

## Social Recovery: A Neglected Dimension of Caring for Women with Perineal Trauma in Iran

### Abstract

**Background:** Social recovery during the postnatal period in women with perineal trauma is a little-known concept. Therefore, this study was designed to explore the experiences of social recovery in women with childbirth-related perineal trauma. **Materials and Methods:** A qualitative approach using content analysis was adopted to study a purposive sample of 22 postnatal women with perineal trauma during birth at Omol-banin Hospital, Mashhad, Iran from April 20<sup>th</sup> to December 25<sup>th</sup>, 2017. The participants were selected between 10 days to one year after childbirth. Data were collected through semi-structured interviews. Conventional content analysis approach was performed, concurrently, with data collection. To organize data, the MAXQDA 10 was used. **Results:** Social recovery after perineal trauma was conceptualized as 'shifting from personal ill-health to interactional empowerment'. Two generic categories emerged from data analysis including 1) impaired individual and social function, which was recognized by social isolation and lack of ability to manage daily life and 2) empowering social interactions, which was characterized by rebuilding social partnerships and returning to an interactive lifestyle. **Conclusions:** Social isolation as the result of neglecting social recovery of women with severe perineal trauma endangers the mental health of mothers. Understanding the concept of social recovery for women with perineal trauma, especially in severe cases, will help health professionals to provide quality postpartum care for women with perineal trauma in a longer period after childbirth.

**Keywords:** Iran, mental health recovery, perineum, postnatal care, social isolation

### Introduction

Perineal trauma are among unpleasant events with high incidence of two thirds of normal deliveries. High grades (third and fourth degree) of these injuries are associated with anal sphincter injuries and rectum involvement.<sup>[1,2]</sup> Although obstetric sphincter injuries are less common and estimated to be about 1 to 3% of deliveries,<sup>[3-5]</sup> some studies reported it between 6 and 11%.<sup>[6,7]</sup> In Iran, the overall incidence of severe cases reported to be 0.5%.<sup>[5]</sup> Due to severe physical and psychological complications, perineal trauma during childbirth, usually threatens maternal health in puerperal and postpartum period.<sup>[8,9]</sup> Puerperium is defined as a period of six-week following childbirth during which the transition to pre-pregnancy status happens. This period is characterized by physiological, psychological, and social changes towards improvement and recovery.

Complications of perineal trauma consisted of physical and mental problems. Physical problems include pain and local discomfort in perineal area,<sup>[10]</sup> infection, persistent pelvic pain, dyspareunia, pelvic floor weakness, prolonged urinary incontinence, and sexual dysfunction. Mental problems are seen as unstable mood and depression, which in severe perineal trauma are deemed as serious complications.<sup>[3,7,9]</sup> Physical complications of perineal trauma affect the quality of marital relationships and repetitive incontinence associated with it threatens the social recovery of affected women due to disruption in their social relationships.<sup>[8,9,11]</sup> Forouzi *et al.* (2009), in a descriptive study showed that poor marital relationships, less spouse attention to wife, inadequate family support, lack of support in caring of infant are the most important perceived social stressors inhibiting women from returning to health during parturition.<sup>[12]</sup> Although Baghirzada *et al.* (2018) in their qualitative study titled

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“Postpartum Recovery”, considered social recovery from a societal perspective with exploratory theme of utilization of care resources in the society,<sup>[13]</sup> Shoorab *et al.* (2019) in a qualitative study regarding women’s experiences of emotional recovery from childbirth-related perineal trauma reported that fecal incontinence following severe perineal trauma threatened the social recovery of affected women due to disruption of women’s social relationships.<sup>[9]</sup> None of these studies (Forouzi, 2009; Baghirzada, 2018 and Shoorab, 2019) provide a clear definition of social recovery in the postpartum period, and so it is not clear what problems women with perineal trauma may face with if their social recovery does not occur. While the role of social recovery has been confirmed in women’s well-being,<sup>[14]</sup> Although social recovery is part of women’s postnatal recovery,<sup>[15]</sup> however, there is no attention to monitoring and managing of the postpartum women’s social recovery in postpartum care records, which are used in the Iranian health system. Findings of different studies showed that physical and psychological aspects are mostly emphasized in postpartum recovery period, while less attention has been paid to other dimensions including social aspects of women’s recovery.<sup>[9,13,16]</sup>

To incorporate the components of social recovery in postnatal care records, it seems necessary to explore the concept of social recovery. To our knowledge, there is no study on social recovery in postnatal period of women with severe perineal trauma, especially in the context of Iranian health system. Given the lack of knowledge and experience for caring of women with severe perineal trauma and to obtain an in depth understanding and insight of social recovery of these women, which is in line with healthcare provision and policy making for maternal health promotion, this study was conducted. The valuable experiences of postpartum women will contribute to a deeper understanding of postpartum social recovery from their perspective. Their experiences along with identification of gaps in the current care plans and promotion of healthcare providers’ knowledge, especially midwives, can lead to better and more thorough policies for mothers with perineal trauma. Therefore, the researchers decided to conduct a qualitative study to explore the experiences of social recovery among women with perineal trauma during childbirth.

## Materials and Methods

This qualitative study, which is part of a larger mixed methods study on developing and validating of an instrument to measure recovery in postpartum women with perineal trauma, was conducted using a conventional content analysis. All interviews were conducted during a time period between 10 days to one year after childbirth in one of the specialized and educational hospitals for women with highest rate of normal childbirth in Mashhad, Iran, between 20<sup>th</sup> April and 25<sup>th</sup> December 2017. Participants included 22 Iranian women who gave

birth to a healthy baby with Apgar score  $\geq 7$  during a normal vaginal delivery, through which a perineal trauma with any degree (from 1<sup>st</sup> to 4<sup>th</sup>) occurred. Participants were selected using purposive sampling with the strategy of maximum variation in terms of time period past from delivery as well as degree of perineal tear. To recruit participants, it was needed to have access to the Hospital Information System (HIS); therefore, at first the permission was sought from the hospital manager to use HIS for searching the eligible participants and their characteristics. The information was sought included phone number and obstetric data (mode of birth and perineal status). Finally, eligible women were invited to participate in the study by the first author. Out of 25 postpartum women who were invited to participate in the study, 22 women accepted to be interviewed. Three participants refused to accept the invitation, two of them due to not having enough time to participate in the interview and the other one for the reason of disagreement of her husband. Exclusion criteria included unwillingness to participate in the study and withdrawal through interview.

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? When did you feel you get back your health? What changes in your social relationships did you experience? How do you perceive the social recovery after birth? 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 room at the gynecology clinic in the hospital. All interviews were audio-taped, except one, in which the participants did not allow her voice to be recorded and the researcher made note. Interviews lasted approximately 40-70 minutes. Four participants (2, 5, 6, and 22) requested to postpone the interviews because they intended to check with their family. Data saturation was achieved after 22 interviews. Each interview was immediately transcribed verbatim and imported into the computer assisted qualitative data analysis software (MAXQDA).

Analysis was carried out using inductive content analysis suggested by Elo and Kings.<sup>[17]</sup> Inductive content analysis was used for understanding the meaning of social recovery after childbirth with perineal trauma, as there was no previous study to deal with the phenomenon under study. This method includes three phases of preparation, organizing and reporting. In preparation phase, the transcripts were read several times to obtain a general understanding and overall insight of the concept, then the related parts to the study were identified. In organizing phase, the process of coding, categorization, and identification of main category was carried out. In reporting phase, the emerged categories regarding postnatal social recovery after perineal trauma was presented in a meaningful manner. The first author carried out the data analysis and the others provided

feedbacks and supervised the process of analysis. For this reason, each transcript was read several times and words or sentences or paragraphs of the text related to the subject were coded. Based on the similarities and differences, subcategories and then generic categories and finally main category were developed.

For trustworthiness, member checking technique was used to establish the tenet of credibility. For this reason, three participants commented on the transcripts after coding. Also it was tried to enhance the credibility of data through conducting interviews with key informants. Expert debriefing, which was provided by the third and fourth authors, was used to make appropriate decisions throughout the analytic process. To maintain dependability, the stages of the research process were described in detail and depth in order to provide the possibility of reviewing the research steps by others. Furthermore, the decision trail of the study was checked through assessing the emergence of subcategories and categories by other qualitative researchers to ensure confirmability. Transferability of data was provided via adopting the strategy of maximum variation in demographic characteristics and degree of perineal lacerations as well as providing detail descriptions of the research process and findings.

### Ethical considerations

Research proposal of this study was approved by the local ethics committee (IR.MUMS.REC.1395.568) affiliated to the Mashhad University of Medical Sciences, Mashhad, Iran. Also, the researcher introduced herself to the women and explained precisely 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. Participants had the right to withdraw at any time from the study without prejudice.

### Results

Twenty-two women with different degrees of perineal injuries participated in this study. Some characteristics of the participants are shown in Table 1. Through data analysis, the main category of “shifting from personal ill health to interactional empowerment” was emerged from two generic categories and four subcategories. The first generic category was “impaired individual and social functions”, which consisted of two subcategories of “social isolation” and “lack of ability to manage daily life”. The second generic category was “empowering social interactions” including subcategories of “rebuilding social partnerships” and “returning to an interactive lifestyle [Table 2].

### Shifting from Personal Ill Health to Interactional Empowerment

The main category of “shifting from personal ill health to interactional empowerment” was emerged from two generic categories of “impaired individual and social functions”

and “empowering social interactions”. Postpartum women with perineal trauma at the beginning of their journey, due to inability to carry out their routine duties, experienced impairment in their individual as well as social functions, which was recognized by social isolation and lack of ability to manage daily life. However, following reduction of their physical problems and regaining their ability to perform pre-delivery routine and daily tasks, they could empower themselves in terms of social interactions, which was characterized by rebuilding social partnerships and returning to an interactive lifestyle. In other words, over the time and in the process of recovery, they moved to the second stage of health improvement process and regained the ability to do the routine tasks and fulfilling social roles. This was reflected by expressing their willingness to engage and interact with others.

### Impaired Individual and Social Function

The category of “impaired individual and social functions” focuses on the participants’ inability of doing selfcare, fulfilling maternal roles, and resuming previous tasks and the impact of all those issues on women’s social function. This category emerged from subcategories of “social isolation” and “lack of ability to manage daily life”.

#### Social isolation

Most participants with major perineal trauma reported reluctance to attendance in social gatherings for certain reasons, mainly due to their physical conditions. However, most of the time, women with minor perineal trauma had no such experience. Restricting or breaking up the social relationships in women with severe perineal trauma was relatively frequent as a result of their embarrassment of postpartum incontinence. They found isolation and acceptance of the situation as the only solution to this post-delivery circumstances.

Six months after delivery, one of the participants with severe perineal trauma, said: *“Having a child after two miscarriages was just a joy... but when I felt bloated I should use the toilet immediately, especially overnight, so I tried to stay at home. I always thought it may resolve spontaneously. My inability to control gas passing restricted me to leave home or communicate with others (participant 14).*

Despite the inner tendency to hold childbirth ceremonies such as baby birth dining party, baby shower, religious ceremonies, and circumcision ceremony, women with severe perineal trauma refrained from those, due to delivery complications such as weakness, pain, and fatigue. One of the participants who suffered from severe perineal rupture and anal sphincter laceration in six months postpartum, said: *“Well, at first I rejected to have baby birth party. I said I am dying and you are going to have a party? My husband and others got upset but then, they had their own little party but I didn’t take part; I just went to bed. I was not in mood to hold circumcision*

**Table 1: Demographic and obstetric characteristics of the participants**

Number of Participant	Age (year)	Parity	Educational level	Birth weight (gram)	Mode of birth	Degree of tear	Days since birth	Treatment approach
1	32	2	Associate degree	3200	ND*	2 <sup>nd</sup> degree	201	Antibiotic + perineal care
2	34	1	Diploma	3500	VD**	Ep***+3 <sup>rd</sup> degree	353	Antibiotic + perineal care + laxative
3	30	2	Diploma	3580	ND	Ep+3 <sup>rd</sup> degree	344	Antibiotic + perineal care + laxative
4	25	2	Diploma	3100	ND	1 <sup>st</sup> degree	15	Antibiotic + perineal care
5	25	1	Diploma	4300	ND	Ep+ 4 <sup>th</sup> degree	159	perineal care + laxative
6	29	2	Primary school	3700	ND	4 <sup>th</sup> degree	192	Antibiotic + perineal care + laxative
7	33	3	Middle school	3800	ND	3 <sup>rd</sup> degree	311	Antibiotic + perineal care + laxative
8	24	3	BSc	2910	VD	Ep+3 <sup>rd</sup> degree	24	Antibiotic + perineal care + laxative
9	26	1	Diploma	2370	ND	Ep+4 <sup>th</sup> degree	189	Antibiotic + perineal care + laxative
10	30	1	Diploma	3900	VD	Ep+4 <sup>th</sup> degree	345	Antibiotic + perineal care + laxative
11	19	1	Middle school	3350	ND	EP	107	Antibiotic + perineal care
12	31	2	Middle school	3780	VBAC****	1 <sup>st</sup> degree	23	Antibiotic + perineal care
13	43	2	Diploma	2480	VBAC	3 <sup>rd</sup> degree	159	Antibiotic + perineal care + laxative
14	25	1	Middle school	3160	ND	Ep+3 <sup>rd</sup> degree	198	Antibiotic + perineal care + laxative
15	19	1	Diploma	3160	ND	Ep+3 <sup>rd</sup> degree	35	Antibiotic + perineal care + laxative
16	29	1	Associate degree	2990	ND	Ep+3 <sup>rd</sup> degree	137	Antibiotic + perineal care + laxative
17	26	1	Diploma	1750	ND	Ep+3 <sup>rd</sup> degree	267	Antibiotic + perineal care + laxative
18	20	1	Middle school	2200	ND	large Ep	56	Antibiotic + perineal care
19	20	1	Middle school	3100	ND	EP	73	Antibiotic + perineal care
20	31	1	Primary school	3200	ND	1 <sup>st</sup> degree	73	Antibiotic + perineal care
21	31	2	Primary school	3020	ND	1 <sup>st</sup> degree	53	Antibiotic + perineal care
22	18	1	Diploma	3030	ND	EP	53	Antibiotic + perineal care

\*ND: Normal Delivery; \*\* VD: Vacuum Delivery; \*\*\* EP: Episiotomy; \*\*\*\*VBAC: Vaginal Birth after Cesarean

**Table 2: Emerged subcategories, generic categories, and main category**

Subcategories	Generic categories	Main category
Social isolation	Impaired individual and social functions	Shifting from personal ill-health to
Lack of ability to manage daily life		
Rebuilding social partnerships	Empowering social interactions	interactional empowerment
Returning to an interactive lifestyle		

party, either: I suffered from perineal pain. I'm worry as it is not clear if I could get my health back" (participant 5).

**Lack of ability to manage daily life**

The participants described their life management as a failure if they were unable to fulfill previous activities or lacked sufficient ability to care of herself. Women with major and minor perineal trauma described the inability in keeping their personal hygiene, nutritional care, and enough rest as loss of control over their life, which was psychologically disturbing. This period was short in women with low degrees of perineal trauma. A primiparous woman with episiotomy during a natural vaginal delivery who had experienced a brief period of this inability said: "At first, I was just tired for ten days, I felt crushed, and I had a sense of fatigue. I couldn't feed myself. I didn't dare to take a bath, I was forced to do it. When you can't take care

of yourself you can't say it's OK, you are not in a good mood" (participant 22).

Another participant, who also suffered from severe perineal rupture, shared a long story of her inability to do personal care. She said: "I couldn't do anything for two months., I was not OK, I felt bad. I couldn't even go to sleep because I suffered from pain and I had to do baby care" (participant 16).

Women with perineal trauma, especially severe ones, suffered from inability to do housework and maternal duties like shopping and housekeeping, breast-feeding and babysitting or older children care for a relatively long period of time. This led to emotional distress due to lack of independence and reliance on others and reduced their control over their lives. More than six months after delivery, a primiparous participant with grade IV laceration, said: "Of course I was upset... I couldn't even do my own work; I couldn't take a bath. I wondered does it get better or not. I couldn't take care of the baby and breastfeed him. It was too hard, I was lying down to breastfeed... If you don't do this you will need somebody to help you... you are in need" (participant 9).

Another participant, who never accepted these problems, said: "How can I say I am OK when I can't be just like I used to be and, you know, do my work... I don't know whether I can carry on my life with my husband" (participant 5).

## Empowering Social Interactions

Regaining of physical ability to take care of themselves, fulfilling maternal roles, resuming previous duties and initiating social functions, helped postpartum women to empower their social interactions. This generic category emerged from two subcategories of “rebuilding social partnerships” and “returning to an interactive lifestyle”.

### Rebuilding social partnerships

Practically, returning to previous jobs, resuming housekeeping tasks, and fulfilling maternal roles showed the improvement of participants’ health status. For women with severe perineal trauma, resuming these tasks could not be accomplished in a short time, as expected. When participants could regain the ability to fulfill expected tasks as their pre-pregnancy status, they acknowledged the recovery. One of the participants in this regard said: “*I can do my work completely... it’s enough to make me sure that I am OK*” (participant 1).

Just like status that showed lack of physical weakness, recapturing the ability to fulfill maternal roles and baby cares was considered as an evidence for women’s recovery. One of the participants in this relation said: *of course I take care of my baby... just as used to be* (participant 21). Another participant, who seriously complained of her perineal tear complications, described her health condition as follows: “*I’ve been better for a month, I mean, I can take care of my baby now, you know, breastfeed him and I could change his diapers*” (participant 5).

### Returning to an interactive life style

Returning to an interactive lifestyle refers to the participants’ diligent efforts to regain their pre-pregnancy abilities and health condition. Women with perineal trauma acknowledging the need for support to recapture their health and active participation in family and society, sought support resources. Being with family (mother, sister, spouse, or mother-in-law) was found to be the best way to compensate inability by participants, especially in women with severe perineal trauma. Caring for these women and their babies or other family children was related to the improved life style, emotional support, and even sometimes financial support of mother, and this was possible with contribution of family members, although sometimes benevolent friends provided another valuable support sources.

Participant No. 2 (with severe perineal tear) described her physical condition as poor. She interpreted her delivery and its complications as something terrible and said: “*The delivery was terrible... I felt thereafter that I’m too weak, I couldn’t stand up for a long time, I wanted to get up, but I had to use my hands to avoid from falling down. I had dizziness so, you know, I asked my mom to stay with me for 40 days, it was a terrible experience. I always had to ask*

*for help even for the simplest things like eating, bathing, etc. until I got better*” (participant 2).

The analysis of the data related to the experiences of the participants showed that although the role of spouses in physical assistance was not as efficient as that of mother and sister, but emotionally it was more important than others. In this regard, participant No. 1, who had experienced mild perineal tear six months ago, considered spouse empathy as the most important factor in her recovery. She said: “*my husband’s attention helped me much more than the others; he healed me so much, I mean, I was not upset any more*” (participant 1).

Some participants, referring to clinics and specialists, believed that the health care provided by the medical team was insufficient for their recovery and they needed supplementary medical care in addition to current care. They did all their best to get most of the existing medical supplies. Nevertheless, some participants were victims of unintentional medical errors, and no compensatory cost or care were provided for them. One of the participant, who was admitted to hospital 10 days after childbirth with pain and vaginal discharge, said: “*I had pain and unusual discharge. After ten days coming back from hospital, they said me that you must goto the operating room again and so I was hospitalized. Finally I stayed for another four days in gynecology department*” (participant 5).

Another primiparous woman referring to the hospital staff, questioned their behaviour and appealed her legal right. She said: *they never said me that you must come to hospital for follow up visit. They just asked me to take my blood test result (for blood glucose level). I didn’t do that... I even couldn’t walk. After forty days, when I wanted to come to hospital, I had to lie down in my car. It was their responsibility to tell me what do I do and, you know, what might happen to me*” (participant 10).

Negligence and medical errors were also reported by some other participants. A participant with vacuum delivery and grade IV tear, which was repaired in the operating room, described lack of follow-up schedule and negligence in administering antibiotics during discharge from the hospital:

“*I was expecting their call me. When it happened they should visit me or at least provide a proper treatment, not just disregarding an important thing like prescribing antibiotics. It was prescribed in the clinic; the doctor gave me some medications there. Honestly, I have a bad memory of this hospital, I have nothing to say*” (participant 8).

While there was no compensation or special care for these errors, one participant who suffered from severe perineal trauma during her second delivery said: *Now they must compensate the costs, how can I afford it? They caused it... my husband is a construction worker and now he is unemployed for a while... I visit a doctor several times for*

*my stitches. After discharge from hospital, I visit the clinic but now they don't admit me and say that I must visit doctor in the office. I am going to get health insurance; if I was covered by insurance I do visit the doctor (participant 6).*

There were various reasons for failure to follow medical recommendations. For participant No. 14, forgetting the recommendations was the reason and thus she said: *"I just couldn't remember what they said (participant 16).*

Another participant referred to her inability due to sickness and being busy and unaware of its importance: *I was not able to do all of that because I was sick...and I was busy and, you know, I didn't know that it is too important (participant 2).*

## Discussion

The findings of this study showed that from participants' perspective, social recovery is a progressive process from ill health towards interactional empowerment. Tendency to social isolation was the beginning of a course that was dominated by the inability to overcome the unpleasant physical conditions. At this stage, depending on the severity of the perceived illness, women's willingness to interact with others reduced even with family members and relatives so that they preferred to be alone. They also departed from their cultural beliefs and values. Over time in the postpartum period, women's diligent efforts to improve the conditions leads to improvement in their personal abilities. The experience and understanding the altered situations was the starting point for recapturing family roles and resuming duties. In this circumstances, women empowered themselves in terms of social interactions getting family and social support, and achieved social recovery, which was characterized by rebuilding social partnerships and returning to an interactive lifestyle.

To our knowledge, no study have reported the concept of postpartum social recovery in women with childbirth-related perineal trauma. But the concept of social isolation as the preliminary step of social recovery in postpartum women with severe perineal trauma due to physical and psychological complications was reported in a meta-ethnographic synthesis of four qualitative studies by Pridis and Dehlan.<sup>[18]</sup> In our study, participants also expressed their emotional concerns associated with disability or marital dysfunction. Similarly, "never being happy" was reported as a sub-theme in a qualitative study with a phenomenological approach on 12 women with severe perineal trauma in Sydney, Australia. In that study, participants described childbirth as an event that ended their emotional and sexual lives; women said that they lost their anal control and this issue disrupted their sexual relationships and even their maternal roles.<sup>[19]</sup> The social recovery explained in our study is somewhat consistent with Glover's model of psychological recovery stages. In the Glover's model, sense of self from passive to active status was the beginning of psychological recovery,

while this transformed to move from disconnectedness to connectedness at the last stages. According to Glover, at the beginning of the recovery process, the patient strive to receive necessary services, thus transforme from a passive state to an active state in her quest for her own abilities. In the last stage i.e., connectedness, she moves away from disabled identity, so that willingly accept roles and responsibilities.<sup>[20]</sup>

The similarities in parts of the social and psychological recovery processes implies the interconnections of mental and social recovery domains. In a part of proposed psychological recovery model, Jacobson and Greenley (2001) referred to the social factors. They classified effective social factors to one's health in existing social factors (external factors) such as policies or cultures governing treatment sectors and individual social factors such as family support and employment (communication).<sup>[21]</sup> These scientists believed that defined psychological recovery depends on family and community support. Therefore, some researchers consider social recovery as part of mental health recovery.<sup>[14]</sup> In this study, women also made extensive efforts to get benefit from family support to gain the ability to control their own lives. Although, traditionally family members (mother, sister or even spouse family members and friends) provide care and support for a postpartum woman for about ten days after birth, in certain cases, where they needed more support they asked it from family. But postpartum women considered spouse support as the most important source, which included physical and practical support, in addition to emotional support. Many studies have also indicated the lack of spouse or parents' support as an important barrier to postpartum women's recovery.<sup>[22-24]</sup> Social interactions meet emotional, cognitive and even financial needs and thus has a positive effect on individuals' health.<sup>[16]</sup> So, it seems essential to use family-based supportive interactions, especially with the participation of spouses to give these patients deserved health care.

In this study, seeking medical services, cares, and receiving the necessary information were the basis for participants' efforts for improvement. Although the majority of participants acknowledged that they were provided wound care instructions during their hospitalization or discharge by midwives and nurses, nevertheless, forgetfulness, physical weakness, inappropriate perineal care at home, and lack of awareness of the importance of perineal care were cited as reasons for prolonged sickness. Therefore, proper interaction between the health care teams and mothers is essential for timely education and emphasis on its importance.

If we consider the lack of social determinants that influence social recovery, such as awareness raising and deprivation from healthcare services as social oppression and inequality in community, the ethical codes for the society dictates recognition of people's needs, planning for resolving

problems, responsibility, accountability, and integration of health services.<sup>[25]</sup> Therefore, solving problems of those patients who suffer from severe perineal or complicated trauma due to medical errors, in the form of follow-up visits in special postnatal units, as recommended by Swenson,<sup>[26]</sup> would be an ethical care for these victims. Midwives specially are the health professionals who could ask for the status of women's support, the level of their awareness, the quality of their care, and as a consequence could give the plans for potential gaps. Also, developing special healthcare records incorporating questions about having a source of supporting the family, insurance coverage and awareness of wound care instructions will be helpful. Active care by healthcare centers and hospitals to follow-up these patients would be a justice-centered response to all medical errors that sometimes occur in the field of maternity services.

It is notable that emotional and financial issues were not considered in the exploration of social recovery in this study, which are the limitations of this research.

## Conclusion

Sometimes due to physical complications of childbirth-related perineal trauma, especially in severe cases, postnatal recovery process of patients would be disrupted and it leads to women's isolation. However, following reduction of their physical problems and regaining their ability to perform pre-delivery routine and daily tasks, they could empower themselves in terms of social interactions. Starting the activities both at home and the community, promises this improving process. To enhance social recovery of postpartum women in the community, healthcare policy makers need to make those health care centers and clinics responsible for taking care of postpartum women. In this regard, health care professionals, particularly midwives, should provide a quality postpartum care for women with perineal trauma in a longer period after childbirth.

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## Conflicts of interest

Nothing to declare.

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