sampling to gain a broader insight into the phenomenon under study. But its limitation was the qualitative nature of the study, which is not generalizable, although the aim of qualitative studies is rather to provide an in-depth, contextualized understanding of different aspects of human experiences. Differences in mood and birth preparedness and complication readiness of women, which affect their pain tolerance and acceptance of birth complications, could affect their experiences of the postpartum recovery.

Conclusion

The results of this study showed that women, especially women with severe perineal trauma, in addition to the routine six-week post-partum care, need longer time of receiving care until completing the natural physical recovery process. Hence, obstetricians and midwives should not consider childbirth as the end point of maternal care and continue their caregiving role until the mother feels better, because physical recovery is achieved when the mother accepts the absence of symptoms. Therefore, researchers suggest that a comparison to be made between the views of delivery team and women who have given birth, especially whom with severe perineal injuries, to investigate the reasons of the difference.

The results of this study can be helpful in designing a patient-centered care with a focus on quality of life, especially, for women with severe perineal trauma. The sense of health in women can determine the time for termination of postpartum healthcare delivery.

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Conflicts of interest

Authors declared no conflicts of interest.

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