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# The Impact of Perineal Trauma on Postpartum Women at Ndola Teaching Hospital, Zambia: A Phenomenological Study

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## Abstract

Perineal trauma following childbirth affects over two-thirds of women in low and medium-income countries (LMICs) birthing in health facilities. Although it is an unfavourable outcome with the potential to affect many aspects of a woman's well-being in both the immediate and long-term, it is still a neglected phenomenon of women's health, particularly in sub-Saharan African countries like Zambia. This study sought to understand the impact of birth perineal trauma on postnatal women at Ndola Teaching Hospital (NTH). This study employed a cross-sectional qualitative design using a descriptive phenomenological approach. Fifteen women who had birthed at NTH and sustained birth perineal trauma were purposively sampled as study participants. Data were collected through face-to-face interviews aided by an interview guide. Four themes, namely, perineal pain, substandard perineal wound management, fear of future reproductive health outcomes and diversion from reality, emerged from the study. Most women experiencing childbirth perineal trauma do not receive adequate care to manage their condition effectively. Therefore, midwives should utilise their professional knowledge and skills when providing postnatal care because morbidity affects women. Thus, it has the potential to negatively affect mother-infant bonding. The study concluded that birth perineal trauma is a distressing phenomenon of childbirth; hence, skillful repair, pain management and sexual counselling can greatly reduce its negative impacts.

## Keywords

Perineal Trauma, Birthing Women, Perineal Pain, Impact

## 1. Introduction

A maternal morbidity is a health condition which is caused by or complicates pregnancy and childbirth and has a negative impact on the woman's well-being and her overall functioning [1]. Perineal trauma is the most common maternal morbidity that is experienced by women during childbirth, yet most women are least prepared for it [2]. This lack of preparation leaves women feeling traumatised, especially if midwives do not understand the severity of the damage [3]. Perineal trauma following childbirth is reported to affect about 70% of women in low and medium-income countries (LMICs) having vaginal births in health facilities [4]. The perineum comprises muscular and fibrous tissues between the anus and the vagina which are subjected to enormous pressure and stretching during childbirth, predisposing it to trauma [5]. Homer and Wilson [6] define perineal trauma as damage to the perineum during the birthing process which can occur spontaneously or intentionally because of an episiotomy.

The study conducted in Kenya by Pinder *et al.* [7] revealed that most midwives had not received training in the identification and repair of perineal injuries and referred women with severe birth trauma to higher levels. Perineal evaluations were compromised by challenges such as heavy workloads, lack of supplies, and poor lighting at night, which further compromised perineal evaluation [7]. In many LMICs, nurse-midwives are the majority of specialized frontline workers who attend to women during childbirth and, hence, play a critical role in identifying perineal traumas. A study conducted in Malawi explored childbirth fear and associated factors among pregnant and postpartum women and found that almost 50% of the participants had moderate to high childbirth fear in the perinatal period. However, they preferred a vaginal birth instead of a caesarean section [8]. Further findings from this study were that childbirth fear was attributed to the pain experienced during and after suturing.

A study was conducted by McDonald *et al.* [9] at a national referral hospital in Uganda among mothers attending a postnatal clinic reported that the mode of delivery might influence the timing of resumption of sexual intercourse. This study illustrates that women who had a vaginal delivery with sutured perineum were far less likely to resume intercourse early compared to women who had an intact perineum or a caesarean section. Cultural demands can influence resumption of intercourse, with some societies resuming within the first week after delivery with the belief that this helps to heal the wounds and to bring good health to the baby [10]. This is against the postnatal recommendation in the intrapartum guidelines to resume sexual intercourse after six weeks [11]. The recommendation of this Uganda study was that the midwife attending to women who sustain perineal trauma should use her/his cultural competence to advocate for women to avoid problems such as infection or wound dehiscence that can result from early resumption of sex before healing takes place.

The WHO [11] postpartum care recommendations are that during each postnatal contact, comprehensive history should be taken and assessments of micturition,

urinary incontinence, bowel function, and healing of any perineal wound should be made as these may be compromised especially in a woman who has a perineal trauma. However, studies conducted at two general hospitals in Zambia reported that the conduct of a physical examination on postnatal mothers is suboptimal [12]. Furthermore, a study conducted at Ndola Teaching Hospital in Zambia showed that the majority of the mothers were less satisfied with the information they received during hospitalisation in their postnatal period. Evidence-based information should address specific women's problems including coping with a perineal trauma.

Perineal trauma during the birthing process affects several birthing women at Ndola Teaching Hospital (NTH), as illustrated by the statistics in Table 1.

Table 1. Perineal traumas at NTH, 2019 to 2023.

| YEAR | 1st QUARTER | 2nd QUARTER | 3rd QUARTER | 4th QUARTER | TOTAL |
|---|---|---|---|---|---|
| 2019 | 1153 | 540 | 546 | 605 | **2,844** |
| 2020 | 631 | 597 | 605 | 484 | **2,317** |
| 2021 | 678 | 746 | 688 | 632 | **2,744** |
| 2022 | 455 | 425 | 483 | 823 | **2186** |
| 2023 | 568 | 298 | 485 | 584 | **1935** |
| | | **CUMULATIVE TOTAL** | | | **12,026** |

The statistics in Table 1 show that perineal trauma occurrences over the 5 years period have been fluctuating, with the highest incidence recorded in 2019 and the lowest in 2023. Approximately 7762 had vaginal births and 1935 sustained perineal trauma indicating a 25% incidence of morbidity in 2023.

While several interventions in maternity care are targeted at preventing and managing maternal morbidities, the morbidity of perineal trauma is still a neglected phenomenon of women's health in Africa [13], and NTH in Zambia is no exception. The common occurrence of perineal trauma during childbirth and limited data on its impact in this locality prompted the researchers to conduct this study so as to answer the research question "what is the impact of perineal trauma on postnatal women at Ndola Teaching Hospital in Zambia?"

## 2. General Objective

To explore the impact of birth perineal traumas on postnatal women at Ndola Teaching Hospital (NTH).

SPECIFIC OBJECTIVES

1. Elucidate the impact of birth perineal traumas on postnatal women at NTH.

2. Appraise the postnatal care accessed by women who sustain perineal traumas at NTH.

3. Extrapolate the coping strategies of postnatal women who sustain perineal traumas at NTH.

## 3. Methodology

This was a cross-sectional descriptive phenomenological study. Qualitative design allows comprehension of different manifestations of a phenomenon because it offers flexible and versatile means to understand women's experiences [14]. Phenomenology allowed participants to express their diverse and subjective nature of phenomena [15], hence providing an in-depth understanding of the phenomenon. This was essential in that the phenomenon of perineal trauma relates to a private matter which women may not ordinarily describe unless they are purposefully engaged.

Detailed descriptions provided vital information on the impact that birth perineal trauma had on women's lives as they saw fit. The study conducted at NTH targeted women who were 24 hours to six months in the postpartum period and had sustained a perineal trauma. Fifteen key informants were purposively selected based on data saturation. Data were collected by the researchers from the homes of the participants using an interview guide with the following questions:

1. Please tell me about how you sustained a perineal trauma during your last childbirth.

2. In which ways has having a perineal trauma impacted you?

3. What were some of the thoughts you remember having during the experience?

4. How would you describe the care that you received from the health workers to manage the trauma?

5. How did you deal with your problems of the perineal trauma?

6. Can you suggest what you think would be useful for another woman in your situation?

Face-to-face interviews lasting between 10 and 40 minutes were conducted. To ensure trustworthiness, the study utilised the Four-Dimensional Criteria (FDC) developed by Lincoln and Guba in 1985 [16]. Upholding credibility, dependability, confirmability and transferability were observed as important factors in maintaining research quality. Ethical clearance was granted by the University of Zambia Biomedical Research Ethical Committee and the National Health Research Authority in Zambia.

## 4. Data Analysis

Data analysis was conducted concurrently with data collection. The content analysis proposed by Graneheim and Lundman in 2004 [17] was used to analyse the data.

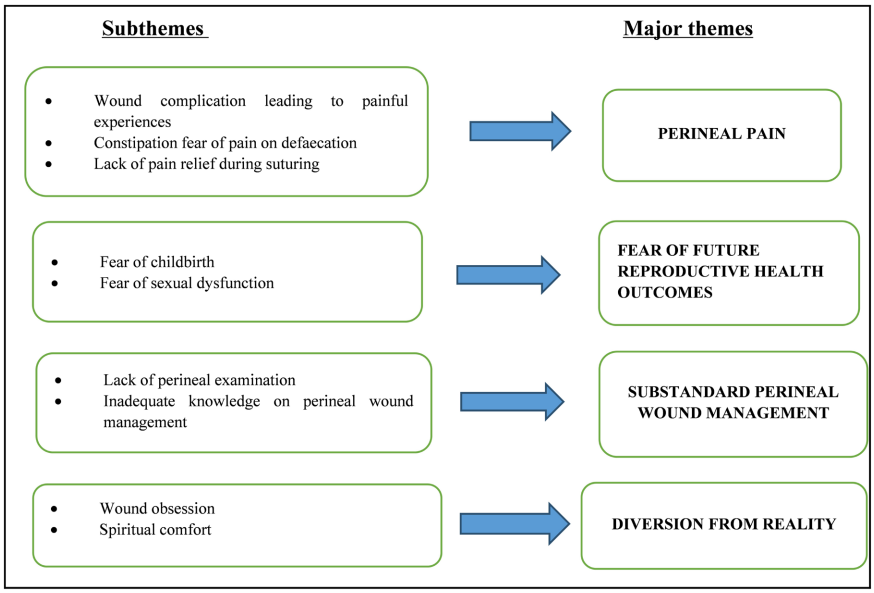
The researcher transcribed each audio recording verbatim and read through the field notes immediately after each interview. The texts were divided into meaning units, which were quotes from interviews related to each other through content or context. The meaning units addressed the aim of the study. The lengthy meaning units were summarised into condensed meanings while preserving the core meaning to facilitate easy data analysis. The final step involved assigning codes to

the condensed meanings which were compared to each other, based on differences and similarities, and then sorted into subthemes. Figure 1 illustrates the similar codes which were grouped into subthemes from which the four major themes namely, perineal pain, fear of future reproductive health outcomes, substandard perineal wound management and diversion from reality emerged.

## 5. Findings

### 5.1. Socio-Demographic Characteristics of Participants

The majority [9] of the participants were between 20 and 29 years old, but the youngest participant was 18 years old, while the oldest was 37 years old. Almost all [12] were married with two single and one engaged participant. Nine participants were primiparous. Five [5] were para 2 and para 5. Midwives conducted deliveries for eleven participants with two conducted by the doctors and two being unassisted deliveries. Episiotomy was the commonest type of perineal accounting for eleven [11] while four [4] had spontaneous second or third degree tears. During data collection, the majority [13] were within six [6] weeks postnatal period.




Subthemes and major themes

Figure 1. Presentation of findings.

### 5.2. First Theme: Perineal Pain

This theme described participants' narratives of pain due to the presence of the perineal wound. Although one participant compared perineal pain to labour pain, she went further to state that perineal pain was more because she continued experiencing it way after she was done with labour. She said the following:

"Both of them are painful. They can just be the same…but I think the wound is more painful because with the labour pains, once I delivered the pain stopped.

The pain for the wound you continue going with it until the wound heals."

A participant who had a caesarean section during a previous delivery made a comparison between the pain of a caesarean wound and perineal wound. She too described perineal pain as being more. She stated:

"I never knew an episiotomy was eh! I just don't know how to describe it… I think the pain I felt after my caesarean section was not as much as the pain I felt after an episiotomy."

The pain that was experienced was not only described as being physical; at times, it was described as being psychological. One participant who experienced a third-degree tear and was interviewed three months after the experience narrated:

"The pain, that pain never goes. The pain of labour goes but the pain of being stitched, you stay with the wound and the pain never goes. I still have it even now. At some point when I remember what I went through I even developed goose pimples. I really feel chilled! Yes, it comes now and again. It will just click in my mind. You just see a scissors and the needle. You even feel weak in the knees."

Participants did not end up just describing the pain from the wound; they also described how the pain impacted their day-to-day lives, such as sitting when breastfeeding. One primipara had this to say:

"In the night she wakes up and starts crying, I have to get up to breast feed her but I can't do that lying down. The struggle comes when I have to sit. It is a lot of work because it really pains."

Avoidance of feeling pain when sitting thus, impacted the duration that some mothers breastfed their infants as narrated by this participant:

"Even just breastfeeding the baby, I had to sit at the edge of the chair to avoid pain. I would get tired… I would remove her from the breast when she really wanted to be breastfeeding."

### 5.3. Wound Complications Leading to Painful Experiences

Although pain was reported by almost all the participants at the time that the wound was occurring and during its management, those who experienced wound complications reported to have undergone more intense and prolonged perineal pain. Participants attributed the complications to reopening to improper supervision of trainees learning how to repair perineal tears and the use of the wrong suturing material. A 26-year-old participant, whose perineal tear reopened at home attributed her complication to improper suturing. She said:

"Mmmmm, it wasn't all that good. I could feel the way they are suturing me is not right, but just because I was in pain, I couldn't do anything. The only thing that was going on in my mind was to let her suture me so that I should rest. She sutured me…, I heard her saying to herself what have I done? Anyway, just like this. After three days, I discovered that it had reopened."

Similarly, an 18-year-old primipara lamented how on arrival to the postnatal ward from labour ward after delivery, the receiving midwife checked her wound and found that it had reopened. She narrated that she was sent back to the labour

ward for re-suturing, which was done two hours later. As if this ordeal was not enough, she stated that her wound reopened again at home after one week. Reflecting on the pain she narrated:

"When I went to postnatal ward, they checked me and found that my wound had reopened, the person who sutured me did not do it properly so I was taken back to labour ward for them to redo the suturing. Yea! There was a lot going through my mind, I thought of the pain I went through and having to go through it again. After one week at home, the wound opened again! Going to be sutured again! I am really worried because this will be the third time for them to repair my wound."

Some participants attributed improper suturing to be a result of trainees conducting repairs unsupervised. One participant narrated how she agonised as the trainee who sutured her was told by the midwife upon finishing that the suturing was incorrectly done; hence, the stitches needed to be removed and suturing done afresh. She was discharged and two days later the wound reopened at home. She went to the local clinic where she was told that the wound was bad and was discharging pus; therefore, she had to be referred back to the hospital for re-suturing.

"I was expecting the people who were knowledgeable, those who had more experience, the people who knew what to do to work on me. He was just told that this was not how it was supposed to be done, and the person who was advising him left the place. Two days later the wound reopened at home. At the clinic they checked the wound and said it had reopened and it started discharging some pus. I ran out of strength and just became speechless. I thought of the pain I had to go through again! It was just too much."

Reopening of perineal wounds often led to infections and exposed women to more severe pain, prolonged worry about the possible outcome of the wound, and impact on future health. A primiparous narrated:

"I cried actually, I felt bad, I really felt bad like…am damaged now, there's pus coming out. The pain and the kind of suturing! The condition was very bad and then the other senior doctor said okey we need to admit you because the wound is very bad. From there, I have been psychologically disturbed because I always think about it like… Am I going to get cured?"

### 5.4. Constipation Due to Fear of Pain on Defaecation

Constipation came out prominently in participants' responses as one of the impacts of perineal trauma. A primiparous participant who was interviewed during the six weeks of postnatal review stated that the perineal trauma impacted her ability to open her bowels due to the pain.

"I was finding it hard to go to the toilet to relieve myself because it was paining. It was very painful. It was difficult."

The causes of constipation were said to be both physical and psychological. A 26-year-old participant said:

"I think the first problem that I encountered which gave me a lot of fear, is that

I had constipation. I think it's a psychological problem which I had whereby if I sneeze, it's paining so you hold back. When you want to go to the toilet to ease yourself you think of the pain, there are stitches there, the pain? So, you hold it back. I think that's what made it worse."

While some participants complained about constipation causing more perineal pain, fear of perineal pain could lead some women to avoid opening bowels, leading to constipation. One participant stated:

"It's painful. I cannot even sit on the toilet pan so I am not even going to the toilet to pass stool. Since yesterday I have not been going to the toilet. The urge is there but mmmm… am afraid of going to the toilet. Eeeeh! I am afraid that when I go and sit on the toilet the stitches can break, then I go back for re-stitching!"

Perineal pain was reported to continue affecting women for some days when opening bowels. One participant wondered if there is a remedy for this and said:

"Umh, then afterwards, that's when you start feeling the pain now especially the part where you have to use the toilet. It is something else. I don't know if there is any medicine where you don't have to feel anything when you go to the toilet. I don't know."

### 5.5. Lack of Pain Relief during Suturing

While intrapartum guidelines provide for the use of local anaesthesia when performing and repairing an episiotomy or perineal tear, most participants narrated that anaesthesia was not used. Many participants narrated feeling a debilitating pain during the time when the episiotomy or perineal tear was being sutured because they were not given the required pain relief medication. One participant narrated:

"When they started stitching inside, I was just feeling little pain but the outside, it was really painful. So, after they finished, I was finding it difficult to walk, to bend, sitting on the toilet, the whole body was painful. They just stitched me like that and nothing was injected into the wound to reduce the pain, so aaaah…I really felt it. It was painful!"

Similarly, another participant highlighted how she found repairing the perineal tear pain unbearable. She said:

"I just covered my face because of the pain; I could feel two pains at the same time. So immediately after feeling the pain of giving birth and the tearing, then suturing again... It was too much."

A para 5 participant narrated that she was irritable during suturing because of the pain and this agitated the midwife. Her graphic narration was as follows:

"She told me that lay down properly I want to stitch you, you have a tear. I just layed there feeling the needle chui! Chui! Mmmmm. It was painful, I became fearful and irritable and when she stitches, I would suddenly move in pain. She told me don't do that! I said my God please. I held on until she finished and she then said am done."

Suturing of episiotomies and perineal tears without use of local anaesthesia

seemed to be common practice among the health personnel who conducted deliveries. Only three participants reported having had local anaesthesia used. One participant who had anaesthesia used during suturing narrated:

"The suturing part was okey… but for me there was an anaesthesia that was given and I didn't feel that much pain."

While local anaesthesia was scarcely used when managing perineal wounds in the labour ward, all the four participants who were admitted to the gynaecology ward for secondary suturing after reopening their initial wounds reported that local anaesthesia was used. Making comparisons between the two suturing episodes, one participant said:

"The first stitching was really painful but the second stitching was much better. When stitching this time, they injected on the part where they were repairing then they repaired… the pain was not that much. It was bearable."

### 5.6. Second Theme: Fear of Future Reproductive Health Outcomes

This major theme describes the fears and uncertainties that sustaining a perineal trauma triggered in the participants, particularly those who still wanted to have children. Most of the fears and uncertainties were centered around their future reproductive health issues, especially since most of them were married and in the reproductive age group. The major theme was informed by two subthemes: fear of childbirth and fear of sexual dysfunction.

### 5.7. Fear of Childbirth

Some participants communicated thoughts of fear of future childbirth as a result of the effects of the perineal trauma they had experienced. The fears were around the reopening of the wound scars during childbirth and having another perineal tear or an episiotomy. One primipara who suffered a broken and infected episiotomy said:

"Umh... I have even told myself that this is the last one because that thing when I think about it again, experiencing the same thing, I feel like this pain will be with me forever. The emotional pain, even the physical pain, am just scared of experiencing it, it can be severe the next time."

Experiencing perineal trauma and its effect induced a desire for one multiparous participant to consider having permanent contraception. She stated:

"I really thought a lot, I said no this injury! All these children I have given birth to both at home and at the hospitals I didn't experience such. My wish was just to have an operation where they tie my womb so that this one becomes the last baby because I passed through a very hard path."

While most participants were fearful of going through the childbirth process again, some participants expressed concerns about how the trauma would affect their ability to conceive or get married. One single mother of two said:

"Umh… if I leave it open like that how can I have another child? I can't conceive nicely. Even if you think about getting married, how can you get married when

you have a vagina which is open? You can't."

A para 2 participant who had sustained a third-degree tear and was interviewed three months after the delivery explained that if she had to conceive again; she would opt to go for a caesarean section because she was fearful of going through a vagina delivery again. She gave a detailed narration of the ordeal of the perineal repair, and said:

**"**It was like I went into a state of confusion. It was like things will never be the same again. Towards the end when they reached the upper part, the medicine got finished and I could feel the stitches being done live. That has still remained in my head. The memories are still fresh! Next time if God is willing, I will just sign the papers for an operation. I would prefer that because I would just be nursing the wound on the tummy."

### 5.8. Fear of Sexual Dysfunction

This subtheme revealed participants' thoughts of future intimacy, more especially the majority of them were married. The participants' thought intimated that perineal injury had affected the state of their vaginas. One such participant stated:

"I was really torn; they turned my private parts inside out and the midwife described it to be looking like torn fish. The other midwife told me that she was not impressed with how they stitched me and I had to go back. I said no I won't go back. I go through the same process I went through? For me it's just like this. So, we just left it the way it was. It looks different".

Several other participants expressed fears and uncertainties about their ability to sexually function normally and safely. The main concern was that the trauma had altered the size and shape of the introitus. One participant expressed fear of not being able to satisfy her husband sexually. She said:

"I was really afraid that how can it be like this each side on its own? Maybe you can be damaged and fail to heal. Sometimes what scares us is that just like this when you go back to your husband then he finds that the wound has re-opened which means even this side it has become big. Yes, the vagina can become big and it may bring problems at home. He can become upset and ask why it has become too big this side and then you start differing every now and then."

The fear and worry about the alteration of the shape and size of the vagina was more focused on it becoming loose, leading to an inability to sexually satisfy a spouse. One participant narrated:

"According to my way of thinking about it, if they don't repair you… it means that's it for you, you are damaged!! There are situations whereby you want to have sex, then when you are having sex then he is just entering as if he is entering into an unknown place! So, like that, men do not really tolerate such."

Another participant who was interviewed nine months after sustaining the perineal trauma narrated that the looseness of the vagina was producing vaginal flatulence; hence, it was causing her embarrassment during sexual intercourse. She said:

"When I stand up, I feel like I am passing gasses but just there in the vagina. It makes noise just like passing flatus. It really puzzles me, am like mmmmh, is this normal? Even when we are having sex! I still hear the sounds of the gasses and I feel embarrassed." Participant 10, pg. 69.

In contrast, some participants were fearful that the repair of the perineal injury had made the vagina so tight that intimacy with their partners would be affected. A primiparous woman who was interviewed almost three months after delivery expressed fear of engaging in sexual intercourse as she assumed that her vagina had become very tight. She narrated:

"It's not the same… the vagina would have been the same if I never had an episiotomy. It's different now. I don't know if it's tighter now. Yes, it is, am afraid! When I touch it now… it feels different. Even my husband has said the same and he is even giving me more time to heal. I don't know how long it will take." Participant 6, pg. 31.

### 5.9. Third Theme: Substandard Perineal Wound Management

This theme emerged from participants' descriptions of inadequacies in the care and management of perineal traumas. When describing the type of care expected from healthcare providers, one primiparous participant who termed the vagina as a very sensitive organ stated:

"Good caring is actually very important, looking at my situation it was my first experience so they were supposed to give me attention. I really would love them to put more concern and should give that care. Looking at the vagina, it's a very sensitive organ so they should pay more attention and be caring so that nothing wrong happens to women."

Some participants who were admitted to the gynaecological ward for management of perineal trauma complications described facing challenges in accessing timely care. One participant described that some of the challenges faced in the caring and management of birth perineal trauma had to do with delays in accessing care for reopened wounds.

"My thought was that immediately I reach the hospital, it would take a short time for me to be seen because they had written on my referral letter that my case was an emergency. I was thinking they would see me if not the very day but at least the following day. But I had to stay there for some days with my baby. I wasn't even on any medication whatsoever. I would see other patients being reviewed while no one was attending to me."

### 5.10. Lack of Perineal Examination

This subtheme expounded on the lack of physical examination during postnatal reviews. Many participants narrated that physical examinations, especially around the perineal area, were not done during postnatal visits. One participant said:

"At 6 days I was still in hospital so I went downstairs to attend the postnatal clinic. They didn't even check me. they just asked me if I was experiencing pain.

At six weeks they didn't check me as well. This one I went to the clinic. They just asked me if it was healed."

Midwives were reportedly depending on women's reported state of their perineal wounds as opposed to performing physical checks. This was irrespective of the severity of the wound sustained. A participant who had sustained a third-degree tear reported:

"I went to the clinic at six days where they just asked me, have you healed? Then I said …yes. I wasn't checked. At six weeks we just went for the baby to get her injections that's all. At the clinic no one was interested in checking. That's what I can say because they just asked "have you healed?" Then I said am healed for me to even manage to sit like this."

Participants who had their perineal wound examined reported that they had to request the examination. Despite making the requests, some participants reported that their requests were met with resistance, while others reported that the examinations were done without the healthcare provider touching them. One participant narrated that the midwife told her that she did not have gloves to use but because she felt that she needed to be examined by a professional, she insisted on being examined; hence, the midwife asked her to open the wound area by herself so that she could see. She said:

"I requested that the midwife should examine my wound. She answered that she did not have gloves. That's how I lied to her that the wound was very painful and I wanted her to check even though it was not painful, I just wanted her to check how it was. The midwife told me to open my legs and I opened up the wound by myself because she said she had no gloves. When I opened up the wound area that's when she said aah!!This wound is very bad."

While some women had the courage to request for perineal examinations, others reportedly went back home with unresolved problems. One participant narrated:

"They just checked my blood pressure and asked me if I had a normal delivery. I said yes, I had a normal delivery. I didn't tell them I had an injury… I was expecting them to check on their own. When I came back home, I felt as if the whole suture had come out from my wound; my mum checked, truly she found the whole suture had come out and the wound was open again."

However, there were still other participants who narrated not having their perineal area examined even during discharge from the hospital. One participant who was merely asked about the state of her perineal wound on discharge said:

"When discharging me, I was just asked about how I was feeling and how the wound was. They never checked me."

In addition to not having perineal wounds examined during discharge and postnatal reviews, many participants explained that they lacked knowledge on how to care and manage perineal wounds. This formed the second subtheme under the theme "substandard perineal wound management".

### 5.11. Inadequate Knowledge of Perineal Wound Management

This subtheme described participants' uncertainties about how to care for perineal

wounds. The uncertainties emanated from not being provided with the information by midwives. The inadequate knowledge and, at times, lack of information on perineal wound management was expressed to have been more challenging for women who were encountering morbidity for the first time. When one primiparous woman was asked to describe how she was cleaning her perineal wound three days after discharge from the hospital; this is what her response was:

"Umh.... Mmm I don't have any knowledge about cleaning it… I don't even know where to start if I were to clean it."

Inadequate knowledge on how to care and manage perineal wounds was not specific to primiparous women only; some women who had given birth before expressed similar concerns. A participant who was para 2, narrated:

"I was expecting some information because I believe in the hospital there are mothers who are giving birth for the first time and there are those like us who have had caesarean sections and it's the first time to have a vaginal delivery… I think the information on how to care for your wound is very important because it's not everybody who has an opportunity of finding out or having people who are health workers."

Some participants who were provided information on perineal wound care explained that the emphasis was on sitting in water. One participant narrated:

"Nothing was explained to us, they just told us about sitting in water that's all. To sit in water, cold water twice a day. Thereafter, I was home for just two days and the wound reopened. It opened… wide open!"

The instruction of sitting in water was at times characterised by conflicting statements from one health provider to the other. This was described to bring about disillusionment in the care and management of perineal wounds. One participant said:

"I was only told to be sitting in plain water by the midwife. It was just sitting in water which is room temperature but there was a doctor who said… add a bit of salt. Actually, I was using plain water because adding salt when I think about the pain, so I just settled for cold plain water."

A participant who had a caesarean section in the previous delivery explained her challenges with sitting in cold water:

"Since I had a caesarean section before, sitting in cold water is something that am suffering from. There is a problem that is coming because caesarean section reacts to cold water but episiotomy needs cold water, so there's just that conflict. Am feeling some pains, such that sometimes I feel like there's a separation between the upper abdomen and the lower abdomen, so then I have to take a lot of hot things again trying to warm my abdomen."

Inadequate knowledge on perineal wound care due to lack of information from healthcare providers led some participants to follow what they were advised by people at home. Nevertheless, some participants described their dependence in healthcare providers, and therefore, expressed their desire to have them being explicit in their explanations in order to ensure that women were very sure of what to do, especially when they were at home. An orphaned primiparous young

mother who was dependent on her old grandmother for advice said:

"So, you really have to emphasise on how we should look after the wounds. What you need to use is this and that. When we come back home this person will tell you this, another one will tell you something else so you get confused. So, you are the ones to give us all the information on what to use so that the wound heals fast and does not bring problems"

Inadequate knowledge and at times lack of information from healthcare professionals on how to care and manage perineal wounds left some women unsure of the safety of physiological functions such as, opening bowels. A para 5 participant described:

"They really didn't tell me anything. I just heard from my neighbour the one I found in the hospital who also had a tear… so I would ask her how are things with you? Are you supposed to go to the toilet? Then she said for me… the day they stitched me I had diarrhea… so I was going to the toilet… but I was sitting in cold water and now am feeling better."

Sometimes the participants had doubts about how to care for the wounds and this participant stated that she resolved to be checking on GOOGLE on how to take care of a perineal wound. She said:

"Yes…what about when I go to the toilet and urinate? Do I have to wait for that other time to sit in water or what am I supposed to do because I know urine is toxic? All these things going through my mind… so if I go to the toilet, urinate and come back… how often should I change my pads? Is it every time I go to the toilet? So, I just started making my own rules and checking on google."

The fourth theme that emerged from the participants' narratives was 'Diversion from reality'.

### 5.12. Fourth Theme: Diversion from Reality

This theme arose from the events, behaviours and adjustments that the women had to engage in as they experienced the impact of perineal trauma in their day-to-day lives. The diversions were described to be either done consciously or they occurred unconsciously. Most of those that took place during labour occurred unconsciously. One participant described how she came up with a timetable on when to perform certain activities so that she had time to attend to her perineal wound. She said:

"I told myself I really need to be strong… I made a timetable for myself so that I make sure that when she (baby) is sleeping in the morning, I would wake up early enough to warm water for bathing and bath. I would sit in water sometimes for 30 minutes or just go an extra time. I would help out mum with cleaning, cooking and washing. I feel again if I just sleep the whole day, my body will feel pains. When I tried to make a programme… it really helped me… especially when I maintain the three periods of sitting in water… am feeling my body getting back to normal."

The most motivating factor for most participants to cope with the morbidity was the presence of the baby. The presence of the baby was explained to give most

of the participants something to look forward to and, hence, helped them to cope with the morbidity. One participant narrated:

"I am encouraging myself… but even when I encourage myself the same thought is coming that what if I don't get healed? I look at my child and say… she's just a baby and am still young. I really need to be there for her. So, it's really helping when I look at her."

### 5.13. Wound Obsession

This subtheme described participants' obsession with checking their traumatised perineal areas. One participant who made a comparison with her previous delivery by caesarean section stated that the caesarean incision was less worrying because she was able to see it easily. The obsession with checking the episiotomy wound from time to time emanated from the fact that it was hard to see. She stated:

"At least with the caesarean wound I could see it...but with episiotomy I am not able to see clearly. I have no idea how it's supposed to look like when it's healing well... so every day I was just thinking perhaps I have pus you know... so every time you are just paranoid... you don't know".

Mirrors were constantly used during bathing and in private rooms to view the wounds. For most women who developed perineal complications, identifications were made during the frequent mirror checks. One participant whose perineal wound reopened, narrated:

"Each time I would take a bath, I would bath with a mirror to check on the wound...So when I was bathing with the mirror, I saw that it had reopened and explained to my grandmother that the wound had reopened."

Another participant narrated that she was able to identify that there was a problem with the wound during one of the mirror checks. Based on what she observed, she asked the midwife to verify her suspicions. She said:

"I just wanted her to check how it was because I used a mirror and checked myself at home..., I saw that the wound had reopened very much." Participant 4, pg. 21.

Though personal mirror checks were helpful in monitoring how wounds were healing, many participants still sought the opinion of significant others who were mostly their mothers to verify their suspicions. A para 2 participant who was engaged to be married was obsessed about the state of her perineum; she asked the mother to check her who advised that they go to the clinic. She stated:

"All the cotton fell off but I was still in pain. That's how I called my mother that come and check my wound because the pain is not stopping. When my mother saw the wound, she found that it had reopened. She said we had to go to the clinic because the wound was not okey."

Viewing of perineal injuries was challenging for some mothers; hence, they depended on other people to confirm their observations. A primiparous participant narrated:

"I told my sister to check because when I was bathing, I saw that two stitches

had come out. Then when she checked she said two have come out. I told the midwife who was working in the night to check me. When she checked she said the wound was broken."

### 5.14. Spiritual Comfort

Some participants attributed what they were going through in relation with their perineal wounds to a design of deity for womanhood. This type of personal explanation was described to make them cope with the injury; hence, they endured it because they believed that they could not change it. One participant who felt that she was not taken care of well by midwives during labour and childbirth, narrated how she felt alone and helpless as she delivered her baby and sustained a tear during the process. She attributed the process and the outcome to destiny. She explained:

"Paying attention is really needed because when we rush to the hospital, we come to you so that you help us by checking on us and guiding us to say do this or that. I believe I wasn't going to have a tear if I was guided well. The problem is they didn't pay attention to me... they were overtaken by sleep and slept. So, in my own knowledge and power, I just said let me do what I can. I sighed to say if my baby dies or it's me to die...let it be...because it would have been my destiny... so let it be."

While other participants were able to point out the various areas in which the presence of a perineal trauma impacted them, others viewed the effects as a normal process for a woman to endure. Responding to how the perineal trauma has impacted her, one participant said:

"The only thing you can do is just accepting it. For me the way I see it, I don't know about others but for me, it is the destiny of the woman to go through these things. So, one just has to be strong because there is nothing you can do.... The wound has already happened. It's just like saying something has happened… there is nothing I can do."

Participants identified multiple ways in which the presence of perineal trauma impacted them and the hardships they had to endure. To manage all the hardships, one participant said that it required a special ability from God. She stated:

"The care of the baby, because in the night she wakes up and starts crying, I have to get up to breast feed her...I can't lay down. The struggle comes when I have to sit, it is a lot of work because it really pains. Am only managing by the grace of God."

## 6. Discussion

### 6.1. Perineal Pain

The major theme of perineal pain that characterised many participants' impact of perineal trauma has been described in some other studies [18] [19] as severe pain. The acute and persistent physical perineal pain impacts many women during the process of wound healing, management and due to complications. The recollection suturing moment brought back feelings of pain and chills in one participant, an indication that psychological factors were also at play. According to Åhlunda

*et al.* [20], women do not have prior knowledge of the intensity and duration of perineal pain to expect and experience.

Most of the women who made comparisons between perineal pain, labour pains and previous caesarean section pain concluded that perineal trauma pain was worse. Furthermore, many participants described experiencing difficulties in breastfeeding due to sitting discomforts. A study by Huber *et al.* [21] reported that perineal trauma could hinder both breastfeeding and bonding between mother and baby. The discomforts arose from tension and pressure exerted on wound sites during the sitting position. Perineal incision pain can be distressing when a complication such as wound infection sets in [22]. Participants in the current study who developed wound complications described the pain as throbbing and ongoing. The complications experienced were attributed to poor suturing skills and incorrect suturing by trainees. In part, limited perineal anatomical knowledge by trainees and midwives leads to incorrect management of injuries [7]. Trainees need close supervision when suturing the perineum to avoid predisposing women to multiple painful re-suturing. Re-suturing especially during early postpartum period is very traumatic because women are fragile and the experience of the trauma is still fresh. Proper restoration of the perineum can help minimise the distressing effects of morbidity [23].

Women who were not provided professional assistance during the birthing process and sustained perineal trauma blamed negligent attitudes by health personnel. The feeling of not receiving adequate care during childbirth can contribute to a negative experience [24]. Just as technical skills are an important element in providers' perspective of quality [11], attributes such as respect, concern and availability characterised the women's perspective of quality service. The descriptions of the impact of perineal trauma by participants are centered on the actions and interactions of care providers [25], implying that childbirth perineal trauma is also a social phenomenon.

Constipation contributed to perineal pain and it came as a result of stool withholding in fear of exerting pressure on the incision site and wound reopening. Participants expressed uncertainty about the safety of opening bowels when a perineum is sutured and feared opening bowels because doing so was painful. Perineal pain can interfere with defaecation and the fear of pain or the wound splitting open can lead women to avoid defecation, worsening existing postpartum constipation [26]. The pain may not necessarily have been a result of the constipation but the trauma due to the proximity of the anus to the perineum. Lack of provision of pharmacological interventions such as laxatives to prevent and manage constipation was revealed through participants' inquiries of whether the health care system had remedies for the problem. Another study [27] showed that laxatives are among routine guidelines for women who sustain perineal trauma.

Perineal pain management was observed to be a neglected area during intrapartum and postpartum care. A study conducted in Zambia on the barriers to respectful maternity care showed that health providers regarded pain during

childbirth to be a norm, which women have to endure [28]. In agreement with this finding and against the WHO [11] guidelines on the use of local anaesthesia in perineal trauma management, most participants narrated that their perineal injuries were repaired without anaesthesia. This practice exposed women to very painful childbirth experiences. Midwives are urged to take an advocacy role and ensure that women are not exposed to undue pain by normalisation of their health problems as a consequence of childbirth [29].

### 6.2. Fear of Future Reproductive Health Outcomes

This major theme entails that childbirth perineal trauma is not just physical but it is a multifaceted phenomenon. Revelation of this theme could help midwives caring for women with perineal trauma to not only focus on their physical wellbeing. Participants described harbouring fear surrounding their future reproductive system functions. Perineal trauma also induced varying emotional feelings. In agreement, Rodríguez-Almagro *et al.* [24] highlight that a traumatic childbirth experience can bring about emotional wounds.

Tocophobia was a common impact, with many participants expressing a fear of experiencing another episode of perineal trauma. Participants narrated how the physical and emotional pain they went through as a result of perineal trauma brought concerns about how soon they would want to give birth vaginally. Others said they did not want to go through the process ever again. He *et al.* [26] also describe how women with perineal trauma fear having another vaginal birth to avoid causing further damage to their bodies. Women who undergo a traumatic birth experience are fearful of being physically damaged during childbirth or worse still even dying [24]. Most women in the current study preferred a vaginal birth irrespective of the perineal trauma. Similar findings emerged in a study conducted in Malawi [8].

Fear of sexual dysfunction as a result of perineal trauma was related to perceived vaginal tightness due to over suturing of the perineal area. Vaginal tightness was explained to lead to dyspareunia and discomfort in women. Such discomforts can cause delays in resumption of sexual activity after delivery; hence, the need for midwives to engage couples and provide appropriate counselling on how the impact can be resolved [30]. Paradoxically, some studies indicate that early resumption of sexual intercourse after childbirth is a fulfilment of cultural expectation irrespective of the state of the perineum and dyspareunia [10].

In contrast to fear of sexual dysfunction due vaginal tightness, other participants' fears emanated from improperly repaired perineal traumas leading to enlargement of the vagina. The enlargement of the vagina was more centered on the inability to sexually satisfy one's spouse in order to maintain marital harmony and stability. In agreement with the concerns raised by participants, perineal trauma has the ability to cause structural and pathological effects on the woman many weeks after its occurrence [31] [32]. In this regard, there is a need for midwives to have adequate training and cultural competence in sexual health in order for them

to appropriately counsel clients on sexual issues [33].

### 6.3. Substandard Perineal Wound Management

Perceiving perineal trauma as a normal occurrence during childbirth by most midwives may pose a danger of trivialising the morbidity and its related impacts. Participants in this study expressed a desire to have perineal examinations performed during postnatal visits. The findings revealed that healthcare providers were not doing it. In agreement with this finding, Muleya *et al.* [12] reported that routine physical examination during postnatal visits was a neglected area in health facilities in Zambia. In other words, the state of perineal wounds of some women who have been birthed in Zambia is unknown because of substandard perineal wound care. Poor postpartum surveillance of perineal trauma by midwives and reliance on women's reports can cause delays in identifying problems when they set in [34]. Routine postnatal check-ups play a pivotal role in the identification of problems that may require follow up assessment and care; hence, all women with perineal trauma irrespective of severity need access to routine postnatal checks [35].

The current study found that advice on the management of childbirth perineal injuries provided on discharge was viewed as inadequate and at times contradictory. Participants narrated making consultations with friends, family members and conducting internet searches for additional information on perineal care. These results also emerged in another study where women felt that health providers did not provide adequate information on perineal trauma; hence, they relied on consultations from other sources [36]. Zulu and Chanda [37] stated that postnatal women in Zambia were usually dissatisfied with the amount of information they received during hospitalisation. Perceived lack of preparation can leave women with negative feelings towards perineal care and postpartum care management in general [2].

### 6.4. Diversion from Reality

Diversion from the realities of the perineal trauma was identified as the main way participants used to handle the perineal trauma. Diversion from reality especially if the situation is traumatic is a common occurrence in many instances. For instance, findings in a study on women in labour revealed that women overlooked their own physical safety and prioritised the safety of their babies in the presence of a traumatic event [38]. This was similar among some participants in this study. Furthermore, participants reportedly obsessed themselves with viewing the state of their perineum or getting involved in house chores instead of concentrating on how they were feeling. Constant mirror checks were not only helpful in diverting the women's attention; they were also helpful in identifying the setting in of wound complications.

However, narrations from most participants revealed that they did not have much insight into how a healing perineal wound was expected to look like; hence, they

relied on inquiring from family member checks to verify their suspicions on wounds not healing properly. This revelation points to the importance of showing postnatal women with perineal wounds pictures of stages of perineal wound healing before discharge, so that they could be able to relate with their personal observations. Postnatal women who sustain a childbirth perineal trauma can experience emotional recovery when they observe improvements in the state of the perineum [39]; but in the case of this study, this could not be achieved because participants were not sure of what improvement in perineal wound healing looked like. A midwife caring for a woman during childbirth has the responsibility to ensure the safety of the mother by being there for the woman physically and mentally [40]. Another way in which participants diverted their attention from the trauma of sustaining a perineal injury was by focusing more on responsibilities such as bathing and caring for their babies.

Participants also reportedly diverted their attention to their spirituality derived from the belief that the deity had put them on a path that was part of their destiny. Spirituality has been shown to consistently play a role in diverting women from the realities of difficult situations experienced during childbirth [41]. While the belief that perineal trauma is a destiny for a woman because of the belief that it is a normal part of womanhood that cannot be changed, and could be helpful in adjusting to the effects of the injury, it could also cause a woman to be reluctant to seek for better services concerning the trauma. This can negatively impact the care seeking behaviours of women with perineal traumas leading to unresolved perineal problems. Midwives should therefore, understand that spirituality is an integral component of maternal care [42].

### 6.5. Implications for Practice

One of the implications of the findings on practice is that childbirth perineal trauma has multifaceted presentations which are usually overt. This therefore, requires that midwives should comprehensively observe postnatal women in order to ensure that they do not discharge those with unresolved problems. Perineal pain is a devastating problem affecting not only the physiological function of the woman but also the care of the baby and other social functions. To this effect, perineal trauma pain management should be prioritised in order to improve postnatal women's overall well-being. Management of pain may also assist in alleviating fears that women may have concerning their future reproductive health outcomes especially if it is coupled with therapeutic sex counselling. It is therefore good practice to ensure that local anaesthesia is given during perineal repairs. Furthermore, there is a need to improve midwifery education on perineal trauma management by using clinical teaching methods such as simulations of suturing on models in skills laboratories in order to gain competence before practicing on labouring women. Students providing perineal trauma management should be closely supervised by competent staff in order to avoid subjecting women to distressing and incorrect perineal suturing procedures.

## 7. Conclusion and Recommendations

The multiple ways in which perineal traumas impact women's well-being entail that midwives should not trivialise the morbidity but use their professional knowledge to alleviate the sufferings imposed on the women by them. While the methodology used in this study provided significant insights into the phenomenon of perineal trauma from women's perspective, we recommend that further research must conducted to expand the scope of the study to focus on the providers of care with the view of improving the quality of perineal trauma management in LMICs.

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## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

## References

[1] Chou, D., Tunçalp, Ö., Firoz, T., Barreix, M., Filippi, V., von Dadelszen, P., *et al.* (2016) Constructing Maternal Morbidity—Towards a Standard Tool to Measure and Monitor Maternal Health Beyond Mortality. *BMC Pregnancy and Childbirth*, **16**, Article No. 45. https://doi.org/10.1186/s12884-015-0789-4

[2] Thapa, S., Acharya, I., Singh, M. and Baral, J. (2017) Maternal Morbidity in Vaginal Delivery with or without Episiotomy in Nulliparous Women. *Medical Journal of Shree Birendra Hospital*, **16**, 41-46. https://doi.org/10.3126/mjsbh.v16i2.17713

[3] Skinner, E.M., Barnett, B. and Dietz, H.P. (2017) Psychological Consequences of Pelvic Floor Trauma Following Vaginal Birth: A Qualitative Study from Two Australian Tertiary Maternity Units. *Archives of Women's Mental Health*, **21**, 341-351. https://doi.org/10.1007/s00737-017-0802-1

[4] Aguiar, M., Farley, A., Hope, L., Amin, A., Shah, P. and Manaseki-Holland, S. (2019) Birth-Related Perineal Trauma in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *Maternal and Child Health Journal*, **23**, 1048-1070. https://doi.org/10.1007/s10995-019-02732-5

[5] Rostaminia, G., Peck, J.D., Van Delft, K., Thakar, R., Sultan, A. and Shobeiri, S.A. (2016) New Measures for Predicting Birth-Related Pelvic Floor Trauma. *Female Pelvic Medicine & Reconstructive Surgery*, **22**, 292-296. https://doi.org/10.1097/spv.0000000000000282

[6] Homer, C. and Wilson, A. (2018) Perineal Tears: A Literature Review. Australian Commission on Safety and Quality in Health Care, Burnet Institute. https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.safetyandquality.gov.au/sites/default/files/2021-05/perineal-tears-literature-review.pdf&ved=2ahUKEwjHjKLFlLmIAxXk_rsIHerREuMQFnoECBQQAQ&usg=AOvVaw0yEGzSZPL_0ARlSCymp_F9

[7] Pinder, L.F., Natsuhara, K.H., Burke, T.F., Lozo, S., Oguttu, M., Miller, L., *et al.* (2017) Nurse-Midwives' Ability to Diagnose Acute Third- and Fourth-Degree Obstetric

Lacerations in Western Kenya. *BMC Pregnancy and Childbirth*, **17**, Article No. 308. https://doi.org/10.1186/s12884-017-1484-4

[8] Khwepeya, M., Lee, G.T., Chen, S. and Kuo, S. (2018) Childbirth Fear and Related Factors among Pregnant and Postpartum Women in Malawi. *BMC Pregnancy and Childbirth*, **18**, Article No. 391. https://doi.org/10.1186/s12884-018-2023-7

[9] McDonald, E.A., Gartland, D., Small, R. and Brown, S.J. (2015) Dyspareunia and Childbirth: A Prospective Cohort Study. *BJOG*, **122**, 672-679.

[10] Iliyasu1, Z., Galadanci, S.H., Danlami, M.K., Salihu, H.M. and Aliyu, M.H. (2018) Correlates of Postpartum Sexual Activity and Contraceptive Use in Kano, Northern Nigeria. *African Journal of Reproductive Health*, **22**, 103-112.

[11] World Health Organisation (2018) Intrapartum Care for a Positive Childbirth Experience. http://apps.who.int/iris/bitstream/10665/260178/1/9789241550215-eng.pdf?ua=1%0Ahttp://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

[12] Muleya, C., Mwape, L., Mukwato, P.K. and Maimbolwa, M. (2018) Postnatal Care within Six Hours Following Delivery at Two Selected General Hospitals of Zambia—Mothers' Experiences. *Open Journal of Nursing*, **8**, 355-371.

[13] Diorgu, F. (2016) Birth Practices in Port Harcourt, Nigeria: A Retrospective Case Study Review. *International Journal of Women's Health and Wellness*, **2**, Article No. 37. https://doi.org/10.23937/2474-1353/1510037

[14] Tuffour, I. (2017) A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Health Communication*, **2**, Article No. 52.

[15] Christensen, M., Welch, A. and Barr, J. (2017) Husserlian Descriptive Phenomenology: A Review of Intentionality, Reduction and the Natural Attitude. *Journal of Nursing Education and Practice*, **7**, 113-118. https://doi.org/10.5430/jnep.v7n8p113

[16] Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., *et al.* (2018) Application of Four-Dimension Criteria to Assess Rigour of Qualitative Research in Emergency Medicine. *BMC Health Services Research*, **18**, Article No. 120. https://doi.org/10.1186/s12913-018-2915-2

[17] Graneheim, U.H. and Lundman, B. (2004) Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness. *Nurse Education Today*, **24**, 105-112. https://doi.org/10.1016/j.nedt.2003.10.001

[18] Wiseman, O., Rafferty, A.M., Stockley, J., Murrells, T. and Bick, D. (2018) Infection and Wound Breakdown in Spontaneous Second-Degree Perineal Tears: An Exploratory Mixed Methods Study. *Birth*, **46**, 80-89. https://doi.org/10.1111/birt.12389

[19] Dudley, L., Kettle, C., Waterfield, J. and Ismail, K.M.K. (2017) Perineal Resuturing versus Expectant Management Following Vaginal Delivery Complicated by a Dehisced Wound (PREVIEW): A Nested Qualitative Study. *BMJ Open*, **7**, e013008. https://doi.org/10.1136/bmjopen-2016-013008

[20] Åhlund, S., Rådestad, I., Zwedberg, S. and Lindgren, H. (2019) Perineal Pain the First Year after Childbirth and Uptake of Post-Partum Check-Up—A Swedish Cohort Study. *Midwifery*, **78**, 85-90. https://doi.org/10.1016/j.midw.2019.08.004

[21] Huber, M., Tunon, K. and Lindqvist, M. (2020) "From Hell to Healed"—A Qualitative Study on Women's Experience of Recovery, Relationships and Sexuality after Severe Obstetric Perineal Injury. https://doi.org/10.21203/rs.3.rs-131822/v1

[22] Senol, K. and Islan E. (2018) Perineal Pain Severity in Postpartum Period Evaluated

Six Hours and Three Months after Delivery. *Journal of Caring Sciences*, **11**, 1691-1696.

[23] Keighley, M.R.B., Perston, Y., Bradshaw, E., Hayes, J., Keighley, D.M. and Webb, S. (2016) The Social, Psychological, Emotional Morbidity and Adjustment Techniques for Women with Anal Incontinence Following Obstetric Anal Sphincter Injury: Use of a Word Picture to Identify a Hidden Syndrome. *BMC Pregnancy and Childbirth*, **16**, Article No. 275. https://doi.org/10.1186/s12884-016-1065-y

[24] Rodrigues, S., Silva, P., Agius, A., Rocha, F., Castanheira, R., Gross, M., *et al.* (2019) Intact Perineum: What Are the Predictive Factors in Spontaneous Vaginal Birth? *Materia Socio Medica*, **31**, 25-30. https://doi.org/10.5455/msm.2019.31.25-30

[25] Reed, R., Sharman, R. and Inglis, C. (2017) Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions. *BMC Pregnancy and Childbirth*, **17**, Article No. 21. https://doi.org/10.1186/s12884-016-1197-0

[26] He, S., Jiang, H., Qian, X. and Garner, P. (2020) Women's Experience of Episiotomy: A Qualitative Study from China. *BMJ Open*, **10**, e033354. https://doi.org/10.1136/bmjopen-2019-033354

[27] Roper, J.C., Amber, N., Wan, O.Y.K., Sultan, A.H. and Thakar, R. (2020) Review of Available National Guidelines for Obstetric Anal Sphincter Injury. *International Urogynecology Journal*, **31**, 2247-2259. https://doi.org/10.1007/s00192-020-04464-5

[28] Smith, J., Banay, R., Zimmerman, E., Caetano, V., Musheke, M. and Kamanga, A. (2020) Barriers to Provision of Respectful Maternity Care in Zambia: Results from a Qualitative Study through the Lens of Behavioral Science. *BMC Pregnancy and Childbirth*, **20**, Article No. 26. https://doi.org/10.1186/s12884-019-2579-x

[29] Slade, P., Balling, K., Sheen, K. and Houghton, G. (2019) Establishing a Valid Construct of Fear of Childbirth: Findings from In-Depth Interviews with Women and Midwives. *BMC Pregnancy and Childbirth*, **19**, Article No. 96. https://doi.org/10.1186/s12884-019-2241-7

[30] McDonald, E.A., Gartland, D., Woolhouse, H. and Brown, S.J. (2018) Resumption of Sex after a Second Birth: An Australian Prospective Cohort. *Birth*, **46**, 173-181. https://doi.org/10.1111/birt.12363

[31] Nassar, A.H., Visser, G.H.A., Ayres-de-Campos, D., Rane, A. and Gupta, S. (2019) FIGO Statement: Restrictive Use Rather than Routine Use of Episiotomy. *International Journal of Gynecology and Obstetrics*, **146**, 17-19. https://doi.org/10.1002/ijgo.12843

[32] Webb, S.S., Yates, D., Manresa, M., Parsons, M., MacArthur, C. and Ismail, K.M.K. (2016) Impact of Subsequent Birth and Delivery Mode for Women with Previous OASIS: Systematic Review and Meta-Analysis. *International Urogynecology Journal*, **28**, 507-514. https://doi.org/10.1007/s00192-016-3226-y

[33] Rezaei, N., Azadi, A., Sayehmiri, K. and Valizadeh, R. (2017) Postpartum Sexual Functioning and Its Predicting Factors among Iranian Women. *Malaysian Journal of Medical Sciences*, **24**, 94-103. https://doi.org/10.21315/mjms2017.24.1.10

[34] Zimmo, K., Laine, K., Vikanes, Å., Fosse, E., Zimmo, M., Ali, H., *et al.* (2017) Diagnosis and Repair of Perineal Injuries: Knowledge before and after Expert Training—A Multicentre Observational Study among Palestinian Physicians and Midwives. *BMJ Open*, **7**, e014183. https://doi.org/10.1136/bmjopen-2016-014183

[35] Lindberg, I., Persson, M., Nilsson, M., Uustal, E. and Lindqvist, M. (2020) "Taken by Surprise" BMJ Open, Women's Experiences of the First Eight Weeks after a Second Degree Perineal Tear at Childbirth. *Midwifery*, **87**, Article ID: 102748. https://doi.org/10.1016/j.midw.2020.102748

[36] Bidwell, P., Sevdalis, N., Silverton, L., Harris, J., Gurol-Urganci, I., Hellyer, A., *et al.* (2021) Women's Experiences of the OASI Care Bundle; A Package of Care to Reduce Severe Perineal Trauma. *International Urogynecology Journal*, **32**, 1807-1816. https://doi.org/10.1007/s00192-020-04653-2

[37] Zulu, M. and Chanda, D. (2018) Mothers Satisfaction with Immediate Postnatal Care provided at Ndola Central Hospital, Zambia. *International Journal of Nursing Research* (*IJNR*), **3**, 135-144.

[38] Meaney, S., Lutomski, J.E., O'Connor, L., O'Donoghue, K. and Greene, R.A. (2016) Women's Experience of Maternal Morbidity: A Qualitative Analysis. *BMC Pregnancy and Childbirth*, **16**, Article No. 184. https://doi.org/10.1186/s12884-016-0974-0

[39] Shoorab, N.J. and Mirteimouri, M. (2019) Women's Experiences of Emotional Recovery from Childbirth-Related Perineal Trauma: A Qualitative Content Analysis. *International Journal of Community Based Nursing & Midwifery*, **7**, 181-191.

[40] Kwaleyela, C., Greatrex-White, S. and Walsh, D. (2019) Being There: Perspectives of Women Giving Birth in Zambia. *Journal of Midwifery and Reproductive Health*, **7**, 1602-1609.

[41] Bélanger-Lévesque, M., Dumas, M., Blouin, S. and Pasquier, J. (2016) "That Was Intense!" Spirituality during Childbirth: A Mixed-Method Comparative Study of Mothers' and Fathers' Experiences in a Public Hospital. *BMC Pregnancy and Childbirth*, **16**, Article No. 294. https://doi.org/10.1186/s12884-016-1072-z

[42] Aziato, L., Odai, P.N.A. and Omenyo, C.N. (2016) Religious Beliefs and Practices in Pregnancy and Labour: An Inductive Qualitative Study among Post-Partum Women in Ghana. *BMC Pregnancy and Childbirth*, **16**, Article No. 138. https://doi.org/10.1186/s12884-016-0920-1