The fallacy of normalcy: A multiphase study exploring women's help-seeking for health problems in the 12 months after childbirth

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Statement of Ethical conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University. The first study is a systematic review, and as such did not require ethics approval. The ethics number for the second study, 'Mothers' views of health problems in the twelve months after childbirth: A concept mapping study' is H0016441, 21 April 2017. For the third study, 'Online help-seeking and discussion groups post-childbirth: A content analysis of health-related support', the approval number is H0017619, 24 August 2018.

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List of abbreviations

ACOG	American College of Obstetricians and Gynaecologists
ACMI	Australian College of Midwives Incorporated
AD	Anxiety and related Disorders
AAP	American Academy of Paediatrics
ANF	Australian Nursing Federation
BMHSU	Behavioural Model of Health Service Use
CHAPS	Child Health and Parenting Service
JBIQARI	The Joanna Briggs Institute Critical Appraisal Tools
GP	General Practitioner
MHL	Maternal Health Literacy
MCHN	Maternal and Child Health Nurses
MDG	Millennium Development Goal
NEAF	National Ethics Application Format
NICE	National Institute for Health and Care Excellence
NHMRC	National Health and Medical Research Council
LGBT	lesbian, gay, bisexual, and transgender, and others
OCD	Obsessive Compulsive Disorder
GAD	Panic Disorder and Generalised Anxiety Disorder
PPD	Postpartum Depression
PPI	Patient and public involvement
SOGC	Society of Obstetricians and Gynaecologists of Canada
QUAL	Qualitative
QUAN	Quantitative
UK	United Kingdom
VDHS	Victorian Department of Human Services
WHO	World Health Organization

Abstract

Post-childbirth morbidities have burdened many women around the world, and women often do not seek treatment for them. Studies suggest that they are inhibited in expressing their needs, and so seek informal rather than professional help for their health problems, though admittedly there is limited evidence about women's help-seeking behaviour. Therefore, this study aimed to explore the key influences on women's help-seeking behaviour in the 12 months post-childbirth. Three different study phases were adopted to answer three questions: (i) what evidence exists in the peer-review literature about women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first the 12 months post-childbirth? (ii) What health problems do women feel require help during the 12-month period after childbirth and what is their help-seeking behaviour? (iii) What do women who participate in post-childbirth online support forum discuss about their health issues?

This study was underpinned by a feminist pragmatist paradigm and used a multiphase mixed methods design. Feminist pragmatism considers multiple views and values experience, which provided a useful lens through which to study women's health problems by hearing women's voices. In the first study phase, a systematic qualitative meta-aggregation was applied to literature about women's perceptions of the barriers and facilitators they experience in seeking help from health professionals. The Behavioural Model of Health Service Use (BMHSU) was used as a lens to view the qualitative research evidence. In phase two, concept mapping, an integrative participatory mixed method, was used to study women's perspectives on help-seeking behaviour for postpartum health problems. Bradshaw`s Taxonomy of Needs was used to explain the results of women's felt need after

childbirth. Concept mapping involved an online group of participants creating 83 brainstorm statements about post-childbirth health problems and help-seeking, and a second group of 15 women sorting and rating the statements based on their perception of the prevalence of the issues and the help-seeking advice they would offer others. For phase three, the content of messages posted by women to an Australian online forum was imported into NVivo 12 Pro for qualitative data analysis. The data were evaluated using directed qualitative content and thematic analysis.

The findings showed that women often did not seek professional help because they accepted problems as a normal part of the motherhood role. Women were more likely to share their problems with family and friends as people they trusted. Online platforms have allowed women to share their problems anonymously, but the support provided demonstrated some normalising of abnormal problems. Feminist pragmatism explains why the normalisation of health problems after childbirth dominates help-seeking behaviour for women after childbirth. The views of women, family and friends, and health care providers more closely adhere to 'the fallacy of normalcy' than recognition of health problems. Family and friends were successful when they encouraged women to seek professional help, but when women do seek professional help the availability and source of help is important. Some health care providers contribute to 'the fallacy of normalcy' for health problems, again decreasing the number of women who can readily access quality care.

This thesis highlights a need to reconsider (qualitatively and quantitatively) the approach to care after childbirth for women's trusted people and healthcare providers by acknowledging 'the fallacy of normalcy' if women are to receive timely and appropriate postnatal care.

Chapter 1: Introduction

When Faith Tan peed on herself and wet the entire floor shortly after the birth of her daughter, she brushed off the incident as a one-time embarrassment. After all, she had a hard time pushing her third baby out. “I didn’t take it seriously, so I left the hospital without telling my doctor about it,” says the 40-year-old administrator. She delivered three kids – now aged 13, 12 and one – by vaginal birth. But that was not a once-off. Faith never quite regained control of her bladder. Wetting herself at least five to six times each day became the new norm. Within a week of delivering, adult diapers had become her postpartum essential. Not even the thickest and most absorbent maternity pads could keep up with her massive urine leakage.

“In a sitting position, I was fine. But when I stood up, everything simply flowed out. It was very embarrassing because my new helper and the kids saw what happened,” says Faith.

On a regular day, she had to change her adult diapers at least twice. To avoid wetting herself so frequently, Faith made a toilet trip every half an hour. She also tried restricting her water intake. “The problem worsened every time I drank something. But it was impossible to stop myself from drinking water because I was constantly thirsty from breastfeeding,” she adds. She would also leak urine whenever she laughed or coughed.

Along with the awful realisation that she could no longer control her bladder, Faith also developed urinary tract infection and severe piles, both at the same time. The latter landed her in the emergency department two weeks after childbirth, while the infection probably came about because she was in adult diapers all day, she shares. “The pain from the piles was terrible, but I didn’t want to be admitted because that would affect my breastfeeding,” she recalls. “Thankfully, the doctors gave me medication and I was able to avoid being hospitalised.”

By the third week, an exhausted Faith felt postnatal blues creep up on her. “Imagine going through all those three conditions within a month during your confinement. I didn’t rest

> at all and felt so down and lost because I didn't know what to do," she says. In a desperate bid to solve her leaky conundrum, she booked an appointment to see her gynae, who recommended strengthening her pelvic muscles with Kegel exercises. Apparently, what she was going through was "pretty normal" for a third time mum, according to her doctor. Those words, however, were hardly reassuring to Faith. "I was so scared. How long would it take for me to regain control of my bladder again?" she says. Until then, she had never done such exercises. Neither had she adhered to traditional confinement practices when she had her first two kids. "My second child was born premature at 28 weeks, so I didn't have the chance to do a proper confinement. Now that I'm an older mum, I had planned to rest well. But I ended up having all these issues!" she says. The incident spurred her to take better care of herself. She did Kegels every day without fail, and took traditional herbs said to help strengthen her pelvic area. She also learnt to sit back and let other people help care for her newborn. "I think my husband felt really bad for me and tried to be more hands-on with the baby. For example, he and the helper would take turns to carry the baby so that I did not put extra pressure on my bladder. I'd only hold the baby when I was seated," Faith says (Gan, 2016).

This story is a common one among women after childbirth, and many women experience different morbidities which affect their personal and social life. As a midwife and researcher, I am familiar with stories such as Faith's. I have had many women who have experienced the same condition for a long time but who did not share their health problems. As a midwife in a postpartum clinic, I used a checklist to make sure I had asked all the relevant questions, but there are many other health problems such lists do not address. This story, and others like it, could be put in the category of 'hidden suffering'.

1.1 Research background and rationale

I am a midwife and have worked in a variety of areas of midwifery practice, including in hospitals, health care centres, private practice, and university midwifery education. I

witnessed many changes in the role of the midwife in my home country, Iran, which have been affected by universal changes in the midwife role. For example, I worked in a private practice where I was able to assist with births in my office. After a while, this activity was banned by the government. Moving to a hospital, my role was to work under obstetricians' supervision during the childbirth process for low risk women. Throughout my midwifery career, I have experienced many of the limitations imposed by a medicalised view of childbirth; indeed, midwives have been gradually marginalised from the childbirth process, being seen as an aid for obstetricians, and shifted to ante and postpartum care.

Moving to university as an academic and researcher, the topic of maternal morbidities has been among my interests for a long time. As a quantitative researcher, I have studied various aspects of postpartum morbidities in the Middle East (Rouhi et al., 2011; Rouhi et al., 2012; Rouhi et al., 2016; Rouhi et al., 2017; Rouhi et al., 2018), and the findings of a longitudinal study have shown that some of the health problems women experience after childbirth do not resolve (Rouhi et al., 2016). This study asked why women experience postpartum health problems for a long time, and what help-seeking behaviour this group of women used. Moving to Tasmania provided a great opportunity for the researcher to answer these questions, not just by being in a different setting, but also because the results of the study would help to improve women's health after childbirth all over the world.

1.2 Maternal morbidities and post-childbirth help-seeking

In the first 12 months following childbirth, many women experience physical and mental health problems collectively called 'maternal morbidity' (Van der Woude, Pijnenborg, & de Vries, 2015). These are defined as: "any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman's wellbeing and/or

functioning" (Chou et al., 2016, p. 1). These health problems occur from conception to post childbirth period (WHO, 2018a) and may even affect women live after their reproductive period (Filippi et al., 2018). These morbidities have been conceptualised as broad and complex and their description has been affected by different perspective's (Barreix et al., 2018; Firoz et al., 2013; Say et al., 2018). This is explained because people in society have different perspectives, whether healthcare providers or policy makers, about the concept of morbidities (McCauley et al., 2020). Globally, about 94 per cent of women experience at least one such morbidity during the first 12 months after childbirth (Moran et al., 2020).

Maternal morbidities have a wide spectrum from life threatening or "maternal near miss", which is defined by WHO as "the near death of a woman who has survived a complication occurring during pregnancy or childbirth or within 42 days of the termination of pregnancy" (Firoz et al., 2013, p. 794), to non-life-threatening or "nonsevere" (Barreix et al., 2018). The life threatening or "maternal near miss" morbidities result from one of the following health problems: postpartum haemorrhage, pre-eclampsia, eclampsia, puerperal endometritis, abortion complications, indirect infections (pyelonephritis, influenza-like illness, sepsis, and other systemic infections), chronic hypertension, severe anaemia, cancer, heart disease, lung disease, renal disease, and hepatic disease (Graham et al., 2016). Overall, for each maternal death there are over five near misses (Graham et al., 2016).

Non-life-threatening morbidities caused by pregnancy and birth can be classified as chronic morbidities and milder morbidities. The first group are not life-threatening but have ongoing adverse impacts for women's through ongoing health problems such as fistulas, uterine prolapse, and dyspareunia. The second group (postpartum maternal morbidities) include health problems such as urinary incontinence, hernias, haemorrhoids, breast

problems, and postpartum depression (Koblinsky et al., 2012). These issues are less life-threatening conditions but the quality of life for these women can been affected for life or cause future health problems (Dantas et al., 2020; Wang et al., 2020).

Although awareness of maternal morbidities has improved, there is no comprehensive information about how women manage their problems, and their ways of seeking help remain unclear. Help-seeking behaviour is known as a 'problem-solving strategy' (Cornally & McCarthy, 2011). Certain factors affect this group of women when seeking help, such as knowledge about post-childbirth morbidities, culturally informed shame or stigma, accessibility of health care providers, and awareness of available treatments (McCallum et al., 2011; Bina, 2014; Brown et al., 2015).

Furthermore, health problems have often been regarded as a normal part of the childbirth process, and many women spend the postpartum period normalising, minimising or hiding their health problems. Indeed, they consider these problems to be a normal part of the childbirth process (Abrams, Dornig, & Curran, 2009; Buurman & Lagro-Janssen, 2013). This normalising and minimising of health problems after childbirth has been found among family and friends, but also among health care providers (Sword et al., 2008; Wuytack, Curtis, & Begley, 2015; Bell et al., 2016).

Health care providers not only normalise health problems after childbirth, they also shift their attention to the infant's need, or to other matters such as breastfeeding and contraception (Fowles, Cheng, & Mills, 2012), leading to the mother's health needs being neglected. Women also ignore their needs because of time and financial constraints which prevent them from attending to their health (Fowles et al., 2012; Moran et al., 2020).

1.2.1 Hidden suffering

About 30 years ago, MacArthur, Lewis and Knox (1991) identified that many women experience postpartum health problems. They argued that these issues are 'hidden' because women are not encouraged to reveal their postpartum health concerns, and because traditional postpartum care does not create the opportunity to disclose them. However, the existence of these health problems and their negative impact from pregnancy to the years after birth has been highlighted by some authors (Filippi et al., 2018; WHO, 2018). Globally, about 94 per cent of women experience at least one such condition during the first 12 months after childbirth (Moran et al., 2020).

As explained in section 1.2; the life threatening or "maternal near miss" could arise from health problems such as postpartum haemorrhage, pre-eclampsia, eclampsia, puerperal endometritis, abortion complications (Graham et al., 2016). These problems are well described, with established plans for treatment (Klainin & Arthur, 2009; Rouhi et al., 2012; Miller et al., 2013; Abdollahi et al., 2014; Woolhouse et al., 2014; Corrigan, 2015; Yusuff et al., 2015; WHO, 2015; Kim & Dee, 2016). However, the less medically identifiable common postpartum morbidities, such as backache or fatigue (Schytt, Lindmark, & Waldenstrom, 2005; McGovern et al., 2007; Rouhi et al., 2011; Hardee, Gay, & Blanc, 2012; Song, Chae, & Kim, 2014; Moran et al., 2020), are not taken into consideration in the traditional routine postpartum check-up (Macarthur et al., 1991; MacArthur et al., 2002; Levitt et al., 2004; Ansara et al., 2005; Cheng, Fowles, & Walker, 2006). Overall, postpartum health services insufficiently identify all postpartum health issues that may have long-term effects on women's health.

The existence of hidden morbidities in the postpartum period shows that women's postpartum needs are not always being met (Cassiano et al., 2015). The problem is compounded by the inhibition postpartum women feel in expressing their needs (Maher & Souter, 2006). To assess the needs of women in the postpartum period, there is a trend toward assessing delivered services (Hohman & Loughran, 2013). Bradshaw (1994) defined four types of need. First is 'felt need', when clients know about their need but do not disclose it. Second is 'expressed need', when someone takes action to meet their felt need. Third is 'normative need', which is need defined by experts, such as policymakers and health professionals, and which usually results in services designed to care for people in society. Normative need can be affected by any difficulties in defining need and by disagreement among experts. Finally, 'comparative need' is simply a comparison of the needs of people in different states of health or geographic areas (Bradshaw, 1972; Bradshaw, 1994; Carver, Ward, & Talbot, 2014). Bradshaw's taxonomy helps to clarify the discussion of needs in relation to the post-childbirth women in the current study.

1.3 Feminist pragmatism as theoretical background

The theoretical background selected for this study is feminist pragmatism. First appearing in the 1990s (Rooney, 1993), the combination of pragmatism and feminism covers the strengths and weaknesses of both theories. Feminist philosophers adopted the core concepts of pragmatism, creating a framework combining "pluralism, lived experience and public philosophy, with feminist theory and practice in order to engage in social issues about women" (Whipps & Lake, 2004, p. 1). Feminists argue that sex is determined biologically, but that gender is a set of socially constructed expectations placed on men and women (Alston et al., 2006). These social expectations shape the roles of women and men in a society, where

the physical strength of men (used in doing agricultural work, for example) has marginalised women to home-based tasks (Liepins, 2000). In health, pregnancy has been accepted as the biological role of women, and Alston et al. (2006) argue that gender construction has forced women to take care of their family members at the expense of ignoring their own health. Gender is thus a determining factor in the lack of understanding of women's health problems.

Creswell (2013, p. 10) argued that there are "different forms of the pragmatism philosophy, but for many pragmatisms as a worldview arises out of actions, situations, and consequences rather than antecedent conditions". Pragmatists believe that the priority is the research problem rather than the methodology. Researchers are not restricted to using special methods and techniques and to collecting and analysing data. Consequently, to better understand the problem, both qualitative and quantitative methods are used (Creswell, 2013). Both feminism and pragmatism emphasise experience; the aim is solving problems, and the researcher's experience helps to form the knowledge about the area of research (Rooney, 1993). Accordingly, feminist pragmatism underpinned this study. Feminist pragmatism will be further explained in the literature review, Chapter 2.

For this study, a mixed methods approach was selected. Qualitative and quantitative methods of research have their own benefits and deficits, so they help us to gather different types of information (Bryman, 2007). With 'mixing or blending', we can achieve a more comprehensive perspective in research questions or hypotheses than either qualitative or quantitative methods could achieve alone (Creswell, 2013).

1.4 Purpose

The aim of this mixed method study was to explore the key influences on women's help-seeking behaviour in the 12 months post-childbirth. To achieve this aim, this study was conducted over three phases.

Phase one was conducting a meta-aggregation systematic review with the objective of exploring women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first 12 months post-childbirth.

Phase two was investigating help-seeking behaviour among Australian women for their health problems in the 12 months post-childbirth. The main objectives were to identify the health problems that women felt required help during this period and to identify their subsequent help-seeking behaviour.

Phase three explored online help-seeking discussions about post-childbirth problems among women who participate in post-childbirth online support forum. This phase had three objectives: identification of health problems by women shared online; identification of women's motivations for questions posted on the forum discussion board; understanding the support given to mothers who have posted questions about post-childbirth morbidities.

- Phase 1: Systematic qualitative meta-aggregation review: Women's help-seeking behaviours within the first 12 months after childbirth
- Phase 2: Concept mapping study: Mothers' views of health problems in the 12 months after childbirth

- Phase 3: Content analysis of health-related support: The 'fallacy of normalcy': a content analysis of women's online post-childbirth health-related support.

1.5 Study aim and research questions

1.5.1 Study aim

The aim of this study was to explore the key influences on women's help-seeking behaviour in the 12 months post-childbirth.

1.5.2 Research questions

1. What evidence exists in the peer-reviewed literature about women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first 12 months after childbirth?
2. What are the health problems that women felt required help during the 12 month period after childbirth, and what help-seeking behaviour did they employ?
3. Which health problems were shared among women who sought help?
4. What were the motivations behind questions mothers posted on the discussion board?
5. What support was given to mothers who had posted questions about post-childbirth morbidities?

1.6 Structure of this study

Chapter 1 has described the aim and research questions, as well as the background of the study.

Chapter 2 presents a review of the literature on post-childbirth maternal morbidities and help-seeking behaviour. The chapter summarises relevant literature on post-childbirth health problems and help-seeking behaviour among women. It explains traditional postpartum care,

physical, mental and societal changes during this period, as well as postpartum care in developed countries and barriers to seeking care. Relevant feminist literature, forming the theoretical background, will also be discussed. Finally, the chapter will address help-seeking behaviour among women during the post-childbirth period.

Chapter 3 illustrates the conceptual framework and research design for this study. In this chapter, the rationale for selecting a mixed methods design is explained. As this study has three phases, the reasons for selecting the research design for each phase are clearly outlined.

Chapter 4 reproduces an article containing a systematic qualitative meta-aggregation review of women's help-seeking behaviours within the first 12 months after childbirth.

Chapter 5 reproduces an article on mothers' views of health problems in the 12 months post-childbirth using a concept mapping methodology.

Chapter 6 reproduces an article about online help-seeking and discussion groups for post-childbirth mothers through a content analysis of health-related support.

Chapter 7 interprets and synthesises the key findings of the three phases in the context of maternal health problems after childbirth.

Chapter 8 presents final statements on the achievements and limitations of this study, as well as recommendations for reform.

1.7 Chapter summary

This chapter has presented an overview of the study. The chapter started with background on maternal morbidities and help-seeking behaviour and the rationale for conducting this study. Following this, it explained the aim of the study, and introduced the three phases

designed to achieve the study's aim. The theoretical and conceptual background for this study has also been described. The feminist pragmatist underpinning of this study was chosen to explain the key findings on the influences on women's help-seeking behaviour in the 12 months post-childbirth. The feminist pragmatist paradigm and multiphase mixed methods design are intended to uncover women's health problems by considering multiple views and valuing experience by listening to (and hearing) women's voices. The next chapter will review the literature relevant to the themes and aim of this study.

Chapter 2: Literature review

A narrative overview has been employed for this review of literature. A narrative overview allows a critical analysis and summary of published articles related to the key concepts relevant to the aim of this thesis (Cronin et al., 2008; Green et al., 2006; Ferrari, 2015). This narrative literature review will highlight the current state of knowledge, including gaps, in women's help-seeking post childbirth. This chapter will clarify the research question.

This chapter presents a review and summary of the relevant literature on post-childbirth health morbidities and help-seeking behaviour among women. It describes the traditional approach to postpartum care, the physical, mental and social changes during the postpartum period, as well as the state of postpartum care in developed countries and barriers to seeking care. Women's needs and the state of post-childbirth care in developed countries are then considered. This chapter will also highlight known barriers to and facilitators of post-childbirth help-seeking behaviour among women including health literacy and other social determinants of health. These issues are interconnected as women's help-seeking is dependent on them being informed about and understanding what health problems /issues are common but not normal. This is exacerbated by the lack of women's views in the literature.

The chapter points out the gaps in the literature which led to the research questions of this study; for example, that postpartum women typically do not seek help for their health

problems, and further that family, friends and even health care providers do not facilitate or acknowledge or dismiss their seeking help. Feminist theory provides an explanation for the lack of women's views in the literature. Before explaining the issues, it is important to clearly define the term 'postpartum'.

2.1 Search strategy

The following question guided this narrative overview: 'What is known about postpartum morbidities, women's help seeking, and obstacles to access of postpartum care?' Electronic databases were searched for published articles: PubMed, CINAHL, Google Scholar and the Cochrane database, and article reference lists scanned to detect additional articles. Only articles published in English, between 2000-2019 were included.

Three separate searches, each building on the last, were conducted of each database. The terms in search (1) were: 'postpartum', 'postnatal', 'perinatal', 'after childbirth', 'following birth', 'postpartum period', 'puerperium', 'birth', The terms in search (2) were: 'maternal', 'women', 'mothers'. The terms in search (3) were: 'postnatal care', 'health care access', 'perinatal care', help-seeking. The terms in search (4) were: 'obstacles', 'barriers', 'facilitators. All searches utilised the Booleans AND or OR to link search descriptors. The primary search found 568 papers but the search for recent literature continued during the candidature. The abstracts were scanned for relevance and those that did not meet the search criteria were excluded, those that did were read in full. The literature was scanned repeatedly over several years for new work. In total seventy-eight papers were included in this chapter after evaluation and synthesised around key concepts.

2.2 Definition of the postpartum period

Traditionally, the postpartum period, or the puerperium, begins one hour after delivery of the placenta and continues for approximately six weeks (WHO, 1998). It is also referred to as "the postnatal period (Latin for "after birth," from *post* meaning "after" and *natalis* meaning "of birth'") or puerperium (Latin for "after childbirth," from *puerperal* meaning "a woman in childbed")" (Thung & Norwitz, 2010, p. 1). It has traditionally been said that during this period, all reproductive organs returning to a 'not pregnant' state (Leah, 2000). The postpartum period is divided into three phases: "the acute period (first 6–12 hours after birth), the subacute phase (2–6 weeks after birth), and the delayed phase (lasting up to 6 months post-delivery)"(Suplee, 2014, p. 780). Recently it has been argued that the 12 months after childbirth is the real period of recovery for woman's health (Walker, Murphey, & Nichols, 2015) and is a crucial intermediate time for her physical and mental wellness (Singh & Kumar, 2014). This extended 12-month postpartum period is the focus of this study.

2.3 Post-childbirth morbidities

Maternal morbidities are defined as "any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman's wellbeing and/or functioning" (Chou et al., 2016, p. 1). Since 1980, postpartum morbidities have received increasing interest in both developed and developing countries. A range of research approaches have been employed to identify long and short term acute and chronic morbidities following childbirth (Field et al., 1983; Gunn, 2003; Vallely, Ahmed, & Murray, 2005; Hogan et al., 2010). In developed countries, such as the USA, UK, and Australia, more emphasis has been placed on the compilation of postpartum morbidity statistics (Gunn, 2003). These studies have focused on the prevalence of post childbirth maternal morbidities.

Maternal morbidities remain a challenge to define, interpret and measure, and the prevalence of both general and specific morbidities has been inadequately addressed in the literature (Vallely et al., 2005; Webb et al., 2008; Hardee, Gay, & Blanc, 2012; Filippi et al., 2018), in spite of the reduction of maternal morbidity after childbirth being one of the UN's eight Millennium Development Goals (MDG 5) (Ronsmans & Graham, 2006; Graham et al., 2016). Many women around the world experience morbidities which they may themselves ignore, or which go neglected by health care providers (Maher & Souter, 2006; Cassiano et al., 2015). Further, Cassiano et al. (2015) found that women are less concerned about their physical and mental health problems due to new conditions, such as caring for the newborn and responsibilities around the house. In addition, the quantitative and qualitative literature covers various aspects of this issue, but has paid relatively little attention to women's views.

Seminal studies such as those by Macarthur, Lewis and Knox (1991) and Glazener et al. (1995) have shown that postpartum morbidity is a worldwide phenomenon, and estimated that 90 per cent of women report having problems related to childbirth during the first eight weeks (Van der Woude et al., 2015; Moran et al., 2020), about 94 per cent of women experience at least one such condition during the first 12 months after childbirth (Moran et al., 2020), and that some women have these morbidities for two (Van der Woude et al., 2015) or even five years after childbirth (Rouhi et al., 2016).

According to the definition provided by Chou et al. (2016), women's health is a culmination of the earlier phases of their life and morbidities defined as 'postpartum' may predate pregnancy or develop during pregnancy. Maternal mortality from pregnancy-related complications still causes about 350,000 deaths per year among women in the third world (Hardee et al., 2012). For every maternal death from pregnancy-related causes, about 20 or

30 women experience acute or chronic morbidity, often with tragic consequences (Hardee et al., 2012; Chou et al., 2016; Say et al., 2018). Thus, maternal mortality is just "the tip of the iceberg and maternal morbidity is the base" (Singh & Kumar, 2014, p. 2). Around the world, the six-week postpartum period is the time of highest risk for women; about 61 per cent of all maternal deaths happen in this time, compared to 24 per cent during gestation and 16 per cent during birth (Singh & Kumar, 2014).

The effects of many postpartum morbidities can be categorised as short term, such as infection, anaemia, perineal tears, urinary tract infection, and depression, or longstanding, such as incontinence, fistulas, pelvic inflammatory disease, genital prolapse, hypertension, haemorrhoids, nerve damage, pituitary failure, anaemia, and infertility (Ferdous et al., 2012). These health issues originate from pregnancy, the first or second week after delivery, but if they are not recognised or treated properly, they can become chronic conditions. Annually, between 15 and 20 million women endure impairments from these long-term morbidities (Vallely et al., 2005), and it is estimated that 50 million are afflicted by morbidities such as haemorrhage, pregnancy-related hypertension, pulmonary embolisms, and puerperal sepsis (Singh & Kumar, 2014). In 2017 approximately 80 million cases of maternal morbidities were reported (Moran et al., 2020).

2.4 Identification of physical and emotional postpartum changes

Childbirth is considered to be the apex of physical and mental changes in a woman's life (Mercer, 2004; Sagayadevan et al., 2015). Traditionally, it has been said that hormonal related changes resulting in the beginning of involution of the organs to the non-pregnant condition, but this period, too, consists of physical, mental, and social changes (Song et al., 2014). To

better understand the nature of postpartum morbidities, we must first look at the changes that occur after childbirth.

2.4.1 Physical changes

Women's bodies undergo significant changes in the postpartum period. In the first six weeks after childbirth, the pelvic organs (uterus, vagina, ligaments and muscles) return to pre-pregnant state. The uterus gradually decreases in size, and the vagina, uterine ligaments, muscles of the pelvic floor, and rectus muscles return to their non-pregnant positions. Postpartum bleeding continues for five to six weeks. In breastfeeding women, ovulation will return at about eight to 10 months, and in four to five weeks for women not breastfeeding. By two to three weeks, all perineal tears and any lacerations should have healed. Changes in renal function and digestion related to pregnancy gradually resolve. The cardiovascular system undergoes dramatic changes during the postpartum period (Abbott, Bowyer, & Finn, 2014; Cunningham et al., 2018). Most major pregnancy-related physical changes gradually subside over six to eight weeks, but for some women, physical morbidities such as back pain, urinary incontinence, bowel problems and fatigue lead to ongoing poor physical health (Webb et al., 2008; Haran et al., 2014; Daly et al., 2018; Jurášková et al., 2020).

There are some key socio-economic factors which are known to affect women's post childbirth health such as physical access, political context, the maternity care system, acceptability, colonialism, cultural factors (Dawson et al., 2019, p. 1), poverty (Graham et al., 2016), social support (Hetherington et al., 2020) and low levels of health literacy (Guy et al., 2014; Brown et al., 2020).

2.4.2. Mental changes

Many women experience some mood changes during this period, such as postpartum 'blues', and some women are at increased risk of developing to postpartum depression and psychosis and anxiety. Postpartum blues have been described as temporary periods of depressive signs, usually occurring four days after childbirth, though for some women it can happen two weeks after childbirth (Rezaie-Keikhaie et al., 2020). The symptoms consist of "anxiety, disturbed sleeping patterns, decreased appetite and irritability" (Derbyshire & Costarelli, 2008, p. 162), which 80 to 85 per cent of all women experience (Corrigan, 2015).

Postpartum depression is more serious than postpartum blues, and is characterised by a variety of different symptoms, which can include "feelings of suicide, obsessive thoughts, and extreme petulance" (Derbyshire & Costarelli, 2008, p.33). Postpartum depression typically appears within six weeks of childbirth (Dindar & Erdogan, 2007). Globally, the claimed prevalence of postpartum depression varies from as low as 0.5 per cent to 60.8 per cent, depending on the scale used (Klainin & Arthur, 2009).

Postpartum psychosis is an acute mental disorder that occurs during the first days to weeks after childbirth. It is a critical situation, potentially endangering the child and mother, which needs emergency intervention. Psychosis is recognised from reports of "auditory hallucinations, grandiose delusional beliefs, and depressive symptoms, with feelings of hopelessness, worthlessness, and uselessness". The prevalence of postpartum psychosis in the general population of women is one to two in 1,000 (0.1 to 0.2 per cent) (Berrisford, Lambert, & Heron, 2015, p. 22).

There are other mental health disorders which impact on women's experience, grouped as 'anxiety and related disorders' (AD). These are by definition "experienced by women during pregnancy and the postpartum period (the first 12 months after birth)" (Abrar et al., 2020, p. 13). AD consists of Obsessive-Compulsive Disorder (OCD), Panic Disorder, Posttraumatic Stress Disorder (PSD) and Generalised Anxiety Disorder (GAD) (Collins, 2018). These mental problems are preventable and categorised alongside with major depressive problems (Fairbrother et al., 2016). The prevalence of prenatal and postpartum AD has been reported at between 9–22% and 11–21% respectively (Fairbrother et al., 2016). Women who have physical health problems during pregnancy have been reported to have more AD (Abrar et al., 2020).

Several elements have been identified as playing a role in postpartum mental health. These factors can be grouped as biological, psychological, and socio-cultural. One biological factor is endocrinological, though it is still not clear which hormones cause postpartum mental problems (Derbyshire & Costarelli, 2008; Glasheen, Colpe, Hoffman, & Warren, 2015; Valadares et al., 2020). Among psychological factors, a history of major depressive episodes and other psychiatric illnesses, such as psychosis, life stressors and anxiety, are known risk factors for postpartum mental health issues (Abdollahi et al., 2014; Stone et al., 2015). Socio-cultural variables also contribute to postpartum mental ill-health. These variables can be grouped in terms of characteristics of the mother: age, occupation, educational attainment, economic status, and whether the pregnancy was unplanned (Klainin & Arthur, 2009; Rouhi et al., 2012). Family income and relationship status with the partner/father of the infant (Stone et al., 2015; Lange et al., 2019; Hetherington et al., 2020; Johansson et al., 2020), the age of the marriage (Abdollahi et al., 2014; Valadares et al., 2020) and negative pregnancy

experiences (Bernazzani & Bifulco, 2003; Koss et al., 2016) also play a part. Socio-cultural characteristics of the infant, including health problems and quality of paediatric care (Rouhi et al., 2012), are also significantly associated with mental disorders in the mother (Shaw et al., 2006).

2.4.2.1 Emphasis on postpartum depression

Since 1998, the World Health Organization (WHO) has made it a priority to address maternal health issues (WHO, 1998, pp. 59, 61). Among postpartum morbidities, more emphasis has been placed on depression (Klainin & Arthur, 2009; Buurman & Lagro-Janssen, 2013) and on the role of health care providers in early detection, better understanding, and referral systems (Jones, Creedy, & Gamble, 2011).

In Australia in 2007, the Perinatal Mental Health Group, and Beyond Blue's Perinatal Mental Health National Action Plan, were established to address mental health issues in Australian women (AHMAC, 2009, p. 4). The National Perinatal Depression Initiative was then launched by the Australian federal, state, and territory governments with the aim of prevention and early recognition of perinatal depression (AHMAC, 2009). The Australian government spent $55 million on the National Perinatal Depression Initiative over five years (Jones et al., 2011). In addition, each state implemented Beyond Blue's Perinatal Mental Health National Action Plan and the National Perinatal Depression Initiative in response to indigenous needs and urgencies (Jones et al., 2011).

According to the Australian National Health and Medical Research Council's Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period (2010), the evaluation of postpartum depression should be done by GPs, midwives and maternal and

child health nurses (Jones et al., 2011). A study by Gunn and colleagues (2003) in Australia identified that health care providers had insufficient knowledge about postpartum depression. However, interventions (such as an educational program for midwives working in Melbourne hospitals, for example) can improve providers' ability to recognise and care for mental illness and psychosocial risks, including depression and domestic violence (Gunn et al., 2006). A national survey by Jones et al. (2011) gathered data on midwives' knowledge about perinatal depression and showed that midwives were not satisfied with their educational curriculum; they felt that they had to rely on other sources of information, such as books, or papers in journals. A systematic review by Austin et al. (2013) on the recognition and supervision of mood disorders in the maternity field showed that, in Australia, the role of midwives in maternal mental health is unclear.

Compared to 20 years ago, there has recently been an improvement in recognition of postpartum mental health problems, which highlights that policy impetus and education can boost knowledge of postpartum health issues among health care providers (Gunn et al., 2003; Jones et al., 2011). To offer adequate emotional care to postpartum women, health care providers must be given information and education. Jones et al. (2011) argue that it is the responsibility of all health care providers to: have knowledge of perinatal depression; use validated screening tools to recognise high risk women; and put referral systems in place to care for and support such women. Although mental health problems have been regarded as a priority for health care providers, many women's and their families' lives continue to be affected by post-childbirth mental disorders.

2.4.3 Social changes

The postpartum period is also a time of alteration in the social aspects of women's lives, driven by new parental responsibilities, changes to personal relationships and body image, and increased infant and family care and household management responsibilities. During this period, all women have special needs as they cope with these major changes (EdalatiFard et al., 2016). In addition, they are expected to deal with often significant impacts on their social and economic resources (Rowe, Holton, & Fisher, 2013; Powell & Karraker, 2019). Adaptation to a new role happens over a long period after childbirth for many new mothers (Fahey & Shenassa, 2013), and this, in turn, requires psychological adjustment (Darvill, Skirton, & Farrand, 2010). It is arguable that social changes should also be considered as one of the postpartum changes, as it is clear that adaption to parenthood puts considerable pressure on many aspects of women's lives (Rowe, Holton, & Fisher, 2013). Recently, there has been renewed interest in the impact of social adjustments on women's health during the months following birth, particularly the first three months postpartum, or the 'fourth trimester' (Verbiest et al., 2018).

2.5 History of postpartum care

In 1975, anthropologist Sheila Kitzinger asserted that "there is a fourth trimester to pregnancy, and we neglect it at our peril" (Kitzinger, 1975, p. 118). Around the world, postpartum care practice was derived from techniques developed in the early 20th Century in response to high rates of maternal and neonatal mortality. At that time, maternal and neonatal care was focused on "observation and examination" (WHO, 2010, p. 3). The first guideline published by the WHO, "Postpartum care of the mother and newborn: A practical guide report" (WHO, 1998) was informed by studies published since the 1980s. For the first

time, the WHO identified the postpartum period as “under-researched and under-served”. This report addressed postpartum care of the mother and newborn and led to new policies for the postpartum period for 189 countries around the world. The aim of the practical guide was to enhance awareness about postpartum, maternal and newborn health, and to provide recommendations for infrastructure to meet the needs of women and families.

The WHO (1998) proposed practices to enhance postpartum health, not only to increase the awareness, abilities and the attitudes of midwifery, nursing and medical students, but also to increase women’s awareness of postpartum issues. Further, the report suggested that all countries prioritise research related to the postpartum period, such as addressing mental health issues, efficient postpartum care, assessment of long-term morbidities, and unified postpartum services (WHO, 1998, pp. 59, 61). The report was introduced as a practical guide for postpartum and postnatal care.

Early in the 21st Century, there was a desire to decrease maternal and neonatal mortality around the world, and to increase the level of women’s awareness as caregivers to be more involved in their own care. The aim of postpartum and postnatal care shifted to focus on increasing the level of awareness among family members and society more broadly to support postpartum women (WHO, 2010, p. 3). In October 2008, reduction of postpartum mortality became an aim for the WHO, which in 2012 shifted to the reduction of major maternal morbidities, such as haemorrhage, infection, anaemia, and depression (WHO, 2013b); other minor health problems, such as backache and fatigue were not addressed. As can be seen, apart from attention on postpartum maternal mental issues (Dennis & Dowswell, 2013), there has been little consideration of other postpartum morbidities such as backache and fatigue. This seems to reflect a shift in policy focus from health professionals to communities.

In 2000, two goals were launched to reduce maternal mortality; Millennium Development Goal (MDG) 4 and MDG 5. The aim of MDG 4 "was to reduce the under-5 mortality rate by two-thirds between 1990 and 2015", and the target for MDG 5 was "to reduce the maternal mortality ratio by three-quarters during the same period" (Lozano et al., 2011, p. 1139). Later in 2015, another global strategy introduced "The Global strategy for women's, children's and adolescents' health (2016–2030)", with three aims broaden their goals from reducing mortality: "survive (end preventable deaths); thrive (ensure health and well-being); and transform (expand enabling environments)"(Kuruvilla et al., 2016, p. 398). This strategy has emphasised to enhance the health and well-being of women, children, and adolescents.

Filippi et al. (2018) introduced a new conceptual framework for maternal morbidities as a women-centred approach. These health problems are not limited to the six weeks after childbirth; this period must expand from preconception to the post-reproductive or post-menopausal periods. Also, socioeconomic conditions, not just? clinical and biological issues, must be considered. The necessity to do longitudinal studies has emerged.

2.5.1 The evolution of postpartum care in the developed world

The aims of postpartum care are healthy mothers and children; the early finding of problems; supporting women to have successful breastfeeding and birth spacing; and avoiding contagious diseases between mother and child (Xiang et al., 2014). The WHO established a practical guide for postpartum and postnatal care in 1998, and has provided periodic updates and new guidelines on postpartum issues to promote these aims (WHO, 2010, 2013b, 2015). In the same year, the WHO asserted that all women should visit a health care provider at a health centre six weeks after childbirth (WHO, 1998). The next update, based on WHO guidance on the postpartum care of the mother and her infant, advised that

all new mothers and their newborns should receive care seven to 10 days and six weeks postpartum (WHO, 2013b).

These timeframes for meeting women's postpartum needs are not universally agreed, however Cheng et al. (2006) argue that postpartum care should cover all women and their infants during the 12 months after childbirth, and that it is important that the schedules offered meet women's individual needs and include opportunities for home visits. A literature review by Stumbras et al. (2016) to assess the strategies and interventions of the postpartum visit demonstrated that the timing of postpartum care is not meeting the needs of women in the US. In a Cochrane review by Naohiro, Dowswell, Shuko and Rintaro (2014) on timetables for home visits in the early postpartum period, the authors suggest that postpartum home care must be organised in line with local demands (Naohiro et al., 2014). Beake et al. (2010) assessed the expectation and experience of postpartum women related to postpartum care and recognised that there is a discrepancy between women's expectations and the content of current postpartum care, especially in terms of breastfeeding support. A systematic review by Haran and her colleagues (2014) showed that, despite the guidelines published by the WHO, Australia, the United Kingdom, and the US each have their own approaches to postpartum maternal and infant care.

2.5.1.1 The United States

The American Academy of Paediatrics (AAP) and the American College of Obstetricians and Gynaecologists (ACOG) formerly advised all postpartum women to pursue postpartum care between four and six weeks after childbirth (DiBari et al., 2014; Menard et al., 2015). Recently ACOG recommends this contact must happen during the first 3 weeks postpartum and the priority is the woman's individual needs (Petersen et al., 2019). This early visit should focus

on infant care, family planning, assisting women to sustain breastfeeding, and the diagnosis and management of chronic and new physical or mental conditions (DiBari et al., 2014). In June 2016, however, ACOG challenged this time frame on the basis that some postpartum morbidities occur earlier than six weeks (Stumbras et al., 2016). They suggested all women start their postpartum care before six weeks, stressing that if women missed their appointments, they be rescheduled (DiBari et al., 2014; Stumbras et al., 2016). Subsequently ACOG recommended this contact should happen during the first 3 weeks postpartum and woman's individual needs should be a priority (Petersen et al., 2019).

In the US, studies from as early as the 1970s have recognised ongoing improvements in maternal and child mortality (Menard et al., 2015), assessment of maternal and child health (especially attention to women with high-risk conditions), domestic violence, and short interval pregnancy (Bryant et al., 2006). Although each state has its own system for postpartum care, they share a common aim: to establish perinatal care (Castro Lopes et al., 2016). However women's views sugget current pre and postpartum care needs remain obscure, and there are demands for more flexible models and considering women's preferences (Peahl et al., 2020).

2.5.1.2 Canada

In Canada, public health services for mothers are provided through a range of sources of care, such as home care, phone consultation, and health centres (Aston et al., 2015). Postpartum visits are scheduled based on immunisation of the infant at six weeks, and at two, four, six and 12 months (Barimani & Vikström, 2015). In Canada, perinatal care is publicly funded, and women have the right to choose their health care providers, as established by the provisions of the *Canada Health Act* (O'Brien et al., 2011). Because of the shortage of

health care providers, especially in remote areas, the Society of Obstetricians and Gynaecologists of Canada (SOGC) previously supported midwifery care. After 1994, midwives were able to serve as health care providers in hospitals, and levels of satisfaction with their services thus began to be documented (O'Brien et al., 2011). But since the 1990s, the maternity care of Canadian women has changed so that family physicians are responsible for postpartum maternity care and midwives do not necessarily have an active role in this area, though this can vary by province. The responsibility of obstetricians has been focused on therapeutic and surgical medication (Guliani, 2015).

2.5.1.3 The United Kingdom

All postpartum women in the UK have the right to free access to postpartum care (National Institute for Health and Care Excellence, NICE, 2015). Women in the UK have their postpartum visit during the six to eight weeks after childbirth. They are given information on postpartum matters such as childcare and sudden infant death syndrome (NICE, 2015). The economic costs of health care in the UK have been a driver to focus on the role of nurses and midwives in the care of family and society (Sutcliffe et al., 2012). Policies in the UK have recognised that nurses' and midwives' postpartum services are both sufficient and cost-effective, especially for low-risk women, and that they give better care than GPs (Report of the Prime Minister's Commission 2010) The timeline for postpartum care recommends visits within 24 hours of birth, and at between two and seven days and between two and eight weeks after birth (Haran et al., 2014). Bick et al. (2020) criticised current postpartum care in the UK and argued that postpartum care in the UK is still not satisfactory (NHS England, 2016).

2.5.1.4 Australia

The Australian health care system offers a wide range of easy access services for all families (Goldfeld, Wright, & Oberklaid, 2003). The most important progress in infant and maternal pregnancy outcomes resulted from policies on family planning in the 1960s and 1970s, and on prenatal care in the 1980s and 1990s (Atrash et al., 2006). Australia's health system has been described as a "[a] web of services, providers, recipients and organisational structures" (AIHW, 2014a, p. 32). It has a universal public health system for all residents, and a good range and coverage of private health insurance (AIHW, 2015b). Before the 1940s, family doctors and midwives had responsibility for antenatal care and birth, but advice presented by obstetric nurses changed this (AIHW, 2016). In the late 1970s and 1980s, "midwifery-led antenatal care and birth outside the hospital" were initiated (AIHW, 2016). Now there is one "standard package of obstetrician + midwife + hospital" (AIHW, 2016, p.1). After discharge from hospital, women are advised to visit their General Practitioner or child health nurse at six weeks postpartum. Despite this, there are no uniform protocols, so postpartum services have been described as "inconsistent across jurisdictions, fragmented across disciplines and sectors" (Brodribb et al., 2013, p. 2). This has resulting in some women's needs going unmet.

In Australia, postpartum care has historically been provided by GPs and Maternal and Child Health Nurses (MCHN) funded by the government (AIHW, 2015a). A survey by Brodibb et al. (2015) showed that almost all women have postpartum visits during the first two weeks postpartum. Women who birthed at a private hospital got fewer referrals, because the GPs were sure that they would have had a postpartum visit by an obstetrician prior to discharge (Brodribb et al., 2015). Because of the lack of a precise schedule for postpartum visits (Haran et al., 2014) and the current trend towards shorter hospital stays for postpartum women

(Jones et al., 2016), the WHO (2013) advised that all postpartum women have postpartum visits at the first two weeks and at around six weeks.

The postpartum morbidities assessed by health care providers at postpartum reviews are focussed on postpartum depression, breastfeeding, diabetes, hypertension, haemorrhage, peripartum hysterectomy, and febrile morbidity in labour (AIHW, 2012). In February 2009, the Review of Maternity Services was published, which showed that "there was no consistent, national reporting of maternal morbidity, no standard national data and no nationally agreed definition of maternal morbidity conditions" (AIHW, 2012, p. 1). This review recommended that: "The Australian Government, across the country, agree and implement arrangements for consistent, comprehensive national data collection, monitoring and review, for maternal and perinatal mortality and morbidity" (AIHW, 2012, p. 1). Although, maternal mortality is not common in Australia (AIHW, 2015b).

It is acknowledged that there is a lack of research and of postpartum care in Australia, with most complications arising at home after discharge from hospital (AIHW, 2012). As recently as 2008, the Australian Government Department of Health and Ageing and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists expressed concern that postpartum care in Australia does not meet the demands of new mothers (AIHW, 2014b). Potential reasons for this failure are identified as: reduction of the length of stay at the hospital after childbirth; absence of family and social support; lack of infrastructure for health care providers and centres; low rate of breastfeeding; and disintegrated care (AIHW, 2014a, 2014b).

While the public health system is available to all Australian citizens, there is also the option of paying for private health care. Women who give birth at a public hospital have their

postpartum care from a registered midwife or child and family health nurse (phone or home visit) during the 10 days after hospital discharge, and are also advised to see their GP for ongoing postpartum care at about six weeks. Postpartum women who give birth in a private hospital stay longer (3 days) in the hospital and have a postpartum follow-up by a private obstetrician at about six weeks (Brodribb, Mitchell, & van Driel, 2016).

It must be noted that Australian women's preference is individualised home care (Forster et al., 2016), which must be provided by well-educated and skilful health care workers (Schmied et al., 2011; Bogossian et al., 2017). Inadequate staff has been recognised as a major barrier to seeking care (McLachlan et al., 2009; Ellberg, Hogberg, & Lindh, 2010).

2.5.1.4.1 Tasmania

Tasmania is an island state off southern Australia and was the site of the present study. The state's community-based child health services were established more than 90 years ago to educate mothers about sanitary parenting and to monitor the growth and development of infants (Annual Report Tasmania, 2014). In 1994, the *Obstetric and Paediatric Mortality and Morbidity Act 1994* (the Act) created the Council of Obstetric and Paediatric Mortality and Morbidity (the Council). The aim of the Council is the assessment of maternal mortality and morbidity (with a focus on postpartum morbidities such as haemorrhage and hypertension), and of children up to 17 years (Annual Report Tasmania, 2014). The check-up for all women in Tasmania at six weeks after childbirth is focused on women's issues such as weight, breasts, and contraception (Medicare Local Tasmania, 2012). Tasmanian women have access to the Child Health and Parenting Service (CHAPS), which is a community-based health promotion service aimed at enhancing the health of children (Annual Report Tasmania, 2014). The other available services are Parenting Centres for women and men to educate them on topics such

as breastfeeding and depression (Royal Hobart Hospital, 2015). It is acknowledged that "Tasmania had the largest average number of models of care per maternity service" (AIHW, 2016, p. 16), but the only studies of the effectiveness of these disparate services identified that the needs of Tasmanian mothers are not being met (Hoang & Le, 2013; Hoang et al., 2014). To date, there is a silence in the literature about the extent and context of postpartum morbidities in Tasmania.

2.6 Obstacles to postpartum care

A comprehensive study of the spectrum of women's postpartum behavioural and psychosocial health care is needed to identify gaps in care. The identification of these gaps, in turn, can be a stimulus to improving care and meeting guidelines for preventive health care in the areas of mental health, diet, physical activity, smoking, and alcohol use, for example (Walker et al., 2016). There are several known obstacles to postpartum care. Women are often disinclined to reveal physical and mental postpartum morbidities in the primary care setting, health professionals do not facilitate discussion of postpartum morbidities, and there is a lack of awareness of evidence-based management of postpartum health morbidities (Hartley et al., 2012).

The project 'Healthy People 2020' (Parento, 2012) aims to increase partnerships with women receiving postpartum care, regardless of demographic and socioeconomic differences. Thus, this area of care has been emphasised as the public preference to enhance postpartum women's health–considered a neglected period in maternal health care (Abushaikha & Khalaf, 2014). Investigating barriers to creating these partnerships is vital for health care providers (Ansong, 2015).

Some known barriers to women using postpartum care are lack of sleep and insufficient time to manage their needs. Risky behaviour such as drug or alcohol abuse is another known factor that can prevent women from seeking and using postpartum care (DiBari et al., 2014). Women who have a health condition during pregnancy presumably are seeking postpartum care (Kabakian-Khasholian & Campbell, 2005). The following section, however, describes barriers recognised in the literature to postpartum women seeking health care: health

literacy, socio-demographic status, economic conditions, psychosocial factors, and cultural/traditional factors.

2.6.1 Mothers not seeking care

Some postpartum health problems are under-reported and under-recognised (Maher & Souter, 2006), and some women experience difficulties in expressing their needs. It is crucial for health care workers to understand why women do not always prioritise their own health issues (Goldfeld et al., 2003; Maher & Souter, 2006). As Maher and Souter (2014) found, one of the reasons for women subordinating their own needs is that their infant's health takes priority. Infants' physical problems, such as premature birth or low birth weight, are other factors in their mothers not seeking postpartum care, as are more significant issues such as infant death or stillbirth (DiBari et al., 2014). Sometimes new mothers experience excruciating pain, such as breast pain, which forces them to seek treatment, and lack of foreknowledge about health issues was common among all mothers.

2.6.1.1 Health literacy

The WHO defines health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (Nutbeam, 1998, p. 357). So, the results of high health literacy for society are health improvement and consequent minimisation of health care expenses. People with high levels of health literacy are equipped with the knowledge to have a better lifestyle in order to prevent, recognise and seek care for their concerns (Guy et al., 2014; Brown et al., 2020). Maternal health literacy (MHL) refers to the ability of women to pursue and increase their knowledge about their family's health. One of the important

factors is that level of education correlates with a woman's use of health information and their seeking of health care services (Mobley et al., 2014; Brown et al., 2020). While the lack of access to health care information for illiterate women can have negative consequences for their and their family's health (Elkhoudri, Amor, & Baali, 2015), this group of women does not even rely on health care providers to seek help or treatment for their morbidities (Elkhoudri et al., 2015). Health literacy thus has a vital role how women and their families seek care.

2.6.1.2 Socio-demographic factors

It is commonly understood that certain socio-demographic factors are barriers to pursuing care. Such factors include age at the time of birth (AIHW, 2014a, 2015a; DiBari et al., 2014), multiparity, unwanted pregnancies (Almeida et al., 2014; DiBari et al., 2014), and place of residence (i.e., whether rural or urban) (Hoang et al., 2014). For women with low levels of education, other linked factors affect their seeking of health care, such as proximity to health care centres (Zamawe, Masache, & Dube, 2015), and a shortage of staff and infrastructure (Chen et al., 2014). In Australia, these issues are regularly assessed by the Australian College of Midwives Incorporated (ACMI), the Australian Nursing Federation (ANF), and the Victorian Department of Human Services (VDHS) – enrolment of midwives in "rural areas" is viewed as a key priority (Forster et al., 2006). The influence of socio-demographic factors should be considered in terms of potential obstacles to seeking care.

2.6.1.3 Economic conditions

Economic conditions can also play an essential role in discouraging postpartum women looking for care. These factors include low income, living in poverty (Almeida et al., 2014; DiBari et al., 2014), lack of insurance coverage, and lack of a job (Kabakian-Khasholian &

Campbell, 2005). There is a significant relationship between poverty and postpartum morbidities, especially mental health issues, which hinder women in seeking care (Guy et al., 2014; Segre et al., 2007). Health care providers must consider the economic status of postpartum women under their care as it has a significant effect on this group of women.

2.6.1.4 Psychological factors

The significance of psychological factors as an obstacle to seeking care has been identified. For some mental health issues, such as postpartum depression, new mothers do not have the knowledge to understand the indicators. There is a fear and embarrassment of the 'stigmatisation' of mental disorders, so they do not look for treatment (McCallum et al., 2011; Bina, 2014; Brown et al., 2015). Furthermore, in some countries with child support organisations, recognising that a mother has postpartum depression may lead to separation of the mother from her child (Dennis & Chung-Lee, 2006). Chung and Lee (2006) suggest that increasing public information relating to mental health problems after childbirth is the best way to prevent complications from unrecognised mental health issues among postpartum women.

Good relationships between health care providers and mothers encourages mothers to use postpartum and ongoing care. An ongoing relationship helps staff recognise women with issues, especially mental health issues, who are afraid of revealing their problems (Dennis & Chung-Lee, 2006). Socially, it has been recognised that postpartum women have problems in revealing their feelings, and that this 'silence' has often been neglected by family, friends, and health care providers (Dennis & Chung-Lee, 2006). Support and understanding of postpartum morbidities from family and friends, and especially from partners (Zamawe et al., 2015), and of the importance of seeking care, is crucial (DiBari et al., 2014). Poor marital relations have

also been found to be a barrier to accessing care, and contribute to poor maternal and child health (Azale, Fekadu, & Hanlon, 2016).

2.6.1.5 Traditional and cultural beliefs

Traditional and cultural beliefs are one of the major influences on postpartum care among asylum seekers, immigrants and minority groups (DiBari et al., 2014). Culture is explained as the 'values, beliefs, attitudes, and practices' amongst a group of people when immigrants bring their culture to a new home, it does not necessarily fit with available services (Lee & Brann, 2015, p.476). Good examples of these cultural differences include: *zuo yuezi* (ZYZ) or 'sitting-the-month' among the Chinese population, which is a traditional practice for women "restraining [them] from going outdoors" (Lee & Brann, 2015, p. 476); or, in Arab culture, staying at home for 40 days after childbirth (Abushaikha & Khalaf, 2014). Both of these traditions affect women's seeking and use of postpartum care. Many factors can combine as barriers, especially in certain cultural groups. In addition to socio-economic complications, women in these groups may experience language barriers, lack of knowledge about available services, lack of feeling that those services are useful, and, in some ethnic groups, a lack of suitable professional care (Dennis & Chung-Lee, 2006; DiBari et al., 2014; Maneze et al., 2016; Navodani et al., 2019). In summary, many different factors can reduce women's ability or willingness to search for and use postpartum care.

2.6.2 Health professionals lack of care/knowledge

Information about the knowledge of health care providers is not adequate (McCauley et al., 2011). Postpartum education for health care providers is crucial, because many postpartum morbidities are not familiar to women's family and health care providers (Khalaf

et al., 2009). Romanno et al. (2010) argue that to improve care for women during the postpartum period, health care providers must enhance their knowledge about safe motherhood. However, some mothers do not think that health care providers are the best resource (Maher & Souter, 2006); Mason (2003) has noted that three characteristics are essential for first-time mothers who are searching for GPs: "accessibility (especially after hours), trust, [and] expertise in child health".

Research also highlights that health care providers can be a barrier to women expressing felt needs after childbirth. Some health care providers lack knowledge about postpartum morbidities, and this translates into a lack of prompting or action (Khalaf et al., 2009; Beake et al., 2010). Recently, it has been argued that a key way to improve postpartum maternal and child health is by making health care providers aware of postpartum morbidities (Cassiano et al., 2015; Mazzo et al., 2015), with a re-balancing of postpartum health visits towards the needs of the woman's postpartum health (Fahey & Shenassa, 2013). The informed health care worker can help the postpartum woman by asking them about these morbidities to bypass the problem of new mothers being either unable to concentrate on their problems over the demands of their infant, or unaware of what is 'normal' in the postpartum state (Beake et al., 2010). The recognition of a woman's unmet needs during her postpartum period by health care providers would help women to recognise postpartum health problems (Cassiano et al., 2015). This issue has been highlighted by other studies, which suggest that health care providers are unable or do not provide full service after childbirth (Beake et al., 2010).

Research shows a concerning lack of knowledge about what is 'normal' in the postpartum period and its morbidities among health care providers, women and their families (Khalaf et

al., 2009; Beake et al., 2010). Postpartum, women need different information based on the time of their visit to a health care provider (Beake et al., 2010). It is suggested that health care providers should enhance their knowledge of how mothers can "bond with their infant, become skilful in techniques of feeding, and grow in confidence as parents" (Beake et al., 2010). While during the first days of this period most women need information about lactation or dealing with settling into a new situation (Beake et al., 2010), there is little clear information provided about the rest of the postpartum period.

Routine physical and psychological assessment of postpartum women by health care providers could begin to address their needs. This could be via a checklist to remind health care workers to collect the required information from the mother and, if appropriate, their partner (Phang et al., 2015). For example, a study by McCauley et al. (2011) in Australia showed that there is a lack of knowledge about mental health problems among midwives, and that consequently they try to avoid women with mental health problems. Additionally, Jones et al. (2012) found that midwives were able to support and care for postpartum women emotionally but that their knowledge base needs consideration. Findings from Jarret (2015) assessing midwifery students near completion of three-year and 78-week midwifery programmes suggest that the reasons behind the lack of knowledge of postpartum morbidities include health professionals' lack of skill, teaching, and support.

2.6.2.1 General Practitioners

Postpartum visits give an opportunity to health care providers such as GPs to assess the physical and mental health of postpartum women and their infants to prevent unforeseen consequences, to establish a network to support women and infants in difficult situations, and serve as an excellent time to give advice on contraception. A cross-sectional study by Hill

et al. (2019) showed that having the prenatal care conducted by GPs, and then having this relationship continue after childbirth is an efficient way to decrease postpartum issues.

New mothers are advised to visit GPs, which can provide a chance to recognise and supervise physical and mental health during the 12 months after childbirth. This can be an important time to enhance postpartum care and to address health issues for new mothers. Hartley et al. (2012) argue that to improve women's health after childbirth, GPs must enhance their skills, and that health care systems should prioritise the demands of new mothers because women had high expectations of postpartum care. For example, GPs and patients have a different perspective on psychological issues such as depression (Ogden et al., 1999). As Cape and Mcculloch (1999) found, patients did not discuss their mental health problems with GPs. The reasons for this related to the behaviour of GPs, who either did not encourage discussion or seemed too busy. Further, women feared 'stigmatisation' or 'embarrassment', or thought that their problems were not interesting to GPs. Overall, women felt it was not easy to speak about their issues with a GP (Cape & Mcculloch, 1999).

On the other hand, in some western countries (Brodribb et al., 2015; Preston, Jaye, & Miller, 2015) the number of GPs who are involved in maternity care is decreasing. Preston, Jaye, & Miller (2015, p. 316) found that, for New Zealand GPs, "interference of maternity care with personal lifestyle and office routine, insufficient training, difficulties retaining competency, and fear of litigation" were all causes of this decrease. But in Australia, GPs are the main source of perinatal care (Brodribb et al., 2015), and are gatekeepers to secondary and tertiary care. (Hartley et al., 2012). In Australia, GPs arrange almost all postpartum check-ups, and in fact some child and family health nurses cover antenatal and postnatal care (Brodribb et al., 2015). In some studies, there is support for the role of GPs in postpartum

visits, with some parents stating that the role of their GP was pivotal to their recovery, and that their GP had given them preventative information about physical and emotional problems.

2.6.2.2 The role of the midwife

The word 'midwife' literally means 'with women', and the International Confederation of Midwives (ICM), the WHO and the International Federation of Gynaecology and Obstetrics (FIGO) recognise the following definition by ICM:

> the midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. (Borrelli, 2014, p. 4)

The role of midwives is to hear, comprehend, and develop problem-solving skills based on the woman's needs. For all these skills, midwives must have practice and social proficiency, not just curative experience (Bashour et al., 2008). The ICM claims that "the world needs midwives, now more than ever", and many communities in the world do not have the number of midwives they need (Brodie, 2013, p. 1075); the WHO (2018b) has predicted that by 2030 more than nine million nurses and midwives will be needed globally.

A systematic review by Perriman, Davis and Ferguson (2018, p.225) assets that "the midwife–women relationship is the vehicle through which trust is built, personalised care is provided, and the woman feels empowered". Midwives are trained to support women who have a variety of expectations and needs, including women with special needs, and to encourage women to seek care and help (Crabbe, 2014; Castro Lopes et al., 2016). In many countries, midwives are the primary health care providers for all pre-, peri- and postpartum

care (Hatem et al., 2008), with the details of the role of midwives being framed by the expectations of their society (WHO, 2010). Various studies from around the world have shown that women are satisfied with their midwifery care during antenatal, intrapartum and postpartum care (Bahadoran, Alizadeh, & Valiani, 2009; Forster et al., 2016). There are no indications that the role of midwife will lose its importance.

The midwife has the key role of providing care immediately after childbirth. Many changes which occur during the postpartum period determine health and related consequences (WHO, 2010). Furthermore, a systematic review by Sutcliffe et al. (2012) comparing midwife-led care with physician-led care among low-risk women showed that midwives were more successful in meeting women's and their infants' need. A chochrane review by Sandall et al. (2016) showed women had a higher rate of maternal satisfaction in midwife-led continuity models of care. A 2011 scoping review on safety in maternity services by the Kings Fund concluded that midwife-led models of care for low–medium risk women are more cost effective compare to obstetrician-led models and improve women's health and post childbirth care and help seeking (Sandall et al., 2011). Also, the Birthplace in England study (Hollowell et al., 2011), by collecting data from 65,000 low-risk births between 2008 and 2010, confirmed that midwifery care is safe, low-cost and beneficial to mothers and their infants, and that consequently the number of midwifery units could see an increase in future. One of the novel methods of postpartum care introduced by Himes et al. (2017) is the use of a web-based platform for groups of women whose economic condition or daily responsibilites hinder them in taking care of themselves.

All midwives must be trained (through continuing education) during their working years to give the best and most efficient care to mothers and their newborns (Hadjigeorgiou & Coxon,

2014). Further, ongoing training helps midwives to have strong "self-esteem and self-confidence" (Hadjigeorgiou & Coxon, 2014, p. 984). A review of the literature shows that not only do some midwives have low confidence and knowledge for dealing with postpartum mental health issues (Elliott et al., 2006), but that this was also evident among student midwives (Jarrett, 2015). Providing a module on perinatal mental health study among midwifery students by Higgins et al. (2016) improved their knowledge about perinatal mental health.

While health services emphasise postpartum mental health issues (Beake et al., 2010), assessment of midwives' awareness showed that there is a lack of knowledge to recognise and refer women with mental health issues so they can get proper care and treatment (Jarrett, 2015; Higgins et al., 2016). Among health care providers, midwives have a significant and essential role to improve maternal and child health, and thus they could increase the "maternal satisfaction level" (Bahadoran, Alizadeh, & Valiani, 2009).

Although the role of the midwife always has been recognised as a key factor in the childbirth process, following the industrial revolution and 'the medicalisation of birth' and safe motherhood (Klima, 2001, p. 285; Davis-Floyd, 2007), the midwife's role has changed significantly. In spite of midwives taking an active part in the childbirth process, they are marginalised by the male-dominated profession of obstetrics (Davis-Floyd, 2007). In these situations, midwives devalued their role (Jordan, 1997). The medicalisation of birth sends the message that having a birth under control of medical process, especially under an obstetrician, is somehow safer and better than a midwife can provide; midwives internalise the obstetrician's power (Davis-Floyd & Davis, 1996; Jordan, 1997; Beckett, 2005). It is worth

noting that this view also led to a higher rate of caesarean sections in the 1960s and '70s (Davis-Floyd & Davis, 1996; Beckett, 2005).

2.6.2.3 Maternal and child health nurses

In Australia, maternal and child health nurses (MCHNs) work in Child and Family Health Centres, and are responsible for giving mothers guidance, and for assessing their infants' growth and development (Brodribb et al., 2013). These nurses are easy to access, and can give useful information relevant to the health of the child and mother (Maher & Souter, 2006). Coordination between GPs and MCHNs has been shown to be helpful in improving postpartum outcomes (Mbwili-Muleya, Gunn, & Jenkins, 2000). Most research has been done on the early stages of the postpartum period, and there are no comprehensive studies on the role and knowledge of GPs and MCHNs in coordination.

2.6.3 Lack of research/evidence

Over the past decade, the nature and extent of postpartum and maternal morbidity have received increasing interest in both developed and developing countries. A range of research approaches have been employed to identify long and short term, acute and chronic morbidities following childbirth (Gunn, 2003; Vallely et al., 2005; Hogan et al., 2010). In developed countries, such as the US, UK, and Australia, more emphasis has been placed on "the systematic documentation of concerning levels of postnatal morbidity" (Gunn, 2003, p. 382). This literature review clearly indicates that there has been a high volume of quantitative research on maternal morbidities, but a lack of research about how women manage and seek help for their health problems after childbirth. Table 2.1, below, compares the maternal

health problems suggested by the WHO (1998; 2013b) with various quantitative and qualitative studies on maternal morbidities.

Although researchers have focused on many health problems which the WHO (1998) did not address, the way they gather information has relied more on quantitatively studies, especially cross-sectional studies with binary assessments (yes/no), which cannot provide a comprehensive assessment of maternal morbidities (Say et al., 2018; Filippi et al., 2018). As well case studies or hospital records can not fully describe the experience of maternal morbidities (Filippi et al., 2018); tending to silence postpartum women's voices which underpins the lack of new maternal health evidence. Qualitative studies are needed to gain a fuller picture of women's' post-partum health problems and their help-seeking behaviours. Better understanding about women's perceptions, views or voices is essential to deliver the best care as possible for them (McCauley et al., 2020).

Ioannidis (2016, p. 2) in his article "Why Most Clinical Research Is Not Useful" introduced some important features for clinical research to demonstrate whether the proposed research is useful. These features are problem base, context placement, information gain, pragmatism, patient centeredness, value for money, feasibility and transparency. The current study addresses many of these features, especially pragmatism and patient centeredness, which underpins that the concept of women's views on post childbirth maternal health and help-seeking is useful to study.

Table 2.1 Maternal health morbidities suggested by WHO and studied by researchers

Subjects of quantitative and qualitative studies	Most frequently reported postpartum health problems in the first six weeks (WHO)
Depression	Depression, anxiety and extreme tiredness
Backache	Backache
Headache	Frequent headaches
Wound infection	Infections (high fever, foul discharge)
Constipation	Pelvic pains
Breast problems	Breast problems
Abnormal vaginal bleeding	Constipation
Difficulty voiding	Bladder problems
Urinary incontinence	Perineal pain
Urinary tract infection	Haemorrhoids
Abnormal vaginal discharge	Anaemia
Fatigue	Sexual relations
Postpartum blues	
Sexual problems	
Sleep problems	
Haemorrhoids	
Faecal incontinence	
Upper back pain	
Lower back pain	
Painful perineum	
Pain from caesarean section wound	
Anxiety	
Tingling in hands/fingers	
Tingling in feet/toes	
Migraine	
High blood pressure	
Varicose veins	
Dizziness/fainting	
Buzzing in ears	
Bowel upsets	
Weakness in arms	
Weakness in legs	
Pain in arms	
Pain in legs	
Shoulder ache	
Neck pain	

2.7 Unmet postpartum needs

Motherhood involves a transition to new psychosocial conditions, new performance expectations, and new needs. For many women, adapting to their new responsibilities is a challenge and these new roles can aggravate their postpartum women's needs (Phang, Koh, & Chen, 2015). While in this period of recovery, women must cope with changes that make them physically and mentally vulnerable (Nilaweera et al., 2016). Further, postpartum morbidities such as depression and fatigue have been recognised as an impediment to their new roles (Phang et al., 2015). New economic and social needs, and lack of, or poor, maternal care put them at risk as well (Mazzo, Soares, & Brito, 2015). This is compounded by a sense of inhibition many postpartum women feel about expressing their needs, which presents further barriers to adapting to their new lives (Maher & Souter, 2006).

Key postpartum needs include social support and information (Phang et al., 2015). For many women, social support, often provided by family and friends, is one of the best ways to achieve their role as a mother. Many new mothers obtain the information they need about the postpartum period from their family and friends. Sometimes this information is not appropriate to their circumstances, and sometimes it is even harmful (Phang et al., 2015).

Traditional sources of health information, such as booklets and information received directly from midwives, are widely used in different parts of the world (Grimes, Forster, & Newton, 2014). Pamphlets, leaflets and brochures with information about infant care and breastfeeding are often provided in hospitals; however, a pilot study using a self-administration questionnaire by Phang et al. (2015) designed to identify the levels of support expected and received by 25 postpartum women in Singapore found that women do not necessarily read these, and that sometimes the information is not clear enough for them to

understand. Other key sources of information among women are the internet, online forums, media such as newspapers and television, parenting classes, and consultations with health care providers (Walker et al., 2017).

A systematic review by Haran et al. (2014) showed that while there are comprehensive clinical guidelines for new mothers, these are specific to certain issues, such as maternal mental health, infant health and breastfeeding. For this reason, many women spend this period feeling pressured, and lacking information suitable to their individual needs. This lack of personal relevance exacerbates any potential problems (EdalatiFard et al., 2016). Mothers' most important concerns during the early postpartum period have typically focused on sleep, consumption of food, and cleanliness (Fahey & Shenassa, 2013). To adapt to these needs, parents need relevant information and practical assistance (Rowe, Holton, & Fisher, 2013). In addition, some women want health care providers to ask questions about their health and to give them emotional support, which requires listening skills (Brodribb et al., 2015).

2.8 Help-seeking behaviour during the post-childbirth period

Help-seeking is defined as a problem-focused, highly adaptive behaviour (Cornally & McCarthy, 2011), manifested in an ability to find help, support, information, guidance or treatment (Ana Fonseca & Canavarro, 2017). It is actively seeking help after recognising a physical or mental health problem (Cornally & McCarthy, 2011), and it is a coping strategy to find a solution for another person's problem, which takes interpersonal skills and social relationships (Rickwood et al., 2005).

Women within the first 12 months after birth are less likely to seek formal help from health professionals such as nurses and medical practitioners, instead seeking informal help from

family and friends (Maher & Souter, 2006; Woolhouse et al., 2009; Cornally & McCarthy, 2011). Known barriers to women seeking support for common maternal morbidities include being unaware of available treatment, lacking knowledge about post-childbirth morbidities, and feeling shame or stigma associated with the morbidity (McCallum et al., 2011; Bina, 2014; Brown et al., 2015). To gain better knowledge of barriers to help-seeking, the present study was underpinned by the Behavioural Model of Health Service Use (BMHSU) as a lens through which to view the relevant factors (Andersen, Davidson, & Baumeister, 2011).

2.8.1 The BMHSU model as a lens

The literature supports the argument that various factors play an important role in help-seeking among women. Some, such as perception of the problem, accessibility of help, and inclination to get treatment, have been suggested as assisting in help-seeking behaviours (Chandrasekara, 2016). Higher education levels and support from family and friends have been shown to enable help-seeking behaviours for women within the first 12 months after childbirth (Dennis & Chung-Lee, 2006). However, there is a limited understanding of how women within the first 12 months after childbirth experience formal help-seeking from health care professionals and services (Abushaikha & Khalaf, 2014).

One limitation of the field of help-seeking research has been the lack of a unifying theory of help-seeking behaviour. A variety of behavioural models have been used to explain help-seeking behaviours, including psychological models such as the Self-Regulation Model (Leventhal et al., 1984), the Health Belief Model (Rosenstock, 1966) and the Theory of Planned Behaviour (Armitage & Conner, 2001). Sociological perspective models have also been used, such as the Network Episode Model (Pescosolido & Boyer, 1999; Kadushin, 2004) and the Behavioural Model of Health Service Use (BMHSU) (Andersen et al., 2011). Among these

theories, sociological models that consider demographic and societal factors may best explain help-seeking behaviour in post-childbirth women, given the existing knowledge on the impact of informal support on health services use. The systematic review in the present study applied the BMHSU model (see Figure 2.1, below) as a lens to view the qualitative research evidence identified (Andersen et al., 2011).

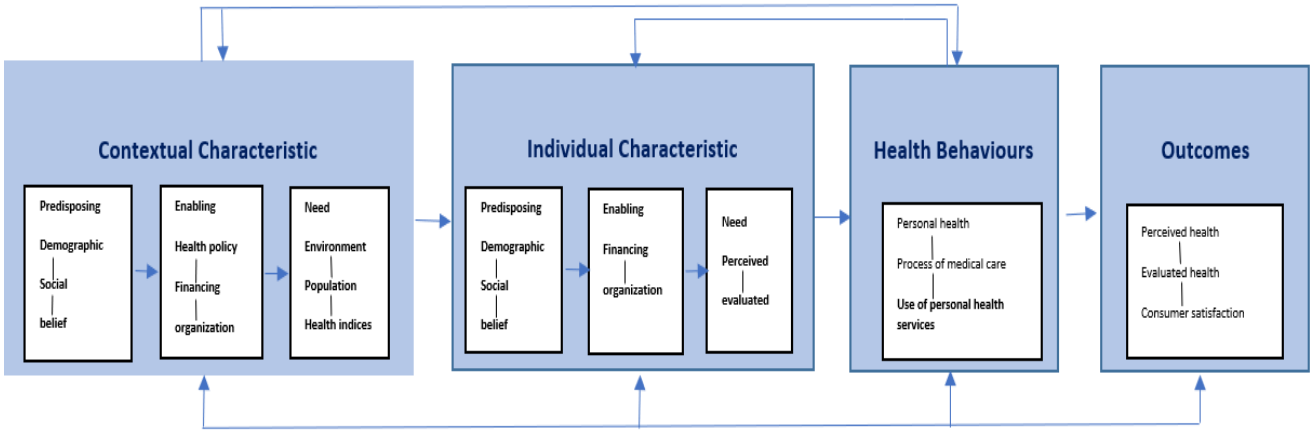

Figure 2.1 The Behavioural Model of Health Services Use, including contextual and individual characteristics (adapted from Magaard et al., 2017)

A concept analysis by Cornally and McCarthy (2011) to understand the meaning of help-seeking behaviours showed that finding help for health problems is a 'problem-focused behaviour'. In the context of maternal morbidities, there are various reasons why women do not seek professional help. For women, help-seeking behaviour is a process: they perceive a problem, experience felt need, and then actively seek help from an informal or formal resource. Guillot (1964) found that women rely on family and friends as an informal source of help, particularly when they have identified barriers to seeking help from formal sources, such as nurses and GPs (Fonseca, Gorayeb, & Canavarro, 2015).

Within this model, contextual and individual characteristics shape women's health behaviour. The BMHSU (Figure. 2.1, above) proposes that health outcomes originate from a mix of contextual characteristics, individual characteristics, and health behaviours (Andersen et al., 2011). The contextual and individual characteristics are categorised into predisposing variables, enabling factors and need variables (Andersen et al., 2011). Family, society and the health care system are all considered contextual characteristics; personal beliefs about health care services, education level and demographic features such as age are classed as individual characteristics (Andersen, 2008). The health behaviours that are influenced by personal practices and the process of medical care shape the use of personal health services (Andersen et al., 2011). The present study has considered only the contextual and individual characteristic elements of the BMHSU model as barriers and facilitators to women's health behaviours and outcomes (see Figure 2.1, above). Anderson et. al (2011) conceptualise the factors important in seeking help as (a) predisposing variables, (b) enabling factors, and (c) need variables, such as the severity of post-childbirth morbidities.

Other studies have also used the BMHSU model to find factors that were important in help-seeking. For example, Fleming and Resick (2017) applied the BMHSU model to the help-seeking behaviour of 372 women who were victims of intimate partner violence, and found that predisposing and need variables were the main factors influencing help-seeking. A systematic review by Magaard et al. (2017) investigated factors associated with help-seeking behaviour among individuals with major depression using the BMHSU model. Their results showed that socio-demographic and need factors appeared most influential on help-seeking behaviour.

2.9 Underpinning theory of the literature reviewed

The present study focused on women's experiences and opinions; consequently, feminist theory was selected. It has been widely argued that pregnancy has been accepted as the biological role of women, but that gender construction has forced them to take care of other family members, leading to women ignoring their own health (Alston et al., 2006). The importance of women's health issues has been highlighted in the 1970s and early 1980s (Kuhlmann & Babitsch, 2002). In this context, feminist activists began to take action to restrict men's power in the area of maternal health and childbirth. Feminist theory draws attention to women's right to control their bodies, and to decide about their childbirth, in spite of men's traditionally dominant influence on their decisions (Crary, 2001).

Historically, women have been considered inferior to men (Smith, 2004; Lewis & Kinser, 2005), and consequently their health has been ignored and marginalised. For many years, inequity in women's health, and even lack of research, has been recognised as normalising problems related to pregnancy and menopause (Klima, 2001). However, improvements in technology and control of disease has led to "the medicalisation of birth" and safe motherhood (Klima, 2001, p. 285). Amy Mullin (2005, p. 54) explains that medicalised pregnancy "involves interpreting pregnancy itself as a disruption to health that necessarily requires expert medical intervention and thinking of pregnancy as primarily about health and illness".

Feminists pay attention to women's lives and their health. The feminist perspective on women's health has witnessed many changes. Beckett (2005, p. 251) describes "the three waves" of feminism and its views on childbirth. In the first wave of feminists in the early 20th century (1860–1920), feminists challenged the medical authorities about why women must

experience pain during labour when pharmacological development in pain relief could reduce it. Although women benefited by receiving pain relief as a result of this movement, it also meant that birth was moved to hospitals under medical professionals' control, far from the support and comfort of home (Leavitt, 1983, 1986).

In the second wave in the mid-20th century (1960s to '70s), feminists questioned the concept of 'normal' childbirth, and proposed caesarean section instead (Beckett, 2005). Women's began to see childbirth as "a time of alienation from the body, from family and friends, from the community, and even from life itself" (Leavitt, 1983, p. 173). However, the increase in the rate of caesarean sections posed questions about the cost and risks to mother and baby (Beckett, 2005). In this period, birth activists critiqued the development of technologies, mainly male-dominated, which interfered in women's decision to have a natural birth and led to the medicalisation of the process (Beckett, 2005).

The term 'medicalisation' is used to explain all health problems. Conrad (2007, p. 5) defines medicalisation as when "a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or 'treated' with medical intervention". This definition clearly shows that women's issues such as childbirth, menstruation, contraception, fertility, pregnancy and menopause have historically been addressed with a medical view: as an illness which should be treated medically (Conrad, 2007). Childbirth has also been regarded as natural, and even as a cultural phenomenon: "natural childbirth discourse itself serves as cultural initiation" (Beckett, 2005, p. 259).

One controversial issue among feminist activists which arose in the second wave concerns pain-killers. Some activists argue that such medical innovations are merely used to control pain during labour (Petersen, 1989), and others that the pain originates from fear. This second

view led to the 'natural childbirth movement' (Beckett, 2005). Further, feminists of the natural birth school criticise the medical view of childbirth, and strongly advocate that childbirth be managed by women, especially midwives as they have an "instinctive understanding of childbirth" (Skowronski, 2015, p.27).

The third wave, contemporary feminism, questions the concept of 'natural' childbirth (Beckett, 2005). They argue that technology, such as epidural analgesia in hospitals, could be used by women if desired (Behruzi et al., 2013). They also criticise the idea of a return to traditional birthing practices carrying connotations of "naturalness" and the "good mother" in contrast to "unnatural" or even "bad" mothers (Skowronski, 2015, p. 27).

Feminism has experienced several waves with each taking a different theoretical perspective on childbirth. In the context of pregnancy and childbirth, feminist activists have sought to restrict men's power in the areas of maternal health and childbirth. These activists argue for women to have control over their bodies, and the right to decide about their childbirth without excessive male influence (Crary, 2001).

2.9.1 Feminism on childbirth: A socially constructed event

As this study focused on post-childbirth maternal morbidities, this section will explain how feminists have viewed health problems after childbirth. It has been acknowledged in the literature that women during the post-childbirth period experience physical and mental health problems. On the other hand, given that from a medical viewpoint these health problems are seen as not normal and women are advised to seek help, why do women not do so? To answer this question, we must consider the structure of society from the liberal feminist perspective (Campbell & Wasco, 2000).

According to the medical view, women must seek help for their postpartum health problems, but women's attitudes to these problems are shaped by social constructions. Schneider (2002, p. 34) assumes that "women's views reflect, more or less, the views of the health professionals, family, friends, and those in the literature".

Some feminist activists claimed that good mothering ought to be defined as being happy and contented after childbirth. Allen (2018), in her book *The Power of Feminist Theory*, defined culture as the combining of internalisation and social practices into habits. Sociocultural factors also play a part in this definition, leading to women internalising the portrait of the good mother (Sawers & Wong, 2018). For some women, their post-childbirth expectations and negative experiences, as well as the changes to their body and their role, bring dissatisfaction and frustration (Sawers & Wong, 2018). This phenomenon is exacerbated when women realise that their infant's need, especially breastfeeding, is a priority. All these factors can lead to post-childbirth mental health problems among women. Rich (1995, p. 5) clearly articulates the significance of changes in women's lives after childbirth:

> Nothing, to be sure, had prepared me for the intensity of the relationship already existing between me and a creature I had carried in my body and now held in my arms and fed from my breasts. Throughout pregnancy and nursing, women are urged to relax, to mime the serenity of Madonnas. No one mentions the psychic crisis of bearing a first child, the excitation of long-buried feelings about one's own mother, the sense of confused power and powerlessness, of being taken over on the other hand and of touching new and physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering, and exhausting.

Because this study focused on women, feminism has been adopted as an underpinning theory. The aim of this study is to explore key influences on women's help-seeking behaviour in the 12 months post-childbirth. As discussed above, feminist theory is concentrated on

women's experience, "ways of being, and thinking and doing", with childbirth a favourite area for feminist research (Jackson et al., 2005, p. 99; Alston et al., 2006). However, in the literature, the feminist approach has mostly covered mental health problems after childbirth, such as depression (Mollard, 2015). This is not surprising. As mentioned above (in section 2.2.2.1), depression has received more attention not only in the literature, but also in health policies around the world.

Studies that have assessed postpartum depression have tried to demonstrate that the feminist approach is the best means to explain postpartum depression, and have rejected the medical model (Buultjens & Liamputtong, 2007; Mollard, 2015). However, studies on the key influences on women's help-seeking behaviour are limited. Thus, this study tries to fill gaps in the literature to explore the key influences on women's help-seeking behaviour in the 12 months post-childbirth.

By conducting a systematic review, the present study will reveal gaps in the literature about exploring women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first 12 months post-childbirth. In the second phase, Australian women were directly asked about the health problems with which they felt they required help during this period after childbirth, and to identify their subsequent help-seeking behaviour. The last phase explored online help-seeking discussions about post-childbirth problems among women who participate in online postpartum support forums.

By completing these three phases, this study paints a comprehensive picture of the key influences on women's help-seeking behaviour in the 12 months post-childbirth. In this

respect, this study was underpinned by the feminist perspective on women's postpartum health problems.

2.10 Chapter summary

The literature review has an important role in research. It provides a contextual and conceptual background of the area of research. This review has shown that post-childbirth morbidities have been a neglected dimension of the post-childbirth period. While there are studies on various aspects of the postpartum period from biomedical and researchers' perspectives, such as the prevalence of short- and long-term conditions, many women still spend the post-childbirth period without the comprehensive information and support they need. Because pregnancy and childbirth have been regarded as a biological and gender role of women, and as normal, the health problems that arise have also, consequently, been considered normal. In this respect, this review of literature supported the feminist perspective on post-childbirth health problems among women. The review also revealed that there is a gap in understanding how women deal with their health problems and how they seek help after childbirth. Indeed, there is a general lack of research from women's perspective. Considering these gaps, there is a need to explore how women needs and seek help are meeting the needs of Australian postpartum women in the 12 months after childbirth. The next chapter will present the conceptual framework and research design for this study.

Chapter 3: Methodology and Research Approach

Chapter 1 set out the rationale for the study's aim and research questions, and the second chapter provided a literature review. This chapter lays out the rationale for the research methodology. It presents the philosophical perspective from which the research decisions were made, and the research approach taken. The research questions and methods are framed within a feminist pragmatist perspective:

> By pragmatism, we mean to search for workable solutions through the practice of research (e.g., follow the fundamental principle of mixed research, including the use of designs and criteria that are situation and context appropriate) to help answer questions that we value and to provide workable improvements in our world (i.e., help in bringing about desired outcomes). (Onwuegbuzie & Johnson, 2006, p. 54)

By selecting feminist theory, women's experience in the context of post childbirth maternal morbidity has been considered. This study consisted of three phases:

1. The first phase began with a systematic qualitative meta-aggregation review of the barriers and facilitators women experience in seeking help from health professionals. This phase studied women's view about post childbirth health problems. The clear lack of women's voices on their postpartum health problems observed in this phase directed this study into the second phase.
2. The second phase comprised concept mapping as part of a mixed methods participatory approach to identify the health problems that women feel require help, and women's subsequent help-seeking behaviour.

3. The third phase was a content analysis of health-related support to explore women's motivations in seeking help and peer support online through messages posted on an Australian online forum during the 12 months post-childbirth. This phase qualitatively assessed women's voices as they requested help-seeking and provided help-seeking advice.

The flow of the research phases:

Phase 1: Systematic qualitative meta-aggregation review: Women's help-seeking behaviours within the first 12 months after childbirth

Phase 2: Concept mapping study: Mothers' views of health problems in the 12 months after childbirth

Phase 3: Content analysis of health-related support: The 'fallacy of normalcy': a content analysis of women's online post-childbirth health-related support.

3.1 Participatory approaches

As has been described in section 2.5.3, there is a lack of research in the area of post childbirth maternal health and help-seeking. Furthermore, the research in this area was limited to studies done by researchers. Therefore, the need to do research 'by' or 'with' the public was evident. The term 'patient and public involvement' (PPI) emerged to improve the quality of research in areas where the public's voice was suppressed by established inequity between researchers and the public (Sand et al., 2020). PPI originated from the UK, in the NHS system and it is argued it is a criterion for democratic societies (Florin & Dixon, 2004). There are three types of PPI: 'Involve', which defines public involvement in research as research being carried out 'with' or 'by' members of the public rather than 'to', 'about' or 'for' them;

'Participation', where people take part in a research study; and 'Engagement', where information and knowledge about research is provided and disseminated (INVOLVE, 2012).

According to INVOLVE (2012), the method for this study is a based on "participation" as it incorporates women's views. Phase two provided an opportunity for women to take part in data generation and analysis, and followed some of the participatory criteria in table 3.1 such as the research is for people and knowledge counts for people.

Although the term 'participatory method' is new, the concept was originated by Lewin in his statement "[n]o action without research; no research without action" (Lewin, 1946), and may be traced back to the mid-19th century and the work of Friedrich Engels' and Karl Marx's (Hall, 1992). This method is about shifting power from the researcher to the participants (Hall, 1992). Participatory methods are not restricted to any "epistemological or methodological criteria" (Abma et al., 2019, p. 126). Participants actively engage in gathering data by specific methods. The most important aspect of participatory research is giving a voice to marginalised groups by selecting an appropriate method. This method must be flexible. Amplifying marginalised voices is a central aim of feminist activists (Alcoff, 1988).

Although women after childbirth have received research attention (Foster et al., 2010), most research on postpartum morbidities has been quantitative (Gunn, 2003; Gunn, 2003; Vallely et al., 2005; Hogan et al., 2010). The literature mostly focuses on clinicians' view, ignoring women's voices. Predefined questions in conventional quantitative and qualitative methods shed light on some parts of post-childbirth period, but less on women`s help-seeking behaviour.

The literature review in chapter 2 highlighted a gap in research seeking deep participation from women and exerting less control on the participants by giving them the freedom to freely express their problems. Consequently, women are considered a marginalised group to research (Woelk, 1992). A range of research approaches have been employed to identify long- and short-term, acute and chronic morbidities following childbirth. The literature review clearly indicated that there has been a high volume of quantitative research on maternal morbidities, while there is a lack of research about how women manage and seek help for these morbidities.

The present study adopted a feminist perspective but, as discussed in section 2.9, there is a conflict between feminism and the medicalisation of natural phenomena. Medical researchers' views have been given priority in research, while the rigour and trustworthiness of participatory methods has been under question, resulting in these methods receiving less attention (Cornwall & Jewkes, 1995). Conventional health research is based on seeking "knowledge to increase understanding", but participatory research focusses on "knowledge for action", placing emphasis on understanding local human priorities (Cornwall & Jewkes, 1995, p. 1667)

Participatory research is broadly defined as "systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change" (Green et al., 1995, p.1). It is a cooperation between researchers and people in the society: "We argue that the key element of participatory research lies not in methods but in the attitudes of researchers, which in turn determine how, by and for whom research is conceptualised and conducted" (Cornwall & Jewkes, 1995, p. 1667).

The key difference between participatory and other research methodologies lies in the location of power in the various stages of the research process (Cornwall & Jewkes, 1995). The practice of participatory research raises personal, political and professional challenges that go beyond the bounds of the production of information (Cornwall & Jewkes, 1995). Participatory research plays a role as a tool to get at the participants' knowledge and needs, and to propose cultural and geographical changes (Israel et al., 2012). Table 3.1, below, summarises the differences between participatory research and conventional research. The table clearly shows that in participatory research the focus is on people and their active engagement in different aspects of research.

Table 3.1 Comparison of participatory and conventional research process (adapted from Cornwall & Jewkes, 1995)

	Participatory research	**Conventional research**
What is the research for?	Action	Understanding with perhaps action later
Who is the research for?	Local people	Institutional, personal and professional interests
Whose knowledge counts?	Local people	Scientists'
Topic choice influenced by?	Local priorities	Funding priorities, institutional agendas, professional interests
Methodology chosen for?	Empowerment, mutual learning	Disciplinary conventions. 'objectivity' and "truth'
Who takes part in the stages of the research process?		
Problem identification	Local people	Researcher
Data collection	Local people	Researcher. enumerator
interpretation	Local concepts and framework	Disciplinary concepts and frameworks
Analysis	Local people	Researches
Presentation of findings	Locally accessible and useful	By researcher to other academics or funding body
Action on findings	Integral to the process	Separate and may not happen
Who takes action?	Local people, with/ without external support	External agencies
Who owns the results?	Shared	The researcher
What is emphasised?	Process	Outcomes

Participatory research has a different meaning in the field of health:

> It is an umbrella term for a school of approaches that share a core philosophy of inclusivity and of recognising the value of engaging in the research process those who are intended to be the beneficiaries, users, stakeholders of the research. (Cargo & Mercer, 2008, p. 326)

The participatory approach covers: the community-based participatory method (CBPR); participatory rural appraisal; empowerment evaluation; participatory action research; the community-partnered participatory method; cooperative inquiry; dialectical inquiry; appreciative inquiry; decolonising methodologies; participatory or democratic evaluation; social reconnaissance; emancipatory research; and forms of action research embracing a participatory philosophy (Cargo & Mercer, 2008).

Phase two of the current study has most of the necessary criteria for of on participatory research shown in table 3.1. It allowed to the participants to become actively involved in generating data, interpreting and analysing data.

Since the 1990s, research on public health has shifted to qualitative methods (Sofaer, 1999) where comprehensive information is needed about the area of interest, and especially participants' views (Steckler et al., 1992). Interviews and focus groups have been used as common qualitative methods in health research (Schneider & Whitehead, 2016). Some seminal papers, including those by Chambers (1992) and Scrimshaw (1992), applied a participatory approach to collecting, analysing and interpreting data, but they could not thoroughly discuss the process of developing hypotheses and expanding theories (Burke, et al., 2005). Participatory methods are "reflective, flexible and iterative" in engaging local people to try to get more information and opinions by using new approaches instead of

conventional methods (Cornwall & Jewkes, 1995, p. 1668). Under this model, participants actively take part in different parts of the study.

Although there are different types of participatory research, they overlap in their method and aims (George, Daniel, & Green, 2006). A review by George, Daniel and Green (2006) showed that participatory research is a good approach to research in health to gain knowledge about the community. Participatory research is consistent with the WHO definition of health promotion as "the process of enabling people to increase control over, and to improve, their health" (George et al., 2006, p. 181). It has been used to study particular health problems, such as diabetes, AIDS, and injury, and with marginalised groups in Asia, Africa and Latin America (George, Daniel, & Green, 2006), as well as societal issues, such as LGBT+ rights (Johnson & Martínez Guzmán, 2013) or among people who use recreational drugs (Boucher et al., 2017).

3.1.1 Difficulties in recruiting in participatory research

Participatory research is a time-consuming process because it requires the establishment of mutual trust between researchers and participants (George et al., 2006). Motivation to participate among people in the community can vary, because people must weigh up the value of their time. People may be unable to participate for other reasons, such as being too busy, and being concerned about privacy (Cornwall & Jewkes, 1995; Daly et al., 2019).

In this study, phase one and three draw on women's views, and phase two took a participatory approach to the problem, and the questions were designed accordingly.

1. Phase one: the systematic review explored women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first

12 months after childbirth. It is a qualitative study which provides women's perspective by analysing women's views.

2. Phase two: the concept mapping adopted for the second phase introduced by William Trochim to gain participants` perspective for research and service design (Trochim & Kane, 2005). This is an integrative mixed method where women provided the conceptual framework through online brainstorming and then sorting and rating.
3. Phase three: a directed qualitative content approach applied for this phase to explore online help-seeking discussions about post-childbirth problems among women who participate in post-childbirth online support forum. It is an integrative mixed method where women's questions and answers to each other were analysed.

Before explaining the philosophical aspect of this study, feminism and pragmatism, basic terminology in the philosophy of science will be explained. The first important term is 'ontology': "the notion that there is a single, objective, real world". Ontology asks, "What is the form and nature of reality, and what can be known about reality?" (Campbell & Wasco, 2000, p. 779). The second term is 'epistemology'; "What is knowledge, how can knowledge be obtained, and what is the relationship between the knower and what can be known?" (Campbell & Wasco, 2000, p. 779). Epistemology and ontology are intertwined. Knowledge is at the core of philosophical terms.

Feminist pragmatism has been adopted for this study, and each of those terms will be defined in the following section.

3.2 A pragmatic theoretical framework

This study explores the key influences on women's help-seeking behaviour in the 12 months post-childbirth. A pragmatic theoretical framework is suitable for this study because it focusses on problems rather than methodologies. This research is based on the pragmatic

hypothesis because it forms a fundamental principle of mixed methods research, and helps researchers to gather different types of information (Bryman, 2007).

Pragmatism is a worldview that "arises out of actions, situations, and consequences rather than antecedent conditions" (Creswell, 2013, p. 10), and allows for a combination of designs for finding the best answer to questions (Hathcoat & Meixner, 2015). Pragmatism is a suitable philosophical underpinning for mixed methods research. The researcher is not restricted to using specific methods and techniques for collecting and analysing data. Instead, by selecting both qualitative and quantitative methods, the researcher is able to get a better understanding of the problem (Creswell, 2013). It helps to provide a set of hypotheses regarding the questions, and it is different from quantitative approaches (positivism-based) and qualitative approaches (interpretivism- or constructivism-based) (Denscombe, 2008).

The next two paragraphs will provide some information on positivism and constructivism. Positivism began in the 18th century, and is based on the idea that objective reality is measurable and predictable (Crossan, 2003). Reductionism focused on small elements which could describe the observed phenomena (Giddings & Grant, 2007). Reductionists rejected the role of the human mind, and consequently metaphysics and transcendental knowledge (Crossan, 2003). These philosophers used mathematics to prove their hypotheses. Later, positivism developed into post-positivism, which has come to be seen as less conservative (Routledge, 2007): "Rather than assuming a linear process of cause and effect, they perceive outcomes as the result of a complex array of causative factors that are in interaction with their outcomes" (Giddings & Grant, 2007, p. 4).

Interpretivists or constructivists expanded their view of reality, and unlike critical theories, which viewed reality through lenses, they believed that social constructs such as gender, race,

class, culture, and economics shape how we must view reality. “There is no “real” reality, no single truth, but multiple truths that are individually constructed” (Campbell & Wasco, 2000, p. 780). Following this tradition, interaction and engagement between researchers and participants helps to assess the real world problems in society.

3.2.1 What is pragmatism?

Pragmatism is one of four creeds of belief that include post-positivism, constructivism, and advocacy/participatory claims (Hathcoat & Meixner, 2015). It is a philosophy founded in 1870s America (Legg & Hookway, 2008). Charles Sanders Peirce (1839–1914) introduced pragmatism to the world, but because he was not a “systematic writer” he did not develop his ideas into a single theory (McDermott, 1981, p. 42). The term pragmatism originated from Peirce’s studies of Kant (1724–1804). In the same manner as Kant, Peirce sought to explain the universality of concepts in experience. Peirce believed that, based on our goals, we could achieve particular research purposes (McDermott, 1981).

Following Peirce, William James argued in 1898 for a new pragmatic movement: ‘Philosophical Conceptions and Practical Results’ (McDermott, 1981, p. 44). The theory was further developed by Mead, Dewey and Murphy, Patton and Rorty in 1990 (Creswell, 2013). While their perspectives differed, the commonality between their hypotheses in practice can be condensed into the phrase ‘a statement is true if its works’ (Patton, 2015, p.152). Pragmatism looks at truth as temporary, conditional and developmental. For a pragmatist, truth is a pathway to our goals, through which we can attain an improved perception of our lives and results related to our goals (Parker, 2005).

3.2.2 What does pragmatic theory tell us about growing knowledge?

A pragmatist would argue that the research problem takes precedence, rather than methodology, and that it can be applied to research by not restricting the researcher to theoretically mandated methods and techniques for collecting and analysing data. Pragmatism proposes that no single or even multiple methodologies or methods of research is superior to another, but rather that it is better that any research problem be addressed by a research method or combination of methods that finds the best answer to our question (Hathcoat & Meixner, 2015). Based on pragmatism, when we confront an unclear situation, we must ask ourselves basic questions: what is the difference between the ways in which we are trying to reach our answers?

3.2.3 Pragmatism and the role of the researcher

Pragmatism is not dedicated to one specific scheme of philosophy; researchers can apply it to adopt methods and approaches based on their goals (Creswell, 2013). It can be viewed from different perspectives, such as the experimental, the classical, the legal and the ethical (Parker, 2005).

In pragmatism, each person has their own understanding of the world, and it gives special attention to developing insight through “joint actions” or “projects” among diverse groups and persons (Morgan, 2007, p. 67). It is not an integrated philosophy; it divides popular awareness and opinion, which is concentrated on a human attempt to create improvement, collect information, manifesting favourable circumstances to maximise individuals’ capabilities (Parker, 2005). In scientific research, pragmatism is considered as a way to practically figure out or discipline our environment (Scott & Briggs, 2009).

Pragmatism is focused on results, on “human working”, which consists of deliberating (thinking), brainstorming (conceptualising) and accomplishment (doing), and the changes they make in our lives (Parker, 2005, p. 126). The growth of truths not only involves adding new truths and revising old ones, but also the rearrangement of stock belief (Parker, 2005).

Pragmatism has been considered in nursing support to improve nurses’ abilities, methodology and practice (Parker, 2005). In Parker’s (2005, p. 131) study, the methodology based on pragmatism was intended to promote “situation-specific, experience–based, and revision-oriented theory development in nursing from pragmatic direction”. In summary, pragmatism as a philosophical system:

1.Focuses on the outcome

2.Emphasises the nature of knowledge, and

3.Tests common ideas (Patton, 2015).

3.3 Feminist theory as the underpinning of the literature review

Because this study is focussed on women’s experiences and the review of the literature showed a lack of women’s voices, a feminist approach is appropriate for this study.

3.3.1 What is feminism?

Historically, the word ‘feminism’ refers to a group of women’s activists in late 19th century England. Feminism theorises that while sex is determined biologically, gender is a social construct (Alston et al., 2006). Gender-related social expectations have shaped the role of women and men in society, where the relative physical strength of men, and its usefulness in agricultural work, resulted in women undertaking domestic work (Liepins, 2000). Women

have also been considered inferior to men (Smith, 2004; Lewis & Kinser, 2005). Consequently, women are marginalised.

Although, there are different feminisms, all of them share a focus on what women do and experience in their personal and social lives (Routledge, 2007). According to Forbes et al. (1999, p. 375), feminists "differ in what they name as the primary features of women's oppressions, in how and where they locate the sources of oppression, and in the strategies they advocate for change". There are four different feminist perspectives: liberal, radical, socialist, and womanist (Campbell & Wasco, 2000).

3.3.1.1 Feminist perspectives

Liberal feminism began in the 1970s. Its key focus is social freedom and equality. The liberal feminist is:

> one who advocates such reforms as legal equality between the sexes, equal pay for equal work, and equal employment opportunities, but who denies that complete equality requires radical alterations in basic social institutions (e.g., the capitalist economic system, the biological family, monogamous marriage, biological motherhood). (Campbell & Wasco, 2000, p. 776).

Among radical feminists, gender oppression is the main concern, and is the reason that women are marginalised in society. They propose that resolving gender oppression will require fundamental societal change (Routledge, 2007). They claim that "classism and racism intersect with sexism, but stipulate that the systematic marginalization of women is the fundamental form of inequality" (Campbell & Wasco, 2000, p. 776).

Marxism, with its emphasis on capitalism, shaped the view of socialist feminism in the 1970s. Socialist feminism critiques capitalism for inequity in race, class and sex (Campbell & Wasco, 2000).

Feminist marginalisation of black women led to the creation of womanism. The interrelationships between race, gender, and class oppression was their focus (Campbell & Wasco, 2000). This form of feminism was more favoured among women with class and racial/ethnic differences.

3.3.1.2 Feminist philosophies

There are three main feminist philosophies: feminist empiricism, feminist standpoint theory, and feminist postmodernism. These will now be described in turn.

3.3.1.2.1 Feminist empiricism

This group of feminists relies on post-positivist realism and liberal feminism. Feminist empiricism holds that social biases such as sex discrimination and androcentrism infiltrate society and science (Turner, 1995). In the 1960s, when much attention was paid to women and science, male scientists tried to marginalise women from mathematics on the basis that they lacked the high-level computational skills required. The belief about the superiority of men in solving complex and analytical mathematics is described clearly by Keller (1983, as cited in Turner, 1995, p.4)

1. “Science is impersonal; women are personal”.
2. “Science deals with things; women deal with people”.

3. “The male way of knowing in its highest development is objective, analytical, scientific investigation. The female way of knowing in its most complete sense is the mother’s intuitive knowledge of her baby”.

4. “Science is reason, unalloyed by feeling. Feeling is a female element while thinking is a male element”.

5. “Science is ‘hard’ and tough-minded; women are ‘soft’ and sentimental”.

6. “Science seeks power; women seek harmony”.

In other words, both social and scientific changes have been targeted by feminist empiricism.

3.3.1.2.2 Feminist standpoint theory

Originating in the 1970s and 1980s, feminist standpoint theory was developed by thinkers interested in women's studies and has become an epistemological base (van der Tuin, 2016). The theory can be summarised in the following aphorism: “a social disadvantage implies an epistemological advantage” (van der Tuin, 2016). This theory is based on radical and socialist feminism, and womanism (Campbell & Wasco, 2000). Because there are multiple realities, such as class, race, gender and sexual orientation in society, a specific reality cannot explain the objective truth (Routledge, 2007). It is said that “social relations have been a powerful force for maintaining a society in which women and other marginalised groups are devalued and seen as other” (Perry, 1994, p. 483). This theoretical viewpoint is targeted at producing social knowledge about marginalised individuals through research (van der Tuin, 2016).

3.3.1.2.3 Feminist postmodernism

Feminist postmodernism combines constructivist and radical feminist traditions (Harding, 1987). Constructivism expanded radical feminism’s view of reality and, unlike critical theories

which viewed reality through different lenses, constructivists believe that social constructions such as gender, race, class, culture, and economics shape how we must view reality. 'There is no 'real' reality, no single truth, but multiple truths that are individually constructed (Campbell & Wasco, 2000). Interaction and engagement between the researchers and participants in a study helps in assessing the world.

Feminist postmodernism rejects a single reality, and sees the concept of truth as a "destructive illusion because researchers may appropriate the power of scientific methods to define what is, or is not, considered knowledge" (Campbell & Wasco, 2000, p. 782). Knowledge is a subjective concept limited by language. Qualitative methods and social science have taken on the advantages of feminist postmodernism, which takes particular interest in the language people use to describe their lives, to scrutinise and decipher their lives (Campbell & Wasco, 2000).

Based on the above, it is can be concluded that all feminist philosophies agree that women have been marginalised, and that knowledge about women has too often been produced through androcentric epistemologies.

3.4 Philosophical themes of feminist pragmatism

In this section, the philosophical themes in feminism and pragmatism will be explained. Feminist pragmatism is a relatively new approach, added to feminist philosophy in the 1990s. Feminist philosophers combined pragmatism's core concepts of "pluralism, lived experience and public philosophy, with feminist theory and practice in order to engage in social issues" (Whipps & Lake, 2004, p. 1). Pluralism lies at the heart of pragmatist philosophy. Pragmatists "understand that knowledge is shaped by multiple experiential viewpoints" (Whipps & Lake,

2004, p. 1). Consequently, pragmatism can be used to assess women's issues in society from different perspectives.

There are four themes relevant to the two philosophies adopted for this study: valuing experience; valuing multiple views, experience and published work; education; and social action. Valuing experience is important in both philosophies. Some feminist activists, such as Jane Addams, suggest that to understand what people want, it is necessary to "move with the people" (Whipps & Lake, 2004, p. 8). It is evident that feminists, by considering women's experience based on pragmatist philosophy, ought to try to listen to marginalised groups in an effort to solve their problems.

The second theme is valuing multiple views, experience and published work. Dualism has been criticised by both pragmatism and feminism, and because of this, sharing values is the first step to solve social problems (Whipps & Lake, 2004). The pluralism of feminist pragmatism considers women's experience in the social context to try to solve women's problems. For some feminists, cultural background is an important subject when considering women's issues. As Schutte (1998, p. 55) believes, "the nature of knowledge is not culture-free but is determined by the methodologies and data legitimated by dominant cultures".

The third theme, education, focuses on change by valuing experience and taking the cultural background into account. By blending education and experience, social action for chang can be generated (Whipps & Lake, 2004).

Social action, as the core of pragmatism, is engagement with social actions, and uses pluralism by involving multiple experiential opinions. Pragmatists emphasise that we must include particular and individual experiences in a pluralistic discussion of multiple realities,

and that all parties involved in an issue must also be involved in the problem-solving process. The common approach taken by pragmatism and feminism is considering social context in efforts to solve problems for women.

Limitations in the 'traditional philosophy' of pragmatism and feminism led to the hybridised feminist pragmatism. The aim of both paradigms is problem-solving, and as such both agree that to get a better view of life political issues must also be considered (Rooney, 1993). Some philosophers criticise pragmatism because it shifts attention from theory to practical results (Nowell, 2015), or feminism because, it is claimed, feminist activists do not achieve equality in society by highlighting women's interests and supressing men's (Levine, 1984). Seigfried (1991) suggests several commonalities between feminism and pragmatism, starting with their person-centred approaches, their commitment to solving problems, and in researchers playing an active role and using their personal experience and knowledge of participants in problem-solving.

Gillberg (2011) detects three main concepts shared by feminism and pragmatism: (a) community, (b) reciprocity, and (c) the concept of study and action, science and social reform. Community is where people share activities and experience the same problems embedded in society. The concept of reciprocity "encompasses both the acknowledgment of the existence of power asymmetries within communities as well as the will to overcome them" (Gillberg, 2011, p. 16). Gillberg adds: "the most basic epistemic meaning of reciprocity is to me that of reciprocal learning". The concept of study and action comes after community and reciprocity. It is "a desire to move beyond one's own history and categories to attempt to understand others; a readiness to work collaboratively with others to advance shared interests and solve shared problems" (Gillberg, 2011, p. 17). As discussed in section 3.4, above, the core concept

of pragmatism is finding the best answer to our questions, and as such the priority is the research problem rather than selecting a methodology (Hathcoat & Meixner, 2015). Adding a feminist perspective to pragmatism helps to highlight women's problems specifically.

3.5 Post-childbirth health problems and feminist ideology

As discussed in chapter 2, section 2.9, feminists put women in the centre of their attention; they argue about the improvement of women's lives and those of the people around them. While there is disagreement about the meaning of 'natural childbirth', feminists view women's health issues after childbirth in terms of psychological, biological, and cultural factors (Mollard, 2015). From a feminist perspective, it is not logical to view women's health problems as one of these factors, but all of them together make huge changes in women's bodies and lives.

Feminism is based on knowledge and context, and various methods are considered legitimate in seeking an understanding of women's experience. As there are differences among women's experiences, to make a judgment about a situation we must consider all factors together, not just one of them. For example, we must consider culture as well as gender (Watson et al., 2008). As feminism is a women-centred approach, the researcher gets involved with women's experiences:

> Feminist research not only studies women and women's experience within the social context, but it also seeks to help women deal with the issues that are revealed as part of the process. Both the knowledge gained and the research process itself may serve a vehicle for creating social change that enhances lives of women. (Ford-Gilboe & Campbell, 1996, p. 173)

The literature review and the earlier part of this chapter dealt with pragmatism. in this section, feminist pragmatism will be elucidated. Doucet, Letourneau and Stoppard (2010, p. 308) described three paradigms related to research on women's mental health: postpositivist, critical theory, constructivism. Finally, they assert that there are "research problems related to the mental health of women that do not align exclusively with either the postpositivist, critical theory or constructivist paradigm" (p. 308), and conclude that, due to the biopsychosocial nature of mental disorders among women, no single approach is adequate on its own. Later, Mollard (2015, p. 378) examined Doucet`s (2010) work to determine "the best fit paradigm" for postpartum depression, and introduced feminist pragmatism as that paradigm.

If we consider a problem in a community where members share experiences and interests, all members of that community will benefit from solving that problem, not just women. In the case of maternal health problems after childbirth, solving these will benefit not only the women suffering from them, but also their family members and, at one further remove, the whole of society.

In summary, and in the context of postpartum morbidities, while pragmatism identifies individuals' thoughts and experiences, feminist pragmatism goes deeper and looks to solve problems by considering physiological changes in their socio-cultural context.

Research Approach

3.6 Research aim

The aim of this study is to explore the key influences on women's help-seeking behaviour in the 12 months post-childbirth, and the research questions ask what the key influences are on women's help-seeking behaviour in the 12 months post-childbirth.

3.7 Mixed methods research

Mixed methods research originated with Campbell and Fiske (1959), and has been described as ending 'the paradigm wars', which debated the benefits and hindrances of quantitative versus qualitative research. With mixed methods, both quantitative and qualitative techniques can be used, in parallel or sequentially (Hoffman, Benne, & Del Mar, 2013). Qualitative and quantitative methods of research have their own benefits and deficits, and so they help us to gather different types of information (Bryman, 2007). By 'mixing or blending', we can achieve a more comprehensive perspective on research questions or hypotheses than by using either qualitative or quantitative methods alone (Creswell, 2013).

The definition of mixed methods research used in the present study was provided by Johnson, Onwuegbuzie, & Turner (2007). By contacting leaders in mixed methods research, the Johnson and colleagues developed the following synthesised definition:

> Mixed methods research is the type of research in which a researcher or team of researchers combine elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breath and depth of understanding and corroboration. (Johnson, Onwuegbuzie, & Turner, 2007, p. 123)

There are various mixed methods strategies. Convergent parallel mixed methods design, which is a common form (Creswell, 2013), was selected for this study prior to sample selection. Under this approach, both qualitative and quantitative data are collected, and each is then interpreted individually before a final comparison of the results reveals whether they affirm or disprove one another (Creswell, 2013).

There are four difficulties in mixed methods research: sampling problems; legitimation or validity; integration; and the challenge of politics. Therefore, in order to enhance the credibility of this study, it is essential that we address each challenge in turn.

3.7.1 Sampling problems

It is important that study findings be generalised across the relevant population. Selecting large random samples is the best way to prevent errors in quantitative studies – larger sample sizes produce smaller errors (Marshall, 1996; Onwuegbuzie, Jiao, & Bostick 2004). In qualitative research, which deals with lived experiences, data saturation will not occur with small sample sizes, and large sample sizes will prevent extraction of "thick, rich data" (Onwuegbuzie & Leech, 2007, p. 242). However, these issues are resolved with a clear rationale for sampling design decisions, determination of data saturation, ethics in research design, member checking, prolonged engagement with and persistent observation of study participants, and triangulation of data sources (Johnson, 2020; p.141).

Teddlie and Yu (2007) proposed a kind of mixed methods study with overlapping quantitative and qualitative approaches to sampling. Their approach used random and purposeful sampling to moderate sampling errors. For the second phase of this study, purposeful sampling was used to resolve sampling problems.

Collins, Onwuegbuzie and Jiao (2007) believed that sampling design consists of sampling scheme(s) and sample size(s), and that it is vital to resolve these issues concurrently (Collins, Onwuegbuzie, & Jiao, 2007). For this study, good sampling decision-making has been supported by 'the types of research goals, objectives, rationale of the study and rationale for mixing qualitative and quantitative approaches, purpose of the study and the purpose for mixing qualitative and quantitative approaches' (Collins, Onwuegbuzie, & Jiao, 2007).

3.7.2 Legitimation or validity or rigour

There are different terms for legitimation in the literature, such as validity, generalisability, and reliability (Onwuegbuzie & Leech, 2007). According to Onwuegbuzie and Johnson (2004, p. 778):

> lack of legitimation means that the extent to which the data have been captured has not been adequately assessed, or that any such assessment has not provided support for legitimation. Thus, the significance of findings in qualitative research is affected by these crises. (Onwuegbuzie & Leech, 2004, p. 778)

In quantitative studies, validity is the prevalent term, and different types of validity are referred to in the literature, such as "measurement-related validity (construct-related validity, criterion-related validity, content-related validity) and design-related validity (internal validity, external validity)" (Collin, 2007, p. 268). However, legitimation is controversial. In qualitative studies, there are different strategies, such as member checking, a frequently used approach, triangulation of data, disconfirming evidence, and finally peer-examination (Collin, 2007). In a mixed methods study, Creswell and Plano Clark (2011) consider 'validity' to be the best term to describe both quantitative and qualitative research. Validity must be conceptualised within research design and throughout – from data collection

and data analysis to interpretation of research. Collins et al. (2007, p. 270) describe ways of improving research validity: "[by] ensuring that inferences stem directly from the underlying sample of units, an appropriate sampling design also can increase theoretical validity and by incorporating audit trails".

3.7.3 Integration

Creswell (2003) points out that integration can occur in each phase; during data collection, analysis or interpretation – though according to Bazeley (2009), it is more desirable to integrate at the conclusion of research. Greenhalgh (2016) mentions that integration occurs during all stages, or is limited to one. Regardless, the aim is to answer the research question by the selected method. The integration challenge can be reduced by selecting 'sampling designs that help researchers to make meta-inferences (i.e., both sets of inferences are combined into a coherent whole) that adequately represent the quantitative and qualitative findings and allow the appropriate emphasis to be placed' (Collins et al., 2007, p. 270).

Combination of the results of qualitative and quantitative methods can be challenging. When different researchers work on different parts of a mixed method study it can lead to conflicts among them (Collins et al., 2007). This challenge can be resolved by selecting realistic, efficient, practical and ethical sampling designs (Collins et al., 2007).

In mixed method approaches, there can be conflict in how qualitative and quantitative methods are adopted and how they can be integrated or combined. Some researchers acknowledge that there is an inconsistency in the philosophical premises of quantitative and qualitative methodologies, so in response they consider using parallel qualitative and quantitative methods to enhance their research's validity. Others investigate areas of

agreement between the two possible choices and try to emphasise the similarities between quantitative and qualitative approaches to support combining them (Denscombe, 2008).

Greene, Caracelli and Graham (1989), through an analysis of 57 empirical mixed methods studies, proposed five purposes for undertaking mixed methods research: triangulation, complementarity, development, initiation and expansion (see also Greene et al., 1989; Creswell & Plano Clark, 2017). In this study, the relevant purposes were:

1. Complementarity – to elaborate, enhance and clarify the results from one method with the results from the other method to provide a deeper understanding of a phenomenon
2. Development – to use the results from one method to help develop or inform the other
3. Expansion – to extend the breadth and range of inquiry by using different methods for different enquiry components (Greene et al., 1989).

3.8 Mixed methods research designs

Various researchers have proposed differing mixed methods research typologies (Creswell, 2013). Researchers are more likely to select simpler mixed methods, and to consider the timing and purpose of the integration (Guest, 2013). According to Creswell and Plano Clark (2017), consideration of the design is more important than the time or sequence in which this occurs. A brief explanation of each of the six major mixed methods designs is given in Table 3.2, below.

Table 3.2 Mixed methods research designs and purposes (adapted from Creswell & Plano Clark, 2011)

Research design	Purpose
Convergent	To obtain different but complementary data on the same topic
Explanatory sequential	To use the qualitative strand to explain initial quantitative findings
Exploratory sequential	To use the quantitative phase to explain initial qualitative findings
Embedded	To include qualitative data to answer a secondary research question within a prominently quantitative study
Transformative	To conduct research that is change orientated and seeks to advance social justice. Purpose is for value-based and ideological reasons rather than reasons related to method
Multiphase	To address a set of incremental research questions that all advance one programmatic research objective

In this study, the aim was to explore the key influences on women's help-seeking in the 12 months post-childbirth. As Creswell and Plano Clark (2017) argue, the best way to explore a phenomenon is by selecting multiple designs; consequently, multiphase designs which consist of quantitative and qualitative methods for each study were considered for this research (Creswell & Plano Clark, 2011). This design is problem-centred and defined as "an iteration of connected quantitative and qualitative studies that are sequentially aligned with each new approach building on what was learned previously to address a central problem objectives" (Creswell & Plano Clark, 2011, p. 100). This is known as 'sandwich design', and suits mixed method studies with different projects in which new questions emerge from each study to be answered by the next (Creswell & Plano Clark, 2011). Pragmatism is the best foundation for this design. As shown in Figure 3.2, below, the result of each study can be published separately but is still part of a larger whole (Creswell & Plano Clark, 2011).

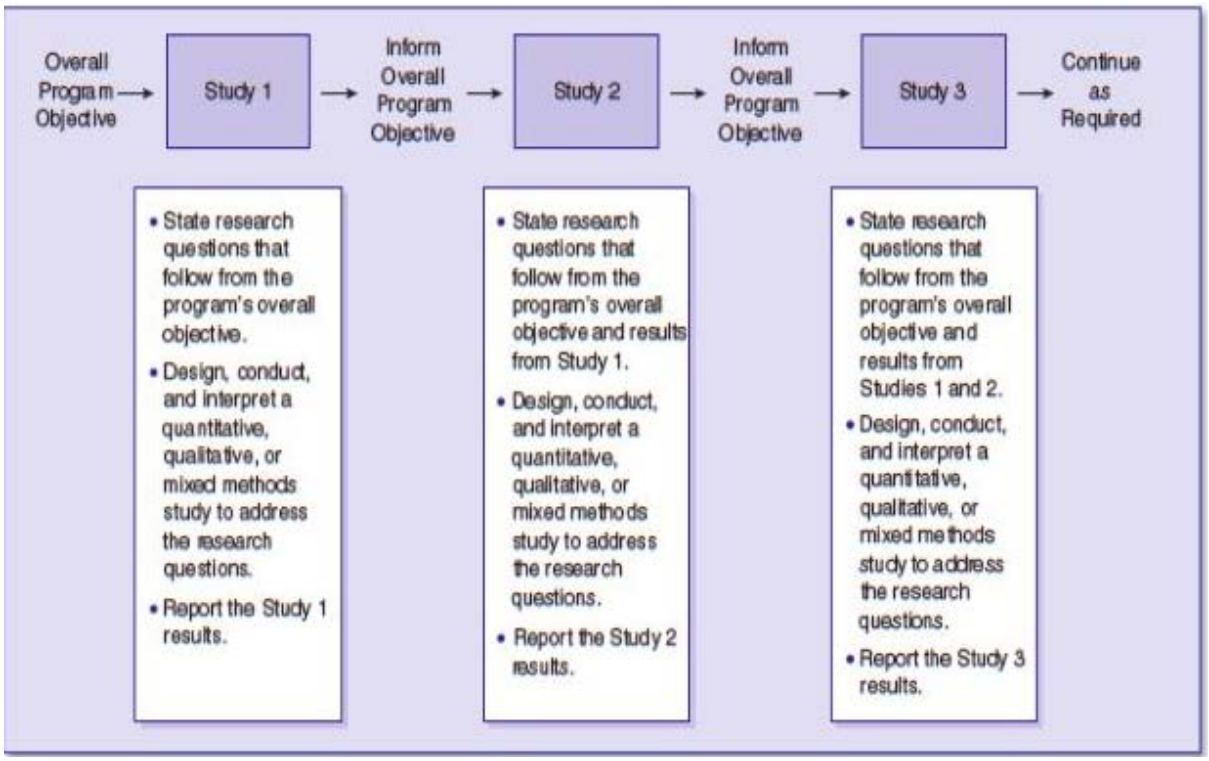

Figure 3.2 Multiphase design flowchart (Creswell & Plano Clark, 2011)

This method has advantages and disadvantages. Greenhalgh's (2016) summary is given in Figure 3.3, below.

Advantages of multiphase design
- Provides in-depth understanding of a complex problem from different points of view.

Challenges of multiphase design
- Can involve complex data analysis and interpretation.
- Results are often not reported together.

Figure 3.3 Advantages and challenges of multiphase design

3.9 The current research projects

This study employed a feminist pragmatist philosophical paradigm. Pragmatists argue that the research problem takes precedence over methodology, and that any research question addressed by a research method or combination of methods that find the best answer to a

question is suitable. Feminist theory has concentrated on women's experiences, "ways of being, thinking and doing" (Jackson et al., 2005, p. 99) and childbirth is a favourite subject for feminist activists (Alston et al., 2006). The study used its pragmatic worldview and multiphase design to focus on identifying key influences on women's help-seeking in the 12 months post-childbirth. Phase one involved a systematic qualitative meta-aggregation review to explore women's perceptions of the barriers and facilitators they experience in seeking help from health professionals during the postpartum period. Phase two, a concept mapping study, sought to identify women's views of health problems during the period. Phase three, a content analysis of health-related support, examined women's motivations in seeking online help and peer support through an online forum. As each phase is presented in its own chapter (chapters 4, 5 and 6 respectively), the specific methods used will be explained in the relevant chapters. For ease of reference, however, they are also summarised in Table 3.3, below.

Table 3.3 Research questions, designs and data sources

Phase	Research question	Design	Data sources	Main point
One	What barriers and facilitators do women perceive to seeking help from health professionals within the first 12 months after childbirth? How do mothers experience access to and health professional support within the first 12 months after childbirth?	QUAL	Systematic searching of Medline via Ovid, CINAHL, EMBASE and Web of Science revealed an initial 691 papers, of which 48 were reviewed. 9 papers (2000–17) were selected.	The qualitative studies will search to provide women's perspective.
Two	What are the health problems that women felt required help during the 12 months after childbirth? What is the subsequent help-seeking behaviour?	MIXED	Two groups of Australian women of women living in Australia were recruited through an online platform using purposive sampling (N = 81) in 2017–18.	Women will provide the conceptual framework through online brainstorming, and then sorting and rating.
Three	Which health problems were shared by women who seek help? What were the motivations for questions mothers posted on the forum discussion board? What support is given to mothers who have posted questions about post-childbirth morbidities?	MIXED	A total of 332 messages posted on a post-childbirth online forum were analysed (2007–18).	Women's questions and answers will be analysed to amplify their voices

3.10 Ethics approval

Research which involves studies on humans, requires ethics approval from a Human Research Ethics Committee. There are four basic principles in ethical research: the values of respect, research merit and integrity, justice, and beneficence (Australian National Health and Medical Research Council Australian, 2018, p. 9). Respect relates to ensuring the dignity of every person and their rights. This study ensured research merit and integrity through the study aims, credibility of data collection, validity, and reliability of results (see further discussion on pages 79-81). Justice was ensured by maintaining the dignity and rights of participants.

This study consisted of three phases, each of which adhered to the National Ethics Application Format (NEAF). Ethics approval was granted for phases two and three by the Tasmanian Human Research Ethics Committee (Social Sciences) on 21 April 2017 (Ethics Reference: H 0016441) and 19 August 2019 (Ethics Reference: H0017619) respectively.

The second phase mixed method concept mapping study used a participatory online method, which posed several ethical challenges. The online method meant the ethics application had to address two concerns, anonymity and consent (Divall, & Spiby, 2020). Protecting the individuals' anonymity for this phase was done by making sure that participants received an automatically generated username and password that gave them an anonymous registration onto the study data collection website. As well, the participants demographic characteristics (location, mother`s age, child's age, the method of childbirth, parity) which were also inclusion criteria, did not provide any risk to revealing the identity of the women. Informed consent was ensured because as soon as participants logged onto the

Concept System® project webpage, they had to read the participant information and provide consent before they could progress into the data collection pages.

The third phase of the study explored online help-seeking discussions from a post-childbirth online support forum. The potential violation of privacy where online forums are used for data, and personal information is potentially released via social networking data, is increasingly debated (Eysenbach & Till, 2001; Michaelidou et al., 2020; Samuel & Buchanan, 2020). However, as this study phase only involved passive analysis (Gunther & James, 2001) and observational research (Moreno et al., 2013) and all posts were anonymous (Eysenbach & Till, 2001) the study maintained respect, justice and beneficence for participant. Furthermore, for this observational study, we sought approval from the weblog/forum moderators to use this publicly accessible data (Eysenbach & Till, 2001). A search of relevant Australian forums resulted in six forums. The approval of the forum 'owners' was an essential first step, and only one forum provide approval. Without the forum owner approval further approaches to women posters was not possible. The forum data was considered an important element of the study as it presented a unique insight into women's help-seeking and support that would not be offered by other forms of data collection. We analysed 332 posts which we considered a substantial data set.

All data are held at the University of Tasmania. Printed data are kept in a locked filing cabinet assigned to the researcher. Electronic versions of data and other project material are stored on a password-protected hard-drive stored at the Faculty of Health Science at the University of Tasmanian, and only the investigators have access to the relevant folder. The

data will be kept until at least five years after publication, and will then be shredded/deleted in accordance with National Health and Medical Research Council (NHMRC) guidelines.

3.11 Chapter summary

Because this study focused on women's experience, participatory feminist pragmatism was selected as an appropriate theoretical framework. Feminist theory argues that women have been marginalised, and pragmatism, by emphasising women's experience, allowed this study to paint an accurate picture using participatory research methods of women's health problems after childbirth. This chapter has given an overview of mixed methods research as a distinct research paradigm. This worldview facilitates research designs and data integration and provides the rationale for selecting a multiphase design. The following chapter presents the first phase of the study: a previously published systematic qualitative meta-aggregation review.

Chapter 4: Postpartum help-seeking behaviours

This chapter was originally published as a paper in the peer-reviewed, online journal *Midwifery*, in February 2019. A PDF of the published manuscript is reproduced as Appendix I.

Rouhi M, Stirling C, Ayton J, Crisp, E. P. 2019. Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review. *Midwifery*, *72*, 39–49. https://doi.org/10.1016/j.midw.2019.02.005

Abstract

Introduction

Women within the first 12 months after birth often do not seek professional help for post-childbirth morbidities. This systematic review uses the Behavioural Model of Health Services Use (BMHSU) to assess the barriers and facilitators to women's help-seeking from health professionals during the first 12 months after childbirth.

Method

A qualitative meta-aggregation was used for the review. Systematic searching of Medline via Ovid, CINAHL, EMBASE and Web of Science revealed an initial 691 papers, of which 48 were reviewed. Nine qualitative papers, peer-reviewed, English papers and published from 2000 to 2017, were identified. Studies selected according to the pre-defined protocol were assessed using The Joanna Briggs Institute Critical Appraisal Tools (JBIQARI).

Results

Seventy-five findings were identified from the approved articles and aggregated into seven categories. Key themes that emerged were that women did not seek help because they accepted problems as a part of the motherhood role or because they feared being judged negatively. Women shared their issues with family and friends as trusted persons. Low health literacy was a barrier to seeking help, as was lack of access to proper care and poor advice from families. The women's cultural context was an essential influence in whether or not they sought help. According to BMHSU, a model of the key influences on women's help-seeking for maternal morbidities introduced by the result of this study.

Keywords: Maternal morbidity, postpartum, Anderson model, unmet need, cultural barriers.

4.1 Introduction

The post-childbirth period (birth through to 12 months) is a time when many women experience maternal morbidities, either indirect or direct, physical or mental health issues (Vanderkruik, Tuncalp, Chou, & Say, 2013). The World Health Organization (WHO) defines maternal morbidity as 'morbidity in a woman who has been pregnant (regardless of the site or duration of the pregnancy), from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes' (Hardee et al., 2012, p. 604). Maternal morbidities affect over 90% of women after childbirth (Wilkie et al., 2017). The most commonly reported morbidities are depression, anxiety, fatigue, backache, sexual problems (such as sexual arousal disorder, orgasmic problems), gastrointestinal problems (constipation) and breastfeeding problems (Glazener et al., 1995; Ansara et al., 2005; Maher & Souter, 2006; Hardee et al., 2012; Khajehei, Doherty, Tilley, & Sauer, 2015; Van der Woude et al., 2015; O'Malley et al., 2018).

Maternal morbidities have a negative impact on mothers' health and well-being including physical and emotional adjustment to parenthood, difficulty returning to sexual activity and late return to employment (McGovern et al., 2007; Haran et al., 2014 Åhlund, Rothstein, Rådestad, Zwedberg, & Lindgren, 2019). Despite this, many women do not seek professional help for morbidities during the 12 months following childbirth (Cheng & Li, 2008) which can exacerbate problems by lowering mothers' quality of life and creating financial, mental health or fatigue issues (Foulkes, 2011; Hardee et al., 2012).

During the first 12 months after birth, there are a range of health professionals and services across multiple settings (tertiary and primary/community health) available to mothers. Help-seeking is defined as a problem-focused, highly adaptive behaviour (Cornally & McCarthy,

2011) demonstrated by an ability to find help, support, information, guidance or a cure (Ana Fonseca & Canavarro, 2017). Women within the first 12 months after birth are less likely to seek formal help from health professionals such as nurses and medical practitioners, instead seeking informal help from family and friends (Maher & Souter, 2006; Woolhouse et al., 2009; Cornally & McCarthy, 2011). Known barriers for women seeking support for common maternal morbidities include being unaware of available treatment, lack of knowledge about post-childbirth morbidities and shame or stigma associated with the morbidity (McCallum et al., 2011; Bina, 2014; Brown, Rance, & Bennett, 2015).

Some factors such as perception of the problem, accessibility of help and inclination to get treatment have been suggested as an effective factor in help-seeking behaviours (Chandrasekara, 2016). Higher education levels and support from family and friends have been shown to enable help-seeking behaviours for women within the first 12 months after childbirth (Dennis & Chung-Lee, 2006). However, there is a limited understanding of how women within the first 12 months after childbirth experience formal help-seeking from health care professionals and services (Abushaikha & Khalaf, 2014).

Better knowledge about women's experiences of barriers and facilitators when help-seeking from health professionals for post-childbirth physical and mental health problems is essential for ensuring suitable services. Improving policymakers' and health care providers' knowledge about this will enable them to design services that increase the number of women seeking professional help and decrease negative outcomes from lack of timely attention for childbirth morbidities (Bryant et al., 2016). The aim of this review therefore is to explore women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first 12 months after childbirth.

4.2 Method

To address the aim, a systematic qualitative meta-aggregation review was conducted following the Joanna Briggs process (Lockwood, Munn, & Porritt, 2015). Meta-aggregation is underpinned by pragmatism which aims to find set of statements from qualitative papers to produce 'lines of action' for policy makers (Hannes & Lockwood, 2011).

This uses a comprehensive and rigorous search of relevant studies to find unbiased knowledge that answers the research question with the findings then extracted and aggregated without any new analysis (Lockwood et al., 2015) which aims to better understand of the problem (Creswell, 2013).

4.2.1 Conceptual framework

A variety of behavioural models have been used to explain help-seeking behaviours, including psychological models such as the Self-Regulation Model (Diefenbach & Leventhal, 1996), the Health Belief Model (Diefenbach & Leventhal, 1996) and the Theory of Planned Behaviour (Armitage & Conner, 2001). Sociological perspective models have also been used, such as the Network Episode Model (Pescosolido & Boyer, 1999), Kadushin's theory (Kadushin, 2004) and the Behavioral Model of Health Service Use (BMHSU) (Andersen et al., 2011). Among these theories, sociological models that consider demographic and societal factors may best explain help-seeking behaviour in post-childbirth women, given the existing knowledge on the impact of informal support on health services use. This systematic review applied the BMHSU model as a lens to view the qualitative research evidence identified (Andersen et al., 2011).

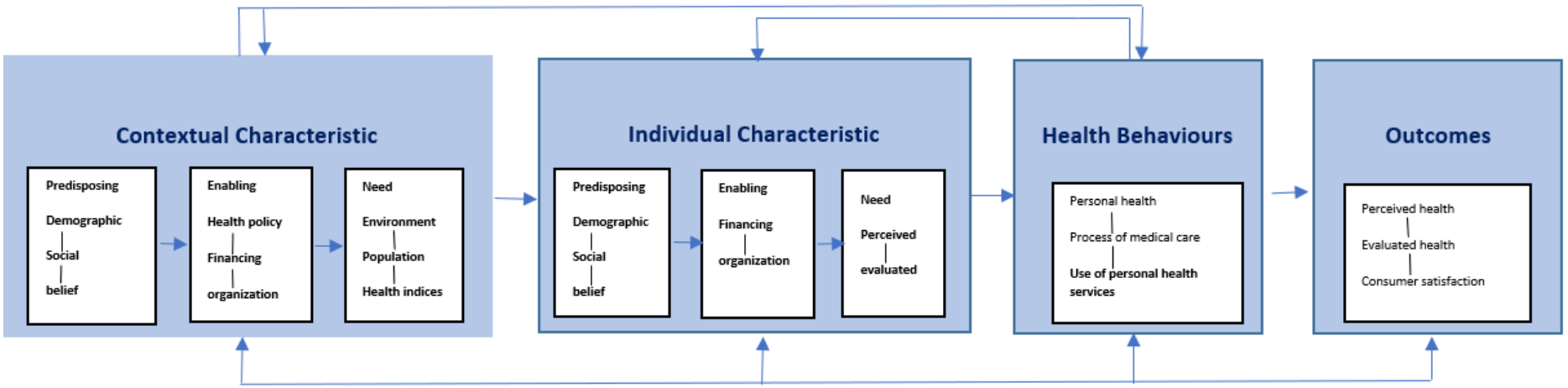

Figure 4.1 Behavioural Model of Health Services Use including contextual and individual characteristics (adapted from Magaard et al., 2017)

The BMHSU (Figure.4.1) proposes that health outcomes originate from a mix of contextual characteristics, individual characteristics, and health behaviours (Andersen et al., 2011). The contextual and individual characteristics are categorised into predisposing variables, enabling factors and need variables (Andersen et al., 2011). Family, society and the health care system are all considered as contextual characteristics; personal beliefs about health care services, educational level and demographic features such as age, are defined as individual characteristics (Andersen et al., 2011). The health behaviours that are influenced by personal practices and the process of medical care shape the use of personal health services (Andersen et al., 2011). This review considered only the contextual and individual characteristic elements of the BMHSU model, as barriers and facilitators to women's health behaviours and outcomes (see Figure 4.1). Anderson et. al (2011) conceptualises the factors important for seeking help as: (a) predisposing variables (b) enabling factors and (c) need variables, such as severity of post-childbirth morbidities.

4.2.2 Search strategy and selection

The review considered qualitative and qualitative components of mixed methods studies, published in peer-reviewed articles in English from January 2000 to December 2017. The inclusion criteria were formulated according to the PICO format (Participant, Interest, Context). 'Participant' was defined as women within the 12 months after childbirth. 'Interest' was defined as any factors that hinder or influence women to access health professional care related to their maternal morbidity issue/s. 'Context' was any international research about help-seeking behaviour among community-dwelling women. Post-childbirth morbidities included any physical and mental health issues such as depression, backache, wound

infection, breast problems, experienced by women during the first 12 month following childbirth.

The following search terms were used: (postpartum OR postnatal OR after childbirth OR puerperium OR birth) AND (maternal OR women OR mothers) AND (behaviour) AND (facilitators) AND (barriers OR morbidity OR help-seeking OR treatment preferences OR behaviour OR facilitators) AND (qualitative OR mixed methods OR evaluation). Modification of the terms by using truncations and Boolean Operators helped to access a full range of papers, see table 4.1 for key words.

Two researchers (MR, SL) searched for English language papers on the following electronic databases in consultation with a subject relevant librarian: MEDLINE, CINAHL (EBSCOhost), EMBASE (Ovid), and ISI Web of Science. The keywords and predefined vocabulary used, exclusion and inclusion criteria are presented in Table 4. 1. To identify additional potentially relevant published papers, we hand-searched the reference lists of all identified relevant papers (n=1).

The search method recognised 971 papers. All papers from databases were added to EndNote library and then duplications (n=691) were manually removed prior to selection of studies (Figure 4.2). Papers were screened and excluded by title and abstract. A full-text copy of 48 studies were retrieved for consideration of eligibility, with 39 of the papers being excluded because they did not address the outcome of interest (n= 3), phenomena of interest (n= 17) and participants of interest (n= 19), see Appendix (II).

Table 4.1 Search methods for identification of studies

Type of study	Qualitative and mixed method studies included in this study.
Approaches	We undertook Internet searching and hand searching
Range of years	The search strategy involved the systematic review of published peer-reviewed articles in the English language published from 2000 to December 2017.
Limits:	Human.
Term used:	'postpartum', 'postnatal', 'after childbirth', 'puerperium', 'birth' "AND", 'maternal', 'women', 'mothers', 'infant', 'baby' "AND" 'behaviour' "AND" 'facilitators' "AND" 'barriers', 'morbidity', 'help-seeking', 'treatment preferences', 'behaviour', 'facilitators' AND 'qualitative', 'mixed methods', 'evaluation'
Post-childbirth period	Defined as 12 months following childbirth.
Post-childbirth morbidities	Physical and mental health issues (i.e. depression, backache, headache, wound infection, constipation, breast problems, urinary incontinence, fatigue, postpartum blues, sexual problems, sleep problems, haemorrhoid, anxiety and faecal incontinence)
Health professional sources of help	GP, Obstetrician/Gynaecologist (OB/GYN), Psychologist, Psychiatrist, Social worker, Child Health and Parenting Centres, Nurse, Midwife, Physiotherapist, Australian Breastfeeding Association (ABA) and Chiropractor.
The BMHSU framework	Theorises that some factors are important for seeking help (a) predisposing variables (b) enabling factors and (c) need variables, such as severity of post-childbirth morbidities {Anderson, 2011)
Help-seeking barriers and facilitators	Broadly defined as any factors that hinder or influence women to access to the health professional related to their health issues.

4.2.3 Quality appraisal

Two researchers (MR, ChS) independently screened the full text of retrieved papers (n=9) by the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) (Appendix III). The checklist consists of ten questions involves three distinct steps: filtering, technical appraisal and theoretical appraisal (Hannes & Lockwood, 2011). Papers were included if both reviewers answered 'yes' to a minimum of seven of ten prompt questions, with disagreements resolved by consensus after reviewing the criteria and definitions.

For this systematic review, eight qualitative papers (Sword et al., 2008; Abrams et al., 2009; Merry et al., 2011; Wittkowski et al., 2012; Buurman & Lagro-Janssen, 2013; Goyal et al., 2015; Wuytack et al., 2015; Bell et al., 2016) and one mixed methods pilot study (Park et al., 2017) met the inclusion criteria.

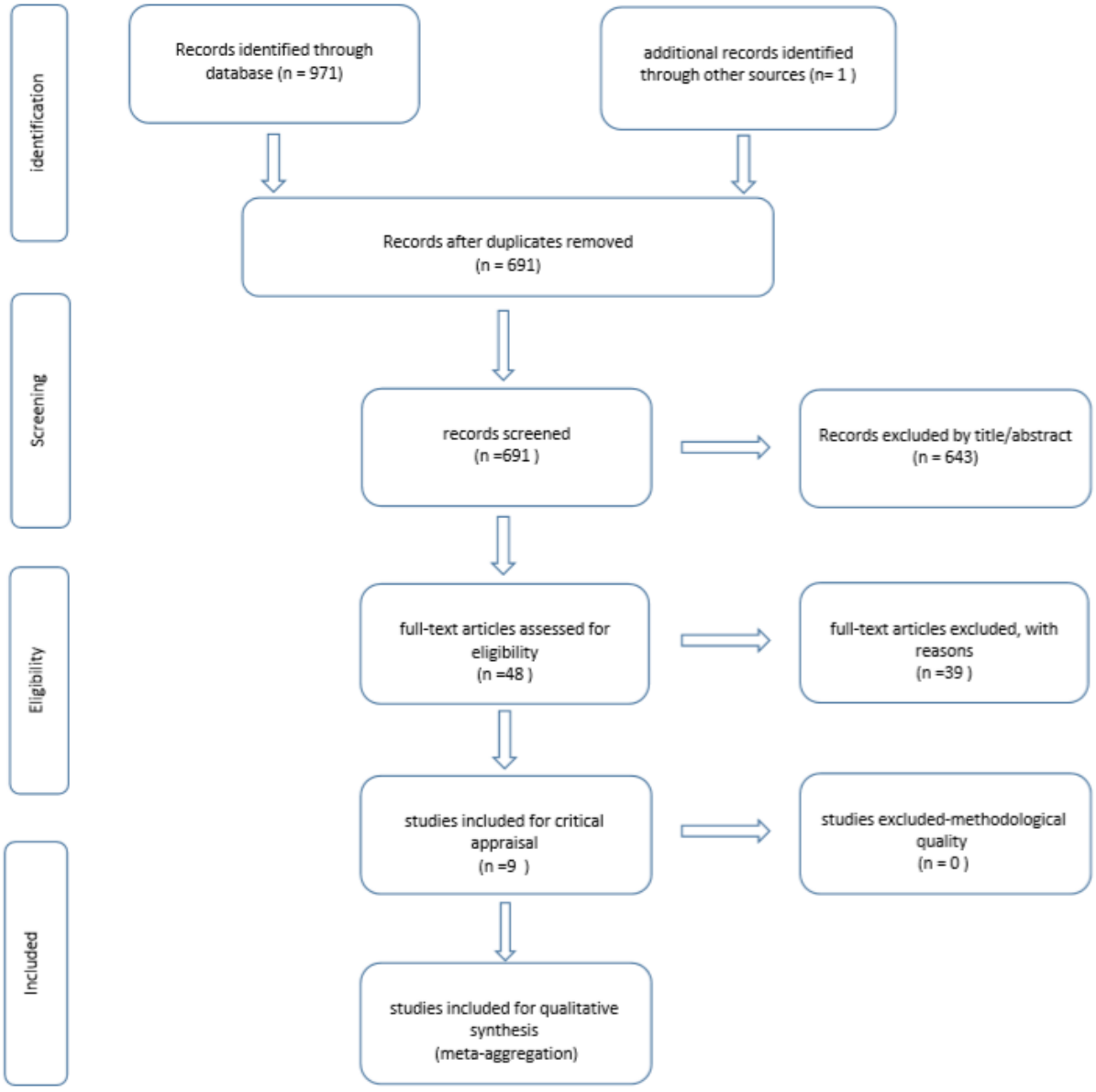

Figure 4.2 Flow diagram of systematic review

4.2.4 Data extraction and management

The review process began with the pre-defined inclusion and exclusion criteria as per our well-defined question providing a framework to find not just the articles, but the relevant findings within articles (Korhonen et al., 2013). Data were collected on the following: author(s) names, publication date, methodology, method, phenomenon of interest, country, setting, participants, data analysis and findings the quality measure, the aim of study, design; morbidity; participants; ethnicity; and phenomena reported (see Table 4.2). There were a limited number of post-childbirth maternal morbidities reported in the papers: depression (Sword et al., 2008; Abrams & Curran, 2009; Wittkowski, Zumla, Glendenning, & Fox, 2012 Goyal, Park, & McNiesh, 2015; Bell et al., 2016; Ta Park et al., 2017), pelvic floor dysfunction (Buurman & Lagro-Janssen, 2013), and pelvic girdle pain (Wuytack et al., 2015). All studies, apart from one identified participant diverse culture background (Wittkowski et al., 2012).

4.2.5 Level of credibility

It is essential for credibility of qualitative research to only consider high quality papers and those without bias (Dixon-Woods, 2006). The different interpretation of qualitative findings makes it difficult to get a deep understanding of the aim of the research's included papers. The studies included in this systematic review were graded as credible according to the JBI credibility criterion, which is defined as the congruity between the research question and findings of the studies based on the theoretical frameworks (JBI, 2014).

4.2.6 Data synthesis

The Meta aggregation process requires achieving the applicable findings that met the review criteria (Hannes & Lockwood, 2011). We extracted 75 findings from the nine papers,

with illustrating quotes about women's perceptions of the barriers and facilitators they experienced in seeking help from health professionals as the first step of meta-aggregation process (Appendix IV). Findings were then aggregated into seven categories according to similarity in meaning (Appendix V). Further analysis of the categories shaped three synthesis statements (Figure 4.3). These statements were formed as key factors that discouraged or convinced a woman to seek help related to her health issues and referenced against the BMHSU framework.

Table 4.2 Characteristics of included studies

Author/s (year)	Abram 2009	Bell 2016	Buurman 2012	Goyal 2015	Merry 2011	Park 2017	Sword 2008	Wittkowski 2017	Wuytack 2015
Methodology	Qualitative, grounded theory	Qualitative, descriptive study	Qualitative study	Exploratory qualitative	Qualitative subproject	Mixed methods pilot study	Qualitative descriptive approach	Qualitative, grounded theory approach	Qualitative, descriptive qualitative design
Method	Interview	Semi-structured interview	Interview	Interview	Interview	Semi structured telephone interviews	Semi structured telephone interviews	Semi structured interviews	Semi-structured interviews
Quality measure	8	7	9	7	7	9	8	10	9
Phenomenon of interest	Investigating Barriers to seek formal help for PPD symptoms	To explore the barriers and facilitators to the use of mental health services reported by women with elevated symptoms of depression in the postpartum period	To explore women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour	To explore Asian Indian mother`s perspectives of postpartum depression	To gain greater understanding of the barriers these vulnerable migrant women face in accessing health and social services postpartum	To explore Vietnamese American mothers' perceptions and experience postpartum traditions, postpartum depression (PPD) and mental health help-seeking behaviour	To explore women's care-seeking experiences after referral for postpartum depression.	To better understand the experience of PND in South Asian mothers living in Great Britain	To explore the health-seeking behaviours of primiparous women with pelvic girdle pain persisting for more than three months postpartum.
Country	USA	Canada	Netherlands, Amsterdam	USA	Canada	USA	Canada	UK	Ireland
Setting	Three Women,	Perinatal mental health	Two practitioner	local area university	Postpartum units in	Women from public	The local public health	Through health visitors	Women attending one

	Infant, and Children (WIC) federal nutrition program clinics Latinas, Mexican immigrants, African American/ Black.	clinic and during a routine visit to the obstetrics clinic	populations in different parts of the Netherlands: one in Amsterdam and one in the eastern part.	groups and social media.	Montreal, Toronto		unit's Healthy Babies, Healthy Children Program	and midwives within the Greater Manchester area	tertiary maternity hospital
Participants	25, Latinas, Mexican immigrants, African American/ Black, low income ethnic minority	48 Canadian women. French or English speaking	26Dutch, Indonesian, Bulgarian women	12 Asian Indian married women living in California	112 African, Asian, European, Latin American	15 women, the majority (n=14) were born in Vietnam, with one mother stating she was born in the USA.	18 women who spoke English	10 Asian women living in UK	23 primiparas, 19 Irish, 4 other European country
Data analysis	Thematic analysis	Inductive content	Constant comparative	Content analysis	In-depth analysis of the texts	Content analysis	Content analysis	Constant comparison	Thematic analysis
Findings	Five core themes: (i) Inevitable and disappointing problems;	Five major themes: 1. Accessibility and Proximity, 2. Appropriateness and Fit, 3. Stigma,	Five core themes: (i) Inevitable and disappointing problems; (ii) Natural recovery; (iii)	Two overarching themes: (1) cultural-specific postpartum traditions;	Six main themes emerged from the data: isolation; difficulties reaching mothers	Seven themes: (1) cultural identity, (2) practice and examples of postpartum traditions, (3) perceptions of	Themes were identified that reflected three levels of influence: individual level, social network level,	The three main overarching core categories related to PND,	Three main themes, each with several categories emerged from the women's accounts of their health-

	(ii) Natural recovery; (iii) Feelings of shame; (iv) The role played by initiates and help-seeking	4. Encouraged by Significant Others to Seek Help, 5. Personal	Feelings of shame; (iv) The role played by initiates and help-seeking	(2) mental health help-seeking behaviour.	postpartum; language barriers; low health literacy; lacking psychosocial	the etiology of sadness/ depression, (4) perceptions about their families' viewpoints of the etiology of depression, (5) lived experiences with depression and help-seeking, (6) speculated professional help-seeking behaviours and alternative resources for sadness/ depression, and (7) barriers to help-seeking.	and health care system level. At each level, specific barriers to and facilitators of care seeking emerged from the analysis of interview transcripts	(1) internalising misery, (2) others will judge me, and I feel on my own, and (3) I talk to my health professional and they don't understand.	seeking behaviours; (1) 'They didn't ask,Ididn't tell', (2) Seeking advice and support, and (3) Coping strategies

4.3 Results

Women's perceptions of the barriers and facilitators they experienced in seeking help from health professionals were allocated to seven categories; they accepted the problems as part of normal childbirth process; lack of knowledge about the problems was obvious, they shared their problems with trusted persons; family and friends influenced women's choice to seek help or not; difficulty to access post-childbirth care or did not address their problems; fear of being judged prevented them to seek help; the women's cultural context was an essential factor in whether or how they sought help. The seven categories were aggregated to three synthesis statements about the topics: Perceived need to seek help, Interpersonal communication, and how society views post-childbirth problems (figure 4.3).

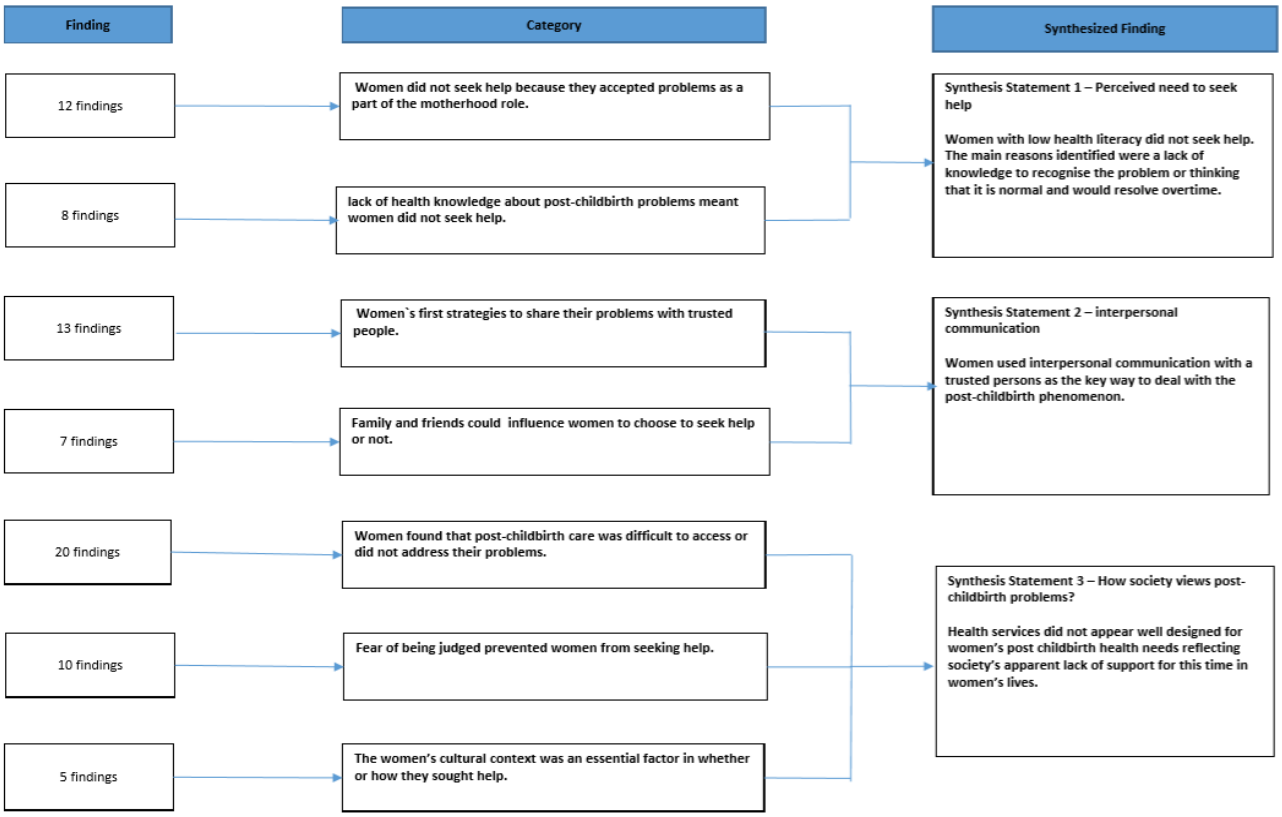

Figure 4.3 Meta-aggregation of findings on facilitators and barriers to help-seeking

4.3.1 Synthesis Statement 1 – Perceived need to seek help

Women with low health literacy were less likely to seek formal help. The main reasons identified were a lack of knowledge to recognise the problem or thinking that the morbidity was normal and would resolve over time. Two categories supported the first synthesis statement.

4.3.1.1. Category - Women did not seek help because they accepted problems as a part of the motherhood role.

Five out of nine studies made references to the post-childbirth problems being seen by women as a normal process of childbirth and not as an ailment (Sword et al., 2008; Abrams et al., 2009; Buurman & Lagro-Janssen, 2013; Bell et al., 2016; Ta Park et al., 2017). Women's perceptions about their conventional role in families (Ta Park et al., 2017) and normalizing of their health problems also led to their belief that their problems were part of the motherhood role (Abrams et al., 2009; Buurman & Lagro-Janssen, 2013). This was reported by all studies for both physical or mental problem. For example, one woman reported: `I simply thought: the urinary incontinence is just part of it. Your whole body is turned inside out after delivery anyway. So, I thought it's just part of the game.' (Buurman & Lagro-Janssen, 2013, p. 408).

Women with physical problems also expressed the view that initially they felt their problem would gradually be resolved (Buurman & Lagro-Janssen, 2013), and for mental issues they felt they were able to self-manage their problems (Bell et al., 2016). Overall, women's accounts showed that their infant`s health had priority over their health (Buurman & Lagro-Janssen, 2013; Bell et al., 2016).

4.3.1.2 Category – A lack of health knowledge about post-childbirth problems meant women did not seek help.

All seven studies confirmed that both women (Sword et al., 2008; Merry, Gagnon, Kalim, & Bouris, 2011; Buurman & Lagro-Janssen, 2013) and trusted persons in their lives (Sword et al., 2008) had a lack of knowledge about post-childbirth health problems:

> 'I just didn't know what I wanted at the time and I didn't know what I wanted to get out of it. I didn't know what was going on.' (Bell et al., 2016, p. 656)

One study showed that provision of information and guidance by health care providers to women about their issues or previously experienced problems assisted women to cope with the problems after childbirth (Sword et al., 2008).

4.3.2 Synthesis Statement 2 – Interpersonal communication

Women used interpersonal communication with a trusted person as the fundamental way to deal with the post-childbirth phenomenon. Two categories supported this synthesis.

4.3.2.1 Category - Women's first strategies were to share their problems with trusted persons.

This category was supported by 14 findings in five studies (Abrams et al., 2009; Merry et al., 2011; Wittkowski et al., 2012; Wuytack et al., 2015; Goyal et al., 2015). Findings suggested that if women could not manage their health issues alone, then they shared problems as the first step in help-seeking (Goyal et al., 2015). Many women spoke to their spouse or other women about their health issues (Abrams et al., 2009; Wittkowski et al., 2012; Goyal et al., 2015). For example, one participant reported about her husband:

> He always says, 'But, who do we ask? Who do we ask? Next time you go to the doctor ask him about how you're feeling. (Abrams et al., 2009, p. 542)

Another study identified a preference for sharing problems with friends from the same age group (Goyal et al., 2015), or some women preferred to talk to a person who they felt was reliable and would listen carefully to their problems without any judgment (Abrams et al., 2009).

4.3.2.2 Category - Family and friends influenced women's choice to seek help or not.

Women were often encouraged by family and friends to seek help, even if their family considered the problems as a part of normal childbirth process (Sword et al., 2008; Wuytack et al., 2015; Bell et al., 2016). If there was a lack of awareness and assistances by partner and family, depressed women often did not feel motivated to seek help (Bell et al., 2016). Some of the women felt their health problems were not significant to the family (Sword et al., 2008) and were even ignored by them (Bell et al., 2016). For example, one woman reported:

> `My mother doesn't want to look after the infant so I can see my psychologist. She believes I don't need it. I have no support from her for this.' (Bell et al., 2016, p. 656)

4.3.3 Synthesis Statement 3 – How society views post-childbirth problems?

Health services did not appear well designed for women's post-childbirth health needs reflecting society's apparent lack of support for this time in women's lives. Three categories supported this synthesis.

4.3.3.1 Category - Women found that post-childbirth care was difficult to access or did not address their problems.

Many of the women reported that professional health care was an unhelpful experience (Abrams et al., 2009) as this participant reported:

> I find they just like brush you off ... my gyne doctor, I thought she would help, she would understand, cause she works in the field. And instead she just like didn't care. I honestly felt that she didn't care and I felt so alone. (Bell et al., 2016, p. 654)

The discrepancy between antenatal and postnatal care was also emphasised by women (Wuytack et al., 2015) as health services often did not forewarn women about possible problems (Bell et al., 2016). Health care professionals rarely asked women about their problems during appointments such as infant checks (Wuytack et al., 2015) with consultations focused on the infant`s need rather than the mother`s (Bell et al., 2016).

There was a lack of psychosocial assessment or assessment of abuse or depression (Merry et al., 2011) and some women reported that they received conflicting advice from different health professionals when they discussed morbidities (Wuytack et al., 2015). Women often struggled to access professional health care as a first line of treatment (Abrams et al., 2009). Among those women who sought professional help, those services that were close to home or online were the priority (Bell et al., 2016).

Among immigrant women, isolation and language obstacles were barriers to accessing health services (Merry et al., 2011). Some factors such as absence of knowledge about who and which services were available (Wittkowski et al., 2012), government-funded (free services) (Merry et al., 2011), and the cost of seeking private treatment (Wuytack et al., 2015) were reported in findings as barriers to care. Continuity of care and having an established relationship with a health care provider facilitated post-childbirth help-seeking in two papers. A 'comfortable relationship' with health care providers was the main reason for seeking help (Sword et al., 2008; Bell et al., 2016):

> `I had already established a relationship with [the clinic] so the counsellor I was seeing there was, I mean, available at any time and I felt that was good and I also had a good rapport with my doctor, so I was alright. I'm not one to easily open up, so if I don't feel comfortable with someone there's no way I'll talk about how I feel.' (Sword et al., 2008, p. 1169)

4.3.3.2 Category - Fear of being judged prevented women from seeking help.

Women's fear of being judged was a barrier to seeking help, with some women stating fears of being labelled as 'crazy,' 'schizo,' or 'psycho' (Abrams et al., 2009; Bell et al., 2016) and a general worry about stigma (Goyal et al., 2015):

> `I'm like I don't wanna be labelled you know. It's like you always feel like you're being labelled as a psychiatric patient.' (Bell et al., 2016, p. 655).

Working women were additionally worried that being labelled as 'depressed' might negatively influence their employment prospects (Sword et al., 2008). This issue was at the forefront in the rare cases were women worried about losing child custody (Sword et al., 2008).

Some women felt that openly discussing urogenital problems was 'taboo' and embarrassing (Buurman & Lagro-Janssen, 2013). They expressed feelings of shame if they had to talk about these (Buurman & Lagro-Janssen, 2013). This also applied to mental symptoms (Sword et al., 2008). These barriers could be exacerbated if women experienced lack of self-esteem about body image (Buurman & Lagro-Janssen, 2013) or if there were a lack of respect for patient`s privacy by health professionals (Bell et al., 2016).

4.3.3.3 Category- The women's cultural context was an essential factor in whether or how they sought help

Culture-specific post-childbirth traditions can help family and friends to support women (Goyal et al., 2015) and conversely a lack of culturally appropriate care was a barrier to accessing care for many immigrant women (Goyal et al., 2015; Ta Park et al., 2017).

> 'I think our Vietnamese never come to those services. Our Vietnamese are very strong. American always comes to see counsellors. Majority of our Vietnamese don't come to see these professions. I have a strong mind. I am sad, but I don't need to see them.' (Ta Park et al., 2017, p. 437)

Findings showed that 'familism' or cultural norms also created strong barriers as some women explained their culture banned women from talking about their mental health issues and did not encourage them to engage with their thoughts and feelings (Wittkowski et al., 2012). Some women therefore preferred to speak to strangers to protect their privacy (Abrams et al., 2009) and sometimes they preferred to get this help anonymously (Goyal et al., 2015).

4.4. Discussion

The studies included in this review only covered depression, pelvic floor dysfunction, and pelvic girdle pain. This is in contrast to reported quantitative studies which have highlighted a wide range of morbidities and suggest the prevalence of morbidities is around 90% during the postpartum period (Cooklin et al., 2018). The limited research presenting a women's perspective on help-seeking for post-childbirth morbidities is surprising given the prevalence of morbidities and suggests a 'hidden' problem. The meta-aggregation results highlight possible reasons for the dearth of qualitative research in this area.

The key facilitators and barriers for women seeking help for health issues after childbirth were summarized as three synthesis statements covering women's perceived need to seek help, interpersonal communication, and how society views post-childbirth problems. The results extracted three coherent themes about factors influencing women's help-seeking behaviour after childbirth.

4.4.1 Perceived need to seek help

These findings show that women normalized, minimized or hid their health issues. This resulted in a lack of perceived need as women often did not understand the importance of their problems or could not distinguish between what is regarded as normal or abnormal when it comes to physical or mental health problems after childbirth. According to the BMHSU Model, this lack of perceived need leads to less demand for services (Bradley et al., 2002). The normalizing, minimizing or hiding of problems means that women conceptualized these problems as a normal process of childbirth and subsequently did not take any action to resolve them (Scrandis, 2005; Rudman & Waldenström, 2007; Chew-Graham et al., 2009; Goodman & Santangelo, 2011).

Low health literacy underpins women's lack of perceived need. The synthesized findings confirmed women (Sword et al., 2008; Merry et al., 2011; Buurman & Lagro-Janssen, 2013; Bell et al., 2016), trusted persons (Sword et al., 2008) and health care providers (Khalaf et al., 2009; Beake et al., 2010) were often unaware of potential problems deriving from childbirth. This low literacy exists across all groups despite the known high prevalence of post-childbirth morbidities during the first 12 months (Cheng & Li, 2008; Haran et al., 2014). Others have highlighted that high-level education is a motivation to seek treatment (Dennis & Chung-Lee, 2006) and so education can be seen as an enabler for women to be empowered to seek help.

Women's perceived need to seek help are framed as individual characteristics in the model but this study suggests perceived need is also a social phenomenon. Evaluated need is categorised as professional judgments by specialist and health care providers in the BMHSU model. It also has social elements, such as access to the latest medical advances and the provision of educational brochures and medical equipment. The included papers for this systematic review showed that lack of evaluated need is one of the reasons for women's lack of knowledge about post-childbirth problems, as women felt health care providers had not prepared them for potential problems after childbirth, in the prenatal period.

4.4.2 Interpersonal communication

The synthesized findings indicated that women used interpersonal communication with trusted persons as the fundamental way to deal with post-childbirth morbidities. Once women decided they needed to seek help, family and friends were found to be the first source of help (O'Mahen & Flynn, 2008). Scrandis (2005) showed that women notably shared their problems with trusted persons through their connections with other women who have the same problem. Overall it is clear that positive interpersonal connections between women and surrounding people encouraged them to seek help.

4.4.3 How society views post-childbirth problems

One of the implications of this systematic review is that society`s views are a barrier to women's post-childbirth problems because there is a general normalising of maternal morbidities. According to the BMHSU Model, social factors at the contextual level influence health service use. More specifically, a community`s health literacy level and ethnic

composition were relevant predisposing influences found in this study for enabling of creating barriers to help-seeking.

The community-based beliefs that derive from community values and culture, direct financial resources and policies for access to services and therefore can also influence evaluated need. The relevance of cultural barriers found by others, such as lack of understanding and support by society and lack of understanding of cultural background by health care providers (Sword et al., 2008) were supported by this review.

Enabling characteristics identified in the BMHSU Model that could offset these elements consists of health policy, financing and organization. These factors reflect the distribution of care services in the community and the community access. As these results highlight, limitations in these services result in non-use by women after childbirth and are compounded by feelings of stigma. This review is supported by others who argue that a key way to improve post-childbirth maternal and child health is improving health care providers' awareness of post-childbirth morbidities (Cassiano et al., 2015; Mazzo et al., 2015), with a re-balancing of post-childbirth health visits toward the needs of the woman's post-childbirth health (Fahey & Shenassa, 2013).

There is little research about the knowledge of health care providers (McCauley et al., 2011). The necessity for improved education for health care providers about maternal morbidities is crucial the lack of knowledge by women's family and health care providers was apparent (Khalaf et al., 2009). To provide appropriate care to women during thepost-childbirth period, it is important that health care providers increase their knowledge about post-childbirth physical and mental care (Romanno et al., 2010).

4.4.4 The BMHSU model

This systematic review applied the BMHSU model as a lens to find women's help-seeking behaviour about their health issues after childbirth (Figure 4.1). We found several of the BMHSU categories more useful than others. Among contextual characteristics and individual characteristics, the predisposing factors 'social' and 'beliefs' were relevant. Health policy and organization as enabling factors were relevant to this systematic review according to contextual characteristics. Among individual characteristics financing and organization characteristics were enabling and evaluated and perceived need factors were also key findings from this systematic review (Magaard et al., 2017). None of our review papers identified relevant demographic details. The BMHSU Model does not specify health literacy. However, this review shows the importance of health literacy as a unique factor to explain help-seeking behaviour and we propose adding health literacy as a predisposing factor for both contextual and individual characteristics. Overall, the BHMSU model was overly complex for our findings.

This meta-aggregation found several pivotal obstacles to post-childbirth care, which has enabled the development of a new framework for understanding barriers and facilitators to women's help-seeking for maternal morbidities (Figure 4.4). We placed women's perception of need at the centre, surrounded by interpersonal communication with trusted persons, and all encompassed by society's views of women and childbirth. A comprehensive study of women's post-childbirth behavioural and psychosocial health care, acknowledging social factors is necessary to address gaps in care. The recognition of these gaps, in turn, can be helping to enhance care and meet guidelines for better post childbirth care.

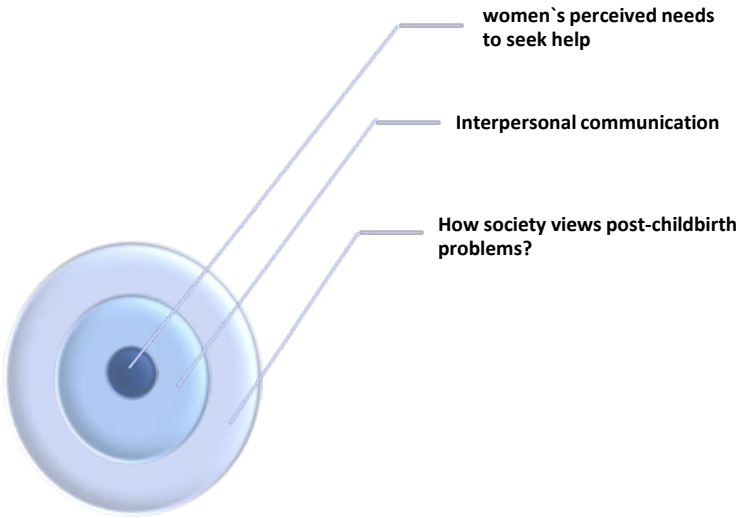

Figure 4.4 A model of the key influences on women's help-seeking behaviour in the 12 months post-childbirth

4.5 Implication for practices

WHO (1998) two decades ago suggested a more comprehensive schedule for postpartum care (6 -12 hours, 3-6 days, 6 weeks, 6 months), with current guidelines by WHO (2015) ended by 6 weeks. Our review suggests that extending offered care by health care providers to 12 months after childbirth, might enable mothers' help-seeking for maternal morbidities and protect the women's health and consequently families` health. Our review also highlights the role for informed health care workers in routine questioning about morbidities to bypass women's lack of perceived need. This could be via a checklist to remind health care workers to collect the required information from the mother and if appropriate, their partner (Phang et al., 2015). Additionally, better educational preparation of women and their families about about maternal morbidities during pregnancy or the during hospital stay could enable help-seeking behaviours.

Further, health service managers need to ensure that access barriers are addressed through quality needs assessment processes, particularly for vulnerable women.

4.6 Limitations

The meta-aggregation approach considers extracted themes from supporting statements such as the participant`s experiences or quotes and creates new knowledge through synthesis not new analysis. This study included papers which reported depression and pelvic issues, but research addressing other common post-childbirth morbidities were not found and it is possible that we failed to identify all available literature. Given quantitative papers show a wide range of morbidities it can be assumed that there is a need for further primary research into women's experiences of post-childbirth help-seeking. Only papers written in English were included and all the studies located were conducted in developed countries, so there is limited applicability of the findings to women in developing countries.

4.7 Conclusion

This review found that women often do not recognise morbidities, or are disinclined to reveal physical and mental post-childbirth morbidities in the primary care setting. We also found that health professionals do not facilitate discussion of post-childbirth morbidities and may have a lack of awareness of evidence-based management of post-childbirth morbidities. Societal lack of knowledge about maternal morbidities was also found by this review suggesting the need for improved health literacy among family, health care providers and the community about these problems is necessary. We identified a model of women's help-seeking for maternal morbidities that addresses our findings more closely than the BHMSU model. The review has highlighted that there is limited literature from a women's perspective

about post-childbirth help-seeking and lack of research in this area may negatively influence policy. Given the identified barriers to help-seeking for women further research and review of the content, quantity and quality of care after childbirth are recommended.

4.8 Chapter summary

This systematic review presented a comprehensive international information published from 2000 to 2017 about women's help-seeking behaviours within the first 12 months after childbirth. However, finding nine papers in this area showed there was a scarcity of research. The 'key findings' of this study were, post-childbirth problems are seen as a part of the motherhood role, women fear being judged negatively, women share their issues with family and friends as trusted persons, low health literacy, Lack of access to proper care and poor advice from families, women's cultural context was an essential influence in whether or not they sought help.

In section 3.6, feminist pragmatism has been emphasised on value of published work. Limited numbers of qualitative studies found in this systematic are a valuable evidence that shows women's voices and their experience have been neglected. It is a confirmation of feminist activists who are trying to show how women marginalised in the scholarly research as well.

Chapter 5: Mothers' views of postpartum health problems

This chapter was originally published as a paper in the peer-reviewed, Journal of Advanced Nursing, in August 2019. A PDF of the published manuscript is reproduced as Appendix VI.

Rouhi, M., Stirling, C., & Crisp, E.P. 2019. Mothers' views of health problems in the twelve months after childbirth: A concept mapping study. *Journal of Advanced Nursing*,00, 1–13. https ://doi.org/10.1111/jan.14187.

Abstract

Introduction: Many women experience physical and mental health problems after childbirth, but there is a gap in understanding how they perceive their health after childbirth. Studies suggest they are inhibited in expressing their needs and so seek informal rather than professional help for their health problems.

Method: A mixed method concept mapping study has been selected for this study. Two groups of Australian women were recruited via an online platform and purposive sampling (n=81) in 2017-2018. A first group created 83 brainstorm statements about post-childbirth health problems and help-seeking, and a second group sorted and rated the statements based on their perception of the prevalence of the issues and the help-seeking advice they would offer to others. Bradshaw`s Taxonomy of Needs was used to theoretically underpin the explanation of the results of women's felt need after childbirth. The aim of this study is identification of the health problems that women feel require help and subsequent help-seeking behaviour during the 12-month period after childbirth.

Results: Multidimensional scaling resulted in six clusters of issues which were categorised into three domains: 'health issues and care', 'support', and 'fitness'. Despite being directly asked, about two-thirds of the women did not report experiencing any health problems.

Conclusion: Our findings showed women had a broader perception of health care needs which included support and fitness. There is a potential gap in services for women who do not have good social support.

Keywords

Help-seeking behaviour, nursing, support, morbidities, Bradshaw taxonomy, social need, felt need, concept mapping.

5.1 Introduction

This paper addresses women's health problems occurring in the first 12 months after childbirth. Post-childbirth health problems are conditions attributed to childbirth resulting in a negative impact on the women's wellbeing and functioning (Chou et al., 2016). These problems remain a challenge to define, interpret and measure (Hardee et al., 2012) and the prevalence of these general and specific health problems is insufficiently addressed and inadequately described in the literature (Haran et al., 2014), making them 'hidden' from sight (Fahey & Shenassa, 2013). Furthermore, women report not being encouraged to reveal their post-childbirth health concerns during 'traditional' post-childbirth care (Haran et al., 2014). The more common post-childbirth health problems such as haemorrhage, hypertension and mood disorders are well described in the literature and clinical practice, with established plans for treatment (WHO, 2015; Hannah Woolhouse, James, Gartland, McDonald, & Brown, 2016). However, hidden post-childbirth health problems, such as backache or fatigue (Schytt et al., 2005; McGovern et al., 2007; Rouhi et al., 2011; Song et al., 2014), are not sufficiently considered in the traditional post-childbirth check-up (Levitt et al., 2004; Cheng et al., 2006; Cheng & Li, 2008). It can be argued that the traditional post-childbirth check-up fails to identify all the health problems that women experience, creating potential long-term effects on their well-being.

5.2 Background

Post-childbirth health problems affect over 90% of women during the 12 months after childbirth (Wilkie et al., 2017). The effects of these problems on women's and infant's health are undeniable (Walker et al., 2015). Research shows there is a concerning lack of knowledge about post-childbirth health problems and what is 'normal' post-childbirth among health care

providers, women and their families (Khalaf et al., 2009; Beake et al., 2010). Post-childbirth care often focuses on the infant`s needs rather than the mother's (Buurman & Lagro-Janssen, 2013; Bell et al., 2016). While we know most women need information about lactation or dealing with adjusting to a new situation during the first days of this period (Beake et al., 2010), there is little information about women's needs during the rest of the 12 months post-childbirth period (Rouhi et al., 2019). Most research about post-childbirth problems focuses on the early post-childbirth period (Kaitz, 2007; Caetano, Mendes, & Rebelo, 2018) or more prevalent problems such as mental health problems (Fisher et al., 2012).

Our earlier systematic review showed there is a paucity of information related to help-seeking behaviours (an ability to seek formal or informal help) among women in this 12-month post-childbirth period (Rouhi et al., 2019). The existing research is focused on non-professional sources of help like family and friends (Maher & Souter, 2006; Woolhouse et al., 2009; Cornally & McCarthy, 2011) and is largely about mental health problems such as depression (Sword et al., 2008; Abrams et al., 2009; Goyal et al., 2015; Bell et al., 2016; Ta Park et al., 2017; Wittkowski et al., 2012), but help-seeking behaviour about other problems appears to have been ignored by women or neglected by health care providers.

The post-childbirth problems are compounded because many post-childbirth women are inhibited in expressing their needs (Maher & Souter, 2006) and when seeking help women's post-childbirth needs are not always adequately met (Cassiano et al., 2015). To explain the concept of health need among women, we applied Bradshaw's Taxonomy of Needs (Bradshaw, 1972). Bradshaw defined four types of need: felt, expressed, normative and comparative need.

Felt need is when clients feel they have a need but never disclose or act upon it. Limited health knowledge is one reason why people may have different perceptions and views about their needs and help-seeking. Expressed need is where people with felt need used services, though this can be influenced by the availability of services and any failure of policies to consider new services (Bradshaw, 1972). Normative need is need defined by experts (such as policymakers and health professionals) and usually results in services designed to care for people in society. Normative need can be affected by difficulties defining need and conflict among experts. Finally, comparative need is simply a comparison of the needs of people in different health or geographic areas (Bradshaw, 1972; Bradshaw, 1994; Carver et al., 2014).

While there are studies about the normative needs of women in the 12 months after childbirth (Dennis & Chung-Lee, 2006; Chew-Graham et al., 2008; Widarsson, Kerstis, Sundquist, Engstrom, & Sarkadi, 2012; Brodribb et al., 2013; Agapidaki et al., 2014; Borglin, Hentzel, & Bohman, 2015), women in one study pointed out that health care providers ignored their felt need (Bailey, 2010). Considering this felt need gap, improved knowledge about post-childbirth health problems with a focus on identifying women's post-childbirth felt needs and help-seeking behaviour up to 12 months after childbirth, is needed if we are to improve or redesign maternal health services.

5.2.1 Aims

This research investigated help-seeking behaviour among Australian women for their health problems in the 12 months after childbirth. The main objectives were to identify the health problems that women felt required help during the 12 months after childbirth and to identify their subsequent help-seeking behaviour.

5.3 Design

We used concept mapping, which is a useful form of structured conceptualisation for gaining consumer participants' perspective for research and service design (Trochim & Kane, 2005). Concept mapping was established by William Trochim of Cornell University, over two decades ago (Trochim & Linton, 1986) and has been used consistently for participatory health services research since.

This approach is an integrative mixed method. It is qualitative in that it uses brainstorming from individuals for ideas, and group processes for unstructured sorting interpretation. Quantitative methods are then used for data analysis including multidimensional scaling and hierarchical cluster analysis (Trochim & McLinden, 2017). The Concept System® (CS Global MAX™) is a software program that can be used to collect or enter the concept mapping qualitative data, then uses 'a non-metric multidimensional scaling algorithm' (Filiberto, 2008, p. 96) to perform structured conceptualisation. This method combines opinion polls and statistical procedures (Nabitz et al., 2005) and has demonstrated high validity and reliability in a pooled analysis (Rosa and Kane, 2012).

Concept Mapping has been employed in areas as diverse as health, social science and management (Nabitz et al., 2005; O'Campo, et al., 2005). It is especially useful as a participatory research for answering ambiguous research questions where there are no clear conceptual frameworks, and when exploring people's views about a specific issue (O'Campo, et al., 2005). It can be used with as few as 10 people or as many as 1000 (Kane & Trochim., 2009), though 8-200 has been applied among most studies, and sorting and rating stages usually involve fewer participants (Vaughn, Jones, Booth & Burke, 2017). Concept mapping helps to produce graphic illustrations of concepts (Kane & Trochim, 2009).

Concept mapping methodology has been used for topics such as anxiety, depression, quality of care for chronic diseases (Trochim & Kane, 2005), and assessment of maternity services for disabled women influenced by domestic violence (Bradbury-Jones et al., 2015). One of the benefits of this methodology is the ability to use face-to-face and/or online sampling, and the analysis of data using the online software (Concept Systems Inc., 2018).

Concept mapping is based on brainstorming of ideas by the target group, followed by some participants sorting and rating the brainstorming results, followed by multidimensional scaling and hierarchical cluster analysis. It has six key steps: (1) preparation, (2) generation, (3) structuring, (4) representation, (5) interpretation, and (6) utilization (Trochim & Kane, 2005).

5.3.1 Sample/Participants

Australian women were recruited for this study using the established concept mapping step one 'preparation' methods (Betsy & Carmen, 2007) in 2017-2018. In total, 81 women took part across the different stages, which is identified as a good number for internal validity with this study approach (Betsy & Carmen, 2007; Filiberto, 2008).

We created a study Facebook page called the 'Hababy Project' and potential participants were alerted to the Facebook page through Facebook 'shares' by contacts of the chief investigator. Information about the project was also advertised by displaying flyers in Child Health and Parenting Services (CHAPS), and local hospitals (see appendices IX and X). The flyer and Facebook shares directed individuals to the 'Hababy Project' Facebook page, which provided a link to access the study`s data collection website. Recruitment criteria were women of reproductive age defined as 15-44 years (Cunningham et al., 2018, p. 3) within the

first-year post-childbirth, who gave birth to a full-term infant, i.e. born after 37 weeks. The exclusions were multi-foetal gestation, i.e. involving twins or triplets. We recruited 66 women online for the brainstorming stage.

Women received an automatically generated username and password that gave them an anonymous registration. Once they logged onto the Concept System® project webpage, they read the participant information and provided consent before progressing into the data collection pages (see Appendix VII). Women provided their demographic characteristics (location, mother`s age, child's age, the method of childbirth, parity) and if this did not match the inclusion criteria, they were unable to submit further information.

5.3.2 Data collection

Data collection is step two 'generation' and step three 'structuring' of concept mapping. Women provided brainstorming statements in response to the focus prompt 'Many women experience physical and/or mental health problems after the birth of their child. Which problems did you experience, and which actions did you take to get help to prevent or treat health problems?' This step was completely anonymous and the Concept System®software (CS Global MAX™) did not allow any tracking of participants for this task.

The researchers refined and selected the final statement set from the list of brainstormed statements (n=83) as per concept mapping protocol. Participants had provided 66 brainstormed statements, but some of the responses contained more than one health problem and these were split into two statements by researchers. We also deleted duplicate statements as per protocol. The final statement set was agreed by the researchers to be sufficiently broad and targeted to the focus of the project (Kane & Trochim., 2009). Once 66

women had been recruited and completed brainstorming statements, over nine months (May 2017-March 2018), this section of the data collection was closed.

5.3.3 Structuring of statements

We continued to recruit online for a second group of women to rate and sort the statements; however, over four months only two people were recruited. We also failed to recruit for a rating and sorting workshop using the Facebook page and flyers in the local hospitals and CHAPS. Finally, we recruited a group of 15 women using a snowball sampling technique. The refined statement set, participant information sheet and consent form were mailed to 20 women with 15 returned. To compensate women for their time, we offered a $20 food shopping voucher. The participants were asked to sort the 83 statements, which had been printed individually onto 7x7 cm cards, into homogeneous categorisations in a way that made logic to them. 'In this activity, you will categorize the statements, according to your view of their meaning or theme'**.**

In the next step, women rated the statements on a scale of 1-5 by responding to the questions: 'how common do you think this issue is for new mothers?' and 'how likely is it that you would recommend to another woman that they seek help for these issues?' by ticking the appropriate box. These questions aimed to identify women's perception of the prevalence of an issue and their help-seeking advice to others. The statements were printed on A4 paper with two five-point rating scales: 1= not common, 2=less common, 3= uncertain, 4= common, 5= more common and 1= not likely, 2= less likely, 3= neutral, 4= likely and 5= very likely.

The women then labelled each category and put their grouped statement cards into plastic bags, one for each category. After receiving the returned cards, the researcher entered the sorting and rating information into the Concept System software.

Ethical considerations

This study was approved by the Tasmanian Social Sciences Human Research Ethics Committee, H0016441, and 21st April 2017. (Appendix (VIII))

5.3.4 Data analysis

All data were run through the Concept System® computer algorithm to achieve a nonmetric multidimensional scaling (MDS). The resulting maps showed the individual statements in two dimential (x,y) space' and grouped into clusters (Rosas & Kane, 2012, p. 237).

A small majority of the women had a normal vaginal birth (51%), 75.1% were multiparous, and an average child`s age 7.34m (SD= 4.49). In total 81 women participated in this study; 66 women completed brainstorming statements and a different group of 15 women sorted and rated the statements.

5.3.5 Validity and reliability

The validity and reliability of concept mapping have been evaluated and found to be consistently high in a pooled analysis (Rosas & Kane, 2012). Rosas and Kane (2012) analysed 69 concept mapping studies and found strong internal representational validity and reliability across sorting and rating components. Validity and reliability were consistent regardless of the numbers of participants, percentages of participant completion and modes of data

collection. Concept mapping has been applied as a reliable and valid methodology across different contextual frameworks (Filiberto, 2008; Trehan, 2015; Doty, 2018) and is recognised as particularly useful for gathering information about consumers' views (Bedi & Alexander, 2009) which has created renewed interest in the method (Trochim and McClinden, 2017).

5.4 Results

The results are the 'representation' step in the concept mapping process where visual maps are produced from the MDS. Only one-third of the statements mentioned a health issue during the 12 months after childbirth despite this being a key part of the focus prompt. The remainder only provided information on help-seeking. The morbidities reported by women in the statements were: backache, depression, post-traumatic stress, tiredness, anxiety, constipation, loss of hair, wound infection, sleep problems, sexual problems, third-degree tears, mastitis, urinary infection, urinary incontinence, vaginal discharge, and one report of a red rash around mouth and chin.

5.4.1 Cluster map

The MDS resulted in 4 to 10 potential clusters, with each cluster representing a different conceptual field. The research team selected 6 clusters as the best fit for the data with cluster names selected from the names that participants gave during sorting or software suggestions.

We grouped cluster concepts into three domains (See Figure 5. 1). The core concept of the first domain was 'health issues and care' and consisted of the clusters '6-week check-ups after childbirth', 'health professional support', and 'mental health consultation'. The second domain was 'support', containing the clusters 'social support' and 'support from family and friends'. The third domain was 'fitness' which contained only the fitness cluster.

The ‘health professional support’ cluster had the largest number of statements with 18, and the ‘fitness’ and ‘mental health consultation’ clusters had the least number of statements with 9.

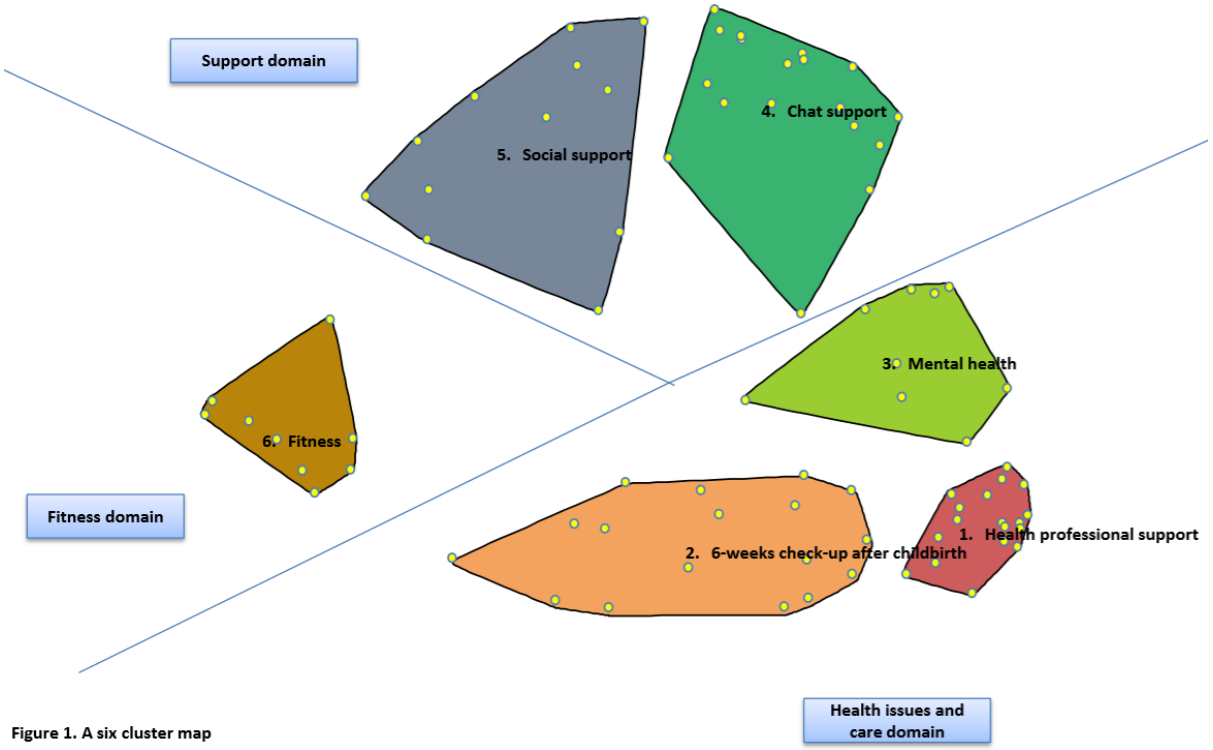

Figure 5.1 A summary of each cluster

Cluster 1: Health professional support

This cluster includes morbidities which women shared with their health care providers. The common morbidities focused on pelvic issues such as wound infection, vaginal discharge, urinary tract infection, urinary incontinence, and sexual issues. The other physical health problems for which women sought help were backache, constipation, losing hair, skin issues, and mastitis. Women said that they sought help for these physical health problems from their chiropractor, GP, obstetrician and gynaecologist.

Cluster 2: Six weeks check-up after childbirth

In this cluster, breastfeeding issues were the strongest problem mentioned for the post-childbirth six-week check. Women took the routine check-up with their health care providers and highlighted that they wanted clear and appropriate information at this time related to post-childbirth problems.

Cluster 3: Mental health consultation

All nine statements in this cluster were composed of items mentioning mental health problems. Women who had mental health problems such as negative thoughts, depressed mood, and anxiety sought specialised help from health care professionals such as nurses, GPs, obstetricians and psychologists.

Cluster 4: Support from family and friends

This cluster focused on the interpersonal communication women adopt to share their problems and get support. Family and friends were the main sources of support for women.

Cluster 5: Social support

The statements in this cluster are related to women's socialization with other mothers or outside the home in order to cope with concerns. Online information was identified as the source of support by some women. Statements such as 'not rush back to work' or 'get out of the house most days, committing to some weekly events' were highlighted as suggestions to take care of themselves.

Cluster 6: Fitness statements

This cluster included statements regarding body fitness and diet. Concerns about weight gained during pregnancy were prominent. Women mentioned some strategies to lose weight such as diet care, daily exercise and walking.

All statements created by the brainstorming process are provided in Table 5. 1, grouped according to the MDS clusters and with the average ratings provided by participants for the scales related to ‘how common’ and ‘how likely’.

Table 5.1 Statements and ratings generated by women in concept mapping presented by cluster

TABLE 1 Statements and ratings generated by women in concept mapping and presented by cluster

	Health issues and care domain	How common	How likely
	Cluster 1: Health Professional Support		
1	Red rash around my mouth& chin extremely dry skin I went to see my GP (General practitioner)	1.9333	2.3333
5	I was constipated during pregnancy and now my obstetrician suggests have a high fibre diet	4.6	4
6	As a new mum suffering from back pain a chiropractor advised me some exercise	3.4667	3.5333
7	I Started losing large amounts of hair, saw my GP (General practitioner)	3.5333	3
9	Being an endurance athlete I had a strong pain in vagina. My obstetrician said your vagina may never look the same	3.0667	3.5333
15	I was worried about my stitches and visited my GP (General practitioner)	3.8667	4.2667
17	Return visit to obstetrician for help with painful intercourse	3.5667	3.9333
31	Saw GP (General practitioner) for issues re ongoing pain and pelvic floor problems	3.2667	3.7333
34	Referred to a women's specialist physio in hospital by OB (obstetrician) as I'd suffered a 3B tear (third degree tear)	3.5333	4.1333
35	Returned to my OB (obstetrician) after a few weeks for treatment of infected episiotomy stitches	3.4667	3.4667
46	My stitches were infected, my Gynaecologist gave me antibiotics	3.1333	3.5333
48	Backache hurts me a lot. I've lost weight and GP (General practitioner) helped me a lot	3.4	3.4286
68	I went to my GP (General practitioner) to talk about my physical issues (pubus symphisitis)	3.6667	3.8667
72	I went to see my GP (General practitioner) a few times because of 2 mastitis episodes and to get my stitches checked (episiotomy)	3.6	3.5333
74	I was leaking urine when I sneezed or coughed and asked my GP (General practitioner)and saw a physio (Physiotherapist)	3.4667	3.8
75	I had a urine infection my doctor gave me some antibiotics	3.8	4
76	visited my obstetrician who helped with a foul-smelling discharge from my vagina	3.4667	3.8667
83	I went to my obstetrician to get my episiotomy wound checked	3.8	4.0667
	Cluster 2: 6-weeks check-up after childbirth		
16	Lactation consultant and specialist osteopath for breastfeeding difficulties	3.8	4.1333
19	Attended Australian Breastfeeding Association meetings	2.6667	2.7333
20	Regular physio (Physiotherapy) treatments and exercise classes	3.9333	1.0667
37	Went to lactation classes at hospital and contacted ABA (Australian Association Breastfeeding) once returned home with support for breastfeeding	3.4667	3.8
39	Visited lactation clinic and spoke to midwives during home visits	3.9333	3.6667
42	Followed instructions given by nurses and obstetrician on leaving the hospital, attended checkups as scheduled to keep me fit	3.6	4
44	Checks at GP (General practitioner)and Health Nurse and sought advice from friends, the GP (General practitioner) and Health Nurse in relation to the baby	4.4	4.2
50	Visit their GP (General practitioner), ask more information	2.9333	3.4
56	6-week postnatal check as recommended with my GP (General practitioner)	4.5333	4
57	Appropriate postnatal exercise to help regain strength, especially of my pelvic floor, under guidance from a physio (Physiotherapist)	3.4	3.8667
61	I went to a physiotherapist to assist with returning to my pre-pregnancy fitness levels	3.2667	3.5333
62	I had frequent follow up with a lactation consultant for breastfeeding issues but found they also provided invaluable support for anxiety and mental health issues	2.9333	2.8667
65	A child health nurse came to our home 10 days postpartum to check on baby and me	3.6667	3.9333
73	A midwife from the hospital came to our home three times after birth and checked on the baby and me	2.7333	2.8667
81	The hospital gave me no information about my recovery	4.0667	3.6667
82	The physio (Physiotherapist) appointments were difficult to get to but were good due to their regularity and the improvements in my pelvic floor function	3.4	4.2857
40	I went to the Physio (Physiotherapist) 3 days after having my daughter When I left the hospital, my hip pain was so bad I could hardly walk It took 3 months to walk and move with out pain	2.2667	3.6

TABLE 1 (Continued)

	Health issues and care domain	How common	How likely
	Cluster 3: Mental health consultation		
21	Several sessions with psychologist who I had previously established connection with	2.6667	3.5333
22	Discussion and debrief with doctors and nurses involved in birth	2.3333	3
25	GP (General practitioner)/Psychologist Mother baby unit/psychiatrist obstetrician	2.8667	3.6667
27	Spoke with health nurse about negative thoughts	3.3333	3.8
45	I suffered some symptoms of post traumatic stress after my emergency cesarean section I now see a counsellor once a week to help minimise these	2.4	3.6
49	Was depressed, GP (General practitioner) and psychological treatment	3.4	4.0667
53	I had difficulty with the sexual relationship, talked with my partner and GP (General practitioner)	3.8667	4
66	I went to my obstetrician to talk about anxiety issues and referral to a perinatal psychologist	2.4	3.3333
67	I went to my GP (General practitioner) to talk about coping with being a new parent and anxiety issues	2.5333	3.8
	Support domain		
	Cluster 4: Chat support		
2	I made sure I spoke with family and friends and voiced how I was feeling	3.7333	3.8
3	I'm mum to four, stressed and overwhelmed support from other mums who in similar situation	3.6667	3.6667
10	Sometimes I was a little outside myself, no appetite that bothered me My mother assured me that this was entirely normal	3.2667	3
12	My mum and my partner support me a lot so now I have enough sleep	3.4667	3.8667
13	Joined to mothers group and I shared my anxiety issues	4.4	4.2
14	My sister has three kids and share any issues with her	4.1333	3.7333
32	Spoke with a friend who had larger babies and had organ prolapse after 3 natural deliveries to get advice and to share my concerns	3.8667	3.5333
33	Sought help and support from friends and family	4.5333	4.3333
36	Partner took 2 weeks off and worked from home for the third week to assist in supporting me	3.5333	4
51	Mental support—close friends and partner, child health nurse Physical Support—lactation consultant, ABA (Australian Association Breastfeeding), GP (General practitioner), obstetrician, child health nurse	3.5333	3.9333
63	I found the greatest moral support to be from my partner about our sexual relation	4.4	3.8667
69	I found support from my local early childhood health centre weekly drop in sessions	2.9333	3.4667
71	I have found moral support with my partner, my mother and the local mother's group	4	4.1333
77	Spoke to friends with babies for advice re feeding and sleeping issues	4.4667	4
78	My family provided mental and physical support through the very early days	4.2667	4.4
80	I rely on support from husband and family for support	4.3333	4.2
64	I found my local mothers' group very supportive in relation to sleep and settling issues	4.2	3.9333
52	I have backache which my mom said it's normal	3.8667	3.9333
	Cluster 5: Social support		
18	Made many social connections with other young families	4.4667	4.1333
23	Spoke openly about my concerns regarding the birth prior to the birth so that my midwife, doctor, and partner could fully understand and support me	2.5333	3.7333
24	I use Google to look up minor concerns about my baby and speak to health professionals about major issues	4.7333	3.9333
26	Attended a mothers group for first time mums	3.9333	3.7333
28	Not rush back to work	3.7333	3.9333
29	Get out of the house most days, committing to some weekly events	4.3333	3.8
30	Spend regular time with other mums and their young children	4.3333	4
47	I'm so tired couldn't sleep well Nobody helped me	3.6667	4
55	Resting as much as possible in the early weeks and not being afraid to ask for help when needed	4.1333	4
59	Online forums were actually amazing at times, when feeling overwhelmed and alone	4.3333	3.9333

(Continues)

TABLE 1 (Continued)

	Health issues and care domain	How common	How likely
70	I have found support regarding breastfeeding with friends, the ABA (Australian Association Breastfeeding) over the phone and a lactation consultant	3.8	3.4667
60	Knew I was likely to struggle mentally/emotionally so just discussed this probability with my partner	3.7333	4.1333
	Fitness domain		
	Cluster 6: Fitness		
4	Feel less energetic than pregnancy	4.0667	4.1333
8	I Put on weight during pregnancy did not manage to lose it after	4.5333	4.0667
11	Extra weight on my waist, legs, back so walking every day	4.2	3.4667
38	Ate a balanced diet to minimise excessive weight gain	4.2667	4.2
41	I tried to prevent health problems by keeping fit through the pregnancy	3.8	3.9333
43	I spent plenty of time walking the baby in the pram and ensured I continued to talk to my friends and take interest in what they were doing	3	3.6667
54	Many short walks with baby in pram or front pack	4.5333	4.0667
58	Prevention by trying to care for my body with appropriate exercise during pregnancy	3.0667	3.9333
79	I haven't sought any assistance for myself, but plan to start Pilates again soon	4	3.8667

5.4.2 Pattern match

We used pattern matching, a graphical and statistical analysis, to compare the two ratings of 'how likely' and 'how common' to provide visualisation of the degree of relationship (Trochim & McLinden, 2017). As a planning tool, pattern matches can point to elements that require attention if there is poor correlation between the two ratings. Pattern matching graphically represents a 'ladder graph' containing two vertical axes of two ratings joined together by lines, with high rating scores situated closer to the top of the pattern match (Figure. 5. 2).

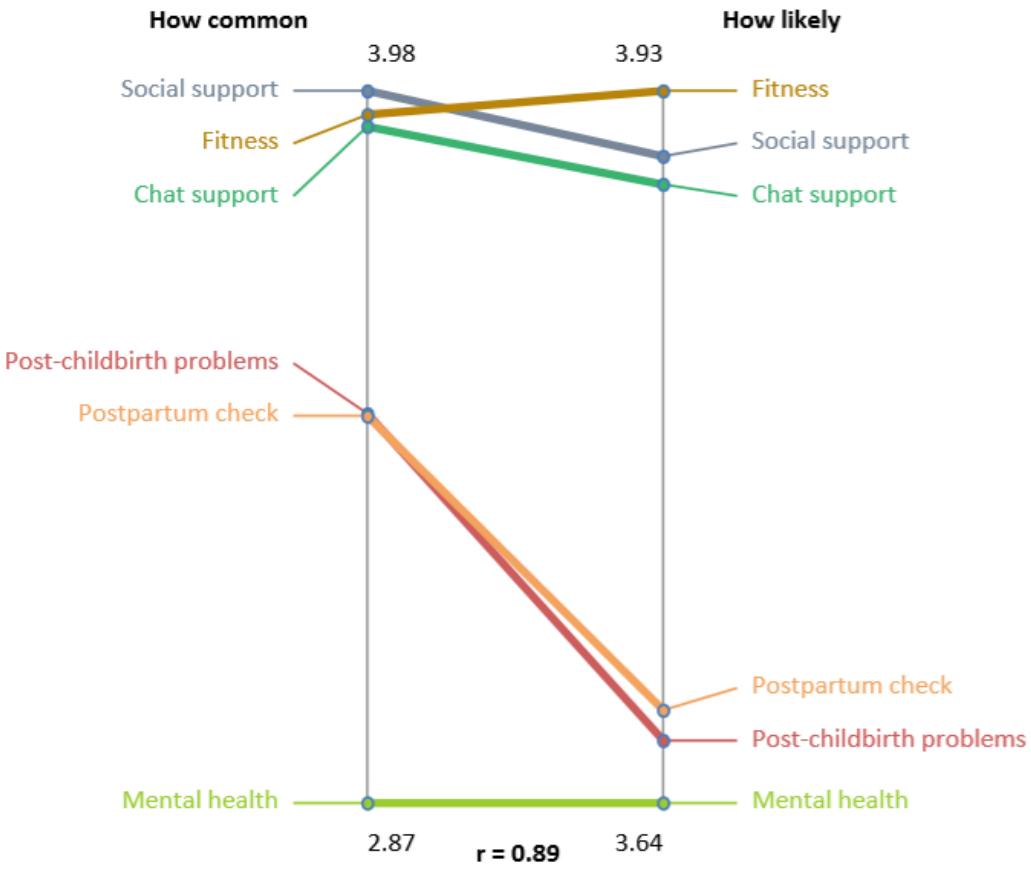

Figure 5.2 Pattern match

The pattern matching showed that women agreed that the need for 'social support', 'support from family and friends' and 'fitness' were prevalent and would be highly recommended to the other women. Surprisingly, participants rated health professional consultations for mental health problems as less prevalent than the likelihood that they would recommend this form of help-seeking. There was a strong positive correlation coefficient (Pearson's r =0.89) between all the ratings.

5.4.3 Go-zones

To understand the priority of the statements rated by women, 'Go-zones', bivariate value plots, are used. All the statements were placed in one of four quadrants. Statements in the green quadrant were those rated above average by women as both more common and more

likely. The mean rating for each zone were: Green, more common (X Axis) 4.27, more likely (Y Axis)4.20; Yellow, more common (X Axis) 3.67, less likely (Y Axis) 3.67; orange, less common (X Axis) 3.07, more likely (Y Axis) 3.93; Grey, less common (X Axis) 2.93, less likely (Y Axis) 3.47 (Figure 5.3).

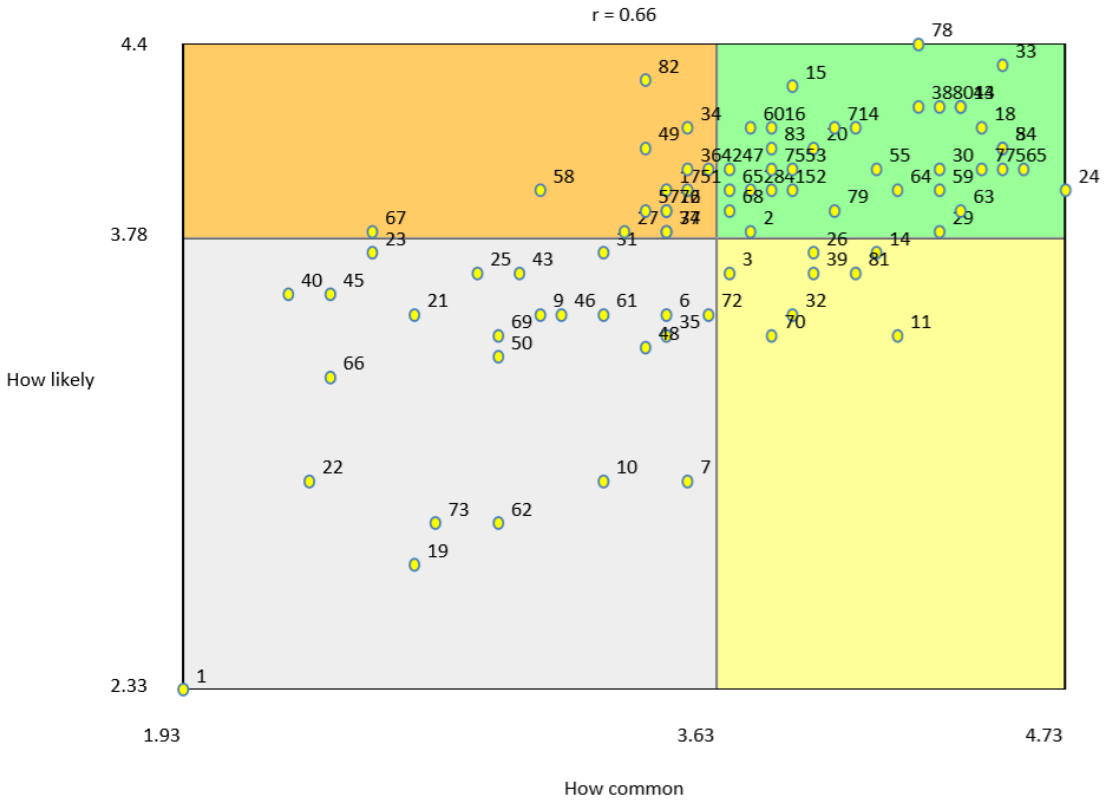

Figure 5.3 Go Zone for all statements

The statements in the green zone covered some physical problems like constipation, backache, stitches, sexual relationship problems, sleep issues, urine infection, lactation issues and mental issues. The green zone also contained statements about sharing problems with family and friends, making a connection with other mothers and local groups, using online platforms to chat, weight gain, and fitness.

The three highest-rated statements suggest that health professionals are not contacted as first resort: 'I use Google to look up minor concerns about my infant and speak to health professionals about major issues' (statement number 24), 'Sought help and support from friends and family'(statement number 33),'My family provided mental and physical support through the very early days' (statement number78).

5.5 Discussion

We applied concept mapping to obtain women's views on the health problems that require help (help-seeking behaviour). Despite the research question, women identified a much broader concept of health problems post-childbirth. We identified three key health and help-seeking domains: 'health issues and care', 'support from family and friends' and 'fitness', highlighting that morbidities are only a small portion of women's concerns at this time. We flagged social and emotional and lifestyle support as key health concerns for which they seek help.

Women identified significant physical and mental health problems in the health issue and care domain. Participants did state the same morbidities reported by other studies during the 12 months after childbirth (Glazener et al., 1995; Ansara et al., 2005; Maher & Souter, 2006; Hardee et al., 2012; Van der Woude et al., 2015). However, in this study, when directly asked to report physical and/or mental health problems experienced after childbirth, only one-third of respondents reported a morbidity. It is possible that this particular group of women did not have many physical and psychological problems after childbirth, although this is in contrast with the literature which suggests a high percentage (over 90%) of women experience at least one health problems after childbirth (Wilkie et al., 2017).

It is also possible that this issue is explained by a lack of 'felt' need by women through normalising problems. The literature supports this explanation as women and their families have been noted to ignore, normalise or minimize health problems after childbirth (Rouhi et al., 2019). Normalizing is also likely compounded by women's tendency to prioritize their infant`s needs (Buurman & Lagro-Janssen, 2013; Bell et al., 2016; Verbiest et al., 2018) instead of their own (Maher & Souter, 2006). Women often conceptualize post-childbirth problems as a normal part of childbirth and subsequently do not take any action to resolve them (Scrandis, 2005; Rudman & Waldenström, 2007; Chew-Graham et al., 2009; Goodman et al., 2011). In such cases, women either did not have felt need or did not turn any felt need into expressed need.

The 'six week check-up' cluster was mostly focused on infant`s needs. Typical health services do not have any follow-up plan after the six-week check for the rest of the 12 months after childbirth (WHO, 2013b). This could be a problem as post-childbirth women need different information depending on the timing of post-childbirth visits (Beake et al., 2010). During the first weeks post-childbirth, most women need information about lactation or dealing with settling down with a new situation (Beake et al., 2010), but there is a dearth of understanding about the information women need after this early post-childbirth period.

Despite the existing knowledge about the investigation of antenatal care in Australia (Brock, Charlton, & Yeatman, 2014) and a study that showed high satisfaction with antenatal care among Australian women (Lucas et al., 2015), there is a lack of comprehensive knowledge about post-childbirth care in Australia. Many women spend this period of time with unmet needs and frustration in getting help (Woodward, Zadoroznyj & Benoit, 2016). Our findings suggest that women have a broader concept of health care needs post-childbirth

encompassing social support. This could be a problem if there is a discrepancy between women's expectations and access to appropriate care. Our systematic review, for example, showed that the use of social support is not always positive for women needing post-childbirth health care (Rouhi et al., 2019).

Our pattern matching showed all clusters apart from 'mental health consultation' had closely matched perceptions of the prevalence of an issue and likelihood of help-seeking advice, but women rated mental health consultations as less prevalent than their importance. This might be the recognition of the barriers for women in accessing mental health services such as accessibility, proximity, stigma (Bell et al., 2016), lack of knowledge about the symptoms (Sword et al., 2008), or cultural and religious issues (Wittkowski et al., 2012) and lack of health care professionals knowledge (Rouhi et al., 2019).

Pattern matching showed 'support from family and friends', 'social support' and 'fitness' were top-rated clusters by women. Other research identifies that social support and the need for information are key post-childbirth needs for women (Phang et al., 2015). For many women, 'social support', which is mostly provided by family and friends, is one of the best ways to both achieve their role as a mother and obtain necessary information about the post-childbirth period (Tammentie et al., 2004; Phang et al., 2015). The importance of support has been highlighted by other studies which show women rely more on support from trusted persons than professional help (Kaitz, 2007; Sword et al., 2008; Abrams et al., 2009; Bell et al., 2016; Negron et al., 2013). This support may though be poorly informed or even lacking suggesting that some women are not getting their needs met.

Despite the barriers to physical activity for women after childbirth (Saligheh, McNamara, & Rooney, 2016), 'fitness' was one of the concerns among our participants. During pregnancy

and the post-childbirth period, women are prone to weight gain and weight retention (Nascimento et al., 2013). But while there are many practical guidelines for exercise during pregnancy (Farpour-Lambert et al., 2018), the post-childbirth period is overlooked (Evenson et al., 2014). Consistent with other studies, women in this study felt that getting information about exercise and getting fit after childbirth were important, but studies show that health care providers do not offer this information (Evenson, Aytur, & Borodulin, 2009; Ferrari et al., 2010).

Go-Zone maps can help policymakers to develop strategies and action planning to resolve post-childbirth issues (Kane & Trochim, 2009). The summary of the statements in the green zone is about both physical and mental issues and help-seeking behaviours such as sharing the problems with family and friends, making the connection with the other mothers and local groups, and using online platforms to chat. A systematic review by Haran et al. (2014) showed that there are comprehensive clinical guidelines for the care of new mothers, but they are specific to certain issues like depression or infant care. Additionally, they showed there is inconsistency about the role and content of post-childbirth visits among developed countries. For this reason, women can spend this period feeling pressured, with a lack of suitable information based on their individual needs (Negron et al., 2013). This potential gap in access to care may exacerbate any problems (EdalatiFard et al., 2016). To adapt to these needs, parents need information and suitable assistance to cope with their new life situations (Rowe, Holton, & Fisher, 2013). A review of current post-childbirth care could address these issues.

5.6 Utilisation of findings

This study provides information about women's concepts of health care needs and help-seeking. These findings can be applied to enhance the quality of post-childbirth care during the 12 months after childbirth with the following recommendations.

1. Women need to be encouraged to talk about their well-being after childbirth. These findings suggest a need to refocus post-childbirth care to include the needs of women.
2. Health care professionals could include information about physical fitness for post-childbirth women.
3. Health care professionals must understand that women's reliance on family and friends for social support could result in unmet needs if the support is lacking.

5.7 Limitations

The study aimed to gain women's perspective. By using online recruitment, we were able to access women nationwide. We had trouble recruiting women for more time-consuming sorting and rating activities, but others have reported similar difficulties recruiting mothers of young children due to lack of time from childcare responsibilities (Verbiest et al., 2018). Despite this, the sample size was consistent with concept mapping criteria (Rosas & Kane, 2012). It is also possible that our sample of women with relatively low felt need was not representative of the broader population.

5.8 Conclusion

This study gained a unique picture of women's views of physical and mental post-childbirth problems and help-seeking behaviours. Women have a much broader concept of post-childbirth problems than health professionals and policymakers and rely heavily on social

support. Not all women have access to good social support suggesting a need to review the content and timing of post-childbirth care. Further research is needed to understand health care provider`s knowledge and practices in maternal post-childbirth health.

5.9 Unpublished data

The next section provides additional data and results from this study that were not published due to the word count limits in the chosen journal.

5.9.1 Sample/Participants

This phase had difficulties recruiting women for the more time-consuming sorting and rating activities, as women have many childcare responsibilities in this twelve month post-partum period. We were unable to recruit using the study website, and then attempted but failed to recruit for a rating and sorting workshop using the Facebook page and flyers in the local hospitals and local community services. Finally, we recruited a group of 15 women using a snowball sampling technique.

5.9.2 Validity and reliability

Trochim defines validity as, "the best available approximation to the truth of a given proposition, inference or conclusion" (cited in Filiberto, 2008; p.5). As discussed on page 129, internal validity has been proven in pooled analysis (Rosa and Kane, 2012). As discussed, concept mapping involves brainstorming, sorting and rating the brainstorming results, followed by multidimensional scaling and hierarchical cluster analysis. The traditional form of reliability like the test-retest correlation which assumes for each test there is a correct answer is not fit for concept mapping because there is no ‘correct’ brainstorming nor sorting category

for participants ideas (Trochim, 1993). Instead, reliability assumes that relatively culturally homogenous participants will have some shared ideas about the topic of women's postpartum help-seeking. The assessment of reliability flips the data matrix and therefore assesses the reliability of participants not of individual statements (Trochim, 1993, p. 2).

5.9.3 Results

Point map

All study data were managed through a computer algorithm to achieve a nonmetric multidimensional scaling (MDS). The concept mapping analysis sorted information to construct a matrix of similarities by placing statements which are close to each other as a point on an x–y axis, which produces a point map (Figure 5.4). The stress value as a statistic that reflects stability within the overall map and the overall degree of correspondence between the input (i.e., the similarity matrix) and the output (i.e., distances between points on the map) using a value called the Stress Value (Kane & Trochim., 2009, p. 27), reported for this study was 0.2289, a stress-value between 0.21 and 0.37 is considered acceptable of data (Kane & Trochim, 2009). Lower values show more congruity between raw and processed data (Kane & Trochim, 2009).

Each of the points on the point map represent a statement with the number beside the point indicating the location of that statement on the point map. Close distance between points showed the similarity between items and sorted statements that sit close to each other defined as a cluster (Filiberto, 2008). In the middle of our points map was the statement: I use Google to look up minor concerns about my baby and speak to health professionals about major issues (statements number 24).

For the Figure 5.4 Map there are more points located at the southeast pole compare to the other parts of map. These statements mostly focused on physical problems that women experience and seek professional help to resolve their health problems such as: 'Red rash around my mouth& chin extremely dry skin I went to see my GP' (statements number 1), 'As a new mum suffering from back pain a chiropractor advised me some exercise' (statements number 6), 'Returned to my OB after a few weeks for treatment of infected episiotomy stitches' (statements number 35).

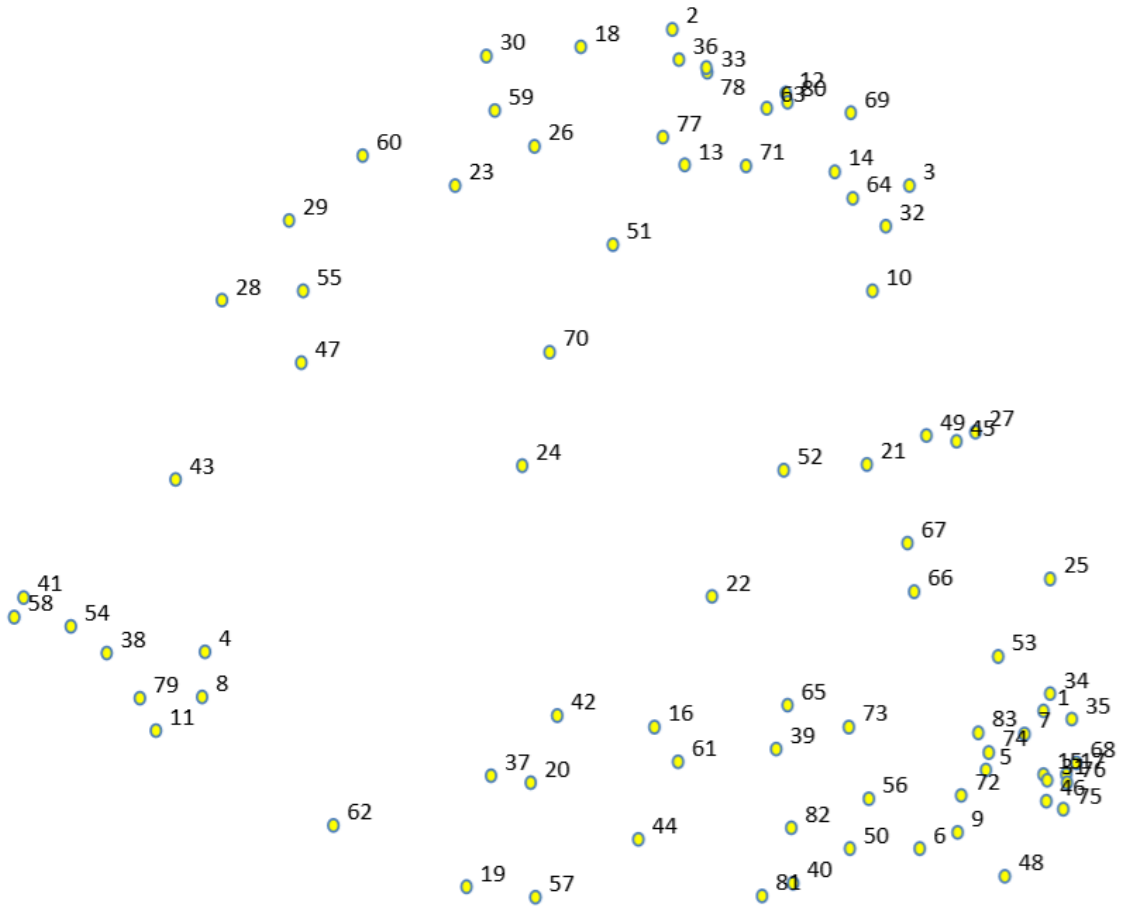

Figure 5.4 Point map for 81 statements

Cluster rating map

The cluster rating map (Figure 5.5) groups statements that were defined as a cluster with the layers for each cluster portraying the average priority ratings of the statements within that cluster given by women on a scale of one to five (five being highest). Clusters with more layers signify they were a higher priority for women. Figure 5.5 represents the average ratings of participant' responses to the question 'how common do you think this issue is for new mothers?' The clusters with the most layers (i.e highest agreement to the question) were 'Support from family and friends', 'Social support' and 'Fitness'. These all had five layers which meant they had an average rating value of 3.78 to 3.98 which translates to participants considering these issues as 'common'.

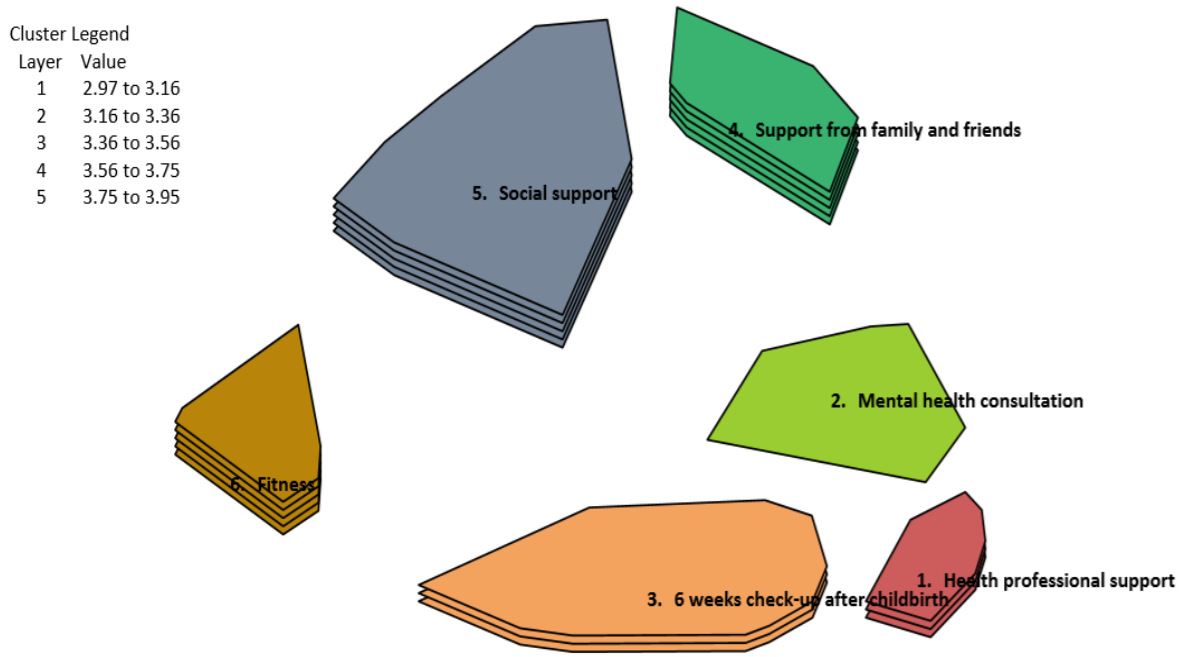

Figure 5.5 Cluster Rating Map for six-cluster, how common do you think this issue is for new mothers?

Figure 5.6 shows that women also highly rated the same clusters highly in answer to the question 'how likely is it that you would recommend to another woman that they seek help

for these issues?'. The average rating value of 3.78 to 3.98 translates to participants considering they were 'likely' to recommend help seeking for these issues.

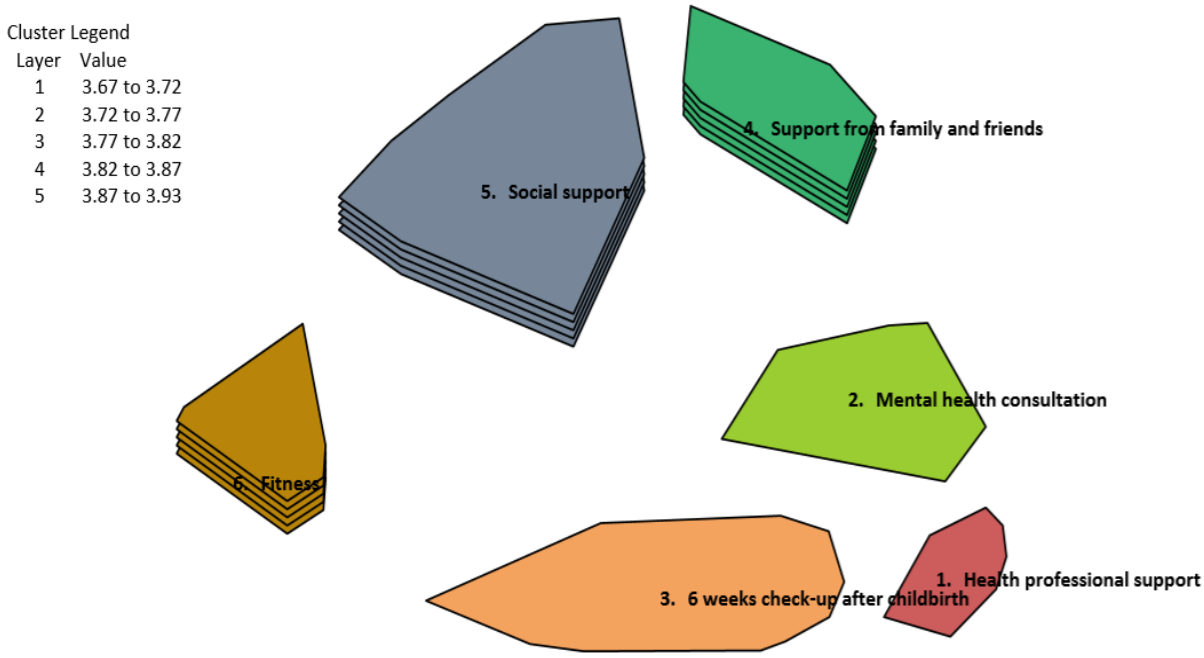

Figure 5.6 Cluster Rating Map for six-cluster. how likely is it that you would recommend to another woman that they seek help for these issues?

5.9.4 Discussion

The cluster rating maps show that 'Support from family and friends', 'Social support' and 'Fitness' were the top-rated clusters by women. These results are in line with the results of pattern matching which was explained in the discussion in section 5.5. These findings are supported by other authors who also found that support from family and friends and social support are an important way to deal with issues after childbirth (Tammentie et al., 2004; Kaitz, 2007; Sword et al., 2008; Abrams et al., 2009; Negron et al., 2013; Phang et al., 2015; Bell et al., 2016). 'Fitness' was rated highly as something women would recommend to another woman as they think this is an issue for new mothers. Fitness is increasingly

important for women though healthcare providers do not necessarily provide women with fitness information (Evenson, Aytur, & Borodulin, 2009; Ferrari et al., 2010).

5.10 Chapter summary

This study applied participatory research to understand women's views of physical and mental post-childbirth problems and help-seeking behaviours. The findings of this study were: women have a broader perception of health care needs which included support and fitness and there is a potential gap in services for women who do not have good social support. As was discussed in section 3.6, above, feminist pragmatism values personal experiences for marginalised groups. In this second phase of the study, concept mapping provided a participatory research approach allowing participants to actively engage in providing and analysing data, successfully allowing women to share their experience about their health problems after birth. Indeed, this phase has picturised women's voice.

Chapter 6: Online help-seeking and discussion groups

This chapter was originally published as a paper in the peer-reviewed journal *Women and Birth*, in August 2019. A PDF of the published manuscript is reproduced as Appendix IX.

Rouhi, M., Stirling, C., & Crisp, E. P. (2020). The 'fallacy of normalcy': A content analysis of women's online post-childbirth health-related support, Women Birth https://doi.org/10.1016/j.wombi.2020.04.007

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Abstract

Background

There is little information about how women seek help after childbirth for their health problems while there are many women around the world who experience physical and mental health problems. Online forums have changed traditional sources of seeking help because they provide an anonymous and non-judgemental environment particularly suited for women with post-childbirth problems.

Methods

A total of 333 messages posted on a post-childbirth online forum were loaded into NVIVO 12 Pro and were analysed using content and thematic analysis. We asked three research questions of the data: which health problems were women posting about; what were women's motivations for posting; and what support was given to mothers in response? Content analysis identified the major health problems, and thematic analysis was used for identifying motivations and the support offered.

Results

Seventeen different health problems were discussed on posts, with a strong emphasis on pelvic problems, following by mental health concerns. The key motivations for seeking online help identified using Sillence`s (2013) 'typology of advice solicitation' were: request for opinion or information (48.85 %), problem disclosure (30.23 %), anyone in the same boat (13.95%). The two main support themes were: peer to peer support (82%) and normalisation

(not always appropriate) of post-childbirth problems (18%). Most of the support offered was emotional (56.9%) followed by practical (22.7%) and informational support (20.4%).

Conclusion

Postpartum adjustment of post-childbirth experiences can be supportive but if ill-informed may provide a barrier to safe and reliable health care. Women appear to use online forums for receiving support for post-childbirth problems with perception of being anonymous and freely talk about their health problems.

Keywords:

Peer support, postpartum, morbidity, online support group, mothers.

6.1 Background

Globally, increasing access to smartphones and tablets allows women to use technology to communicate. Among the digital platforms that have been introduced since the 1990s, forums and weblogs are the most popular sources of finding health information, especially among women (Husbands, 2008; Lupton, 2016). Pregnant and post-childbirth women are among the highest users of formal and informal blogs (Lupton, 2016; Walker et al., 2017; Sanders & Crozier, 2018; Wright, Matthai, & Meyer, 2019). Previous studies have shown that women use online platforms for breastfeeding or parents' concerns (Niela-Vilen et al., 2014; Asiodu et al., 2015; Alianmoghaddam et al., 2019; Wagg et al., 2019). These online interactions by peer support are a way to help isolated mothers with a different socioeconomic background to achieve better adjustment where access to healthcare providers have time and cost limitations (Nolan et al., 2015; Guerra-Reyes et al., 2016).

Postpartum period has been defined as the first 6- weeks after childbirth (WHO, 2015). Traditionally it is said during this period changes which has happened during pregnancy, will return to a "non pregnant" state (Leah, 2000). Many women experience physical and mental health problems, they consider these changes as a part of normal childbirth process or postpartum adjustment which has been confirmed by family and friends (Rouhi et al., 2019).

Motherhood involves many physical and mental health changes and women need adequate knowledge to safely navigate these changes (Lupton, 2016). The traditional forms of getting this information, such as pamphlets or face-to-face services, have partly been replaced by online forums where women share their experiences. Online settings also provide anonymity and privacy, allowing women to talk freely about their health problems without fear of judgement and embarrassment (Doty & Dworkin, 2014; Slomian et al., 2017) and

having access to global information (Kauer et al., 2014; Furkin, 2018). The online information-seeking affects the women's decision-making about their health or infant's health as well (Slomian et al., 2017).

Plantin and Daneback's systematic review (2009) showed that many parents search the internet to find health information and advice. However, our own previous systematic review found very few studies related to the help-seeking behaviours of women in the 12-month post-childbirth period (Rouhi et al., 2019). The limited evidence base showed that women largely report relying on family and friends to seek help for their post-childbirth health problems. To build on this work, this paper describes research exploring online help-seeking discussions about post-childbirth problems among women who participate in post-childbirth online support forums. We asked three research questions: Which health problems were shared by women who seek help? What were the motivations for questions mothers posted on the forum discussion board? What support is given to mothers who have posted questions about post-childbirth morbidities?

6.2 Method

We applied a directed qualitative content approach which can be used to analyse text or data gathered from audio, video, printed data such as books, papers and pamphlets or online sources to find themes or patterns (Hsieh & Shannon, 2005). The directed content method originated in the 18th century in Scandinavia (Hsieh & Shannon, 2005) and is used widely as either a qualitative or quantitative method in health research (Coulson, Buchanan, & Aubeeluck, 2007; Evans, Donelle, & Hume-Loveland, 2012; Henderson, Rosser, Keogh, & Eccleston, 2012; Smedley & Coulson, 2017; Furkin, 2018). While conventional content analysis looks to increase knowledge about less studied phenomena, directed content analysis helps

to endorse or expand an existing theoretical framework with a more qualitative focus (Hsieh & Shannon, 2005). This method has helped to answer midwifery research questions considering why participants use a service and the nature of their concerns (Vaismoradi, 2013).

6.2.1 Online recruitment

A comprehensive online search was conducted to find a list of Australian forums which contained post-childbirth online support forums. Those forums which were active within the last 365 days, had at least 50 active individuals and more than 30 posts on the forum per day met the inclusion criteria. The moderators of these forums were contacted to explain the aim of the study and request permission to include the forum in our study. From six Australian parenthood forums only one granted permission to analyse posts. We approached moderators for consent rather than forum participants so as not to disturb participants.

Participants' I.D. numbers and I.P. addresses were blocked so the identity of the forums and participants were not visible to the researchers. This prevented violation of privacy, which is increasingly debated in social media research where the online personal information is released via social networking data (Eysenbach & Till, 2001).

6.2.2 Data management

The recruited forum website had a variety of forums about parenting from conception to children`s issues, but we only analysed content from one forum, which concentrated on post-childbirth problems and covered women's health problems. This forum had 332 posts related to post-childbirth health problems. The content of messages posted to this forum by women was imported into NVivo 12 (2018), a qualitative data analysis software program, for analysis.

Messages retrieved from March 2007 to March 2019 were used to catch a broad range of conversations. In the first step, 127 posts were analysed for evidence about physical and mental health problems shared by women as 'posters' (P). Of these there were 49 original posts, 21 threads (T) and 78 comments from 'commenters' (C) over the eight years. In this study a 'poster' was defined as a woman who posted the original thread, and 'commenters' as those women who responded to the original posts.

As some original posts and comments consisted of multiple questions and comments, in total 63 advice solicitations and 270 comments to original posts were identified. This data was considered adequate for the study as previous studies have analysed different numbers of interactions from 120 message posts to 921 messages (Eichhorn, 2008; Porter & Ispa, 2013; Furkin, 2018). All quotes of posts are unaltered, with no corrections for grammar or spelling, but abbreviations are defined in brackets.

6.2.3 Data analysis

To answer the first question, all health problems which were shared by women seeking help were documented and quantitatively analysed using the NVivo 12 (2018) coding system. We used word clouds provided by NVivo 12 (2018). Word clouds are a tool to visually depict and interpret the findings: the more frequent the word use, the bolder the colour and larger the size. The table 1 shows the morbidities that were shared by women as motivation to seek help.

To answer the second question regarding the motivations of women posters (P) on the forum discussion board, the 'typology of advice solicitation' modified by Sillence (2103) was applied as a predefined categorisation. This typology originally derived from Goldsmith (2000,

p. 6) who evaluated oral advice interactions and identified six patterns of interaction. Sillence (2013) adopted this categorisation for her study which was focused on online breast cancer support group and applied five types of advice solicitation as an outcome of her analysis. This typology has been used successfully to analyse and categorise online interactions in areas as diverse as online breastfeeding advice, online support communities (Smedley & Coulson, 2017; Furkin, 2018).

To answer the third question, a qualitative thematic analysis approach was used (Braun & Clarke, 2006) to examine what support was given to the posters about their health problems post-childbirth. Thematic analysis is a 'careful reading and re-reading of the data' which allows identification of emerging themes and their categorisation (Fereday & Muir-Cochrane, 2006, p. 82). We followed the six steps of the approach described by Braun and Clarke (2006, p. 87) which consist of: 'familiarizing yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes, and producing the report'. The researchers read all extracted data to be familiar with the data and developed initial codes. The codes were then collapsed into themes. The final set of themes were checked and compared to the extracted texts and approved by the research team through discussion. Finally, the research team discussions, along with reflection on the study aims of the study and our previous studies helped us to interpret the themes and identify the overarching themes.

6.2.4 Credibility

The intercoder reliability or reproducibility across coders is a concern in qualitative content analysis (Campbell, Quincy, Osserman, & Pedersen, 2013). To have consistency in the coding process, one researcher codes all of the transcripts and these are double checked by the

researchers with the final set of codes agreed by the team (Burla et al., 2008), with 70% agreement in coding considered reliable (Frey, Botan, & Kreps, 2000). Credibility was ensured by the first author undertaking '…prolonged engagement, persistent observation, triangulation, negative case analysis, [and] referential adequacy' (Hsieh & Shannon, 2005, p. 1280). Peer debriefing was undertaken by all authors with the team looking for negative examples or data which did not fit the categories. This resulted in adjustments to the categories and provided a balance to the position of the first author who as a midwife and studied women's post-childbirth health problems for a long time and had an unbiased view of the results.

6.3 Results

A total of 332 postings were collected and analysed from the forum. The results are presented in three sections answering the research questions. In addition, two overarching themes of appropriate and inappropriate normalisation that spanned both motivations and support were identified. We labelled these 'postpartum adjustment' and 'the fallacy of normalcy'.

6.3.1Which health problems were shared by women who seek help?

Women shared 17 health problems, which ranged from mental health problems like depression and anxiety to physical concerns like mastitis, uterine infection, constipation, overweight and weight loss, and fatigue (Table 6.1).

Table 6.1 Physical and mental health problems shared by women

Morbidities categorisation	Morbidities reported by the initial posts (21 threads) N (%)	How many commenters replied
Urogenital problems	9 (40)	132
Gastrointestinal problems	5 (23)	3
Breastfeeding issues	1 (5)	3
Obesity & weight loss	2 (9)	20
Mood problems	5 (23)	132

About 90% of the health problems were focused on pelvic issues. Figure 6.1 is a word cloud which shows the key health problems discussed with larger words representing more frequent use in the forums; bladder problems and incontinence being prominent. However, there was a key sub-forum focused on women's pelvic issues which dominated this word cloud; therefore, we excluded the pelvic issues in the second word cloud which depicts the weighting of the other health problems, with depression, anxiety, sleep and fitness as key concerns for women (Figure 6. 2).

Figure 6.1 Physical and mental health problems shared by women

Figure 6.2 Health problems excluding pelvic problems

6.3.2 What were the motivations in questions women posted on the forum discussion board?

To answer the second question, we analysed the common themes in help-seeking of original posts using the 'typology of advice solicitation' modified by Sillence (2013). Each of the 63 original posts were allocated to one the following advice solicitation categories: request for opinion or information (48.85 %), problem disclosure (30.23 %), anyone in the same boat (13.95%), and request for advice (6.97%). Announcement of a plan of action has been excluded because no post fitted.

6.3.2.1 Request for opinion or information

About half of women requested an opinion or some information (48.85%). This category defines 'questions such as ''What do you think?'' or ''What do you think of X?'' as a request to get information or opinion' (Sillence, 2013, p. 481). Included in this category is any post where it is not clear whether the poster wanted someone to solve their problem or provide emotional support.

This is demonstrated in the following quote where the poster asked about the difference between depression and postnatal depression by briefly explaining a past history of depression which shows she knew what depression was but could not distinguish it from postnatal depression:

> 'Im [I`m] just wondering what the difference is between depression and pnd [post-natal depression]? how can you tell the difference? I suffered Depression through high school and came of my meds just before I fell pregnant. My twins are 8 months old and Ive [I`ve] gone back to what I was like when I was in high school. The doctor put me back on my meds. I just feel like crap, but its got nothing to do with the babies. I can cope with them except when im [I`m] already feeling like crap and they are cranky. Everything in life,

> besides being a mother and my babies, just feels like its crap. I just dont [don`t] know how the 2 are different' (T5P).

While the poster only asks for information about depression, she also provides a lot of detail about her personal situation which suggests she is struggling with 'feeling like crap'. This was seen in many posts where a simple request for information was presented alongside disclosure of information about a difficult-sounding situation.

6.3.2.2 Problem disclosure

About one-third of the posters (30.23 %) revealed a problem. Definition of this category means that women did not directly ask a question about their problems but appear to be trying to vent their concerns. Analysis of the posts showed they were requesting 'advice, sympathy, solidarity, etc' (Sillence, 2013, p. 481), as seen in the following quote where the poster shows her frustration about her situation and is looking for women who identify with her situation. She asked for advice about how she could 'juggle everything':

> Hi, I am new here and hoping I can find some people who understand and that i can talk to. I work full time and have 2 kids, 1 and 3. I love my kids but hate my life the way it is and just don't see anyway for it to get better. How do i juggle everything? (T13P).

It is ambiguous for the reader to know whether she needed information or to receive emotional support as the poster only disclosed her problem. This ambiguous approach to the original post was used by about one-third of women.

6.3.2.3 Anyone in the same boat

About 13.95% of the original posts were in this category, and asked if others were going through the same situation, or asked is 'anyone in the same boat' (Sillence, 2013, p. 481). The interactions in this category were concentrated only on pelvic issues and blood loss. In

one of the threads, for example, the poster declared her concerns about incontinence as a barrier to jumping on her trampoline and asked 'Anyone else struggle with bladder problems':

> 'Hi sorry if TMI [too much information] but my second bub is 10 months old! I'm ok with day to day stuff but can't jump on the trampoline with my 3 year old! I go to the toilet before I get on with her but have to weans [sic] heavy pad because it just keeps coming even tho ive [sic] just emptied my bladder I stayed very fit with my second pregnancy and did lots of pelvic floor etc! Feeling frustrated coz [sic] I love getting on the trampoline with my kids! Anyone else struggle with bladder problems??' (T20P).

It is surprising that the poster did not appear to have sought professional care for what is clearly a post-childbirth morbidity and instead had normalised her problem. However, she received replies that encouraged her to get appropriate professional health support to which she responded:

> 'Thanks! I'm going to see a Physio who specializes in pelvic floor problems! Will go back to my obstetrician if that doesn't work! Been doing exercises myself too! Hopefully I won't be wearing a nappy any time soon hehe!' (T20P).

In this case, commentator' responses resulted in the poster seeking appropriate health care.

6.3.2.4 Request for advice

Request for advice accounted for 6.97% of original posts. According to Sillence (2013, p. 481) advice solicitation consists of messages that contains these phrases: (a) 'I need your advice''; (b) What should I do?''; and (c) ''Should I do X?'. In this category, posters disclosed health problems and followed up with asking for direct advice.

This poster opened her post by explaining her leaking and asking, “What should I do?”:

> Overnight I woke twice to feed my 4 month old DS [Dear son] and both times my pj [pyjamas] pants were a bit wet and I could feel myself leaking a bit (sorry, I feel like this is TMI [too much information]). Is it possible to have incontinence 4 months after having a infant?? I had no problems when I was pregnant. What should I do?? I feel too embarrassed to tell anyone! (T11P).

While this poster is not sure about the incontinence, it is clear in this original post she was looking for any advice about the incontinence and also that embarrassment was a barrier to disclosing her problem to others.

6.3.3 What support is given to women who have posted questions about post-childbirth morbidities?

A total of 270 comments were collected and analysed. Upon coding by content analysis and thematic analysis, we found the ‘peer support’ offered by commenters were emotional support (56.9%) followed by practical (22.7%) and informational support (20.4%).

6.3.3.1 Emotional support

The most common specific support given by the commenters was emotional support (56.9%, n= 125). In response to the posters’ descriptions of their problems faced during the 12 months after childbirth, commenters showed their empathy, sympathy and encouragement. They tried to show that others experienced the same condition, so the posters were not alone. This commenter expressed her emotional support by providing explanations about how she managed her depression and confirmed ‘how hard the road can be’, and she also tried to provide a comprehensive picture of depression and solutions:

> ‘There are differences between PND [postnatal depression]and depression however they also share many similarities! PND usually starts a few days after birth or, interestingly in your case, many women relapse after 6 or so months of birth! Nobody can say for sure why women experience PND however having a history of depression, enviromental [sic] stressors (- such as attending to those two cherubs 24/7!) and hormone levels can be three good reasons. …Going back on your meds sounds like a good idea and look at it as a temporary thing until you get back on your feet. …. Because you are a mum, you are very precious to those babies who need you - so, please get help if you feel you can't manage - sometimes medication alone isn't enough. I too am a mum and suffered PND [postnatal depression]! How hard the road can be and I take my hat off to you as you have twins! - but these feelings will pass with help and time. Believe me. Be gentle on yourself too’ (T5C4).

She correctly pointed out that postnatal depression and depression are the same and asked the poster to consider counselling support and be gentle with herself, and to ask for support from family and friends or any public services.

Another commenter assured a poster with a query about incontinence that ‘there are lots more of us out here’ and encouraged her to make a contact with a specialist clinic. At the end, she emotionally supported the poster by recommending that ‘be strong and be grateful that you have this forum and people to give answers’. Interestingly many commenters believed that the previous generation suffered in silence but that discussion about incontinence is now accepted by the public:

> ‘You are not alone. Remember that ad in the parent’s rooms that the Federal Government put out - one in three - well you are one of the one in three and there are lots more of us out here. My problems were very bad after DD1[dear daughter1] but have remarkably improved with each delivery but worsened during each pregnancy. Coughing, sneezing and vomiting are all danger points. There are indeed physios that specialise in the area but in the interim, Tena lady make a thin panty liner that will get you through the day in confidence. Keep the pelvic floor exercises going. I have thrown out the material that the hospital gave me after DS [dear son] was born but the hospital that you and i went to

now have a wellness clinic with people who specialise in this - and I am pretty sure that they have a general number you call to start off with. In the meantime - be strong and be grateful that you have this forum and people to give answers - previous generations had to suffer in silence' (T19C5).

Commenters confirmed that many women experienced physical and mental health problems. Furthermore, the commenter believed that new generation speak out their experienced problems and there are some potential supports in the society.

6.3.3.2 Practical support

Practical support was provided by about one-fourth of commenters (22.7%, n=50). This support was limited to physical health problems such as bladder issues and getting back into shape. Commenters suggested solutions like Kegel exercise or special pads for urinary incontinence or suggesting following an online group to lose weight. In Thread #9, in reply to the original poster asking for any opinion about losing weight, some suggestions like the following were provided by commenters:

'I'm currently on keto (high fat, low carb) and have managed to lose 7.5kg in 6 weeks with no real exercise except for a good walk once a week. It's pretty easy to stick to and even DH [dear husband] is loving the food!' (T9C4).

In reply, unlike the others, this commenter reminded her about how breastfeeding could be affected by diet and proposed an easy way to lose weight when her child got older and less reliant on breastfeeding:

'If you are breastfeeding, I would suggest holding off on dieting for now - you will need to keep yourself well nourished so the infant doesn't deplete your nutrients. ie your breastmilk will always be fine, you need to eat well to keep yourself healthy. In terms of exercise, I found walking worked for me in the early days postpartum. I wasn't up for

much else. I did join a gym when my youngest was a bit older - 12 months? and got into cardio and weight bearing exercise then' (T9C13).

Normalising the bladder issues was evident among commenter`s posts. However, they suggested some practical supports like Kegel exercises as the first option and then to seek professional help:

'Its [It is] perfectly normal. The stress of the birth/s cause the pelvic floor muscles to weaken. Normally doing your pelvic floor exercises will help. If not though id me [sic] making an appointment with your gp [General Practitioner] to see a gynaecologist. I have a first degree cystocele which is a slight movement on the bladder. Meaning it has moved slightly down in the pelvic cavity which is the early stages of a prolapse. Which causes incontinence. If you feel there is something not right about your situation (only you know your body) please head to a specialist. Its worth getting these things checked sooner rather than later as if they catch it at the early stages it can ge [sic] fixed easier' (T20C2).

In this case, even though the commenter normalised the bladder issue they suggested that if they listen to their body it helps them to distinguish abnormalities in the early stages.

6.3.3.3 Informational support

The third type of support provided by commenters was informational support (20.4% n=45). The commenters replied by offering advice, recommendations and information to assist with solving any physical and mental health problems raised by the original posters. In Thread #20, in reply to a poster who was seeking information on whether there were other ways to solve urinary incontinence apart from exercise:

'I had the same problem a couple of months after having my second. I spoke to my GP [General Practitioner] who referred me to a physiotherapist at the public hospital I birthed at and she was great. She assessed the strength of my pelvic floor and gave lots of suggestions to help strengthen it. There's a machine you can hire that sends an electrical pulse that tightens up the muscles, it's a bit strange to use but I definitely felt

> results. If you make an appointment with your doctor they should be able to refer you to someone that can offer some more advice' (T20C2).

The commenter discussed her experience with her GP and explained the process of healing that she experienced and convinced the poster to seek professional help.

6.3.4 Overarching theme: Appropriate and inappropriate normalisation of post-childbirth health problems

Postpartum care in regard to maternal health problems is set by WHO (2015) as assessment of urinary incontinence, depression, postpartum bleeding and lochia by health care providers. A key finding from this study was 'normalisation' of health problems after childbirth. Reading through the online discussions among women, we extracted two subthemes related to the concept of normalisation. The first subtheme is 'postpartum adjustment' and the second is 'the fallacy of normalcy'.

'Postpartum adjustment' describes the process by which women perceive the discussed problems to be a normal part of adjustment after childbirth, and consequently normalise difficulties such as infant problems or managing motherhood roles, and tasks plus any physical and maternal mental health adjustment during the first six week after childbirth.

However, our analysis revealed that most of the commenters tried to justify any maternal health problems as a normal process after childbirth during the first 12 months after childbirth. We called this 'the fallacy of normalcy', as any health problems that extend beyond the postpartum period of six weeks are not normal and need professional help.

6.3.5 'Postpartum adjustment'

'Postpartum adjustment' is proposed as the main reason for health problems in the first six weeks post-childbirth. Women reminded each other that during this period, they must adapt to a new role; their personal and social life have changed dramatically, with the priority being a focus on the infant`s needs, like breastfeeding. They give encouragement that adjustment to the demands and burden of motherhood gradually gets easier and women should get help from family and friends as well:

> 'I honestly feel that the first 6 weeks after having a infant are the most challenging weeks of your entire life. I think many people underestimate just how exhausting it actually can be. Your number 1 priority is you and bub. Housework etc is waaay down the bottom of the list. Get out of the house. Go for a walk around the block with bub. Go out for lunch. If you're BF [breastfeeding] and not 100% comfortable feeding in public yet, choose places with good feeding/parents rooms or somewhere where you will feel comfortable feeding. Link in with a mothers [sic] group either through your local child health or find one online. Just having a reason to leave the house each week at a set time can make a world of difference. Talk to someone about how you're feeling. Whether it's your DP [dear parents]/DH [dear husband], your GP [General Practitioner] or even someone from Beyond Blue etc. If you are really struggling there is absolutely NO shame in asking for help' (T21C6).

Another commenter tried to encourage the poster that problems get better and 'Hang in there':

> '… With both of mine I found the first 6 weeks was soooo bloody hard! Then it started to get easier as we all got into the swing of things, feeding and sleeping got better, smiles started to appear, and I was able to get out and about a bit more. Hang in there lovely, you can do this!' (T21C21).

Commenters also remind each other that physical and hormonal changes occur and their children`s problems are part of the motherhood adjustment as well. Importantly, their

comments reflected the struggle with the new role as a mother and how mothers must adapt and embrace their problems in this period and be kind to themselves:

> 'It definitely gets better! Those first few weeks of motherhood are hard!! It is a big adjustment, plus you are tired and have lots of hormones making things even harder. The feeding and changing etc is also at its most demanding. I would try and get out whenever you can. A little walk or a trip to a cafe makes a huge difference. Also, don't put too much pressure on yourself. Just do whatever you need to do to get through the first couple of months and then it does get a bit better. I personally love this article about the "fourth trimester". It was the most helpful thing anyone ever shared with me as a new parent and hope it helps you too: https://pregnantchicken.com/whatyou...bout-newborns/ ' (T21C5).

Another commenter clearly explained there is a new lifestyle after childbirth with a dramatic change in their role and showed their sympathy as they are not alone:

> 'I think there's also a process of grieving the old life you had that's now disappeared. i think there's a lot of pressure to love your new role of mum instantly and unquestioningly, and that we're supposed to be ok and even excited about the disposal of our old childless lives. it's such a silly notion when you think about it, but we accept the model that's presented to us as though it's gospel and normal. it takes a while to adjust into any new role, and it takes a while to adjust to a new lifestyle and be upset about the lives we had that we no longer have. under any other circumstance, a new job, a move to a new city/state/country, etc, we would recognize hey, … go easy on yourself OP, becoming a mum is a rude shock to many. you are most definitely not alone xx' (T21C29).

Commenters convinced the posters to ignore the problems as part of postpartum adjustment and their attention shifted to the infant`s need and mother`s new role.

6.3.6 'The fallacy of normalcy '

In this subtheme posters and commenters discussed health problems which are not normal and may even require the intervention of professional health care providers to resolve. Some commenters normalised the problems and encouraged the posters to ignore these as part of a normal process after childbirth, but others, while agreeing the problem was normal, suggested seeking medical or family help.

In one thread, the poster was asking for practical advice about the wetness and odour originating from her incontinence. Her description showed she had severe and continual urinary incontinence. The poster appeared to accept her problem as normal and instead of seeking professional help, she sought advice on products to hide the odour of her incontinence. Concerningly, most commenters seemed to agree that it is a normal condition and advised the poster on different products to resolve the wetness and odour, suggesting 'absorbent & fragranced' incontinence products:

> 'I think some of them upset the natural Ph of the vagina-leaving you more susceptable [sic] to yeast infections and what not. The vagina is meant to be self cleaning. Having said that though i'm sure there would be nothing wrong with using some cleansing wipes or something-so long as you were just using it on the labia etc and not internally IYKWIM? Perhaps you could have a look and see if they make some wipes like the ones for babies but for intimate adult use. Something for sensitive skin/unfragranced perhaps? I'm pretty sure they make some special liners for incontinence that are a bit more absorbent & fragranced etc-to stop the wet patch problem' (T21C2).

One commenter replied by introducing a pad that she used to resolve her incontinence:

> I use the Tena lady incontinence pads - they are especially for urine leakage and incontinence so more absorbent. You can ask the company for free samples etc. They

> aren't the only company that makes incontinence pads - they are located within the sanitary pad section as well (T21C9).

A small proportion of women addressed it as normal incontinence but advised her to seek further help:

> Also just in regard to incontinence you can see a physio about it and they can help you with advice and exercises etc. I went to one at the hospital following the birth of my bub and I had incontinence issues as well and the physio helped! Try your hospital first since they will have contacts in that specialised area (T21C12).

Another commenter experienced bowel incontinence for a long time and encouraged the poster to check the other potential problems as well. Interestingly the commenter introduced diet modification to manage anal fissure:

> 'Not as a rule...but if I hang on too long or bladder is too full and I cough, sneeze it can happen. I tend to put it down to old age  Jax, that is tough with the other department. Do you mind me saying, are you sure that is the only reason...I only say that cos I had issues for the last six months (TMI warning) like leaking a bit of mucus from the bowel every time I went to the loo to urinate and at other times had to clench my butt...turns out I had rather large growth (discovered and removed when I had a colonoscopy) I don't say this to make you worry, but to heed warnings when things aren't normal. Obiviously [sic] you know your body better than me, but this is my experience and as you say, its helpful to share. Anal fissures can be managed with diet and drinking lots of water so you don't get constipated Angike' (T6C14).

Some of the commenters think that urinary incontinence is normal but faecal incontinence is not and needs professional attention, like this poster:

> 'Urinary stress incontinence is completely normal during pregnancy and even after, but I'd be encouraging you to seek further medical advice if there is any faecal incontinence' (T16C2).

While some of the commenters think that incontinence is normal some of the commenters considered exhaustion as 'not normal' and showed their sympathy, like this mum:

> 'I agree with the others - definitely doesn't sound normal!! But without knowing what your psychosocial disability is, it's hard to distinguish whether it's related to that or something else?? So sorry you're going through this' (T15C8).

Some commenters reminded posters that bleeding, and fatigue are not a normal situation after birth and encouraged the others to get professional help:

> 'I echo everyone's sentiments. What you're describing doesn't sound 'normal', especially fatigue/tiredness that is so severe you're forgetting to go to the toilet/eat/drink etc. It may well be psychosomatic, but I would definitely be doing as others have suggested and getting full bloods done. I know that the thought of that (going to the Doctor etc) is probably hard, but it's very worrisome what you're describing, especially feeling everything is a 'failure'. At least by getting a professional to see/hear/test you, you can find out what is really going on with your mind and body' (T15C6).

It was evident that 'the fallacy of normalcy' is found in online blogs both from posters and commenters, and while some of the commenters guided posters to ignore their problems as a normal process after birth, others recommended the poster get help from different health professionals.

6.4 Discussion

This study sought to provide a picture of women`s online interactions by analysing the discussion boards in a post-childbirth forum.

In the current study, although women shared different health problems, pelvic issues, especially incontinence and prolapse, followed by mental health problems were the key health issues motivating women to post on the online forum. This is consistent with our

previous systematic review (Rouhi et al., 2019) which showed that pelvic issues and depression are the most researched area, which could be related to healthcare providers concentrating more on mood disorders and incontinence problems than other health issues. Recent studies highlight that women are now more informed about pelvic problems and depression (Alderdice et al., 2013; Rouhi et al., 2019). While this fairly narrow range of health problems were found in the online forum our previous concept mapping study showed women have a much broader perception of healthcare needs after birth which include fitness and social connection (Rouhi et al., 2019).

To answer the second question, we analysed the common themes in help-seeking of original posts by the "typology of advice solicitation" modified by Sillence (2013). Consistent with other studies, our findings have shown that new mothers often use the online environment to get information support for their infants' problems or themselves through social networking (Walker et al., 2011; Sillence, 2013; Jang et al., 2015; Nolan et al., 2015; Guerra-Reyes et al., 2016; Furkin, 2018; Alianmoghaddam et al., 2019; Wagg et al., 2019). Motherhood is a challenging time for women and studies show that they struggle to cope with the stress and demands during this time especially for breastfeeding (Gibson & Hanson., 2013; Parry et al., 2013; Lupton et al., 2016; Alianmoghaddam et al., 2019). Prenatal care equips women for labour and delivery topics but does not prepare them for post-childbirth problems (Guerra-Reyes et al., 2016; Valtchanov et al., 2017; Rouhi et al., 2019).

'What support is given to mothers who have posted questions about post-childbirth morbidities?' was the third question. In the online setting peer support was prominent among women to resolve their anxiety and uncertainties about infant care and breastfeeding concerns where family and friends could not help them to cope with these ambiguities

(Strange et al., 2014; Alianmoghaddam et al., 2019; Rouhi et al., 2019). The online forum assisted them to share concerns with other mothers who have the same problems during the transition of motherhood and make 'unique bonds' in a mutuality of endorsement, sympathy and responsiveness (Nolan et al., 2012, p. 180). Furthermore, reading other posts about their post-childbirth challenges helped them to compare their problems and gave them a feeling of comfort (Doty & Dworkin, 2014).

In our study, while most of the posters asked informational support, surprisingly most of the peer support given was emotional support as women shared their stories and emphasised to posters that they were not alone (Doty & Dworkin, 2014). A critical review by Doty and Dworkin (2014) to assess online social support for parents, confirmed that there is unclear meaning for emotional support among parents, but the most prevalent meanings were 'overcoming isolation, sharing experiences, building self-esteem, and empathizing' (p.185).

This inconsistency between asking for information by posters and replying with emotional support by commenters may be explained by the theory of optimal matching described by Cutrona and Suhr (1992). They proposed two types of support: action-facilitating support and nurturant support. Action-facilitating support assists people by providing informational and tangible support, while nurturant support provides emotional, network and esteem support. In our study, most of the commenters provided emotional support by offering empathy or sympathy and did not necessarily propose solutions to the problems. Cutrona and Suhr (1992) proposed that when people are in stressful situations that cannot be controlled, emotional support is adopted to help eliminate the stress. In the context of post-childbirth problems, we believe that women recognise post-childbirth health problems as stressful events so emotional support is proposed as the first nurturant support.

6.4.1 Postpartum adjustment and the fallacy of normalcy

In the current study, postpartum adjustment and normalisation of women's health problems after childbirth are proposed as the key framing of health problems. Because the first six weeks post-childbirth is widely recognised as postpartum adjustment time when women return to a nonpregnant state, (WHO, 2015) issues outside this period are not well supported by health care services.

'Normalisation' of post-childbirth health problems emerged as a key finding during the analysis. The term 'normalisation' comes from Bank-Mikkelsen who worked with people with mental problems (Wolfensberger et al., 1972). Robinson (1993) later assessed this concept among people living with a chronic condition. She showed this group of people attempt to have a normal life with a chronic health condition by "covering up" their symptoms. This conceptualisation has been used in the area of post-childbirth maternal morbidities in our previous study and is a dominant issue among families that often conceals health problems after childbirth (Rouhi et al., 2019).

In this study, we adopted the term 'the fallacy of normalcy' conceptualised on the women`s perception of their health problems after childbirth. Our previous study (Rouhi et al., 2019) showed women often think that health problems after childbirth are part of the normal process after childbirth, which will resolve on their own without the need to seek help. 'The fallacy of normalcy' hinders women from seeking professional help and family and friends contribute to this, often convincing women it is normal even to have mental health or pelvic problems (Wuytack et al., 2015).

Among women who selected online forums as a source of getting help and support, the online setting, where women are able to read others' posts and comments, they compare

their problems with others and this provides them with another way to normalise their problems (Gibson & Hanson., 2013; Doty & Dworkin, 2014).

For post childbirth health problems, the six weeks after childbirth is recognised as a recovery period, and many women think that all morbidities in this period are a normal part of postpartum adjustment. This study sought to provide a picture of women`s online interactions by analysing the discussion boards in a post-childbirth forum.

Online forums, by providing anonymity, privacy, lack of embarrassment, support, and appropriate normalisation, help women to access to information globally (Schoenebeck, 2013; Kauer et al., 2014; Furkin, 2018). But consistent with the current research, women also give unauthorised medical advice to each other (Coulson & Greenwood, 2012; Slomian et al., 2017). It is unknown how many of these women act according to the suggestions they receive, but there is no doubt that the post-childbirth period is a stressful time for women and to cope with this period women need to search for information about their concerns. The internet is the most used source of information to manage health problems (Doty & Dworkin, 2014; Slomian et al., 2017), and the credibility of the information shared by women raises important questions within online support groups (Esquivel et al. 2006), The accuracy of exchanged information needs further investigation (Coulson & Greenwood, 2012).

6.5 Conclusion

The result of this study demonstrates that online sharing of post-childbirth concerns is prevalent among women. Post-childbirth women have a desire to get information and will seek this online. The women seek help by asking for online support for their health problems.

In this vein, women have access to informal information and independently decide about their health problems in an online setting. It is important to direct women to high-quality health information to answer their post childbirth health concerns in addition to accessing peer emotional support through online forums.

6.6 Implications for Practice

We recommend that to ensure reliable online information, healthcare providers should provide websites with content that is monitored by professionals in this area and be able to reply to questions promptly. The design of the websites should be provided in multiple languages to address community needs. Women should be prepared during their pregnancy for inevitable health problems and be reminded by healthcare workers about what is normal or abnormal to meet the mothers' needs post-childbirth.

6.7 Strengths and Limitations

The result of this study clearly showed that women use online forums as a source of information and becoming more popular among women. This study only looked at one particular Australian public forum, and other forums and private online groups may have highlighted different results. Our results were restricted to Australian women who communicate in English and are computer literate, therefore it is unknown what concerns are held by those who are unfamiliar with English or using a computer.

6.8 Ethical statement

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee H0017619 24 August 2018. See Appendix (X)

6.9 Chapter summary

In this study the key finding was the 'normalisation' (not always appropriate) of post-childbirth problems. Indeed, women by sharing their experiences, validate health problems after childbirth as normal. As feminist pragmatism confirms that our knowledge has been shaped by different viewpoints, consequently women accept normalisation of health problems as it has been approved by family and friends and healthcare providers. For those women who are concerned about their privacy, online forums provide a safe and secure setting far from stigma and embarrassment.

Chapter 7: Discussion

This study assessed maternal morbidities and women's help-seeking behaviour during the first 12 months post-childbirth, and aimed to assess key influences on that behaviour. Feminist pragmatism served as the guiding philosophical paradigm for this study because women were at the centre of the subject, and because pragmatism argues that the research problem rather than methodology takes precedence; any research question can be addressed by a method or combination of methods that finds the best answer to the question. The pragmatist approach helped this study to gather different types of information related to help-seeking behaviour among women in its three separate but related phases. In pragmatist philosophy, pluralism facilitates understanding of multiple experiential viewpoints, and feminism also shaped the woman-centred framework of this study. This study gathered its data using a participatory research approach. This was justified by the fact that women's needs, and perceptions have been largely absent from the existing literature, as Chapter 2 revealed.

In Chapter 3, the flow of the three research phases was set out. In phase one, a systematic review sought knowledge about women's perceptions of the barriers and facilitators they experience in seeking help from health professionals. Phase two employed a concept mapping method as a manifestation of pure participatory research to investigate the health problems that women felt required help and their subsequent help-seeking

behaviour. Finally, the third phase examined women's motivations to seek help and peer support online, using content analysis to assess text exchanged in forum posts.

The results of three phases showed that most postpartum health problems are normalised, either appropriately or inappropriately. In phase one, we identified a model with which to identify the key influences on women's help-seeking behaviour as 'layers' around women's help-seeking (see Figure 4.4, above).

In phase two, it became apparent that normalisation can act as a filter between these layers: from women's own perceived needs, through communication with family and friends, to the social view of health problems as normal (also seen in health professionals' interactions with women), resulting in limited help-seeking behaviour.

In phase three, a key finding from this study was the 'fallacy of normalcy' of post-childbirth problems among women also occurred on online forums, where anonymity helps women to discuss their health freely.

This chapter provides a synthesis and discussion of the findings from the three phases, outlining how they met the research aim: to identify the key influences on women's help-seeking in the 12 months post-childbirth.

7.1 Key findings

This study had several key findings. First, the systematic qualitative meta-aggregation review provided three synthesis statements: perceived need to seek help; interpersonal communication; and how society views post-childbirth problems. It highlighted that women often did not seek help because they accepted their problems as a part of the motherhood role, or because they feared being judged negatively by others. Instead, women tended to share their issues with family and friends as trusted persons, which at times could result in

them receiving poor advice. Apart from perceptions of normality or feelings of embarrassment, there were several other barriers to women seeking professional care. Low health literacy was such a barrier, as was lack of access (including limited financial resources and lack of relevant health services) to proper care. A woman's cultural context, too, was an essential influence on whether or not she sought help.

Second, from the concept mapping study of health problems and subsequent help-seeking behaviour, participants identified six categories of help-seeking. These were synthesised into three key domains: health issues and care; support; and fitness. Despite being directly asked, about two thirds of our respondents did not report experiencing any health problems. The findings showed that women had a broad perception of their health care needs, which included general support and fitness. These results suggest that women who do not have good and well-informed social support could experience difficulty in accessing services for post-childbirth problems.

Third, the content and thematic analysis of the online discussion groups revealed that pelvic problems and mental health concerns were the most commonly raised topics. The key motivation for seeking online help – identified using Sillence's (2013) typology of advice solicitation – was 'request for opinion or information' (48.85 per cent). Most of the peer support pertained to 'emotional support' (56.9 per cent). A key finding was the 'normalisation' (not always appropriate) of post-childbirth problems. Normalising post-childbirth experiences can be supportive, but if ill-informed normalisation may act as a barrier to women accessing safe and reliable health care.

This study was underpinned by a modified version of the BMHSU (Behavioural Model of Health Service Use) to present the key influences on women's help-seeking in the 12 months

post-childbirth, which included two domains: normalisation of most problems, either appropriately or inappropriately; and reduced professional help-seeking. Additionally, these results enabled the development of a new conceptual model for understanding the key influences on women's help-seeking for maternal morbidities (see Figure 7.1, below). The model developed from this study places women's perception of seeking help as the first step. After this, the next step is women sharing their health problems with family and friends. Finally, those women who were encouraged by trusted persons share their health problems with health care providers. Findings from each of the three data chapters (Chapters 4 to 6) highlighted 'normalisation' as a key concept influencing women's help-seeking. Our findings show that normalisation comes from women, trusted persons, and from society more broadly – all three of the identified key influences on women's help-seeking.

In the context of maternal help-seeking after childbirth, if women's felt need changed to an expressed need, then they mostly sought help from trusted persons, or, in the case of embarrassing problems, complete strangers online. The three phases of this study showed that, by confirming the normalisation of health problems after childbirth, family, friends and other women only encourage small numbers of women to seek professional help. For those women who selected professional help as a last resort, the prior normalisation of their health problems was sometimes confirmed by health care providers. This pattern was visible in all three phases of this study. Imagine a funnel: the narrow end represents the number of women who seek appropriate professional help, and the broad end the process of normalisation – the focus of the next section.

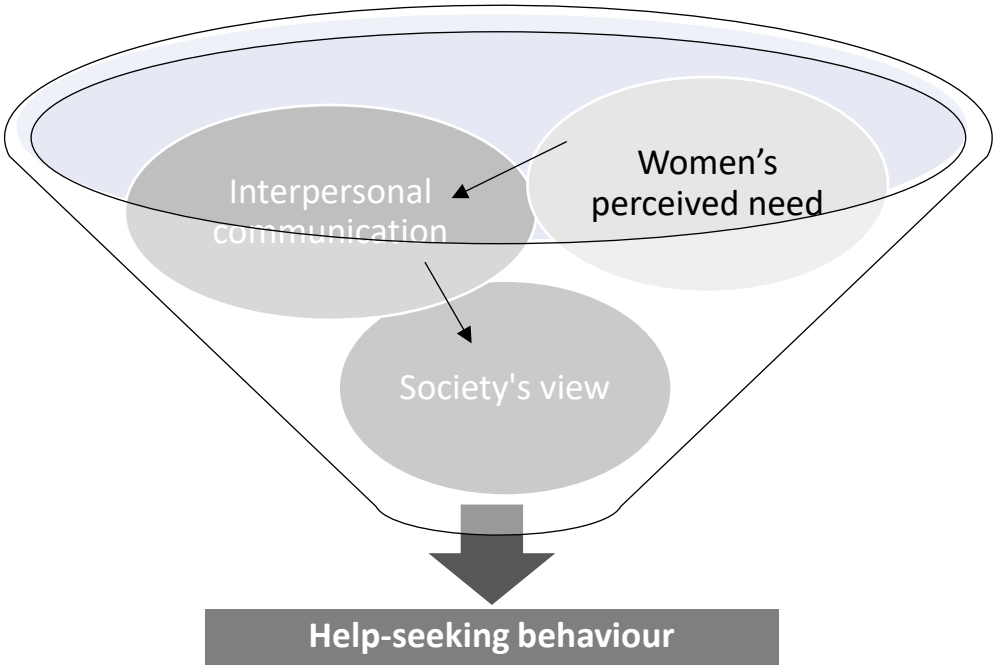

Figure 7.1 Conceptual model of key influences on women's help-seeking for maternal morbidities

7.2 Normalisation of post-childbirth health problems

In this study, the process of normalisation was found to be a common reason to overlook or accept post-childbirth health problems among family and friends, health care providers, on online forums, and among women themselves (see Figure 7.1, above). All three phases highlighted the role of normalisation.

In phase one, the systematic review (Chapter 4), the literature supported this explanation of top-to-bottom normalisation, as women and their families were noted to ignore, normalise or minimise health problems after childbirth. Twelve findings from five studies identified that women do not necessarily recognise that they have a health need. These women are in

category 1: women who do not seek help because they have accepted their problems as a part of the motherhood role. Eight findings from four studies confirmed a second category: lack of health knowledge about post-childbirth problems causing women not to seek help. These two categories led to the first synthesis statement: 'perceived need to seek help'. The findings of this study add to the literature on normalisation of health problems (see, for example, Scrandis, 2005; Rudman & Waldenström, 2007; Chew-Graham et al., 2008; Goodman & Santangelo, 2011).

The normalisation of maternal health problems post-childbirth was also evidenced by the results of the second phase, the concept mapping study. In cluster 3, chat support, women confirmed the normalisation of their health problems. As disscused in Chapter 3, methodology, concept mapping was introduced as a pure participatory method in which researchers do not have any power, ceding it instead to the participants. Thus, the findings of this study depict women's views of their post-childbirth concerns, rather than the researchers'.

In the third phase, a content analysis of women's disscusion also confirmed normalisation of health problems. In this phase, women freely and anonymously asked their questions about their health problems on online forums. The content of their discussions showed that women normalised health problems inappropriately, even when they may have required professional intervention to resolve. Some commenters normalised the problems and encouraged the posters to ignore them as expected parts of the process after childbirth, but others, while agreeing the problem was normal, suggested seeking medical or family help. This phase showed that 'normalisation' must be considered in combination with 'the fallacy of normalcy', which hinders women from seeking help for their health problems, and

encouraged them to rationalise that the problems would resolve on their own. Family and friends contribute to this 'fallacy of normalcy', often convincing women their problems are nothing out of the ordinary.

This study adopted feminist pragmatism to help explain why the normalisation of health problems after childbirth dominates women's help-seeking behaviour. The views of women, their family and friends and health care providers all closely adhere to 'the fallacy of normalcy'. However, family and friends were successful when they encouraged women to seek professional help, and when women do seek professional help the availability and source of that help is important. But some health care providers contribute to 'the fallacy of normalcy', again decreasing the number of women who can readily access quality care.

The normalisation of health problems post-childbirth is summarised by the proposed conceptual model of the key influences on women's help-seeking for maternal morbidities (see Figure. 7.1, above). Evidence suggests that many women initially ignore their health problems, as they consider them to be a normal part of the process after childbirth (see Sword et al., 2008; Wagg, 2010; Buurman & Lagro-Janssen, 2013; Wagg, Kendall, & Bunn, 2017). Phase three confirmed that one of the health problems most commonly shared by women was urinary incontinence. Their discussions showed normalisation of health problems – indeed, 'the fallacy of normalcy' was evident. An Integrative literature review by Koch (2006) to assess help-seeking behaviour for UI symptoms among women of all ages showed that fewer than 38 per cent sought help for their symptoms, and that women normalised their problems as a part of aging or childbirth.

This study showed that women's perception of their health problems after childbirth is an important factor in the normalisation of their problems (Rouhi et al., 2019). In the systematic

review, Chapter 4, it was seen that when women attributed their symptoms to the normal process after childbirth, they did not seek help from family and friends. As one mother in a study by Buurman and Lagro-Janssen (2013, p. 410) who said: “No, I didn’t call in medical help because my relatives, especially my mum and my gran, said that it would just pass off. So I was like if my mum and my gran say so, it’ll be all right’’ (28 years, uncomplicated home delivery, second child). In the mid-1970s, Rubin (1975) demonstrated that beyond the motherhood myth there are women who are neglected. In the 1980s, some studies paid attention to women’s health after childbirth, and results showed that recovery after childbirth takes longer than the traditionally accepted six weeks (Field et al., 1983). This finding has been supported by later studies (see, for example, Sword et al., 2008; Wagg, 2010; Wagg et al., 2017).

The second bubble in Figure 7.1, above, represents those women who did realise their problem was a health problem, and whose felt need changed to expressed need (Bradshaw, 1972). However, family and friends, as the next source of help, often confirmed women’s own normalisation of their experiences. Take, for example, this woman’s statement in Sword et al. (2008, p. 1167):

> I had called my mom to tell her like I’m not feeling and I was crying and stuff, she just like brushed it off… And I’m like, no, this is really bad, like I don’t feel like myself. And she said, well, you’ll get used to it.

In the content analysis of online discussions (phase three, Chapter 6), women confirmed that the normalisation of their health problems after childbirth by family and friends had resulted in their not seeking professional help. Normalisation is a logical explanation for this choice not to get further help (Sword et al., 2008; Wagg, 2010; Rouhi et al., 2019).

The third bubble in Figure 7.1, above, represents society's views about post-childbirth health problems, and their effect on women encouraged by trusted persons to seek professional medical help. This includes normative needs, for which healthcare providers are able to either normalise the post-childbirth health problems or provide treatment according to accepted practices. Thirty-five findings were synthesised into three categories dealing with how health services did not support women after childbirth to seek help: post-childbirth care being difficult to access or not addressing their problems; fear of being judged; and cultural context. The systematic review, Chapter 4, confirmed that society does not support postpartum women, and also identified that healthcare providers try to make a logical picture of women's health problems by normalising them, as this statement from Wuytack et al. (2015, p. 10) exemplifies: "When I went to the 2-week and 6-week check, the doctor never asked me; he just said, 'How was I?' And I said I was fine, I didn't say anything. It was all about my baby."

In the early '80s, Field et al. (1983) assessed women after childbirth and noticed that many experience physical and mental health problems, and that their needs were not being met by health care providers. Indeed, most of the literature has focused on normative needs (see, for example, Chew-Graham et al., 2008; Widarsson et al., 2012; Brodribb et al., 2013; Agapidaki et al., 2014; Borglin et al., 2015), and less on women's felt needs (Bailey, 2010). Health services did not appear to be well designed for women's post-childbirth health needs, reflecting a lack of societal support for women during this period in their lives.

The findings of the concept mapping study showed that all clusters apart from 'mental health consultation' had closely matched perceptions of the prevalence of an issue and the likelihood of help-seeking advice. Women also rated the importance of mental health

consultations higher than their availability – in other words, demand outstripped supply. This might indicate recognition of the barriers for women in accessing mental health services, including accessibility, physical proximity, stigma (Bell et al., 2016), lack of knowledge about the symptoms of mental health conditions (Sword et al., 2008), cultural and religious matters (Wittkowski et al., 2012), and lack of knowledge on the part of health care professionals (Rouhi et al., 2019). These factors drove women to seek help from online forums, where they found an anonymous and non-judgemental environment (Chapter 6) – though normalisation of post-childbirth health problems occurred online as well.

7.2.1 How normalisation influenced perception of illness

This study found that women's perception of illness was shaped by their help-seeking for post-childbirth health problems. As Calnan (1987) explained, the concept of health and illness differs from person to person, though women traditionally learn that health problems following childbirth are not to be regarded as illness. Further, according to the BMHSU, social characteristics such as level of education, age, and culture, and matters such as attitude and knowledge about health also influence the perception of health and illness (Andersen et al., 2011).

The results of all three phases showed that women conceptualised their health problems as a normal process of childbirth, and consequently did not take any action to resolve them. The results of the systematic review, Chapter 4, showed that most women are reluctant to discuss health problems after childbirth, and felt that their symptoms should be tolerated as part of childbirth. Other studies have also provided evidence that women consider pregnancy and childbirth to be natural phenomena (Mercer, 2004; Buurman & Lagro-Janssen, 2013; Sagayadevan et al., 2015), that women experience dramatic physical and mental changes

during this period, and that women are informed about these changes by their health care providers (Mercer, 2004; Buurman & Lagro-Janssen, 2013; Sagayadevan et al., 2015). Song et al. (2014) found that because women experience dramatic changes during pregnancy, they believe that the post-childbirth period is the end of pregnancy's hormonal and physical changes. Wagg (2010) also found that women are less likely to seek help for incontinence, for example, because of lack of knowledge about the problem. The present study places this normalisation at the centre of women's help-seeking or lack of it.

7.3 Interpersonal communication: The role of family and friends in seeking help

The conceptual model of the key influences on women's help-seeking for maternal morbidities considers 'interpersonal communication' to be the next step after women feel personal need for assistance. Interpersonal communication in the context of a relationship with trusted persons is women's preferred strategy for dealing with post-childbirth morbidities and seeking help. This finding emerged from the systematic review (Chapter 4) and pattern matching (Chapter 5), where 'support from family and friends' were women's top-rated clusters. It is worth reiterating that the findings of this study, supported by feminist theory, emphasised that trusted persons also participate in normalising postpartum problems.

A long history of research has shown that family and friends are an important source of help for women experiencing health problems, beginning with seminal studies such as that by Guillot (1964). Later, McIntosh (1993) highlighted the role of family and friends in help-seeking by women with depression. In McIntosh's study, families expected that women share their problems only with family. Once women decide they require intervention, informal support by family and friends becomes the most important factor encouraging or impeding

their seeking of professional help (O'Mahen & Flynn, 2008; Scrandis, 2005; Fonseca & Canavarro, 2017). O'Mahen and Flynn (2008) studied the behaviour of women who were likely depressed, as measured by the Edinburgh Postnatal Depression Scale (EPDS), during the perinatal period. For these women, family and friends were the first source of support. According to Jacobs (2017), postpartum women in Canada eschewed professional help for pelvic floor problems because their relatives normalised them. Fisher (2005), by drawing a community picture of help-seeking behaviour among rural women experiencing post-childbirth depression, confirmed that family and friends influenced women to make their decision by providing informal support. The importance of social networks of family and friends has been proven among the general population, as well, including for young athletes, for example (Gulliver, Griffiths, & Christensen, 2012).

Overall, it is clear that interpersonal communication with others mostly acted to normalise health problems after childbirth; however, positive interpersonal connections between women and surrounding people did sometimes encourage women to seek help.

7.4 Community views on post-childbirth health problems

The feminist approach reveals that normalisation of health problems after childbirth is common. The third stage of women's help-seeking is affected by how their community views postpartum health problems. These beliefs derive from community values and culture related to seeking help, and thus can also influence evaluated need. The effect of women's cultural context will be discussed in the next section, followed by normative needs, and the process of socialising health problems online.

7.4.1 Cultural context and post-childbirth help-seeking

In the systematic review (Chapter 4), women's cultural context was revealed as an essential factor in whether or how they sought help. The review showed that culture is firmly embedded in the context of maternal morbidities and women's help-seeking. Allen (2018), in her book *The Power of Feminist Theory*, defined culture as the combining of internalisation and social practices into habits. Culture is "long-abandoned" and settled topic among scholars (Small, Harding, & Lamont, 2010, p. 6); it is defined as the ''values, beliefs, attitudes, and practices'' among a group of people (Lee & Brann, 2015, p. 476). Cultures in which shame, fear of stigma, and taboo abound push women to conceal their health problems (Li, Low, & Lee, 2007). In the systematic review, one category of cultural effect concerned women reporting that they were too embarrassed to discuss their health problems openly, even with their partner (Macarthur et al., 1991; Glazener et al., 1995; Mason et al., 1999; Herron-Marx et al., 2007). Cultural norms also create strong barriers, such as when a culture bars women from talking about their mental health issues, or does not encourage them to engage with their thoughts and feelings (Wittkowski et al., 2012).

Further, in the case of women's health problems after childbirth, culture is one of the factors in determining what is considered an 'normal' or an 'illness'. As has previously been established, the concepts of 'health' and 'illness' are different among different people (Calnan, 1987). Also, culture informs how women experience illness, and how they communicate to seek help.

One of the categories extracted from the systematic review was 'feeling of shame'. Some women felt that openly discussing urogenital problems was 'taboo' and embarrassing,

eliciting shame (Buurman & Lagro-Janssen, 2013). This also applied to symptoms of mental illness (Sword et al., 2008).

A lack of formal care can lead to self-care through religious practices as sources of strength, comfort, and healing. For example, religion and prayer have been introduced as a strategy to manage postpartum depression among low-income ethnic minority mothers in the United States (Abrams et al., 2009). However, women's religious and cultural practices do not encourage them to engage with their thoughts and feelings (Wittkowski et al., 2012)

Some cultural norms ban women from talking about their physical problems, especially urogenital (Wagg et al., 2017) and mental health problems (Klainin & Arthur, 2009), carrying connotations of shame, embarrassment and stigma. It is not surprising, then, that culturally informed shame and embarrassment can work to discourage women from disclosing their health problems (Bina, 2014). If a society looks at mental health problems such as depression as resulting from a lack of belief in God, women will hide their problems (Amankwaa, 2003).

A general concern about stigma associated with mental health disorders hinders women from talking about them (Goyal et al., 2015). Sometimes, the stigma of being seen as a bad mother is heavier than of being labelled 'depressed' (Bilszta et al., 2010). As a result, being in denial about postpartum morbidities explains refusal of treatment and feeling ashamed (Chan, Williamson, & McCutcheon, 2009).

In the systematic review (Chapter 4), the majority of women in the included studies were ashamed of their pelvic floor problems – a comorbidity also highlighted by women in their online discussions (see Chapter 6). Feelings of shame inhibited many women from seeking help. They talked about their problems with a select number of people, usually their partner,

female relatives and some close female friends. They preferred to discuss their problems with 'initiates', that is, women who had given birth themselves. Pelvic floor problems were, for most women, still a taboo. The women were afraid of admitting they had pelvic floor problems because, in their culture, these are associated with being dirty and old (Buurman & Lagro-Janssen, 2013) and therefore no longer capable of carrying out the 'natural' female role of motherhood (Aston, 2002). The feeling of shame has been reported by women as a reason for not taking any action to resolve their urinary incontinence (Lepire & Hatem, 2007).

A number of women within the study had not felt comfortable enough to discuss their problems with their partners or family members because of embarrassment, causing a number of women to feel isolated with their morbidity. Based on the systematic review, women are often reluctant to discuss their health problems after childbirth, which has resulted in a limited body of literature regarding women's post-birth experiences.

7.4.2 Normative needs

According to the present study, women sought help from health care providers when their needs went unmet by family and friends, or when they were encouraged to do so by people around them. According to Bradshaw's (1972) Taxonomy of Needs, normative need is defined by experts, such as policymakers and health professionals, and usually results in services being designed to care for people in society. Normative need can be affected by difficulties in defining need, and by conflict among experts. Felt need and normative need are different (Bradshaw, 1972), and this is supported by the findings of other studies in which postpartum women were not satisfied with their care (Ellberg et al., 2010; Fahey & Shenassa, 2013). Care is often dominated by normative need – in other words, by what health professionals perceive as need (Bailey, 2010).

Health care providers assess women on the basis of normative need according to pre-defined models of postpartum care. These models are limited to mental health and urinary incontinence during the six to eight weeks following childbirth, and otherwise prioritise the infant's care (WHO, 2015). Current health services do not have any follow-up plan after the six-week check for the rest of the 12 months after childbirth (WHO, 2013b). This could be a problem, as women need different information depending on the timing of their post-childbirth visits (Beake et al., 2010). During the first weeks, most women need information about lactation or dealing with settling into a new situation (Beake et al., 2010). There is a dearth of understanding about the information women need after this early post-childbirth period, however.

The systematic review (Chapter 4) and the content analysis of women's online help-seeking behaviours (Chapter 6) showed that pelvic issues and depression were the most common health problems women were concerned about. This is consistent with the WHO's (1998) practical guidelines on caring for women after birth. Although the WHO has updated the postpartum care guidelines several times since 1998, the content of care still focuses on depression and urinary incontinence (WHO, 2015). This emphasis leads to women, and even health care providers, not considering other post-childbirth maternal morbidities (Gutiérrez, 2019; Meaney et al., 2016; Rouhi et al., 2019).

The concept mapping (Chapter 5) confirmed that the needs of women who chose to share their problems with healthcare providers after childbirth had been neglected because of a shift in focus to their infant's needs (Maher & Souter, 2006; Fahey & Shenassa, 2013; Meaney et al., 2016). It is evident that women's felt need has been ignored by healthcare providers; consequently, women think that their health problems are a normal part of childbirth, and

thus they do not actively seek help for themselves. Women seem to feel that if the problems they experience were important, they would be addressed by health care providers. This concerning issue manifested itself in women being dissatisfied with postpartum care compared to prenatal care; the content of postpartum care has been determined by health care professionals, and women's felt need for more support and information has been ignored (Bailey, 2010). It is therefore essential to understand the thoughts and feelings of women to achieve comprehensive care through the development of health practices that appreciate women's needs without underestimating the attention due to the infant (Correa et al., 2014). Post-childbirth health visits should be re-balanced towards the needs of women (Fahey & Shenassa, 2013).

One of the categories identified in the systematic review (Chapter 4) was lack of health literacy among women, trusted persons, and health care providers about maternal morbidities (Khalaf et al., 2009; McCauley et al., 2011). Women found this frustrating, and their partners often knew nothing about what was going on during and after childbirth (Meaney et al., 2016). Women must be prepared for these problems, as women's concerns during the post-childbirth are different from health care providers': health care providers are mainly looking to find any symptoms of infection and bleeding, so their focus is on medical rather than biopsychosocial matters, while women's concerns were primarily fatigue and emotional problems (Tully, Stuebe, & Verbiest, 2017). An Australian study by Cooklin et al. (2018) on the first eight weeks post-childbirth showed that a large percentage of women struggle with various mental and physical health problems. However, depression and pelvic issues were the main problems to receive health professionals' attention.

7.4.3 Socialising health problems in online forums

The ideal of the 'good mother' and judgment by women about whether they are considered good mothers makes the period after birth a challenging time for many women. For those women who cannot share their health problems with trusted persons, online forums are the best option to seek help, as the findings in phase 3 (Chapter 6) indicate. In the online setting, where women are able to read others' posts and comments, they compare their problems, and this provides women with another way to normalise their experiences (Gibson & Hanson., 2013; Doty & Dworkin, 2014). These results are consistent with other studies that have found that women feel inadequately prepared for the postpartum period. However, adequate preparation requires that patients have a more comprehensive description of what they might encounter physically and emotionally postpartum (Martin et al., 2014).

Online forums, by providing anonymity, privacy, lack of embarrassment, support, and appropriate normalisation help women to access to information globally; (Schoenebeck., 2013; Kauer et al., 2014; Furkin, 2018). Women also give unsuitable or inaccurate medical advice to each other, however (Coulson & Greenwood, 2012; Slomian et al., 2017). It is unknown how many women act according to the suggestions they receive, but there is no doubt that the post-childbirth period is a stressful time for women, and that to cope with this period women must search for information about their concerns. The internet is the most commonly used source of information to manage health problems (Doty & Dworkin, 2014; Slomian et al., 2017), and the credibility of the information shared by women within online support groups raises important questions (Esquivel et al. 2006). In short, the accuracy of exchanged information needs further investigation (Coulson & Greenwood, 2012).

7.5 Women's perceived need to seek help

Childbirth has long been regarded as a natural phenomenon. Similarly, many women around the world conceptualise post-childbirth health problems as a normal part of the process and consequently do not take any action to resolve them (Rouhi et al., 2019). As discussed in the literature review (Chapter 2), using Bradshaw's Taxonomy of Needs, it seems that women either do not have felt need or do not turn felt need into expressed need. Major reasons for this include: accepting post-childbirth health problems as part of a normal process (normalisation); hoping these problems will gradually resolve with time; and their the infant's needs taking priority. The next section will explain these reasons. Normalisation, which is a key element of this study, will be discussed comprehensively at the end of this chapter.

7.6 Women's post-childbirth needs as a conceptual framework

In the literature review (Chapter 2), Bradshaw's (1994) Taxonomy of Needs was used to clarify the concept of needs in relation to the post-childbirth women in the study. By identifying the four types of need – felt, expressed, normative and comparative – this study was able to identify whose needs were or were not being met. Needs are important in the BMHSU that was applied in the systematic review (Chapter 4). The BMHSU treats 'need' as an individual characteristic which influences health behaviours. In this model, individual need shapes reactions to health problems (Andersen et al., 2011).

However, the results of phase two, concept mapping, show that perception of need is influenced by broader social norms. Social norms rooted in traditional beliefs hold that talk of postpartum health problems raise questions as to the fitness of the mother. The shame and embarrassment that hinder women from talking about urinary incontinence or mental

health problems are a good example of the effects of these social norms. Others, too, have regarded need as a "social phenomenon" whereby social norms embedded in the society suppress women's need (Andersen et al., 2011, p. 39). Under this social norm, women do not seek help because their problems are not confirmed by family and friends, who see health problems as a normal consequence of childbirth. Women will seek help from health care providers when this course of action is encouraged by trusted persons. Although health care providers must assess women's felt need, low health literacy and social norms overcome their efforts. This phenomenon is clearly depicted in the model adopted for this study (see Figure 7.1, above).

But how do social norms relate to need? Aside from felt need, normative need has been recognised as a barrier to seeking help among women after childbirth. Predesigned care is a result of normative need, and leads women's felt need being ignored (Bailey, 2010). The systematic review clearly showed that women were disappointed with postpartum care. There is comprehensive information available about antenatal care, and health care providers advise women about every aspect of their health in this period, including diet and exercise. However, in this study, women confirmed that health care providers shifted their attention mostly to the infant's need, leaving women's need marginalised or ignored.

The discrepancy between women's need and normative need is further highlighted by the result of the second study (Chapter 5). Women have a broader perception of health care needs, including support and fitness. Furthermore, as shown in the third phase (Chapter 6), women seek help by asking for online support for their health problems. This can be taken as a tacit criticism of the post-childbirth care provided by health care providers, and poses a question: why do women rely on online help, even when it is not reliable?

This study shows that 'felt need' is a motivation for women to seek help for their health problems after childbirth. It is also possible that this lack of help-seeking is explained by a lack of felt need on the part of women, as a result of their problems being normalised, leading to reduced demand for services. This could be explained, alternatively, by the findings of concept mapping (Chapter 5), in which women directly asked about their postpartum health problems answered that they consider them a normal consequence of pregnancy and not as illness.

7.7 Normalisation of women's post-childbirth health problems as feminist praxis

This study adopted a feminist pragmatist philosophical paradigm, and explanations from this paradigm could also be used to explain 'normalisation'. Disagreement among feminist activists reveals two different attitudes about the nature of childbirth. Some feminists support natural birth, and regard 'the natural' as a cultural phenomenon: 'natural childbirth discourse itself serves as cultural initiation' (Beckett, 2005, p. 259). Others advocated for the use of improved technology to ameliorate suffering associated with birth, leading to "the medicalisation of birth" and the idea of safe motherhood (Klima, 2001, p. 285). The conflict between these two views demonstrates how feminist views normalise post-childbirth morbidities: where opponents of the medicalisation of childbirth try to convince women to endure health problems as a natural part of the process, advocates of medicalising post-childbirth health problems consider them pathologies.

This study revealed that feminist perspectives on the normalisation of health problems after childbirth are embedded in society comparably to the medicalisation of health problems. Feminist theory states that pregnancy and childbirth have been regarded as a biological and gender role for women. This idea makes these two processes 'normal', and consequently, the health problems arising from them must be considered normal as well.

Beliefs about what is normal for women are rooted in how society views normality more broadly (Aston et al., 2015). In a society where postpartum morbidities are seen as normal, it is logical that women in that society would normalise their own health problems, too. Additionally, it must be remembered that for many years, inequity in women's health, and even lack of research, has led to the normalisation of problems related to pregnancy and menopause, and to ignoring women (Klima, 2001).

This study's feminist paradigm could explain why women normalise their health problems after childbirth. A pioneer in the area of maternal health, especially postpartum depression, is Jody Thomson, the Mothers Program Coordinator at the Women's Health Clinic in Winnipeg, Manitoba, Canada. Thomson developed the 'Coping with Change' program after working one-on-one with women who self-identified as postpartum depressed. 'Coping with Change' is built on:

> the feminist philosophy that places women at the centre of care and acknowledges and deconstructs the larger social norms and expectations placed on mothers and provides coping strategies for mothers dealing with these various maternal physicals, mental and social changes. (Green, 2009, p. 12)

Here, coping is conceptualised as a behavioural and cognitive attempt to control situations beyond the person's expectations, which leads to stress (Lazarus & Folkman, 1984). Folkman and Lazarus (1980, p. 219) introduced the theory of stress as a result of "cognitive appraisal and coping". They classified coping strategies into "problem-focused and emotion-focused". Problem-focused coping tends to predominate when people feel that something constructive can be done, while emotion-focused coping tends to predominate when people feel that the stressor is something that must be endured.

Later, Carver, Scheier and Weintraub (1989, p. 267) further sub-divided these two coping strategies: “problem-focused coping (active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental social support) and emotion-focused coping (seeking of emotional, social support, positive reinterpretation, acceptance, denial, turning to religion)”. The findings of this study suggest that, in the context of post-childbirth maternal health problems, women are more likely to adopt an emotion-focused strategy.

Other studies have shown that women adopt different strategies to cope with stressors after childbirth, such as infant care (Baskale, 2019). For example, women equipped with information about infant care by their antenatal sessions tend to be better at problem-solving after birth (Currie, 2009). In addition, women adopt different strategies to cope with motherhood adjustment depending on their ethnic or cultural background (Edge & Rogers, 2005; Ngai, Chan, & Holroyd, 2012). Another emotion-focused coping strategy reported by Mason, Glenn, Walton and Hughes (2001) was denial. They realised that women who had urinary incontinence during the 12 months after childbirth did not seek help despite the high prevalence of this morbidity. The main reasons for this were that women felt that they did not need help, or they had no interest in expressing the problem to health care providers. Our findings suggest that culture primarily influences coping strategies through normalisation – which can be cultural, social, or a mixture of the two.

Coping strategies adopted by Australian women during breastfeeding, for example, included “increasing breastfeeding knowledge, staying relaxed and ‘looking after yourself’, the use of positive self-talk, challenging unhelpful beliefs, problem-solving, goal setting and the practice of mindfulness” (O’Brien et al., 2009, p. 1). In a study by Ngai et al. (2012, p. 4), the coping strategies used by first-time Hong Kong Chinese women during the six weeks after

childbirth were “making personalised and achievable decisions seeking emotional and spiritual solace”. In contrast, Edge and Rogers (2005) found that Black Caribbean mothers in the UK rejected postpartum depression as an ailment, and did not seek professional help, relying instead on spirituality as a source of strength.

7.7.1 Acceptance of health problems after childbirth as a coping strategy

Assessing coping strategies from a feminist perspective clearly explains why women accept health problems after childbirth as an emotion-focussed strategy. In the current study, it is clear that women using emotion-focussed coping must accept and tolerate their problems because they either believe that they are *not* problems, or that there is nothing they can do to resolve them. This was revealed by phase one, the systematic review (Chapter 4), and was clearly visible among women who used online platforms to seek help, as well (Chapter 6). When women with physical health problems said that they initially felt their problems would self-resolve and that they considered their health problems not to be serious enough and as part of the childbirth process, consequently they did not seek help. This strategy of acceptance has also been observed in prior qualitative studies (see, for example, Mason et al., 1999; Herron-Marx, Williams, & Hicks, 2007).

The idea of problems being self-resolving emerged as an emotion-focused coping strategy in the work of Wagg (2010). In that study, women ignored the symptoms of urinary incontinence in the hope they would go away. Women who saw their urinary incontinence as a problem (a problem-focused strategy), on the other hand, did Kegel exercises to reduce the symptoms. While perineum and breast problems gradually ease over time, some problems may worsen after childbirth (Mason et al., 2001).

Communication with family and friends after childbirth may inadvertently persuade women to accept problems as normal. This idea is discussed in the next section.

7.7.1.1 Prioritising infants' needs

Giving pre-eminence to the needs of infants is one of the adjustments of motherhood, and according to the feminist approach, it is another explanation for women ignoring their own requirements. This was supported by the systematic review (Chapter 4) and the 'six-week check-up' cluster (Chapter 5), which showed a strong focus on infants' needs during postpartum care. The analysis of the concept mapping study also showed priority being given to infants' needs over women's. Others have found, similarly, that the transition to motherhood and infant care were important concerns for women post-childbirth (see Forster et al., 2008; Buurman & Lagro-Janssen, 2013; Bell et al., 2016; Verbiest et al., 2018). Lupton (2011) argues that infant need prioritisation originates from the cultural authorisation of a mothering model in which women consider their infant vulnerable and in need of maternal protection – thus the infant's need overrides the mother's.

Another explanation for infant need prioritisation is mother-blaming: "a sexist bias toward studying mothers' contributions to child and adolescent maladjustment and at the same time ignoring similar contributions by fathers" (Jackson & Mannix, 2004, p. 151). In this way, too, the mother's need is subordinated to the child's.

7.8 Health literacy and help-seeking

One logical conclusion of the assessment of interpersonal communication in this study would be that low health literacy is a barrier to seeking help, as confirmed by the systematic review (Chapter 4). Other elements like educational level have shown the impact of lack of

health literacy on the influence of family and friends. Health literacy is the ability "to gain access to, understand and use information in ways which promote and maintain good health" (Nutbeam, 1998, p. 357). The BMHSU as used in Chapter 4 does not include health literacy. However, the review shows the importance of health literacy as a unique factor in help-seeking behaviour, and this study proposes adding health literacy as a predisposing characteristic of both contexts and individuals. In the current study, low health literacy was observed across all three layers (see Figure 7.1, above).

The concept of low health literacy was particularly significant in the findings of the systematic review (Chapter 4) and regarding online help-seeking (Chapter 6). Firstly, low health literacy underpins women's lack of perceived need. Second, the findings from the papers included in the systematic review confirmed that women, trusted persons and health care providers were often unaware of potential problems stemming from childbirth. This lack of knowledge about health problems would exacerbate the high prevalence of post-childbirth morbidities, as has been evidenced by other studies, while high health literacy would motivate help-seeking (Dennis & Chung-Lee, 2006). When there is a belief that health problems after childbirth are normal, women accept their health problems as a coping strategy, and as such feel that it is not worth seeking help. Contrariwise, increased health literacy promotes help-seeking.

7.9 Summary

The views of women, and their families and friends and health care providers, closely follow the feminist approach, where normalisation of postpartum health problems reduces help-seeking. Women seek help for problems that they cannot rationalise as 'normal', or when they have foreknowledge of them, such as urinary incontinence, for example. If they do

not seek help on their own behalves, they must communicate with others. At this stage, the availability of help is important. If they think a problem is not normal, they try to find any help they can, which usually starts with sharing with family and friends. Health care providers are treated as the last resort, and if they confirm the normalisation of health problems after childbirth, this leads to few women going further and seeking their help. The nested design for this study (see Figure. 7.1, above) represents this dwindling number of help-seeking women at each stage as a narrowing funnel, with the number of women who actually seek health professional help at its outlet.

The next and final chapter offers conclusions on the study, and discusses the limitations of the research. Finally, it makes some suggestions for further research, and recommendations for policymakers.

Chapter 8: Conclusion

This study explored women's views of physical and mental post-childbirth morbidities and help-seeking behaviours, with the aim of finding the key influences on women's help-seeking behaviour in the 12-month period post-childbirth. Each of its three phases emphasised one area of women's voice on postpartum health.

The results of the systematic review, phase one, showed the dearth of qualitative research in this area. The limited research presenting women's perspectives on help-seeking for post-childbirth morbidities is surprising, given the prevalence of morbidities, and suggests a hidden problem. Low health literacy was evident among women and their trusted persons. Further, it was found that women often do not recognise morbidities, or are disinclined to reveal physical and mental post-childbirth morbidities in the primary care setting. This problem is worsened when health professionals do not facilitate discussion of post-childbirth morbidities, and may themselves lack awareness of evidence-based management of post-childbirth morbidities.

In phase two, the concept mapping of women's views of health problems in the 12 months after childbirth demonstrates that women have a much broader conception of post-childbirth problems than health professionals and policymakers, and that they rely heavily on social support. Not all women have access to good social support, however, suggesting a need to review the content and timing of post-childbirth care. This phase also found that health

professionals do not facilitate discussion of post-childbirth morbidities, and may lack awareness of evidence-based management practices.

Finally, the result of the third phase demonstrates that online sharing of post-childbirth concerns among women is prevalent. Women seek help by asking for online support for their health problems. In this vein, women have access to informal information and independently decide about their health problems in an online setting. It is vital to direct women to high-quality health information to answer their post-childbirth health concerns, in addition to accessing peer emotional support through online forum.

This study has achieved its main aim, which was to find the key influences on women's help-seeking behaviour in the 12 months post-childbirth. The key factor is 'the fallacy of normalcy'. Although presaged by the term 'normalisation', the result of the three phases clearly showed 'the fallacy of normalcy' to be more suitable. The justification of normalisation of post-childbirth health problem is rooted in sociocultural matters, about which feminist theory conceptualises the myth of the 'good mother' as accepting all post-childbirth health problems as normal. This picture was carved in previous generations' minds, and it has been passed down to us. It leads to women, family and friends normalising post-childbirth health problems, and, consequently, to women ignoring those problems – indeed, they ignore themselves.

On the other hand, if women are the centre of attention during pregnancy, after birth this attention shifts to the infant. Infants' need is prioritised over women's as, according to a feminist explanation, mothers, because of their gender role, are to blame for whatever happens to their infants. Thus, women's attention must be focussed on the infant's need, and their own need will be ignored. This focus on the infant to the detriment of the mother has

been confirmed by healthcare providers, as well, with women in this study asserting that healthcare providers often ignored their health problems during the predefined models of assessment and care given to infants.

Lack of health literacy was also common, and was not limited to women and trusted persons. Unfortunately, healthcare providers, too, were unable to accurately assess mothers' health problems because they did not have the necessary knowledge, in spite of having academic qualifications.

The systematic review, phase 1, clearly showed a lack of literature on women's help-seeking, and analysing nine papers revealed normalisation as the main reason women are ignored. The other issue highlighted in this study was the limited number of participatory studies; most were researcher-centred, instead. Consequently, women's voices have been ignored as well.

For those women who shared their post-childbirth health issues online – where there is no monitoring by healthcare professionals, not only did the discussion among women mostly confirm the normalisation of health problems, inappropriate suggestions were also made, potentially leading to bad outcomes.

In summary, the result of the three sub-studies revealed normalisation of health problems after childbirth to be accepted by society, family and friends as the sources from which women sought help. Online help-seeking must shift to high-quality and comprehensive health information monitored by knowledgeable health care professionals.

8.1 Limitations

This study is not without limitations. For example, the meta-aggregation approach considers extracted themes from supporting statements such as the participants' experiences or quotes, and creates new knowledge through synthesis, not new analysis. This study included papers which reported depression and pelvic issues, and research addressing other common post-childbirth morbidities was not found, and it is possible that we failed to identify all available literature. Given that quantitative papers show a wide range of morbidities, it can be assumed that there is a need for further primary research into women's experiences of post-childbirth help-seeking. Only papers written in English were included, and all the studies located were conducted in developed countries, so the applicability of the findings to women in developing countries is limited.

Secondly, phase two involved a concept mapping study to gain women's perspectives about their postpartum health problems. Using online recruitment enabled access to women across Australia. There were difficulties however recruiting women for the more time-consuming sorting and rating activities, which required changes to the recruitment strategy and further ethics approval. Others have reported similar difficulties recruiting mothers of young children which is assumed to be due to lack of time because of childcare responsibilities. We used a convenience sample of 81 women, so it is possible that our sample of women with relatively low felt need was not representative of the broader population. Further studies with more diverse groups would resolve this issue.

Lastly, phase three looked at one particular Australian public forum, and data from other forums or private online groups may have yielded different results. Further, the results were restricted to Australian women who communicate in English and are computer literate. It is

therefore unknown what concerns non-English speaking women and/or women without computer access may hold.

8.2 Strengths

This study's focus on women's views and participatory method, without the interference of the researchers in the process of data gathering, provided an opportunity to listen to women's voices. The systematic review, phase one, proved that this is an under-researched area. In phase two, asking direct questions led to women revealing their concerns and problems through concept mapping, and phase three assessed women's discussions with each other through content analysis. Consequently, the findings of this study illustrated women's problems in their own, rarely heard, language. One of the strengths of this study was its combining of three separate but linked studies to thoroughly address the research aim.

Feminist pragmatism was the philosophy underpinning this study. It helped in considering women's experience after childbirth, which has been marginalised by the male-dominated medicalisation frame. Feminist pragmatism allowed judgement of the sociocultural aspects of post-childbirth health problems to contribute to the aims of this study. The multiphase, mixed methods studies conducted, adhering to participatory feminist pragmatism, helped the researchers to draw better conclusions.

8.3 Recommendations

The following recommendations are based on the findings of the study. Our findings highlight the potential role informed health care workers could play in routine questioning about morbidities for post-childbirth women. Routine questioning that helped identify health

issues could help to bypass women's lack of perceived need. Preparing a comprehensive checklist to remind health care workers to collect the required information from the mother and, if appropriate, their partner, would go some way to achieving this. The timing of routine questioning could follow the National Immunisation Program Schedule and WHO time frame: 6 days, 2 months, 4 months, 6 months, 12 months with an expansion to 18 months post childbirth.

Better education should be offered to prepare women and their families for maternal morbidities associated with pregnancy. This could be provided during the hospital stay and proposed timing to promote help-seeking.

This study has highlighted that there is limited literature from women's perspective about post-childbirth help-seeking. The lack of research in this area may negatively influence policy. Given the identified barriers to help-seeking for women, further research, and review of the content, quantity and quality of care after childbirth, are recommended.

The findings suggest a need to refocus post-childbirth care to include the needs of women. Women must be informed about health problems in advance, and they ought to be asked direct questions about their problems as their new responsibilities may distract them from their own problems. Women need to be encouraged to talk about their own wellbeing after childbirth and need to be directly asked about any possible health problems at all post childbirth visits.

According to the WHO, postpartum care includes care received during the first six to 12 hours, three to six days, six weeks, and six months after childbirth, though this study showed that six weeks after childbirth was usually the last occasion of care and mostly focused on the

infant. The systematic review suggested that extending the care offered by health care providers to 12 months after childbirth might enable mothers' help-seeking for morbidities, and protect women's, and thus families', health. Further, phase two provided evidence that an individualised approach to post-childbirth care would promote women's health as well.

Phase two demonstrated that women's needs differ from person to person, and that providing individualised care would thus be beneficial. Policymakers and health care providers should inform women about the benefits of physical fitness, for example.

Further research is needed to understand health care providers' knowledge and practices in maternal post-childbirth health, and health service managers must ensure that access barriers are addressed through quality needs assessment processes, particularly for vulnerable women.

References

Abbott, J., Bowyer, L., & Finn, M. (2014). *Obstetrics & gynaecology: An evidence-based guide*: Edinburgh Churchill Livingstone/Elsevier, [2014] Second edition.

Abdollahi, F., Sazlina, S. G., Zain, A. M., Zarghami, M., Asghari Jafarabadi, M., & Lye, M. S. (2014). Postpartum depression and psycho-socio-demographic predictors. *Asia Pac Psychiatry, 6*(4), 425-434. doi:10.1111/appy.12152

Abma, T., Banks, S., Cook, T., Dias, S., Madsen, W., Springett, J., & Wright, M. T. (2019). *Participatory research for health and social well-being*: Springer.

Abrar, A., et al. (2020). Anxiety among women experiencing medically complicated pregnancy: A systematic review and meta-analysis. *Birth, 47*(1), 13-20. doi:10.1111/birt.12443

Abrams, L. S., & Curran, L. (2009). "And you're telling me not to stress?" A grounded theory study of postpartum depresion symptoms among low-income mothers. *Psychology of Women Quarterly, 33*(3), 351-362.

Abrams, L. S., Dornig, K., & Curran, L. (2009). Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. *Qual Health Res, 19*(4), 535-551. doi:10.1177/1049732309332794

Abushaikha, L., & Khalaf, I. (2014). Exploring the roles of family members in women's decision to use postpartum healthcare services from the perspectives of women and health care providers. *Women & Health, 54*(6), 502-512.

Agapidaki, E., Souliotis, K., Jackson, S. F., Benetou, V., Christogiorgos, S., Dimitrakaki, C., & Tountas, Y. (2014). Pediatricians' and health visitors' views towards detection and management of maternal depression in the context of a weak primary health care system: a qualitative study. *BMC Psychiatry, 14*. doi:10.1186/1471-244x-14-108

Alcoff, L. (1988). Cultural feminism versus post-structuralism: The identity crisis in feminist theory. *Signs: Journal of women in culture and society, 13*(3), 405-436.

Åhlund, S., Rothstein, E., Rådestad, I., Zwedberg, S., & Lindgren, H. (2019). Urinary incontinence after uncomplicated spontaneous vaginal birth in primiparous women during the first year after birth. *International Urogynecology Journal*. doi:10.1007/s00192-019-03975-0

Australian Institute of Health and Welfare 2009, Framework for the National Perinatal Depression Initiative 2008-09 to 2012-13, by AIHW, Australian Government.

Australian Institute of Health and Welfare 2012, Maternal morbidity data in Australia: an assessment of the feasibility of standardised collection. (978-1-74249-382-4) by AIHW, Australian Government

Australian Institute of Health and Welfare 2014, Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: by AIHW, Australian Government (1032-6138)

Australian Institute of Health and Welfare 2014b, Foundations for enhanced maternity data collection and reporting in Australia, National Maternity Data development Project Stage 1 by AIHW, Australian Government (978-1-74249-559-0)

Australian Institute of Health and Welfare 2015a, Australia's mothers and babies 2013 by AIHW, Australian Government

Australian Institute of Health and Welfare 2015b, Maternal deaths in Australia 2008-2012 by AIHW, Australian Government (1449-8863)

Australian Institute of Health and Welfare 2016, Maternity Care Classification System Maternity Model of Care Data Set Specification national pilot report by AIHW, Australian Government (978-1-74249-889-80

Australian National Health and Medical Research Council Australian (2018). National Statement on *Ethical Conduct in Human Research: 2007 (Updated 2018)*. National Health and Medical Research Council Retrieved from www.nhmrc.gov.au/guidelines/publications/e72.

Alderdice, F., McNeill, J., & Lynn, F. (2013). A systematic review of systematic reviews of interventions to improve maternal mental health and well-being. *Midwifery, 29*(4), 389-399. doi:http://dx.doi.org/10.1016/j.midw.2012.05.010

Alianmoghaddam, N., Phibbs, S., & Benn, C. (2019). "I did a lot of Googling": A qualitative study of exclusive breastfeeding support through social media. *Women Birth, 32*(2), 147-156. doi:https://doi.org/10.1016/j.wombi.2018.05.008

Allen, A. (2018). The power of feminist Theory: Domination, Resistance, Solidarity. Boulder, CO: Westview Press.

Almeida, L. M., Santos, C. C., Caldas, J. P., Ayres-de-Campos, D., & Dias, S. (2014). Obstetric care in a migrant population with free access to health care. *International Journal of Gynecology & Obstetrics, 126*(3), 244-247. doi:http://dx.doi.org/10.1016/j.ijgo.2014.03.023

Alston, M., Allan, J., Dietsch, E., Wilkinson, J., Shankar, J., Osburn, L., . . . Moore, E. (2006). Brutal neglect: Australian rural women's access to health services. *Rural and Remote Health, 6*(1), 475.

Amankwaa, L. C. (2003). Postpartum depression among African-American women. *Issues in Mental Health Nursing, 24*(3), 297-316.

Andersen, R. M. (2008). National health surveys and the behavioral model of health services use. *Med Care, 46*(7), 647-653. doi:10.1097/MLR.0b013e31817a835d

Andersen, R. M., Davidson, P. L., & Baumeister, S. E. (2011). Improving access to care in America. In Changing the US health care system: key issues in health services policy and management. 3a. edición. San Francisco: Jossey-Bass (pp. 3-31). USA: John Wiley and Sons.

Annual Report Tasmania. (2014). Council of Obstetric & Paediatric Mortality & Morbidity. Annual Report 2012. *Department of Health and Human Services*.

Ansara, D., Cohen, M. M., Schei, B., Gallop, R., & Kung, R. (2005). Predictors of women's physical health problems after childbirth. *Journal of Psychosomatic Obstetrics and Gynecology, 26*(2), 115-125. doi:10.1080/01443610400023064

Ansong, E. (2015). The Association Between Household Consumer Durable Assets and Maternal Health-Seeking Behavior in Ghana. *Women and Health, 55*(5), 485-504. doi:10.1080/03630242.2015.1022815

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *British journal of social psychology, 40*(4), 471-499.

Asiodu, I. V., Waters, C. M., Dailey, D. E., Lee, K. A., & Lyndon, A. (2015). Breastfeeding and use of social media among first-time African American mothers. *J Obstet Gynecol Neonatal Nurs, 44*(2), 268-278. doi:https://doi.org/10.1111/1552-6909.12552

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., . . . Randel, P. (2015). The Power of Relationships: Exploring How Public Health Nurses Support Mothers and Families During Postpartum Home Visits. *Journal of Family Nursing, 21*(1), 11-34. doi:10.1177/1074840714561524

Atrash, H. K., Johnson, K., Adams, M., Cordero, J. F., & Howse, J. (2006). Preconception Care for Improving Perinatal Outcomes: The Time to Act. *Maternal and Child Health Journal, 10*(1), 3-11. doi:10.1007/s10995-006-0100-4

Austin, M.-P. V., Middleton, P., Reilly, N. M., & Highet, N. J. (2013). Detection and management of mood disorders in the maternity setting: The Australian Clinical Practice Guidelines. *Women and Birth, 26*(1), 2-9. doi:http://dx.doi.org/10.1016/j.wombi.2011.12.001

Azale, T., Fekadu, A., & Hanlon, C. (2016). Treatment gap and help-seeking for postpartum depression in a rural African setting. *BMC Psychiatry, 16*, 1.

Bahadoran, P., Alizadeh Sh., & Valiani, M. (2009). Exploring the role of midwives in health care system in Iran and the world. *IRiranian Journal of Nursing and midwiferyResearch, 14*(3), 117-122.

Bailey, S. (2010). Postnatal care: exploring the views of first-time mothers. *Community Practitioner, 83*(12), 26-29.

Barimani, M., & Vikström, A. (2015). Successful early postpartum support linked to management, informational, and relational continuity. *Midwifery, 31*. doi:10.1016/j.midw.2015.04.009

Bashour, H. N., Kharouf, M. H., Abdulsalam, A. A., El Asmar, K., Tabbaa, M. A., & Cheikha, S. A. (2008). Effect of postnatal home visits on maternal/infant outcomes in Syria: a randomized controlled trial. *Public Health Nurs, 25*(2), 115-125. doi:10.1111/j.1525-1446.2008.00688.x

Baskale, H. (2019). Effects of Infant Care Education on Problem Solving and Motherhood Experience: A Mixed-Methods Study. *International Journal of Childbirth Education, 34*(2).

Barreix, M., et al. (2018). Standardizing the measurement of maternal morbidity: Pilot study results. *International Journal of Gynecology & Obstetrics, 141*, 10-19.

Bazeley, P. (2009). Integrating data analyses in mixed methods research. In: SAGE Publications Sage CA: Los Angeles, CA.

Beake, S., Rose, V., Bick, D., Weavers, A., & Wray, J. (2010). A qualitative study of the experiences and expectations of women receiving in-patient postnatal care in one English maternity unit. *BMC Pregnancy Childbirth, 10*, 70. doi:10.1186/1471-2393-10-70

Beckett, K. (2005). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory, 6*(3), 251-275.

Bedi, R. P., & Alexander, D. A. (2009). Using Multivariate Concept-Mapping for Examining Client Understandings of Counselling. *Canadian Journal of Counselling, 43*(2), 76-91.

Behruzi, R., Hatem, M., Goulet, L., Fraser, W., & Misago, C. (2013). Understanding childbirth practices as an organizational cultural phenomenon: a conceptual framework. *BMC Pregnancy and Childbirth, 13*(1), 205.

Bell, L., Feeley, N., Hayton, B., Zelkowitz, P., Tait, M., & Desindes, S. (2016). Barriers and Facilitators to the Use of Mental Health Services by Women With Elevated Symptoms of Depression and Their Partners. *Issues in Mental Health Nursing, 37*(9), 651-659. doi:10.1080/01612840.2016.1180724

Bernazzani, O., & Bifulco, A. (2003). Motherhood as a vulnerability factor in major depression: The role of negative pregnancy experiences. *Social Science and Medicine, 56*(6), 1249-1260. doi:10.1016/S0277-9536(02)00123-5

Berrisford, G., Lambert, A., & Heron, J. (2015). Understanding postpartum psychosis. *Community Practitioner, 88*(5), 22-23.

Betsy, L. M., & Carmen, R. W. V. V. (2007). Understanding Power and Rules of Thumb for Determining Sample Sizes. In. Web server without geographic relation, Web server without geographic relation (org): TQMP.

Bick, D., et al. (2020). Better Births–But why not better postnatal care? *Midwifery, 80*.

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression -- beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing, 27*(3), 44-54.

Bina, R. (2014). Seeking Help for Postpartum Depression in the Israeli Jewish Orthodox Community: Factors Associated with Use of Professional and Informal Help. *Women and Health, 54*(5), 455-473. doi:10.1080/03630242.2014.897675

Bogossian, F., Brodribb, W., Farley, R., Goodwin, H., Tin, A., & Young, J. (2017). A feasibility study to improve practice nurses' competence and confidence in providing care for mothers and infants. *Contemp Nurse, 53*(5), 503-514. doi:10.1080/10376178.2017.1281087

Borglin, G., Hentzel, J., & Bohman, D. M. (2015). Public health care nurses' views of mothers' mental health in paediatric healthcare services: a qualitative study. *Prim Health Care Res Dev, 16*(5), 470-480. doi:10.1017/S1463423615000055

Borrelli, S. E. (2014). What is a good midwife? Insights from the literature. *Midwifery, 30*(1), 3-10. doi:https://doi.org/10.1016/j.midw.2013.06.019

Boucher, L. M., et al. (2017). Expanding conceptualizations of harm reduction: results from a qualitative community-based participatory research study with people who inject drugs. *Harm reduction journal, 14*(1), 18.

Bradbury-Jones, C., Breckenridge, J. P., Devaney, J., Duncan, F., Kroll, T., Lazenbatt, A., & Taylor, J. (2015). Priorities and strategies for improving disabled women's access to maternity services when they are affected by domestic abuse: a multi-method study using concept maps. *BMC Pregnancy Childbirth, 15*, 350. doi:10.1186/s12884-015-0786-7

Bradshaw. (1972). A Taxonomy of Social Need. In R. Richard Cookson, R. Sainsbury, & C. Glendinning (Eds.), *Jonathan Bradshaw on Social Policy Selected Writings 1972–2011* (pp. 367). USA: University of York.

Bradshaw, J. (1994). The conceptualization of need: A social policy perspective. . In J. P. G. W. (Eds.) (Ed.), *Researching the peoples' health* (pp. 44–57). London, UK: Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:https://doi.org/10.1191/1478088706qp063oa

Brock, E., Charlton, K. E., & Yeatman, H. (2014). Identification and evaluation of models of antenatal care in Australia – A review of the evidence. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 54*(4), 300-311. doi:doi:10.1111/ajo.12210

Brodie, P. (2013). 'Midwifing the midwives': addressing the empowerment, safety of, and respect for, the world's midwives. *Midwifery, 29*(10), 1075-1076. doi:http://dx.doi.org/10.1016/j.midw.2013.06.012

Brodribb, W., Zadoroznyj, M., & Dane, A. (2013). The views of mothers and GPs about postpartum care in Australian general practice. *BMC Fam Pract, 14*, 139. doi:10.1186/1471-2296-14-139

Brodribb, W. E., Mitchell, B. L., & Van Driel, M. L. (2015). Postpartum consultations in Australian general practice. *Australian Journal Of Primary Health*. doi:10.1071/PY14082

Brodribb, W. E., Mitchell, B. L., & van Driel, M. L. (2016). Practice related factors that may impact on postpartum care for mothers and infants in Australian general practice: a cross-sectional survey. *BMC Health Services Research, 16*(1). doi:10.1186/s12913-016-1508-1

Brown, A., Rance, J., & Bennett, P. (2015). Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulties. *J Adv Nurs*. doi:10.1111/jan.12832

Brown, J., et al. (2020). Can a Community-Led Intervention Offering Social Support and Health Education Improve Maternal Health? A Repeated Measures Evaluation of the PACT Project Run in a Socially Deprived London Borough. *Int J Environ Res Public Health, 17*(8). doi:10.3390/ijerph17082795

Brown, S., et al. (1998). Maternal health after childbirth: results of an Australian population based survey. *BJOG: An International Journal of Obstetrics and Gynaecology, 105*(2), 156-161. doi:10.1111/j.1471-0528.1998.tb10045.x

Brown, S., Gartland, D., Perlen, S., McDonald, E., & MacArthur, C. (2015). Consultation about urinary and faecal incontinence in the year after childbirth: a cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology, 122*(7), 954-962.

Bryant, A., Blake-Lamb, T., Hatoum, I., & Kotelchuck, M. (2016). Women's Use of Health Care in the First 2 Years Postpartum: Occurrence and Correlates. *Maternal and Child Health Journal, 20*(1), 81-91. doi:10.1007/s10995-016-2168-9

Bryant, A. S., Haas, J. S., McElrath, T. F., & McCormick, M. C. (2006). Predictors of compliance with the postpartum visit among women living in healthy start project areas. *Matern Child Health J, 10*(6), 511-516. doi:10.1007/s10995-006-0128-5

Bryman, A. (2007). Barriers to Integrating Quantitative and Qualitative Research. *Journal of Mixed Methods Research, 1*(1), 8-22. doi:10.1177/2345678906290531

Burke, J. G., O'Campo, P., Peak, G. L., Gielen, A. C., McDonnell, K. A., & Trochim, W. M. (2005). An introduction to concept mapping as a participatory public health research method. *Qual Health Res, 15*(10), 1392-1410. doi: 10.1177/1049732305278876

Burke, J. G., O'Campo, P., Peak, G. L., Gielen, A. C., McDonnell, K. A., & Trochim, W. M. K. (2005). An introduction to concept mapping as a participatory public health research method. *Qual Health Res, 15*. doi:10.1177/1049732305278876

Burla, L., Knierim, B., Barth, J., Liewald, K., Duetz, M., & Abel, T. (2008). From text to codings: intercoder reliability assessment in qualitative content analysis. *Nurs Res, 57*(2), 113-117. doi:10.1097/01.NNR.0000313482.33917.7d

Buultjens, M., et al. (2007). When giving life starts to take the life out of you: women's experiences of depression after childbirth. *Midwifery, 23*(1), 77-91. doi:10.1016/j.midw.2006.04.002

Buurman, M. B., & Lagro-Janssen, A. L. (2013). Women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour: a qualitative interview study. *Scand J Caring Sci, 27*(2), 406-413. doi:10.1111/j.1471-6712.2012.01044.x

Caetano, A., Mendes, M., & Rebelo, Z. (2018). Maternal concerns in the postpartum period: an integrative review. *Preocupaciones maternas en el posparto: revisión integradora., 4*(17), 149-159. doi:10.12707/RIV17074

Calnan, M. (1987). Lay beliefs about health and illness. In S. French (Ed.), *Physiotherapy: A psychosocial approach*. Newyork: Tavistock Publications.

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56*(2), 81-105. doi:10.1037/h0046016

Campbell, J. L., Quincy, C., Osserman, J., & Pedersen, O. K. (2013). Coding In-depth Semistructured Interviews. *Sociological Methods & Research, 42*(3), 294-320. doi:10.1177/0049124113500475

Campbell, R., et al. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American journal of community psychology, 28*(6), 773-791.

Cape , J., & Mcculloch, Y. (1999). Patients' reasons for not presenting emotional problems in general practice consultations. *British Journal of General Practice, 49*, 875-879.

Cargo, M., & Mercer, S. L. (2008). The Value and Challenges of Participatory Research: Strengthening Its Practice. *Annual Review of Public Health, 29*(1), 325-350. doi:10.1146/annurev.publhealth.29.091307.083824

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. *Journal of personality and social psychology, 56*(2), 267.

Carver, N. A., Ward, B. M., & Talbot, L. A. (2014). Using Bradshaw's Taxonomy of Needs: Listening to women in planning pregnancy care. *Contemporary Nurse, 30*(1), 76-82. doi:10.5172/conu.673.30.1.76

Cassiano, A. D. N., Holanda, C. S. M. d., Costa, R. K. d. S., Morais, F. R. R. d., & Maranhão, T. M. d. O. (2015). Nursing care to woman in immediate puerperium: a narrative description. *Revista de Pesquisa: Cuidado é Fundamental Online, 7*(1), 2061. doi:10.9789/2175-5361.2015.v7i1.2061-2071

Castro Lopes, S., Nove, A., Ten Hoope-Bender, P., de Bernis, L., Bokosi, M., Moyo, N. T., & Homer, C. S. (2016). A descriptive analysis of midwifery education, regulation and association in 73 countries: the baseline for a post-2015 pathway. *Hum Resour Health, 14*(1), 37. doi:10.1186/s12960-016-0134-7

Chambers, R. (1992). *Rural apprasial: rapid, relaxed and participatory*: Institute of Development Studies (UK).

Chan, S. W., Williamson, V., & McCutcheon, H. (2009). A comparative study of the experiences of a group of Hong Kong Chinese and Australian women diagnosed with postnatal depression. *Perspectives in Psychiatric Care, 45*(2), 108-118. doi:10.1111/j.1744-6163.2009.00211.x

Chandrasekara, W. S. (2016). Help Seeking Attitudes and Willingness to Seek Psychological Help: Application of the Theory of Planed Behavior. *International Journal of Management, Accounting & Economics, 3*(4), 233-245.

Chen, L., Qiong, W., van Velthoven, M. H., Yanfeng, Z., Shuyi, Z., Ye, L., . . . Ting, Z. (2014). Coverage, quality of and barriers to postnatal care in rural Hebei, China: a mixed method study. *BMC Pregnancy Childbirth, 14*, 31. doi:10.1186/1471-2393-14-31

Cheng, C., Fowles, E. R., & Walker, L. O. (2006). Postpartum maternal health care in the United States: a critical review. *Journal of Perinatal Education, 15*(3), 34-42.

Cheng, C., & Li, Q. (2008). Integrative review of research on general health status and prevalence of common physical health conditions of women after childbirth. *Womens Health Issues, 18*. doi:10.1016/j.whi.2008.02.004

Chew-Graham, C., Chamberlain, E., Turner, K., Folkes, L., Caulfield, L., & Sharp, D. (2008). GPs' and health visitors' views on the diagnosis and management of postnatal depression: a qualitative study. *British Journal of General Practice, 58*(548), 169-176.

Chew-Graham, C., Sharp, D., Chamberlain, E., Folkes, L., & Turner, K. M. (2009). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice, 10*. doi:10.1186/1471-2296-10-7

Chou, D., Tuncalp, O., Firoz, T., Barreix, M., Filippi, V., von Dadelszen, P., . . . Maternal Morbidity Working, G. (2016). Constructing maternal morbidity - towards a standard tool to measure and monitor maternal health beyond mortality. *BMC Pregnancy Childbirth, 16*, 45. doi:10.1186/s12884-015-0789-4

Collins, K. M. T., Onwuegbuzie, A. J., & Jiao, Q. G. (2007). A Mixed Methods Investigation of Mixed Methods Sampling Designs in Social and Health Science Research. *Journal of Mixed Methods Research, 1*(3), 267-294. doi:10.1177/1558689807299526

Concept Systems Inc (2018). The concept system® global maxtm [webbased platform]. Retrieved from https ://conce ptsys temsg lobal.com/ index.php?forwa rd=/home.php.

Conceição, S. C. O., Samuel, A., & Yelich Biniecki, S. M. (2017). Using concept mapping as a tool for conducting research: An analysis of three approaches. *Cogent Social Sciences, 3*(1), 1404753. doi:10.1080/23311886.2017.1404753

Conrad, P. (2007). The medicalization of society: On the transformation of human conditions into treatable disorders: JHU Press.

Collins, S. J. (2018). *An interpretative phenomenological analysis of mothers' negative experiences and emotions during early motherhood.*

Cooklin, A., Amir, L., Nguyen, C., Buck, M., Cullinane, M., Fisher, J., . . . Team, C. S. (2018). Physical health, breastfeeding problems and maternal mood in the early postpartum: a prospective cohort study. *Archives of Women's Mental Health, 21*(3), 365-374.

Cooklin, A. R., Amir, L. H., Jarman, J., Cullinane, M., Donath, S. M., & Team, C. S. (2015). Maternal Physical Health Symptoms in the First 8 Weeks Postpartum Among Primiparous Australian Women. *Birth, 42*(3), 254-260. doi:http://dx.doi.org/10.1111/birt.12168

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: a concept analysis. *Int J Nurs Pract, 17*(3), 280-288. doi:10.1111/j.1440-172X.2011.01936.x

Cronin, P., et al. (2008). Undertaking a literature review: a step-by-step approach. *British Journal of Nursing, 17*(1), 38-43. doi:10.12968/bjon.2008.17.1.28059

Cornwall, A., & Jewkes, R. (1995). What is participatory research? *Social Science & Medicine, 41*(12), 1667-1676. doi:https://doi.org/10.1016/0277-9536(95)00127-S

Correa, M. S., Feliciano, K. V., Pedrosa, E. N., & Souza, A. I. (2014). Women's perception concerning health care in the post-partum period: a meta-synthesis. *Open Journal of Obstetrics and Gynecology, 4*(07), 416

Corrigan, C. P. K., Andrea N.; Groh, Carla J. (2015). Social Support, Postpartum Depression, and Professional Assistance: A Survey of Mothers in the Midwestern United States *The Journal of Perinatal Education,, 24*(1), 48-60. doi:http://dx.doi.org/10.1891/1058-1243.24.1.48

Coulson, N. S., Buchanan, H., & Aubeeluck, A. (2007). Social support in cyberspace: a content analysis of communication within a Huntington's disease online support group. *Patient Educ Couns, 68*(2), 173-178. doi:10.1016/j.pec.2007.06.002

Coulson, N. S., & Greenwood, N. (2012). Families affected by childhood cancer: an analysis of the provision of social support within online support groups. *Child: Care, Health & Development, 38*(6), 870-877. doi:10.1111/j.1365-2214.2011.01316.x

Crabbe, K. H., A. (2014). Public health and wellbeing: A matter for the midwife? doi:http://dx.doi.org/10.12968/bjom.2014.22.9.634

Crary, A. (2001). A question of silence: Feminist theory and women's voices. *Philosophy, 76*(3), 371-395.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed. ed.): SAGE Publications.

Creswell, J. W., & Plano Clark, V. L. (2017). *Designing and conducting mixed methods research* (Third edition, international student edition ed.). los Angles, USA: SAGE.

Creswell, W., John. (2013). Research design, qualitative, quantitative and mixed methods approaches. USA: SAGE.

Crossan, F. (2003). Research philosophy: towards an understanding. *Nurse Researcher (through 2013), 11*(1), 46.

Cunningham, F. G., Leveno, K. J., Bloom, S. L., Spong, C. Y., Dashe, J. S., Hoffman, B. L., . . . Sheffield, J. S. (2018). *Williams obstetrics* (D. M. Twickler & M. S. Mahendroo Eds. 24 ed.). New York McGraw-Hill Education.

Currie, J. (2009). Managing Motherhood: Strategies Used by New Mothers to Maintain Perceptions of Wellness. *Health Care for Women International, 30*(7), 653-668. doi:10.1080/07399330902928873

Cutrona, C., & Suhr, J. (1992). Controllability of Stressful Events and Satisfaction With Spouse Support Behaviors. *Communication Research, 19*(2), 154-174. doi:10.1177/009365092019002002

Daly, D., et al. (2019). Stop, think, reflect, realize-first-time mothers' views on taking part in longitudinal maternal health research. *Health Expect, 22*(3), 415-425. doi:10.1111/hex.12861

Daly, D., et al. (2018). Urinary incontinence in nulliparous women before and during pregnancy: prevalence, incidence, type, and risk factors. *International Urogynecology Journal, 29*(3), 353-362. doi:10.1007/s00192-018-3554-1

Dantas, T. H. M., et al. (2020). Disability and functioning of women with low-risk pregnancy: Assessment using the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). *International Journal of Gynecology & Obstetrics, 148*(1), 53-58. doi:10.1002/ijgo.12985

Darvill, R., Skirton, H., & Farrand, P. (2010). Psychological factors that impact on women's experiences of first-time motherhood: a qualitative study of the transition. *Midwifery, 26*. doi:10.1016/j.midw.2008.07.006

Davis-Floyd, R. (2007). Daughter of time: the postmodern midwife (part 1). *Rev Esc Enferm USP, 41*(4), 705-710. doi:10.1590/S0080-62342007000400023

Dawson, P., et al. (2019). Barriers to equitable maternal health in Aotearoa New Zealand: an integrative review. *International Journal for Equity in Health, 18*(1), 168.

Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33*(4), 323-331. doi:10.1111/j.1523-536X.2006.00130.x

Dennis, C. L., & Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Syst Rev*(2), CD001134. doi:10.1002/14651858.CD001134.pub3

Denscombe, M. (2008). Communities of Practice: A Research Paradigm for the Mixed Methods Approach. *Journal of Mixed Methods Research, 2*(3), 270-283. doi:10.1177/1558689808316807

Derbyshire, E., & Costarelli, V. (2008). Dietary factors in the aetiology of postnatal depression. *Nutrition Bulletin, 33*(3), 162-168. doi:10.1111/j.1467-3010.2008.00703.x

DiBari, J. N., Yu SM, Chao SM, & Lu MC. (2014). Use of postpartum care: predictors and barriers. *J Pregnancy, 2014*, 530769. doi:http://dx.doi.org/10.1155/2014/530769

Diefenbach, M. A., & Leventhal, H. (1996). The common-sense model of illness representation: Theoretical and practical considerations. *Journal of social distress and the homeless, 5*(1), 11-38.

Dindar, I., & Erdogan, S. (2007). Screening of Turkish Women for Postpartum Depression Within the First Postpartum Year: The Risk Profile of a Community Sample. *Public Health Nursing, 24*(2), 176-183. doi:10.1111/j.1525-1446.2007.00622.x

Divall, B., & Spiby, H. (2020). Online forums for data collection: ethical challenges from a study exploring women's views of birth plans. Nurse researcher, 28(1).

Doty, A. M. B. (2018). Identification of Approaches to Improve Patient Trust in Health Systems A Group Concept Mapping Study. *Journal of Healthcare Management, 63*(5), e116-e129. doi:10.1097/JHM-D-17-00037

Doty, J. L., & Dworkin, J. (2014). Online Social Support for Parents: A Critical Review. *Marriage & Family Review, 50*(2), 174-198. doi:10.1080/01494929.2013.834027

Doucet, S. A., Letourneau, N. L., & Stoppard, J. M. (2010). Contemporary paradigms for research related to women's mental health. *Health Care for Women International, 31*(4), 296-312.

EdalatiFard, F., Mirghafourvand, M., Mohammad-Alizadeh Charandabi, S., Farshbaf-Khalili, A., Javadzadeh, Y., & Asgharian, H. (2016). Effects of Zinc and Magnesium Supplements on Postpartum Depression and Anxiety: A Randomized Controlled Clinical Trial. *Women Health, 57*(9), 1115–1128. doi: 10.1080/03630242.2016.1235074

Edge, D., & Rogers, A. (2005). Dealing with it: Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. *Social Science & Medicine, 61*(1), 15-25.

Eichhorn, K. C. (2008). Soliciting and Providing Social Support Over the Internet: An Investigation of Online Eating Disorder Support Groups. *Journal of Computer-Mediated Communication, 14*(1), 67-78. doi:10.1111/j.1083-6101.2008.01431.x

Elkhoudri, N., Amor, H., & Baali, A. (2015). Self-reported postpartum morbidity: prevalence and determinants among women in Marrakesh, Morocco. *Reproductive Health, 12*(1), 1.

Ellberg, L., Hogberg, U., & Lindh, V. (2010). 'We feel like one, they see us as two': new parents' discontent with postnatal care. *Midwifery, 26*(4), 463-468. doi:https://doi.org/10.1016/j.midw.2008.10.006

Elliott, S., Sarkar, A., Green, L., & Ross-Davie, M. (2006). A public health role in perinatal mental health: Are midwives ready? *British Journal of Midwifery, 14*(6), 330-334.

Evans, M., Donelle, L., & Hume-Loveland, L. (2012). Social support and online postpartum depression discussion groups: a content analysis. *Patient Educ Couns, 87*(3), 405-410. doi:10.1016/j.pec.2011.09.011

Evenson, K. R., Aytur, S. A., & Borodulin, K. (2009). Physical activity beliefs, barriers, and enablers among postpartum women. *Journal of Women's Health (15409996), 18*(12), 1925-1934. doi:10.1089/jwh.2008.1309

Evenson, K. R., Mottola, M. F., Owe, K. M., Rousham, E. K., & Brown, W. J. (2014). Summary of international guidelines for physical activity after pregnancy. *Obstet Gynecol Surv, 69*(7), 407-414. doi:10.1097/OGX.0000000000000077

Eysenbach, G., & Till, J. E. (2001). Ethical issues in qualitative research on internet communities. *BMJ, 323*(7321), 1103-1105. doi:10.1136/bmj.323.7321.1103

Fahey, J. O., & Shenassa, E. (2013). Understanding and meeting the needs of women in the postpartum period: the Perinatal Maternal Health Promotion Model. *J Midwifery Womens Health, 58*(6), 613-621. doi:10.1111/jmwh.12139

Fairbrother, N., et al. (2016). Perinatal anxiety disorder prevalence and incidence. *Journal of Affective Disorders, 200*, 148-155.

Farpour-Lambert, N. J., Ells, L. J., Martinez de Tejada, B., & Scott, C. (2018). Obesity and Weight Gain in Pregnancy and Postpartum: an Evidence Review of Lifestyle Interventions to Inform Maternal and Child Health Policies. *Front Endocrinol (Lausanne), 9*(546), 546. doi:10.3389/fendo.2018.00546

Feeley, N., Bell, L., Hayton, B., Zelkowitz, P., & Carrier, M.-E. (2016). Care for postpartum depression: What do women and their partners prefer? *Perspectives in Psychiatric Care, 52*(2), 120-130.

Ferdous, J., Ahmed, A., Dasgupta, S. K., Jahan, M., Huda, F. A., Ronsmans, C., . . . Chowdhury, M. E. (2012). Occurrence and Determinants of Postpartum Maternal Morbidities and

Disabilities among Women in Matlab, Bangladesh. *Journal of Health, Population and Nutrition, 30*(2). doi:doi.org/10.3329/jhpn.v30i2.11308

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods, 5*(1), 80-92. doi:10.1177/160940690600500107

Ferrari, R. e., Evenson, K. R., Moos, M. K., Melvin, C. L., & Herring, A. H. (2010). Provider Advice About Weight Loss and Physical Activity in the Postpartum Period*,* 397.

Ferrari, R. (2015). Writing narrative style literature reviews. *Medical Writing, 24*(4), 230-235. doi:10.1179/2047480615Z.000000000329

Field, S., Draper J, Kerr M, & MJ, H. (1983). Women's illness in the postnatal period *Maternal and Child Health Journal*, 302-304.

Filiberto, D., M. (2008). *A Structured conceptualization approach to survey design.* (PhD), Cornell University, Ithaca, New York, USA.

Filippi, V., et al. (2018). A new conceptual framework for maternal morbidity. *International Journal of Gynecology & Obstetrics, 141*, 4-9. doi:10.1002/ijgo.12463

Firoz, T., et al. (2013). Measuring maternal health: focus on maternal morbidity. *Bull World Health Organ, 91*(10), 794-796. doi:https://doi.org/10.2471/BLT.13.117564.

Fisher, J., Cabral de Mello, M., Patel, V., Rahman, A., Tran, T., Holton, S., & Holmes, W. (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bull World Health Organ, 90*(2), 139G-149G. doi:10.2471/BLT.11.091850

Fisher, V. M. (2005). *Help-seeking for depression in rural women: A community portrait.* (Doctor of Philosophy), Virginia Commonwealth University, Richmond, Virginia, USA.

Fleming, C. J. E., & Resick, P. A. (2017). Help-Seeking Behavior in Survivors of Intimate Partner Violence: Toward an Integrated Behavioral Model of Individual Factors. *Violence & Victims, 32*(2), 195-209. doi:10.1891/0886-6708.VV-D-15-00065

Florin, D., et al. (2004). Public involvement in health care. *BMJ, 328*(7432), 159-161. doi:10.1136/bmj.328.7432.159

Flynn, M., & Stana, A. (2012). Social Support in a Men's Online Eating Disorder Forum. *International Journal of Men's Health, 11*(2), 150-169. doi:10.3149/jmh.1102.150

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of health and social behavior*, 219-239.

Fonseca, A., & Canavarro, M. C. (2017). Women's intentions of informal and formal help-seeking for mental health problems during the perinatal period: The role of perceived

encouragement from the partner. *Midwifery, 50*, 78-85. doi:10.1016/j.midw.2017.04.001

Fonseca, A., Gorayeb, R., & Canavarro, M. C. (2015). Women's help-seeking behaviours for depressive symptoms during the perinatal period: Socio-demographic and clinical correlates and perceived barriers to seeking professional help. *Midwifery, 31*(12), 1177-1185.

Forbes, D. A., et al. (1999). Warrantable evidence in nursing science. *Journal of Advanced Nursing, 29*(2), 373-379.

Ford-Gilboe, M., & Campbell, J. (1996). The mother-headed single-parent family: a feminist critique of the nursing literature. *Nursing Outlook, 44*(4), 173-183.

Forster, D. A., McKay, H., Powell, R., Wahlstedt, E., Farrell, T., Ford, R., & McLachlan, H. L. (2016). The structure and organisation of home-based postnatal care in public hospitals in Victoria, Australia: A cross-sectional survey. *Women and Birth, 29*(2), 172-179.

Forster, D. A., McLachlan, H. L., Rayner, J., Yelland, J., Gold, L., & Rayner, S. (2008). The early postnatal period: exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia. *BMC Pregnancy Childbirth, 8*. doi:10.1186/1471-2393-8-27

Forster, D. A., McLachlan, H. L., Yelland, J., Rayner, J., Lumley, J., & Davey, M. A. (2006). Staffing in postnatal units: is it adequate for the provision of quality care? Staff perspectives from a state-wide review of postnatal care in Victoria, Australia. *BMC Health Serv Res, 6*, 83. doi:10.1186/1472-6963-6-83

Forster, D. A., et al. (2016). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy and Childbirth, 16*(1), 28.

Foster, J., Burgos, R., Tejada, C., Caceres, R., Altamonte, A. T., Perez, L. J., . . . Hall, P. (2010). A community-based participatory research approach to explore community perceptions of the quality of maternal-newborn health services in the Dominican Republic. *Midwifery, 26*(5), 504-511. doi:https://doi.org/10.1016/j.midw.2010.06.001

Foulkes, M. (2011). Enablers and barriers to seeking help for a postpartum mood disorder. *J Obstet Gynecol Neonatal Nurs, 40*(4), 450-457. doi:10.1111/j.1552-6909.2011.01264.x

Fowles, E. R., Cheng, H. R., & Mills, S. (2012). Postpartum health promotion interventions: a systematic review. *Nurs Res, 61*(4), 269-282. doi:10.1097/NNR.0b013e3182556d29

Frey, L. R., Botan, C. H., & Kreps, G. L. (2000). Investigating communication: An investigation to research method. In.

Furkin, J. (2018). Mom to mom: online breastfeeding advice. Doctoral dissertation, University of Kentucky.

Gan, E. (2016). TRUE STORY: "I peed on myself several times a day after giving birth". https://www.herworld.com/solutions/true-story-i-peed-myself-several-times-day-after-giving-birth/)

George, M. A., Daniel, M., & Green, L. W. (2006). Appraising and funding participatory research in health promotion. 1998-99. *International Quarterly of Community Health Education, 26*(2), 171-187.

Giallo, R., et al. (2015). Differentiating maternal fatigue and depressive symptoms at six months and four years post partum: Considerations for assessment, diagnosis and intervention. *Midwifery, 31*(2), 316-322.

Gibson, L., & Hanson., V. (2013). 'Digital Motherhood': How Does Technology Support New Mothers? *CHI*. doi:10.1145/2470654.2470700

Giddings, L. S., et al. (2007). A Trojan horse for positivism?: A critique of mixed methods research. *Advances in Nursing Science, 30*(1), 52-60.

Gillberg, C. (2011). A methodological interpretation of feminist pragmatism. In *Contemporary* Feminist Pragmatism, edited by M. Hamington and C. Bardwell-Jones, 217–237. London: Routledge.

Glasheen, C., Colpe, L., Hoffman, V., & Warren, L. (2015). Prevalence of Serious Psychological Distress and Mental Health Treatment in a National Sample of Pregnant and Postpartum Women. *Maternal & Child Health Journal, 19*(1), 204-216. doi:10.1007/s10995-014-1511-2

Glazener, C. M. A., Abdalla, M., Stroud, P., Templeton, A., Russell, I. T., & Naji, S. (1995). Postnatal maternal morbidity: extent, causes, prevention and treatment. *BJOG: An International Journal of Obstetrics and Gynaecology, 102*(4), 282-287. doi:10.1111/j.1471-0528.1995.tb09132.x

Goldfeld, S. R., Wright, M., & Oberklaid, F. (2003). Parents, infants and health care: Utilization of health services in the first 12 months of life. *Journal of Paediatrics and Child Health, 39*(4), 249-253. doi:10.1046/j.1440-1754.2003.00146.x

Goldsmith, D. J. (2000). Soliciting advice: The role of sequential placement in mitigating face threat. *Communication Monographs, 67*(1), 1-19. doi:10.1080/03637750009376492

Goodman, C., Drennan, V., Scheibl, F., Shah, D., Manthorpe, J., Gage, H., & Iliffe, S. (2011). Models of inter professional working for older people living at home: a survey and review of the local strategies of English health and social care statutory organisations. *BMC Health Services Research, 11*(1), 337-337. doi:10.1186/1472-6963-11-337

Goodman, J. H., & Santangelo, G. (2011). Group treatment for postpartum depression: a systematic review. *Arch Womens Ment Health, 14*(4), 277-293. doi:10.1007/s00737-011-0225-3

Goyal, D., Park, V. T., & McNiesh, S. (2015). Postpartum depression among Asian Indian mothers. *MCN The American Journal of Maternal/Child Nursing, 40*(4), 256-261. doi:10.1097/NMC.0000000000000146

Graham, W., et al. (2016). Diversity and divergence: the dynamic burden of poor maternal health. *The Lancet, 388*(10056), 2164-2175. doi:https://doi.org/10.1016/S0140-6736(16)31533-1

Green, B. N., et al. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of chiropractic medicine, 5*(3), 101-117.

Green, F. J. (2009). Coping with Change: Integrating Feminist Praxis with Maternal Health Promotion and Education. *Journal of the Motherhood Initiative for Research and Community Involvement, 11*(1).

Green, L. W., George, A., Daniel, M., Frankish, J., & Herbert, C. J. (1995). Study of participatory research in health promotion : review and recommendations for the development of participatory research in health promotion in Canada: [Ottawa] : Royal Society of Canada.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis, 11*(3), 255-274.

Greenhalgh, T. M. (2016). Understanding research methods for evidence-based practice in health. [electronic resource]: JW Wiley.

Grimes, H. A., Forster, D. A., & Newton, M. S. (2014). Sources of information used by women during pregnancy to meet their information needs. *Midwifery, 30*, e26-e33. doi:10.1016/j.midw.2013.8.007

Guerra-Reyes, L., Christie, V. M., Prabhakar, A., Harris, A. L., & Siek, K. A. (2016). Postpartum Health Information Seeking Using Mobile Phones: Experiences of Low-Income Mothers. *Maternal and Child Health Journal, 20*(1), 13-21. doi:10.1007/s10995-016-2185-8

Guest, G. (2013). Describing mixed methods research: An alternative to typologies. *Journal of Mixed Methods Research, 7*(2), 141-151.

Gunther, E., et al. (2001). Ethical Issues In Qualitative Research On Internet Communities. *BMJ: British Medical Journal*(7321), 1103.

Guillot, E. E. (1964). Patterns of help for post-partum mothers. *Children, 11*, 147-151.

Guliani, H. (2015). Mix of Maternity Care Providers in Canada. *Healthcare Policy, 11*(1), 46-60.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2012). Barriers and facilitators to mental health help-seeking for young elite athletes: a qualitative study. *BMC Psychiatry, 12*(1), 157.

Gunn, J. (2003). Guidelines for assessing postnatal problems: introducing evidence-based guidelines in Australian general practice. *Family Practice, 20*(4), 382-389. doi:10.1093/fampra/cmg408

Gunn, J., Hegarty, K., Nagle, C., Forster, D., Brown, S., & Lumley, J. (2006). Putting woman-centered care into practice: a new (ANEW) approach to psychosocial risk assessment during pregnancy. *Birth, 33*(1), 46-55. doi:10.1111/j.0730-7659.2006.00073.x

Gutiérrez, V. B. (2019). Lack of care? Women's experiences of maternity bladder management. *British Journal of Midwifery, 27*(1), 15-25. doi:10.12968/bjom.2019.27.1.15

Guy, S., Sterling, B. S., Walker, L. O., & Harrison, T. C. (2014). Mental Health Literacy and Postpartum Depression: A Qualitative Description of Views of Lower Income Women. *Archives of Psychiatric Nursing, 28*(4), 256-262. doi:10.1016/j.apnu.2014.04.001

Hadjigeorgiou, E., & Coxon, K. (2014). In Cyprus, 'midwifery is dying...'. A qualitative exploration of midwives' perceptions of their role as advocates for normal childbirth. *Midwifery, 30*(9), 983-990. doi:10.1016/j.midw.2013.08.009

Hall, B. L. (1992). From margins to center? The development and purpose of participatory research. *The American Sociologist, 23*(4), 15-28. doi:10.1007/bf02691928

Hall, W., & Irvine, V. (2009). E-communication among mothers of infants and toddlers in a community-based cohort: a content analysis. *J Adv Nurs, 65*(1), 175-183. doi: 10.1111/j.1365-2648.2008.04856.x

Hannes, K., & Lockwood, C. (2011). Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *J Adv Nurs, 67*(7), 1632-1642. doi:10.1111/j.1365-2648.2011.05636.x

Haran, C., van Driel, M., Mitchell, B. L., & Brodribb, W. E. (2014). Clinical guidelines for postpartum women and infants in primary care–a systematic review. *BMC Pregnancy and Childbirth, 14*(1), 1-9. doi:10.1186/1471-2393-14-51

Hardee, K., Gay, J., & Blanc, A. K. (2012). Maternal morbidity: neglected dimension of safe motherhood in the developing world. *Glob Public Health, 7*(6), 603-617. doi:DOI: 10.1080/17441692.2012.668919

Harden, A., & Thomas, J. (2005). Methodological Issues in Combining Diverse Study Types in Systematic Reviews. *International Journal of Social Research Methodology, 8*(3), 257-271. doi:10.1080/13645570500155078

Harding, S. G. (1987). *Feminism and methodology: Social science issues*: Indiana University Press.

Hartley, S., Sutherland, G., Brown, S., & Yelland, J. (2012). 'You're more likely to tell the GP if you're asked': women's views of care from general practitioners in the first postpartum year. *Aust J Prim Health, 18*(4), 308-312. doi:http://dx.doi.org/10.1071/PY11111

Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database Syst Rev*(4), CD004667. doi:10.1002/14651858.CD004667.pub2.

Hathcoat, J. D., & Meixner, C. (2015). Pragmatism, Factor Analysis, and the Conditional Incompatibility Thesis in Mixed Methods Research. *Journal of Mixed Methods Research*. doi:10.1177/1558689815622114

Henderson, E. M., Rosser, B. A., Keogh, E., & Eccleston, C. (2012). Internet Sites Offering Adolescents Help With Headache, Abdominal Pain, and Dysmenorrhoea: A Description of Content, Quality, and Peer Interactions*,* 262.

Herron-Marx, S., Williams, A., & Hicks, C. (2007). AQ methodology study of women's experience of enduring postnatal perineal and pelvic floor morbidity. *Midwifery, 23*(3), 322-334.

Hetherington, E., et al. (2020). Trajectories of social support in pregnancy and early postpartum: findings from the All Our Families cohort. *Social Psychiatry and Psychiatric Epidemiology, 55*(2), 259-267.

Higgins, A., et al. (2016). Impact of perinatal mental health education on student midwives' knowledge, skills and attitudes: A pre/post evaluation of a module of study. *Nurse Education Today, 36*, 364-369.

Higgins, A., et al. (2016). Mothers with mental health problems: Contrasting experiences of support within maternity services in the Republic of Ireland. *Midwifery, 36*, 28-34.

Hill, S., Tapley, A., van Driel, M. L., Holliday, E. G., Ball, J., Davey, A., . . . Magin, P. (2019). Australian general practice registrars and their experience with postpartum consultations: A cross-sectional analysis of prevalence and associations. *Aust N Z J Obstet Gynaecol*. doi:10.1111/ajo.13034

Himes, K. P., et al. (2017). Healthy beyond pregnancy, a web-based intervention to improve adherence to postpartum care: randomized controlled feasibility trial. *JMIR human factors, 4*(4), e26.

Hoang, H., & Le, Q. (2013). Comprehensive picture of rural women's needs in maternity care in Tasmania, Australia. *Australian Journal of Rural Health, 21*(4), 197-202 196p. doi:10.1111/ajr.12043

Hoang, H., Le, Q., & Terry, D. (2014). Women's access needs in maternity care in rural Tasmania, Australia: a mixed methods study. *Women Birth, 27*(1), 9-14. doi:10.1016/j.wombi.2013.02.001

Hoffman, T., Benne, S., & Del Mar, C. (2013). *evidence - based practice across the health professions* (2nd ed.). Australia,NSW: churchil livingstone.

Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., . . . Murray, C. J. L. (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet, 375*(9726), 1609-1623. doi:10.1016/s0140-6736(10)60518-1

Hohman, M., & Loughran, H. (2013). What Do Female Clients Want From Residential Treatment? The Relationship Between Expressed and Assessed Needs, Psychosocial Characteristics, and Program Outcome. *Journal of Dual Diagnosis, 9*(1), 3-10. doi:10.1080/15504263.2012.749164

Hollowell, J., et al. (2011). Birthplace programme overview: background, component studies and summary of findings.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qual Health Res, 15*(9), 1277-1288. doi:10.1177/1049732305276687

Husbands, L. (2008). Blogging the Maternal: Self-Representations of the Pregnant and Postpartum Body. *Atlantis, 32*(2).

INVOLVE. (2012). *What is public involvement in research?* Retrieved from https://www.invo.org.uk/find-out-more/what-is-public-involvement-in-research-2/.

Ioannidis, J. P. (2016). Why Most Clinical Research Is Not Useful. *PLoS Med, 13*(6), e1002049. doi:10.1371/journal.pmed.1002049

Israel, B. A., Eng, E., Schulz, A., & Parker, E. A. (2012). Introduction to methods for CBPR for health. In D. Satcher (Ed.), *Methods for community-based participatory research for health* (second ed., pp. 681). San FranciscoUSA: Jossey-Bass.

Jackson, D., et al. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice, 10*(4), 150-158.

Jackson, D., Mannix, J., Faga, P., & Gillies, D. (2005). Raising Families: Urban women's experiences of requiring support. *Contemporary Nurse, 18*(1-2), 97-107.

Jacobs, L. C. (2017). *Help-seeking behaviour of women with urinary incontinence.* (degree of Master of Science), Stellenbosch University, Stellenbosch, South Africa.

Jang, J., Dworkin, J., & Hessel, H. (2015). Mothers' Use of Information and Communication Technologies for Information Seeking. *CyberPsychology, Behavior & Social Networking, 18*(4), 221-227. doi:10.1089/cyber.2014.0533

Jarrett, P. (2015). Student midwives' knowledge of perinatal mental health. *British Journal of Midwifery, 23*(1), 32-39.

JBI. (2014). Joanna Briggs Institute reviewers' manual: 2014 edition. *Australia: The Joanna Briggs Institute*.

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. American Journal of Pharmaceutical Education, 84(1).

Johnson, K., et al. (2013). Rethinking concepts in participatory action research and their potential for social transformation: Post-structuralist informed methodological reflections from LGBT and trans-collective projects. *Journal of Community & Applied Social Psychology, 23*(5), 405-419.

Johansson, M., et al. (2020). Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: a qualitative study. *International Journal of Qualitative Studies on Health and Well-being, 15*(1), 1722564.

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research, 1*(2), 112-133. doi:10.1177/1558689806298224

Jones, C. J., Creedy, D. K., & Gamble, J. A. (2011). Australian Midwives' Knowledge of Antenatal and Postpartum Depression: A National Survey. *Journal of Midwifery & Women's Health, 56*(4), 353-361. doi:10.1111/j.1542-2011.2011.00039.x

Jones, C. J., et al. (2012). Australian midwives' attitudes towards care for women with emotional distress. *Midwifery, 28*(2), 216-221.

Jones, E., Taylor, B., MacArthur, C., Pritchett, R., & Cummins, C. (2016). The effect of early postnatal discharge from hospital for women and infants: a systematic review protocol. *Syst Rev, 5*, 24. doi:10.1186/s13643-016-0193-9

Jordan, B. (1997). Authoritative knowledge and its construction. *Childbirth and authoritative knowledge: Cross-cultural perspectives*, 55-79.

Jurášková, M., et al. (2020). Association between Stress Urinary Incontinence and Depressive Symptoms after Birth: the Czech ELSPAC Study. *Scientific Reports, 10*(1), 6233. doi:10.1038/s41598-020-62589-5

Kabakian-Khasholian, T., & Campbell, O. M. (2005). A simple way to increase service use: triggers of women's uptake of postpartum services. *BJOG, 112*(9), 1315-1321. doi:10.1111/j.1471-0528.2004.00507.x

Kabakian-Khasholian, T., Shayboub, R., & Ataya, A. (2014). Health after childbirth: patterns of reported postpartum morbidity from Lebanon. *Women Birth, 27*(1), 15-20. doi:http://dx.doi.org/10.1016/j.wombi.2013.02.002

Kadushin, C. (2004). Introduction to social network theory. *Boston, Ma*.

Kaitz, M. (2007). Maternal concerns during early parenthood. *Child: Care, Health and Development, 33*(6), 720-727. doi:10.1111/j.1365-2214.2007.00729.x

Kane, et al. (2009). Concept Mapping for Applied Social Research. In L. B. D. J. Rog (Ed.), *The SAGE Handbook of Applied Social Research Methods* (pp. 413-434): SAGE Publications, Inc.

Kane, M., & Trochim, W. (2009). Concept Mapping for Applied Social Research. In L. B. D. J. Rog (Ed.), *The SAGE Handbook of Applied Social Research Methods* (pp. 435-475).

Kane, & Trochim. (2009). Concept Mapping for Applied Social Research. In L. B. D. J. Rog (Ed.), *The SAGE Handbook of Applied Social Research Methods* (pp. 413-434): SAGE Publications, Inc.

Kauer, S. D., Mangan, C., & Sanci, L. (2014). Do online mental health services improve help-seeking for young people? A systematic review. *Journal of Medical Internet Research, 16*(3), e66.

Kendal, S., Kirk, S., Elvey, R., Catchpole, R., & Pryjmachuk, S. (2017). How a moderated online discussion forum facilitates support for young people with eating disorders. *Health Expectations, 20*(1), 98-111. doi:10.1111/hex.12439

Khajehei, M., Doherty, M., Tilley, P. J. M., & Sauer, K. (2015). Prevalence and risk factors of sexual dysfunction in postpartum Australian women. *The Journal Of Sexual Medicine, 12*(6), 1415-1426. doi:10.1111/jsm.12901

Khalaf, I. A., Abu-Moghli, F. A., Callister, L. C., Mahadeen, A. I., Kaawa, K., & Zomot, A. F. (2009). Jordanian health care providers' perceptions of post-partum health care. *International Nursing Review, 56*(4), 442-449. doi:10.1111/j.1466-7657.2009.00733.x

Kim, Y., & Dee, V. (2016). Self-Care for Health in Rural Hispanic Women at Risk for Postpartum Depression. *Matern Child Health J*. doi:10.1007/s10995-016-2096-8

Kitzinger, S. (1975). The fourth trimester? *Midwife, health visitor & community nurse, 11*(4), 118.

Klainin, P., & Arthur, D. G. (2009). Postpartum depression in Asian cultures: a literature review. *Int J Nurs Stud, 46*(10), 1355-1373. doi:10.1016/j.ijnurstu.2009.02.012

Klima, C. S. (2001). Women's health care: a new paradigm for the 21st century. *The Journal of Midwifery & Women's Health, 46*(5), 285-291.

Koblinsky, M., et al. (2012). Maternal morbidity and disability and their consequences: neglected agenda in maternal health. *J Health Popul Nutr, 30*(2), 124-130. doi:10.3329/jhpn.v30i2.11294

Koch, L. H. (2006). Help-seeking behaviors of women with urinary incontinence: an integrative literature review. *Journal of Midwifery & Women's Health, 51*(6), e39-e44.

Koss, J., et al. (2016). Influence of perinatal depression on labor-associated fear and emotional attachment to the child in high-risk pregnancies and the first days after delivery.

Medical Science Monitor: International Medical Journal of Experimental and Clinical Research, 22, 1028.

Kuhlmann, E., & Babitsch, B. (2002). *Bodies, health, gender—bridging feminist theories and women's health.* Paper presented at the Women's Studies International Forum.

Kuruvilla, S., et al. (2016). The Global strategy for women's, children's and adolescents' health (2016-2030): a roadmap based on evidence and country experience. *Bull World Health Organ, 94*(5), 398-400. doi:10.2471/BLT.16.170431

Lange, I. L., et al. (2019). What maternal morbidities are and what they mean for women: A thematic analysis of twenty years of qualitative research in low and lower-middle income countries. *PLoS One, 14*(4), e0214199.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*: Springer publishing company.

Leah, L. A. (2000). Health problems after childbirth. *Journal of Midwifery & Women's Health, 45*(1), 55-57. doi:doi:10.1016/S1526-9523(99)00003-3

Leavitt, J. W. (1983). " Science" Enters the Birthing Room: Obstetrics in America since the Eighteenth Century. *The Journal of American History, 70*(2), 281-304.

Leavitt, J. W. (1986). Under the shadow of maternity: American women's responses to death and debility fears in nineteenth-century childbirth. *Feminist Studies, 12*(1), 129-154.

Lee, A., & Brann, L. (2015). Influence of Cultural Beliefs on Infant Feeding, Postpartum and Childcare Practices among Chinese-American Mothers in New York City. *Journal of Community Health, 40*(3), 476-483. doi:10.1007/s10900-014-9959-y

Legg, C., et al. (2008). Pragmatism. In E. N. Z. (ed.) (Ed.), *Stanford encyclopedia of philosophy*.

Lepire, E., & Hatem, M. (2007). Adaptation and use of health services by primiparous women with urinary incontinence. *Journal of obstetric, gynecologic, and neonatal nursing, 36*(3), 222-230. doi:10.1111/j.1552-6909.2007.00143.x

Leventhal, H., Nerenz, D., Steele, D., Baum, A., & Singer, J. (1984). Handbook of psychology and health. *A handbook of psychology and health, 4*.

Levine, L. (1984). The Limits of Feminism. Social Analysis: The International Journal of Social and Cultural Practice(15), 11-19.

Levitt, C., Shaw, E., Wong, S., Kaczorowski, J., Springate, R., Sellors, J., . . . McMaster University Postpartum Research, G. (2004). Systematic review of the literature on postpartum care: methodology and literature search results. *Birth, 31*(3), 196-202. doi:10.1111/j.0730-7659.2004.00305.x

Lewin, K. (1946). Action Research and Minority Problems. *Journal of Social Issues, 2*(4), 34-46. doi:10.1111/j.1540-4560.1946.tb02295.x

Lewis, J. A., & Kinser, P. A. (2005). Understanding gender construction: creating space for feminist health care practice and research. *Health Care for Women International, 26*(5), 422-429.

Li, F. L. W., Low, L. P. L., & Lee, D. T. F. (2007). Coping with stress incontinence: women's experiences of everyday inconveniences. *International Journal of Urological Nursing, 1*(3), 112-119.

Liepins, R. (2000). Making men: the construction and representation of agriculture-based masculinities in Australia and New Zealand. *Rural sociology, 65*(4), 605-620.

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare, 13*(3), 179-187. doi:10.1097/xeb.0000000000000062

Lozano, R., et al. (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *The Lancet, 378*(9797), 1139-1165. doi:http://dx.doi.org/10.1016/S0140-6736(11)61337-8

Lucas, C., Charlton, K., Brown, L., Brock, E., & Cummins, L. (2015). Review of patient satisfaction with services provided by general practitioners in an antenatal shared care program. *Australian Family Physician*(5), 317.

Lupton, D. (2016). The use and value of digital media for information about pregnancy and early motherhood: a focus group study. *BMC Pregnancy Childbirth, 16*(1), 171. doi:10.1186/s12884-016-0971-3

Lupton, D., Pedersen, S., & Thomas, G. M. (2016). Parenting and Digital Media: From the Early Web to Contemporary Digital Society. *Sociology Compass, 10*(8), 730-743. doi:10.1111/soc4.12398

Lupton, D. A. (2011). 'The best thing for the infant': Mothers' concepts and experiences related to promoting their infants' health and development. *Health, risk & society, 13*(7-8), 637-651.

Macarthur, C., lewis M, & Knox G. (1991). health after childbirth: an investigation of long term health problems beginning after childbirth in 11701 women. (Vol. 1). london: HMSO.

MacArthur, C., Winter, H. R., Bick, D. E., Knowles, H., Lilford, R., Henderson, C., . . . Gee, H. (2002). Effects of redesigned community postnatal care on womens' health 4 months after birth: a cluster randomised controlled trial. *The Lancet, 359*(9304), 378-385. doi:10.1016/s0140-6736(02)07596-7

McCauley, M., et al. (2020). 'Good health means being mentally, socially, emotionally and physically fit': women's understanding of health and ill health during and after pregnancy in India and Pakistan: a qualitative study. *BMJ open, 10*(1).

Magaard, J. L., Seeralan, T., Schulz, H., & Brütt, A. L. (2017). Factors associated with help-seeking behaviour among individuals with major depression: A systematic review. *PLoS One, 12*(5), 1-17. doi:10.1371/journal.pone.0176730

Maher, J., & Souter, K. (2006). 'It's much easier to get help for the infant': Women, postpartum health and maternal and child health care groups. *Health Sociology Review, 15*(1), 104-111. doi:10.5172/hesr.2006.15.1.104

Maneze, D., DiGiacomo, M., Davidson, P. M., Salamonson, Y., Everett, B., & Poudel, C. (2016). Health-Seeking Behaviors of Filipino Migrants in Australia: The Influence of Persisting Acculturative Stress and Depression. *Journal of Immigrant and Minority Health, 18*(4), 779-786. doi:10.1007/s10903-015-0233-x

Martin, A., Horowitz, C., Balbierz, A., & Howell, E. (2014). Views of Women and Clinicians on Postpartum Preparation and Recovery. *Maternal & Child Health Journal, 18*(3), 707-713. doi:10.1007/s10995-013-1297-7

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-526.

Mason, K. (2003). The family GP: a valued resource for families with young babies. *Australian Family Physician, 32*(10).

Mason, L., Glenn, S., Walton, I., & Appleton, C. (1999). The experience of stress incontinence after childbirth. *Birth (Berkeley, Calif.), 26*(3), 164-171. doi:10.1046/j.1523-536x.1999.00164.x

Mason, L., Glenn, S., Walton, I., & Hughes, C. (2001). Women's reluctance to seek help for stress incontinence during pregnancy and following childbirth. *Midwifery, 17*(3), 212-221. doi:10.1054/midw.2001.0259

Mazzo, D., Soares, M., H., & Brito, s. (2015). Empirical indicators of the affected human needs of puerperal women: Validation by focus group. *Online Brazilian Journal of Nursing, 14*(1), 41-50.

Mbwili-Muleya, C., Gunn, J., & Jenkins, M. (2000). General practitioners: Their contact with maternal and child health nurses in postnatal care. *Journal of Paediatrics and Child Health, 36*(2), 159-163. doi:10.1046/j.1440-1754.2000.00467.x

McCallum, S. M., Rowe, H. J., Gurrin, L., Quinlivan, J. A., Rosenthal, D. A., & Fisher, J. R. (2011). Unsettled infant behaviour and health service use: a cross-sectional community survey in Melbourne, Australia. *J Paediatr Child Health, 47*. doi:10.1111/j.1440-1754.2011.02032.x

McCauley, K., Elsom, S., Muir-Cochrane, E., & Lyneham, J. (2011). Midwives and assessment of perinatal mental health. *Journal of Psychiatric & Mental Health Nursing, 18*(9), 786-795. doi:10.1111/j.1365-2850.2011.01727.x

McDermott, J. j. (1981). The Philosophy of John Dewey. Vol 1, The Structure of Experience. Vol. 2, The Lived Experience / ed. with an introd. and. comment. by John J. McDermott. Chicago: University of Chicago Press.

McGovern, P., Dowd, B., Gjerdingen, D., Dagher, R., Ukestad, L., McCaffrey, D., & Lundberg, U. (2007). Mothers' health and work-related factors at 11 weeks postpartum. *Ann Fam Med, 5*(6), 519-527. doi:http://dx.doi.org/10.1370/afm.751

McIntosh, J. (1993). Postpartum depression: women's help-seeking behaviour and perceptions of cause. *Journal of Advanced Nursing, 18*(2), 178-184.

McLachlan, H. L., Gold, L., Forster, D. A., Yelland, J., Rayner, J., & Rayner, S. (2009). Women's views of postnatal care in the context of the increasing pressure on postnatal beds in Australia. *Women Birth, 22*. doi:10.1016/j.wombi.2009.04.003

McQueen, A., et al. (2003). Tiredness and fatigue in the postnatal period. *Journal of Advanced Nursing, 42*(5), 463-469.

Meaney, S., Lutomski, J. E., O'Connor, L., O'Donoghue, K., & Greene, R. A. (2016). Women's experience of maternal morbidity: a qualitative analysis. *BMC Pregnancy and Childbirth, 16*(1), 184.

Medicare Local Tasmania. (2012). Maternity Shared Care Resource, For General Practitioners.

Menard, M. K., Kilpatrick, S., Saade, G., Hollier, L. M., Joseph Jr, G. F., Barfield, W., . . . Conry, J. (2015). Levels of maternal care. *American Journal of Obstetrics and Gynecology, 212*(3), 259-271. doi:http://dx.doi.org/10.1016/j.ajog.2014.12.030

Mercer, R. T. (2004). Becoming a Mother Versus Maternal Role Attainment. *Journal of Nursing Scholarship, 36*(3), 226-232. doi:10.1111/j.1547-5069.2004.04042.x

Merry, L. A., Gagnon, A. J., Kalim, N., & Bouris, S. S. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health, 102*(4), 286-290.

Michaelidou, N., et al. (2020). Users' ethical perceptions of social media research: Conceptualisation and measurement. *Journal of Business Research*.

Miller, B. J., Murray, L., Beckmann, M. M., Kent, T., & Macfarlane, B. (2013). Dietary supplements for preventing postnatal depression. *Cochrane Database Syst Rev, 10*, CD009104. doi:10.1002/14651858.CD009104.pub2

Mobley, S., Thomas, S., Sutherland, D., Hudgins, J., Ange, B., & Johnson, M. (2014). Maternal Health Literacy Progression Among Rural Perinatal Women. *Maternal & Child Health Journal, 18*(8), 1881-1892. doi:10.1007/s10995-014-1432-0

Mohamad Yusuff, A. S., Tang, L., Binns, C. W., & Lee, A. H. (2015). Prevalence and risk factors for postnatal depression in Sabah, Malaysia: a cohort study. *Women Birth, 28*(1), 25-29. doi:http://dx.doi.org/10.1016/j.wombi.2014.11.002

Mollard, E. (2015). Exploring Paradigms in Postpartum Depression Research: The Need for Feminist Pragmatism. *Health Care for Women International, 36*(4), 378-391. doi:10.1080/07399332.2014.903951

Moran, P. S., et al. (2020). Economic burden of maternal morbidity–A systematic review of cost-of-illness studies. *PLoS One, 15*(1), e0227377.

Moreno, M. A., Goniu, N., Diekema, D., & Moreno, P. S. (2013). Ethics of social media research: Common concerns and practical considerations. *Cyberpsychology, Behavior, and Social Networking, 16*(9), 708-713. doi:10.1089/cyber.2012.0334

Morgan, D. L. (2007). Paradigms Lost and Pragmatism Regained: Methodological Implications of Combining Qualitative and Quantitative Methods. *Journal of Mixed Methods Research, 1*(1), 48-76. doi:10.1177/2345678906292462

Moreno, M. A., et al. (2013). Ethics of social media research: Common concerns and practical considerations. *Cyberpsychology, Behavior, and Social Networking, 16*(9), 708-713. doi:10.1089/cyber.2012.0334

Mullin, A. (2005). Reconceiving pregnancy and childcare: Ethics, experience, and reproductive labor: Cambridge University Press.

Nabitz, U., Van Den Brink, W., & Jansen, P. (2005). Using concept mapping to design an indicator framework for addiction treatment centres. *Int J Qual Health Care, 17*(3), 193-201. doi:10.1093/intqhc/mzi037

Naohiro, Y., Dowswell, T., Shuko, N., & Rintaro, M. (2014). Cochrane in context: Schedules for home visits in the early postpartum period. *Evidence-Based Child Health, 9*(1), 100-102. doi:10.1002/ebch.1957

Nascimento, S. L., Pudwell, J., Surita, F. G., Adamo, K. B., & Smith, G. N. (2013). The effect of physical exercise strategies on weight loss in postpartum women: a systematic review and meta-analysis. *International Journal Of Obesity, 38*, 626. doi:10.1038/ijo.2013.183.

National Institute for Health and Care Excellence 2015. Postnatal care up to 8 weeks after birth. Clinical guideline. Published: 23 July 2006. www.nice.org.uk/guidance/cg37

Navodani, T., Gartland, D., Brown, S. J., Riggs, E., & Yelland, J. (2019). Common maternal health problems among Australian-born and migrant women: A prospective cohort study. *PLoS One, 14*(2), e0211685.

Negron, R., Martin, A., Almog, M., Balbierz, A., & Howell, E. A. (2013). Social support during the postpartum period: mothers' views on needs, expectations, and mobilization of support. *Matern Child Health J, 17*. doi:10.1007/s10995-012-1037-4

Ngai, F. W., Chan, S. W., & Holroyd, E. (2012). Maternal coping during early motherhood among first-time Chinese mothers. *J Health Psychol, 17*(2), 189-196. doi:10.1177/1359105311415728

NHS England. (2016). *Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/.

Niela-Vilen, H., Axelin, A., Salantera, S., & Melender, H. L. (2014). Internet-based peer support for parents: a systematic integrative review. *Int J Nurs Stud, 51*(11), 1524-1537. doi:http://dx.doi.org/10.1016/j.ijnurstu.2014.06.009

Nilaweera, I., Rowe, H., Hau, N., Burns, J., Doran, F., & Fisher, J. (2016). Sri Lankan-born women who have given birth in Victoria: a survey of their primary postpartum health-care needs. *Australian Journal Of Primary Health, 22*(2), 133-139. doi:10.1071/PY14067

Nirje, B. (1994). The Normalization Principle and Its Human Management Implications. *The International Social Role Valorization Journal, 1*(2), 19-23.

Nolan, M. L., Mason, V., Snow, S., Messenger, W., Catling, J., & Upton, P. (2012). Making friends at antenatal classes: a qualitative exploration of friendship across the transition to motherhood. *J Perinat Educ, 21*(3), 178-185. doi:10.1891/1058-1243.21.3.178

Nolan, S., Hendricks, J., & Towell, A. (2015). Social networking sites (SNS); exploring their uses and associated value for adolescent mothers in Western Australia in terms of social support provision and building social capital. *Midwifery, 31*(9), 912-919. doi:https://doi.org/10.1016/j.midw.2015.05.002

Nowell, L. (2015). Pragmatism and integrated knowledge translation: exploring the compatabilities and tensions. *Nurs Open, 2*(3), 141-148. doi:10.1002/nop2.30

Nutbeam, D. (1998). Health promotion glossary. *Health Promotion International, 13*(4), 349-364.

NVivo 12. (2018). QSR International Pty Ltd. NVivo qualitative data analysis Software. (Version Version 12.).

O'Brien, B., Chalmers, B., Fell, D., Heaman, M., Darling, E. K., & Herbert, P. (2011). The Experience of Pregnancy and Birth with Midwives: Results from the Canadian Maternity Experiences Survey. *Birth: Issues in Perinatal Care, 38*(3), 207.

O'Mahen, H. A., & Flynn, H. A. (2008). Preferences and perceived barriers to treatment for depression during the perinatal period. *J Womens Health (Larchmt), 17*(8), 1301-1309. doi:10.1089/jwh.2007.0631

O'Brien, M. L., Buikstra, E., Fallon, T., & Hegney, D. (2009). Strategies for success: a toolbox of coping strategies used by breastfeeding women. *Journal of Clinical Nursing, 18*(11), 1574-1582.

O'Malley, D., et al. (2018). Prevalence of and risk factors associated with sexual health issues in primiparous women at 6 and 12 months postpartum; a longitudinal prospective

cohort study (the MAMMI study). *BMC Pregnancy and Childbirth, 18*(1), 196. doi:10.1186/s12884-018-1838-6

O'Neill, A. T., Hockey, J., O'Brien, P., Williams, A., Morris, T. P., Khan, T., . . . Yoong, W. (2017). Knowledge of pelvic floor problems: a study of third trimester, primiparous women. *International Urogynecology Journal, 28*(1), 125-129. doi:10.1007/s00192-016-3087-4

Ogden, J., Boden, J., Caird, R., Chor, C., Flynn, M., Hunt, M., . . . Thapar, V. (1999). 'You're depressed'; 'No I'm not': GPs' and patients' different models of depression. *British Journal of General Practice, 49*(439), 123-124.

The Oxford English Reference Dictionary. (2000) (Vols. 113). Madavor Media.

Onwuegbuzie, A. J., et al. (2004). Enhancing the interpretation of "significant" findings: The role of mixed methods research. *The Qualitative Report, 9*(4), 770-792.

Onwuegbuzie, A. J., et al. (2007). Sampling designs in qualitative research: Making the sampling process more public. *Qualitative Report, 12*(2), 238-254.

Parento, E. W. (2012). HEALTH EQUITY, HEALTHY PEOPLE 2020, AND COERCIVE LEGAL MECHANISMS AS NECESSARY FOR THE ACHIEVEMENT OF BOTH. *Loyola Law Review, 58*, 655.

Parker, M. E. (2005). *Nursing Theories and Nursing Practice* (Vol. 2nd ed). Philadelphia: F.A. Davis Company.

Parry, D. C., Troy D. Glover, & Mulcahy, C. M. (2013). From ʒStroller-Stalkerʒ to ʒMomancerʒ. *Journal of Leisure Research*. doi: 10.18666/jlr-2013-v45i1-2941

Patton, M. Q. (2015). Qualitative research & evaluation methods : integrating theory and practice: Thousand Oaks, Calif : SAGE. Fourth edition.

Peahl, A. F., et al. (2020). Patient Preferences for Prenatal and Postpartum Care Delivery: A Survey of Postpartum Women. *Obstetrics & Gynecology, 135*(5), 1038-1046. doi:10.1097/aog.0000000000003731

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery, 62*, 220-229.

Perry, P. A. (1994). Feminist empiricism as a method for inquiry in nursing. *Western Journal of Nursing Research, 16*(5), 480-494.

Pescosolido, B. A., & Boyer, C. A. (1999). How do people come to use mental health services? Current knowledge and changing perspectives.

Petersen, E. E., et al. (2019). Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017. *Morbidity and Mortality Weekly Report, 68*(18), 423.

Petersen, K. K. (1989). Labor Pains: Modern Midwives and Home Birth. Deborah A. Sullivan Rose Weitz (Vol. 67): University of North Carolina Press.

Phang, K. N., Koh, S., & Chen, H. (2015). Postpartum social support of women in Singapore: A pilot study. *International Journal of Nursing Practice, 21*, 99-107. doi:10.1111/ijn.12340

Plantin, L., & Daneback, K. (2009). Parenthood, information and support on the internet. A literature review of research on parents and professionals online. *BMC Fam Pract, 10*, 34. doi:10.1186/1471-2296-10-34

Porter, N., & Ispa, J. M. (2013). Mothers' online message board questions about parenting infants and toddlers. *Journal of Advanced Nursing, 69*(3), 559-568. doi:doi:10.1111/j.1365-2648.2012.06030.x

Powell, D. N., et al. (2019). Expectations, experiences, and desires: Mothers' perceptions of the division of caregiving and their postnatal adaptation. *Journal of Family Psychology, 33*(4), 401.

Preston, H., Jaye, C., & Miller, B. J. (2015). General practice registrars' views on maternity care in general practice in New Zealand. *J PRIM HEALTH CARE, 7*(4), 316-323.

Report of the Prime Minister's Commission (2010). Front Line Care: the future of nursing and midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010. (978-0-9565138-1-6). London: COI for the Prime Minister's Commission on the Future of Nursing and Midwifery in England. First published March 2010.

Rezaie-Keikhaie, K., et al. (2020). Systematic Review and Meta-Analysis of the Prevalence of the Maternity Blues in the Postpartum Period. *J Obstet Gynecol Neonatal Nurs, 49*(2), 127-136. doi:https://doi.org/10.1016/j.jogn.2020.01.001

Rich, A. (1995). Of woman born: Motherhood as experience and institution: WW Norton & Company.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Advances in Mental Health, 4*(3), 218-251. doi:10.5172/jamh.4.3.218

Robinson, C. A. (1993). Managing Life with a Chronic Condition: The Story of Normalization. *Qualitative Health Research, 3*(1), 6-28. doi:10.1177/104973239300300102

Romanno, M., Cacciatore, A., Giordano, R., La Rosa, B., & (2010). Postpartum period: Three distinct but continuous phases. . *Journal of prenatal medicine, 4*(2), 22-25.

Ronsmans, C., & Graham, W. J. (2006). Maternal mortality: who, when, where, and why. *The Lancet, 368*(9542), 1189-1200. doi:https://doi.org/10.1016/S0140-6736(06)69380-X

Rooney, P. (1993). Feminist-Pragmatist Revisionings of Reason, Knowledge, and Philosophy. *Hypatia, 8*(2), 15-37.

Rosas, S. R., & Kane, M. (2012). Quality and rigor of the concept mapping methodology: a pooled study analysis. *Eval Program Plann, 35*(2), 236-245. doi:10.1016/j.evalprogplan.2011.10.003

Rosenstock, I. (1966). Why people use health services. The Milbank Memorial Fund Quarterly, 44, 94–127. In.

Rouhi, M., Heravi, M., Usefi, H., Salehi, K., Habibzadeh, S., & Shojaee, M. (2012). Prevalence and persistence of health problems after child birth and maternal correlations with parity. *Journal of health promotion management, 1*(4), 10.

Rouhi, M., Mohammed-alizadeh , S., Usefi, H., & Rouhi, N. (2011). Postpartum morbidity and help-seeking behaviours in Iran. *British Journal of Midwifery, 19*(3), 178-184. doi:10.12968/bjom.2011.19.3.178

Rouhi, M., Rouhi, N., Mohamadpour, S., & Tajrishi, H. P.-R. (2018). Vitamin D reduces postpartum depression and fatigue among Iranian women. *British Journal of Midwifery, 26*(12), 787-793. doi:10.12968/bjom.2018.26.12.787

Rouhi, M., Rouhi, N., Vizheh, M., & Salehi, K. (2017). Male child preference: Is it a risk factor for antenatal depression among Iranian women? *British Journal of Midwifery, 25*(9), 572-578. doi:10.12968/bjom.2017.25.9.572

Rouhi, M., Stirling, C., Ayton, J., & Crisp, E. P. (2019). Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review. *Midwifery, 72*, 39-49. doi:10.1016/j.midw.2019.02.005

Rouhi, M., Stirling, C., & Crisp, E. P. (2019). Mothers' views of health problems in the twelve months after childbirth: A concept mapping study. *JAN*.

Rouhi, M., Stirling, C., & Crisp, E. P. (2020). The 'fallacy of normalcy': A content analysis of women's online post-childbirth health-related support, Women Birth https://doi.org/10.1016/j.wombi.2020.04.007

Rouhi, M., Vizheh, M., Rouhi, L., Esmaili, H., Vaziri, L., & Gherekhlou, Z. F. (2016). Postpartum morbidities in Iranian women 5 years after childbirth: A longitudinal study. *British Journal of Midwifery, 24*(4), 268-274.

Routledge, F. S. (2007). Exploring the use of feminist philosophy within nursing research to enhance post-positivist methodologies in the study of cardiovascular health. *Nursing Philosophy, 8*(4), 278-290.

Rowe, H. J., Holton, S., & Fisher, J. R. W. (2013). Postpartum emotional support: a qualitative study of women's and men's anticipated needs and preferred sources. *Australian Journal Of Primary Health, 19*(1), 46-52. doi:http://dx.doi.org/10.1071/PY11117

Royal Hobart Hospital. (2015). Maternity Information Package Your guide to Pregnancy, Birth and Early Parenting.

Rubin, R. (1975). Maternity Nursing Stops Too Soon. *AJN The American Journal of Nursing, 75*(10), 1680-1984.

Rudman, A., & Waldenström, U. (2007). Critical views on postpartum care expressed by new mothers. *BMC Health Services Research, 7*(1), 178. doi:10.1186/1472-6963-7-178

Sagayadevan, V., Siau Pheng, L., Abdin, E., Vaingankar, J., Helen, C., Siow Ann, C., . . . Chong, S. A. (2015). Retrospective observation of mental disorders during postpartum period: Results from the Singapore mental health study. *BMC Women's Health, 15*, 1-9. doi:10.1186/s12905-015-0279-x

Saligheh, M., McNamara, B., & Rooney, R. (2016). Perceived barriers and enablers of physical activity in postpartum women: a qualitative approach. *BMC Pregnancy and Childbirth, 16*(1), 131. doi:10.1186/s12884-016-0908-x

Samuel, G., et al. (2020). Guest Editorial: Ethical Issues in Social Media Research. In: SAGE Publications Sage CA: Los Angeles, CA.

Sand, A.-S., et al. (2020). Patient and public involvement in health research: A Nordic perspective. *Scandinavian Journal of Public Health, 48*(1), 119-121. doi:10.1177/1403494819863522

Sandall, J., et al. (2011). Staffing in maternity units. Getting the right people in the right place at the right time.

Sandall, J., et al. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*(4). doi:10.1002/14651858.CD004667.pub5

Sanders, R. A., & Crozier, K. (2018). How do informal information sources influence women's decision-making for birth? A meta-synthesis of qualitative studies. *BMC Pregnancy and Childbirth, 18*(1), 21. doi:10.1186/s12884-017-1648-2

Sawers, M., & Wong, G. (2018). Pregnancy and Childbirth: Postpartum Anxiety (PPA) and Support for New Mothers. *Journal of the Motherhood Initiative for Research & Community Involvement, 9*(2), 45-59.

Say, L., et al. (2018). Maternal morbidity: Time for reflection, recognition, and action. *International Journal of Gynaecology and Obstetrics, 141*(Suppl Suppl 1), 1.

Schmied, V., Donovan, J., Kruske, S., Kemp, L., Homer, C., & Fowler, C. (2011). Commonalities and challenges: a review of Australian state and territory maternity and child health policies. *Contemp Nurse, 40*(1), 106-117. doi:http://dx.doi.org/10.5172/conu.2011.40.1.106

Schneider, Z. (2002). Pregnant women's experiences of models of care in some hospitals in Victoria. *Australian Journal of Advanced Nursing, The, 19*(3), 32.

Schneider, Z., & Whitehead, D. (2016). *Nursing and midwifery research : methods and appraisal for evidence-based practice*: Chatswood, NSW Elsevier Australia (a division of Reed International Books Australia Pty Ltd), 2016. 5th edition.

Schoenebeck., S. A. (2013). *The Secret Life of Online Moms: Anonymity and Disinhibition on YouBeMom.com*. Paper presented at the Proceedings of the Seventh International AAAI Conference on Weblogs and Social Media.

Schutte, O. (1998). Cultural alterity: Cross-cultural communication and feminist theory in north-south contexts. *Hypatia, 13*(2), 53-72.

Schytt, E., Lindmark, G., & Waldenstrom, U. (2005). Physical symptoms after childbirth: prevalence and associations with self-rated health. *BJOG, 112*(2), 210-217. doi:http://dx.doi.org/10.1111/j.1471-0528.2004.00319.x

Scott, P. J., & Briggs, J. S. (2009). A Pragmatist Argument for Mixed Methodology in Medical Informatics. *Journal of Mixed Methods Research, 3*(3), 223-241. doi:10.1177/1558689809334209

Scrandis, D. A. (2005). Normalizing Postpartum Depressive Symptoms With Social Support. *Journal of the American Psychiatric Nurses Association, 11*(4), 223-230. doi:10.1177/1078390305280940

Scrimshaw, S. C. (1992). Adaptation of anthropological methodologies to rapid assessment of nutrition and primary health care. *Rapid assessment procedures: Qualitative methodologies for planning and evaluation of health related programmes*, 25-38.

Segre, L. S., O'Hara, M. W., Arndt, S., & Stuart, S. (2007). The prevalence of postpartum depression - The relative significance of three social status indices.

Seigfried, C. H. (1991). Where are all the pragmatist feminists? *Hypatia, 6*(2), 1-20.

Shaw, E., Levitt, C., Wong, S., Kaczorowski, J., & The McMaster University Postpartum Research, G. (2006). Systematic Review of the Literature on Postpartum Care: Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health. *Birth, 33*(3), 210-220. doi:10.1111/j.1523-536X.2006.00106.x

Sillence, E. (2013). Giving and Receiving Peer Advice in an Online Breast Cancer Support Group. *Cyberpsychology, Behavior, and Social Networking, 16*(6), 480-485. doi:10.1089/cyber.2013.1512

Singh, A., & Kumar, A. (2014). Factors associated with seeking treatment for postpartum morbidities in rural India. *Epidemiol Health, 36*, e2014026. doi:http://dx.doi.org/10.4178/epih/e2014026

Skowronski, G. A. (2015). Pain Relief in Childbirth: Changing Historical and Feminist Perspectives. *Anaesthesia and Intensive Care, 43*(1_suppl), 25-28. doi:10.1177/0310057x150430s106

Slomian, J., Bruyere, O., Reginster, J. Y., & Emonts, P. (2017). The internet as a source of information used by women after childbirth to meet their need for information: A web-based survey. *Midwifery, 48*, 46-52. doi:10.1016/j.midw.2017.03.005

Small, M. L., Harding, D. J., & Lamont, M. (2010). Reconsidering culture and poverty. In: Sage Publications Sage CA: Los Angeles, CA.

Smedley, R. M., & Coulson, N. S. (2017). A thematic analysis of messages posted by moderators within health-related asynchronous online support forums. *Patient Education and Counseling, 100*(9), 1688-1693. doi:https://doi.org/10.1016/j.pec.2017.04.008

Smith, J. D. (2004). Australia's rural and remote health: A social justice perspective: Tertiary Press.

Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research, 34*(5 Pt 2), 1101.

Song, J., Chae, H., & Kim, C. (2014). Changes in perceived health status, physical symptoms, and sleep satisfaction of postpartum women over time. *Nursing & Health Sciences, 16*(3), 335-342. doi:10.1111/nhs.12109

Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T., & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: an introduction. In: Sage Publications Sage CA: Thousand Oaks, CA.

Stone, S. L., Diop, H., Declercq, E., Cabral, H. J., Fox, M. P., & Wise, L. A. (2015). Stressful Events During Pregnancy and Postpartum Depressive Symptoms. *Journal of Women's Health (15409996), 24*(5), 384-393. doi:10.1089/jwh.2014.4857

Strange, C., Fisher, C., Howat, P., & Wood, L. (2014). Fostering supportive community connections through mothers' groups and playgroups. *Journal of Advanced Nursing*(12), 2835. doi:10.1111/jan.12435

Stumbras, K., Rankin, K., Caskey, R., Haider, S., & Handler, A. (2016). Guidelines and Interventions Related to the Postpartum Visit for Low-Risk Postpartum Women in High and Upper Middle Income Countries. *Matern Child Health J*. doi:10.1007/s10995-016-2053-6

Suplee, P. D. (2014). Redefining and Understanding the Needs of Women in the Postpartum Period and Beyond. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 46*(13), 780-781.

Sutcliffe, K., Caird, J., Kavanagh, J., Rees, R., Oliver, K., Dickson, K., . . . Thomas, J. (2012). Comparing midwife-led and doctor-led maternity care: a systematic review of reviews.

Journal of Advanced Nursing, 68(11), 2376-2386. doi:10.1111/j.1365-2648.2012.05998.x

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qual Health Res, 18*(9), 1161-1173. doi:10.1177/1049732308321736

Ta Park, V., Goyal, D., Nguyen, T., Lien, H., Rosidi, D., & Ta Park, V. M. (2017). Postpartum Traditions, Mental Health, and Help-Seeking Considerations Among Vietnamese American Women: a Mixed-Methods Pilot Study. *Journal of Behavioral Health Services & Research, 44*(3), 428-441. doi:10.1007/s11414-015-9476-5

Tammentie, T., Tarakka, M., Astedt-Kurki, P., Paavilainen, E., & Laippala, p. (2004). Family dynamics and postnatal depression. *Journal of Psychiatric and Mental Health Nursing, 11*(2), 141-149. doi:10.1111/j.1365-2850.2003.00684.x

Teddlie, C., et al. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*(1), 77-100.

Thung, S. F., & Norwitz, E. R. (2010). Postpartum care: we can and should do better. *Am J Obstet Gynecol, 202*(1), 1-4. doi: https://doi.org/10.1016/j.ajog.2009.08.028

Trehan, D. M. (2015). *The Impact of Concept Mapping as a Learning Tool on Student Perceptions of and Experiences with Introductory Statistics.* (text), Kent State University / OhioLINK, Kent, Ohio, USA. Retrieved from https://login.ezproxy.utas.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edsndl&AN=edsndl.oai.union.ndltd.org.OhioLink.oai.etd.ohiolink.edu.kent1447770974&site=eds-live Available from EBSCOhost edsndl database.

Trochim, W., & Kane, M. (2005). Concept mapping: an introduction to structured conceptualization in health care. *Int J Qual Health Care, 17*(3), 187-191. doi:10.1093/intqhc/mzi038

Trochim, W., & Linton, R. (1986). Conceptualization for planning and evaluation. *Evaluation and Program Planning, 9*(4), 289-308. doi:10.1016/0149-7189(86)90044-3

Trochim, W., & McLinden. (2017). Introduction to a special issue on concept mapping. *Eval Program Plann, 60*, 166-175. doi:https://doi.org/10.1016/j.evalprogplan.2016.10.006

Trochim, W. (1993). *The reliability of concept mapping.* Paper presented at the annual conference of the American Evaluation Association.

Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: a critical transition period with unmet maternal health needs. *American Journal of Obstetrics and Gynecology, 217*(1), 37-41. doi:10.1016/j.ajog.2017.03.032

Turner, P. (1995). An overview of feminist perspectives as they relate to science and mathematics education. *The Mathematics Educator, 6*(1).

Valadares, G., et al. (2020). Maternal Mental Health and Peripartum Depression. In J. Rennó Jr, G. Valadares, A. Cantilino, J. Mendes-Ribeiro, R. Rocha, & A. Geraldo da Silva (Eds.), *Women's Mental Health: A Clinical and Evidence-Based Guide* (pp. 349-375). Cham: Springer International Publishing.

Vaismoradi, M. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study Qualitative descriptive study. *Nursing & Health Sciences, 15*(3), 398-405. doi:10.1111/nhs.12048

Vallely, L., Ahmed, Y., & Murray, S. F. (2005). Postpartum maternal morbidity requiring hospital admission in Lusaka, Zambia - a descriptive study. *BMC Pregnancy Childbirth, 5*(1), 1. doi:doi:10.1186/1471-2393-5-1

Valtchanov, B. L., Parry, D. C., Glover, T. D., & Mulcahy, C. M. (2017). Neighborhood at your Fingertips: Transforming Community Online through a Canadian Social Networking Site for Mothers. *Gender, Technology and Development, 18*(2), 187-217. doi:10.1177/0971852414529481

Van der Woude, D. A., Pijnenborg, J. M., & de Vries, J. (2015). Health status and quality of life in postpartum women: a systematic review of associated factors. *Eur J Obstet Gynecol Reprod Biol, 185*, 45-52. doi:http://dx.doi.org/10.1016/j.ejogrb.2014.11.041

Vanderkruik, R. C., Tuncalp, O., Chou, D., & Say, L. (2013). Framing maternal morbidity: WHO scoping exercise. *BMC Pregnancy Childbirth, 13*, 213. doi:http://dx.doi.org/10.1186/1471-2393-13-213

Van der Tuin, I. (2016). Feminist standpoint theory. The Wiley Blackwell encyclopedia of gender and sexuality studies, 1-4.

Vaughn, L. M., Jones, J. R., Booth, E., & Burke, J. G. (2017). Concept mapping methodology and community-engaged research: A perfect pairing. *Eval Program Plann, 60*, 229-237. doi:10.1016/j.evalprogplan.2016.08.013

Verbiest, S., Tully, K., Simpson, M., & Stuebe, A. (2018). Elevating mothers' voices: recommendations for improved patient-centered postpartum. *Journal of Behavioral Medicine, 41*(5), 577-590. doi:10.1007/s10865-018-9961-4

Wagg, A. (2010). Women's Experiences, Beliefs and Knowledge of Urinary Symptoms in the Postpartum Period and the Perceptions of Health Professionals. (Doctor of Philosophy), University of Hertfordshire, UK.

Wagg, A. J., Callanan, M. M., & Hassett, A. (2019). Online social support group use by breastfeeding mothers: A content analysis. *Heliyon, 5*(3), e01245. doi:10.1016/j.heliyon.2019.e01245

Wagg, A. R., Kendall, S., & Bunn, F. (2017). Women's experiences, beliefs and knowledge of urinary symptoms in the postpartum period and the perceptions of health professionals: a grounded theory study. (PhD Article in Press), University of Hertfordshire, Retrieved from https://www.scopus.com/inward/record.uri?eid=2-

s2.05020496682&doi=10.1017%2fS1463423617000366&partnerID=40&md5=eb092e76e518a4001f4f59f4b8a2ae62 Scopus database.

Walker, L. O., Mackert, M. S., Ahn, J., Vaughan, M. W., Sterling, B. S., Guy, S., & Hendrickson, S. (2017). e-Health and new moms: Contextual factors associated with sources of health information. *Public Health Nurs*. doi:10.1111/phn.12347

Walker, L. O., Murphey, C. L., & Nichols, F. (2015). The Broken Thread of Health Promotion and Disease Prevention for Women During the Postpartum Period. *The Journal of Perinatal Education, 24*(2), 81-92. doi:http://dx.doi.org/10.1891/1058-1243.24.2.81

Walker, S. K., Dworkin, J., & Connell, J. (2011). Variation in Parent Use of Information and Communications Technology: Does Quantity Matter? *Family and Consumer Sciences Research Journal, 40*(2), 106-119. doi:https://doi.org/10.1111/j.1552-3934.2011.02098.x

Wang, E., et al. (2020). Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review. *Obstetrics & Gynecology, 135*(4), 896-915. doi:10.1097/aog.0000000000003762

Watson, R., McKenna, H., Cowman, S., & Keady, J. (2008). *Nursing Research: Designs and Methods E-Book*: Elsevier Health Sciences.

Webb, D. A., Bloch, J. R., Coyne, J. C., Chung, E. K., Bennett, I. M., & Culhane, J. F. (2008). Postpartum physical symptoms in new mothers: their relationship to functional limitations and emotional well-being. *Birth, 35*(3), 179-187. doi:http://dx.doi.org/10.1111/j.1523-536x.2008.00238.x

Whipps, J., et al. (2004). Pragmatist feminism. In Stanford encyclopedia of philosophy. (2nd ed.). Sage.http://plato.stanford.edu

WHO. (1998). safe motherhood, postpartum care of the mother and newborn: a practical guide. report of a technical working group

WHO. (2005). Global health promotion scaling up for 2015: a brief review of major impacts and developments over the past 20 years and challenges for 2015. Paper presented at the 6th Global Conference on Health Promotion, Bangkok, Thailand. Available from: http://www. who. int/healthpromotion/conferences/6gchp/hpr_conference_ background. pdf (accessed May 2008).

WHO. (2010). World Health Organization: WHO Technical Consultation on Postpartum and Postnatal Care. Geneva, Switzerland: WHO Document Production Services.

WHO. (2013a). *Health literacy: The solid facts*. Copenhagen: WHO regional office for Europe.

WHO. (2013b). World Health Organization recommendations on postnatal care of the mother and newborn. Geneva, WHO.

WHO. (2015). Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. Geneva, Switzerland

WHO. (2018a). ICD-11 for mortality and morbidity statistics. *Retrieved June, 22*, 2018.

WHO. (2018b). WHO global coordination mechanism on the prevention and control of noncommunicable diseases: final report: WHO GCM.

Widarsson, M., Kerstis, B., Sundquist, K., Engstrom, G., & Sarkadi, A. (2012). Support needs of expectant mothers and fathers: a qualitative study. *J Perinat Educ, 21*(1), 36-44. doi:10.1891/1058-1243.21.1.36

Wilkie, S., Crawley, R., Button, S., Thornton, A., & Ayers, S. (2017). Assessing physical symptoms during the postpartum period: reliability and validity of the primary health questionnaire somatic symptom subscale (PHQ-15). *J Psychosom Obstet Gynaecol*, 1-8. doi:10.1080/0167482X.2017.1289167

Wittkowski, A., Zumla, A., Glendenning, S., & Fox, J. R. E. (2012). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. *Journal of Reproductive & Infant Psychology, 30*(5), 480-492. doi:10.1080/02646838.2011.639014

Woelk, G. B. (1992). Cultural and structural influences in the creation of and participation in community health programmes. *Social science & medicine (1982), 35*(4), 419-424. doi:10.1016/0277-9536(92)90334-M

Wolfensberger, W. P., Nirje, B., Olshansky, S., Perske, R., & Roos, P. (1972). The principle of normalization in human services. In T. P. o. N. a. a. h. m. m. e. o. definition (Ed.), *The Principle of Normalization In Human Services* (Vol. 18, pp. 114). University of Nebraska Medical Center.

Woodward, B. M., Zadoroznyj, M., & Benoit, C. (2016). Beyond birth: Women's concerns about post-birth care in an Australian urban community. *Women & Birth: Journal of the Australian College of Midwives, 29*(2), 153-159. doi:https://dx.doi.org/10.1016/j.wombi.2015.09.006

Woolhouse, H., Brown, S., Krastev, A., Perlen, S., & Gunn, J. (2009). Seeking help for anxiety and depression after childbirth: results of the Maternal Health Study. *Arch Womens Ment Health, 12*(2), 75-83. doi:10.1007/s00737-009-0049-6

Woolhouse, H., Gartland, D., Perlen, S., Donath, S., & Brown, S. J. (2014). Physical health after childbirth and maternal depression in the first 12 months post partum: Results of an Australian nulliparous pregnancy cohort study. *Midwifery, 30*(3), 378-384 377p. doi:10.1016/j.midw.2013.03.006

Woolhouse, H., James, J., Gartland, D., McDonald, E., & Brown, S. J. (2016). Maternal depressive symptoms at three months postpartum and breastfeeding rates at six months postpartum: Implications for primary care in a prospective cohort study of primiparous women in Australia. *Women and Birth*. doi:10.1016/j.wombi.2016.05.008

Wright, E. M., Matthai, M. T., & Meyer, E. (2019). The Influence of Social Media on Intrapartum Decision Making.

Wuytack, F., Curtis, E., & Begley, C. (2015). The health-seeking behaviours of first-time mothers with persistent pelvic girdle pain after childbirth in Ireland: A descriptive qualitative study. *Midwifery, 31*, 1104-1109. doi:10.1016/j.midw.2015.07.009

Xiang, Y. X., Xiong, J. Y., Tian, M. M., Yuan, F., & Feng, Z. C. (2014). Factors influencing the utilization of postpartum visits among rural women in China. *J Huazhong Univ Sci Technolog Med Sci, 34*(6), 869-874. doi:10.1007/s11596-014-1366-1

Zamawe, C. F., Masache, G. C., & Dube, A. N. (2015). The role of the parents' perception of the postpartum period and knowledge of maternal mortality in uptake of postnatal care: A qualitative exploration in Malawi. *International Journal of Women's Health, 7*, 587-594. doi:10.2147/IJWH.S83228

Appendices

Appendix I

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Review Article

Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review☆,☆☆,★,★★

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ABSTRACT

Introduction: Women within the first 12 months after birth often do not seek professional help for post-childbirth morbidities. This systematic review uses the Behavioural Model of Health Services Use (BMSHU) to assess the barriers and facilitators to women's help-seeking from health professionals during the first twelve months after childbirth.

Method: A qualitative meta-aggregation was used for the review. Systematic searching of Medline via Ovid, CINAHL, EMBASE and Web of Science revealed an initial 691 papers, of which 48 were reviewed. Nine qualitative papers, peer-reviewed, English papers and published from 2000 to 2017, were identified. Studies selected according to the pre-defined protocol were assessed using The Joanna Briggs Institute Critical Appraisal Tools (JBIQARI).

Results: Seventy-five findings were identified from the approved articles and aggregated into seven categories. Key themes that emerged were that women did not seek help because they accepted problems as a part of the motherhood role or because they feared being judged negatively. Women shared their issues with family and friends as trusted people. Low health literacy was a barrier to seeking help, as was lack of access to proper care and poor advice from families. The women's cultural context was an essential influence in whether or not they sought help. According to BMSHU, a model of key influences on women's help-seeking for maternal morbidities introduced.

Introduction

The post-childbirth period (birth through to 12 months) is a time when many women experience maternal morbidities, either indirect or direct, physical or mental health issues (Vanderkruik et al., 2013). The World Health Organization (WHO) defines maternal morbidity as "morbidity in a woman who has been pregnant (regardless of the site or duration of the pregnancy), from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Hardee et al., 2012, p. 604). Maternal morbidities affect over 90% of women during the first year after childbirth (Wilkie et al., 2017). The most commonly reported morbidities are depression, anxiety, fatigue, backache, sexual problems (such as sexual arousal disorder, orgasmic problems), gastrointestinal problems (constipation) and breastfeeding problems (Ansara et al., 2005; Glazener et al., 1995; Hardee et al., 2012; Khajehei et al., 2015; Maher and Souter, 2014; Van der Woude et al., 2015).

Maternal morbidities have a negative impact on mothers' health and well-being including physical and emotional adjustment to parenthood, difficulty returning to sexual activity and late return to employment (Haran et al., 2014; McGovern et al., 2007). Despite this, many women do not seek professional help for morbidities during the first year following childbirth (Cheng and Li, 2008) which can exacerbate problems by lowering mothers' quality of life and creating financial, mental health or fatigue issues (Foulkes, 2011; Hardee et al., 2012).

During the first 12 months after birth, there are a range of health professionals and services across multiple settings (tertiary and primary/community health) available to mothers. Help-

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seeking is defined as a problem-focused, highly adaptive behaviour (Cornally and McCarthy, 2011) demonstrated by an ability to find help, support, information, guidance or a cure (Fonseca and Canavarro, 2017). Women within the first 12 months after birth are less likely to seek formal help from health professionals such as nurses and medical practitioners, instead seeking informal help from family and friends (Cornally and McCarthy, 2011; Maher and Souter, 2014; Woolhouse et al., 2009). Known barriers for women seeking support for common maternal morbidities include being unaware of available treatment, lack of knowledge about post-childbirth morbidities and shame or stigma associated with the morbidity (Bina, 2014; Brown et al., 2015; McCallum et al., 2011)

Some factors such as perception of the problem, accessibility of help and inclination to get treatment have been suggested as an effective factors in help-seeking behaviours (Chandrasekara, 2016). Higher education levels and support from family and friends have been shown to enable help-seeking behaviours for women within the first 12 months after childbirth (Dennis and Chung-Lee, 2006). However, there is a limited understanding of how women within the first 12 months after childbirth experience formal help-seeking from health care professionals and services (Abushaikha and Khalaf, 2014).

Better knowledge about women's experiences of barriers and facilitators when help-seeking from health professionals for post-childbirth physical and mental problems is essential for ensuring suitable services. Improving policymakers' and health care providers' knowledge about this will enable them to design services that increase the number of women seeking professional help and decrease negative outcomes from lack of timely attention for childbirth morbidities (Bryant et al., 2016). The aim of this review therefore is to explore women's perceptions of the barriers and facilitators they experience in seeking help from health professionals within the first 12 months after childbirth.

Method

To address the aim, a systematic qualitative meta-aggregation review was conducted following the Joanna Briggs process (Lockwood et al., 2015). Meta-aggregation is underpinned by pragmatism which aims to find set of statements from qualitative papers to produce 'lines of action' for policy makers (Hannes and Lockwood, 2011).

This uses a comprehensive and rigorous search of relevant studies to find unbiased knowledge that answers the research question with the findings then extracted and aggregated without any new analysis (Lockwood et al., 2015) which aims to better understand of the problem (Creswell, 2013).

Conceptual framework

A variety of behavioural models have been used to explain help-seeking behaviours, including psychological models such as the Self-Regulation Model (Diefenbach and Leventhal, 1996), the Health Belief Model (Diefenbach and Leventhal, 1996) and the Theory of Planned Behaviour (Armitage and Conner, 2001). Sociological perspective models have also been used, such as the Network Episode Model (Pescosolido, 1991), Kadushin's theory (Kadushin, 2004) and the Behavioral Model of Health Service Use (BMHSU) (Anderson et al., 2011). Among these theories, sociological models that consider demographic and societal factors may best explain help-seeking behaviour in post-childbirth women, given the existing knowledge on the impact of informal support on health services use. This systematic review applied the BMHSU model as a lens to view the qualitative research evidence identified (Anderson et al., 2011).

The BMHSU (Fig. 1) proposes that health outcomes originate from a mix of contextual characteristics, individual characteristics, and health behaviours (Anderson et al., 2011). The contextual and individual characteristics are categorised into predisposing variables, enabling factors and need variables (Anderson et al., 2011). Family, society and the health care system are all considered as contextual characteristics; personal beliefs about health care services, educational level and demographic features such as age, are defined as individual characteristics (Anderson et al., 2011). The health behaviours that are influenced by personal practices and the process of medical care shape the use of personal health services (Anderson et al., 2011). This review considered only the contextual and individual characteristic elements of the BMHSU model, as barriers and facilitators to women's health behaviours and outcomes (see Fig. 1.). Anderson et al. (2011) conceptualises the factors important for seeking help as: (a) predisposing variables (b) enabling factors and (c) need variables, such as severity of post-childbirth morbidities.

Search strategy and selection

The review considered qualitative and qualitative components of mixed-methods studies, published in peer-reviewed articles in English from January 2000 to December 2017.The inclusion criteria were formulated according to the PICo format (Participant, Interest, Context). 'Participant' was defined as women within the first year after childbirth. 'Interest' was defined as any factors that hinder or influence women to access health professional care related to their maternal morbidity issue/s. 'Context' was any international research about help-seeking behaviour among community-dwelling women. Post-childbirth morbidities included any physical and mental health issues such as depression, backache, wound infection, breast problems, experienced by women during the first twelve month following childbirth.

The following search terms were used: (postpartum OR postnatal OR after childbirth OR puerperium OR birth) AND (maternal OR women OR mothers) AND (behaviour) AND (facilitators) AND (barriers OR morbidity OR help-seeking OR treatment preferences OR behaviour OR facilitators) AND (qualitative OR mixed methods OR evaluation). Modification of the terms by using truncations and Boolean Operators helped to access a full range of papers.

Two researchers (MR, SL) searched for English language papers on the following electronic databases in consultation with a subject relevant librarian: MEDLINE, CINAHL (EBSCOhost), EMBASE (Ovid), and ISI Web of Science. The keywords and predefined vocabulary used, exclusion and inclusion criteria are presented in Table 1. To identify additional potentially relevant published papers, we hand-searched the reference lists of all identified relevant papers ($n = 1$).

The search method recognised 971 papers. All papers from databases were added to EndNote library and then duplications ($n = 691$) were manually removed prior to selection of studies (Fig. 2). Papers were screened and excluded by title and abstract. A full-text copy of 48 studies were retrieved for consideration of eligibility, with 39 of the papers being excluded because they did not address the outcome of interest ($n = 3$), phenomena of interest ($n = 17$) and participants of interest ($n = 19$).

Quality appraisal

Two researchers (MR, ChS) independently screened the full text of retrieved papers ($n = 9$) by the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) (Appendix A). The checklist consists of ten questions involves three distinct steps: filtering, technical appraisal and theoretical appraisal (Hannes and Lockwood, 2011). Papers were included if both reviewers answered

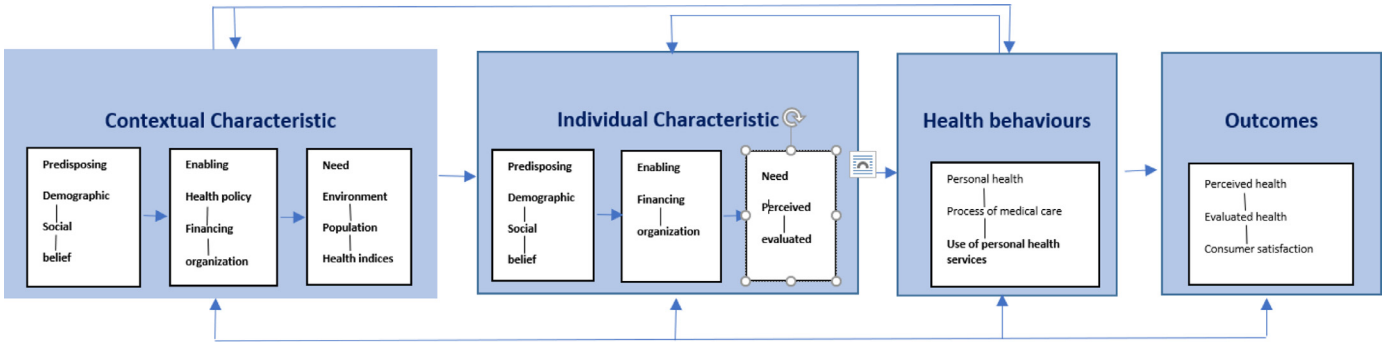

Fig. 1. A Behavioural model of Health Services Use including contextual and individual characteristics. Adapted from Magaard et al. (2017).

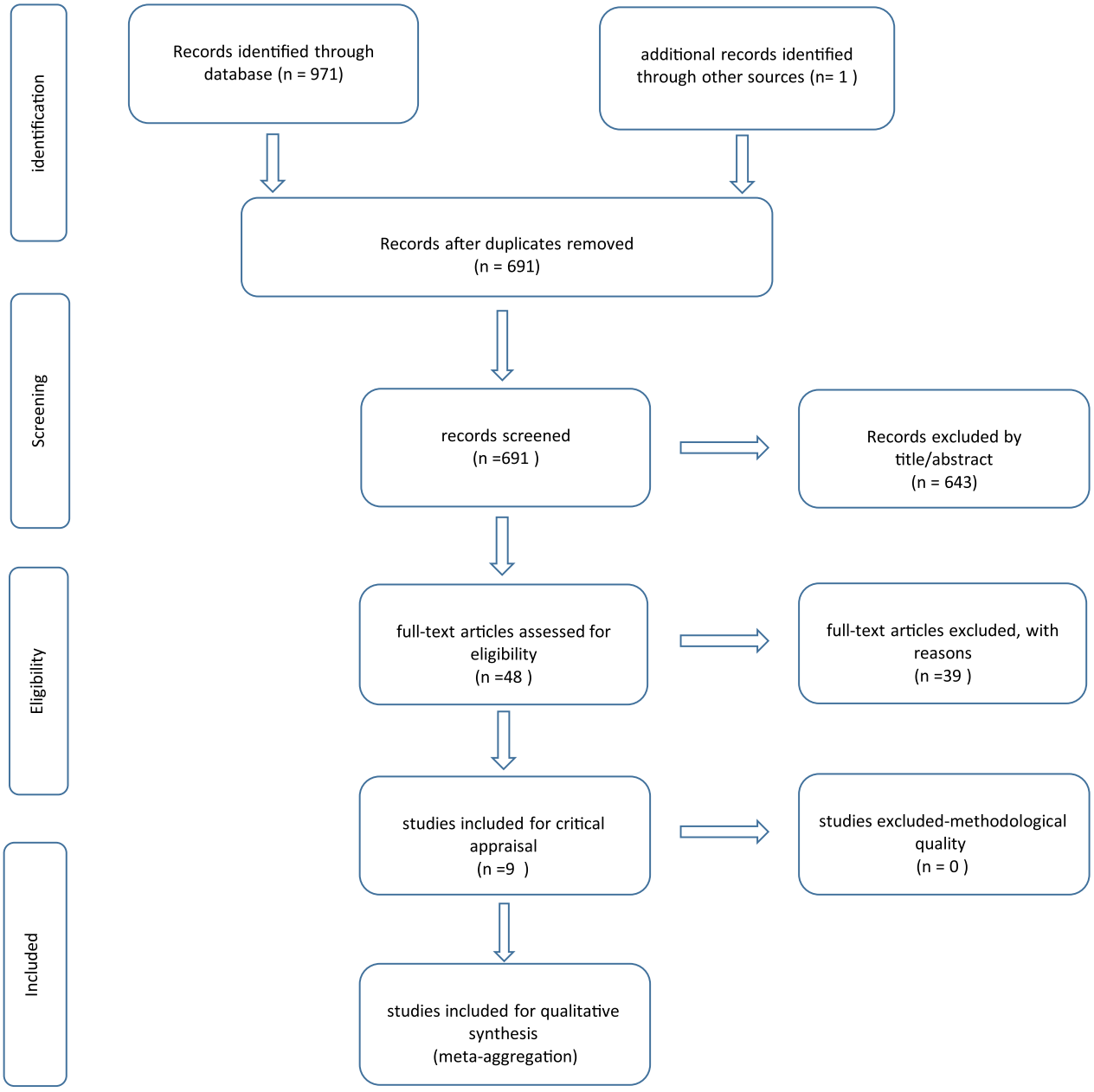

Fig. 2. Flow diagram of trial.

Table 1
Characteristics of included studies.

Author/s (year)	Abram et al. (2009)	Bell et al. (2016)	Buurman (2012)	Goyal et al. (2015)	Merry et al. (2011)	Park et al. (2017)	Sword et al. (2008)	Wittkowski (2017)	Wuytack et al. (2015)
Methodology	Qualitative, grounded theory	Qualitative, descriptive study	Qualitative study	Exploratory qualitative	Qualitative subproject	Mixed-methods pilot study	Qualitative descriptive approach	Qualitative, grounded theory approach	Qualitative, descriptive qualitative design
Method	Interview	Semi-structured interview	Interview	Interview	Interview	Semi structured telephone interviews	Semi structured telephone interviews	Semi-structured interviews	Semi-structured interviews
Quality measure	8	7	9	7	7	9	8	10	9
Phenomenon of interest	Investigating Barriers to seek formal help for PPD symptoms	To explore the barriers and facilitators to the use of mental health services reported by women with elevated symptoms of depression in the postpartum period	To explore women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour	To explore Asian Indian mother's perspectives of postpartum depression	To gain greater understanding of the barriers these vulnerable migrant women face in accessing health and social services postpartum	To explore Vietnamese American mothers' perceptions and experience postpartum traditions, postpartum depression (PPD) and mental health help-seeking behaviour	To explore women's care-seeking experiences after referral for postpartum depression.	To better understand the experience of PND in South Asian mothers living in Great Britain	To explore the health-seeking behaviours of primiparous women with pelvic girdle pain persisting for more than three months postpartum.
Country	USA	Canada	Netherlands, Amsterdam	USA	Canada	USA	Canada	UK	Ireland
Setting	Three Women, Infant, and Children (WIC) federal nutrition program clinics Latinas, Mexican immigrants, African American/Black.	Perinatal mental health clinic and during a routine visit to the obstetrics clinic	Two practitioner populations in different parts of the Netherlands: one in Amsterdam and one in the eastern part.	local area university groups and social media.	Postpartum units in Montreal, Toronto	Women from public	The local public health unit's Healthy Babies, Healthy Children Program	Through health visitors and midwives within the Greater Manchester area	Women attending one tertiary maternity hospital

(*continued on next page*)

Table 1 (*continued*)

Author/s (year)	Abram et al. (2009)	Bell et al. (2016)	Buurman (2012)	Goyal et al. (2015)	Merry et al. (2011)	Park et al. (2017)	Sword et al. (2008)	Wittkowski (2017)	Wuytack et al. (2015)
Participants	25, Latinas, Mexican immigrants, African American/Black, low income ethnic minority	48 Canadian women, French or English speaking	26 Dutch, Indonesian, Bulgarian women	12 Asian Indian married women living in California	112 African, Asian, European, Latin American	15 women, the majority ($n = 14$) were born in Vietnam, with one mother stating she was born in the USA.	18 women who spoke English	10 Asian women living in UK	23 primiparas, 19 Irish, 4 other European country
Data analysis	Thematic analysis	Inductive content	Constant comparative	Content analysis	In-depth analysis of the texts	Content analysis	Content analysis	Constant comparison	Thematic analysis
Findings	Five core themes: (i) Inevitable and disappointing problems; (ii) Natural recovery; (iii) Feelings of shame; (iv) The role played by initiates and help-seeking	Five major themes: 1. Accessibility and Proximity, 2. Appropriate-ness and Fit, 3. Stigma, 4. Encouraged by Significant Others to Seek Help, 5. Personal	Five core themes: (i) Inevitable and disappointing problems; (ii) Natural recovery; (iii) Feelings of shame; (iv) The role played by initiates and help-seeking	Two overarching themes: (1) cultural-specific postpartum traditions; (2) mental health help-seeking behaviour.	Six main themes emerged from the data: isolation; difficulties reaching mothers postpartum; language barriers; low health literacy; lacking psychosocial	Seven themes: (1) cultural identity, (2) practice and examples of postpartum traditions, (3) perceptions of the etiology of sadness/ depression, (4) perceptions about their families' viewpoints of the etiology of depression, (5) lived experiences with depression and help-seeking, (6) speculated professional help-seeking behaviours and alternative resources for sadness/ depression, and (7) barriers to help-seeking.	Themes were identified that reflected three levels of influence: individual level, social network level, and health care system level. At each level, specific barriers to and facilitators of care seeking emerged from the analysis of interview transcripts	The three main overarching core categories related to PND, (1) internalising misery, (2) others will judge me, and I feel on my own, and (3) I talk to my health professional and they don't understand.	Three main themes, each with several categories emerged from the women's accounts of their health-seeking behaviours; (1) 'They didn't ask, I didn't tell', (2) Seeking advice and support, and (3) Coping strategies

'yes' to a minimum of seven of ten prompt questions, with disagreements resolved by consensus after reviewing the criteria and definitions.

For this systematic review, eight qualitative papers (Abrams et al., 2009; Bell et al., 2016; Buurman and Lagro-Janssen, 2013; Goyal et al., 2015; Merry et al., 2011; Sword et al., 2008; Wittkowski et al., 2012; Wuytack et al., 2015) and one mixed-methods pilot study (Park et al., 2017) met the inclusion criteria.

Data extraction and management

The review process began with the pre-defined inclusion and exclusion criteria as per our well-defined question providing a framework to find not just the articles, but the relevant findings within articles (Korhonen et al., 2013). Data were collected on the following: author(s) names, publication date, methodology, method, phenomenon of interest, country, setting, participants, data analysis and findings the quality measure, country and setting, the aim of study, design; morbidity; participants; ethnicity; and phenomena reported (see Table 1). There were a limited number of post-childbirth maternal morbidities reported in the papers: depression (Abrams et al., 2009; Bell et al., 2016; Goyal et al., 2015; Park et al., 2017; Sword et al., 2008; Wittkowski et al., 2012), pelvic floor dysfunction (Buurman and Lagro-Janssen, 2013), and pelvic girdle pain (Wuytack et al., 2015). All studies, apart from one identified participants diverse cultures background (Wittkowski et al., 2012).

Level of credibility

It is essential for credibility of qualitative research to only consider high quality papers and those without bias (Dixon-Woods, 2006). The different interpretation of qualitative findings makes it difficult to get a deep understanding of the aim of the research 's included papers. The studies included in this systematic review were graded as credible according to the JBI credibility criterion, which is defined as the congruity between the research question and findings of the studies based on the theoretical frameworks (JBI, 2011).

Data synthesis

The Meta aggregation process requires achieving the applicable findings that met the review criteria (Hannes and Lockwood, 2011). We extracted 75 findings from the nine papers, with illustrating quotes about women's perceptions of the barriers and facilitators they experienced in seeking help from health professionals as the first step of meta-aggregation process. Findings were then aggregated into seven categories according to similarity in meaning (Table 1). Further analysis of the categories shaped three synthesised statements (Fig. 3). These statements were formed as key factors that discouraged or convinced a woman to seek help related to her health issues and referenced against the BMHSU framework.

Results

Women's perceptions of the barriers and facilitators they experienced in seeking help from health professionals were allocated to seven categories; they accepted the problems as part of normal childbirth process; lack of knowledge about the problems was obvious, they shared their problems with trusted people; family and friends influenced women's choice to seek help or not; difficulty to access post-childbirth care or did not address their problems; fear of being judged prevented them to seek help; the women's cultural context was an essential factor in whether or how they sought help. The seven categories were aggregated to three synthesis statements about the topics: Perceived need to seek help, Interpersonal communication, and How society views post-childbirth problems (Fig. 3).

Synthesis statement 1 – perceived need to seek help

Women with low health literacy were less likely to seek formal help. The main reasons identified were a lack of knowledge to recognise the problem or thinking that the morbidity was normal and would resolve over time. Two categories supported the first synthesis statement.

Category – Women did not seek help because they accepted problems as a part of the motherhood role.

Five out of nine studies made references to the post-childbirth problems being seen by women as a normal process of childbirth and not as an ailment (Abrams et al., 2009; Bell et al., 2016; Buurman and Lagro-Janssen, 2013; Park et al., 2017; Sword et al., 2008). Women's perceptions about their conventional role in families (Park et al., 2017) and normalizing of their health problems also led to their belief that their problems were part of the motherhood role (Abrams et al., 2009; Buurman and Lagro-Janssen, 2013). This was reported by all studies for both physical or mental problem. For example, one woman reported: 'I simply thought: the urinary incontinence is just part of it. Your whole body is turned inside out after delivery anyway. So, I thought it's just part of the game.' (Buurman and Lagro-Janssen, 2013, p. 408)

Women with physical problems also expressed the view that initially they felt their problem would gradually be resolved (Buurman and Lagro-Janssen, 2013), and for mental issues they felt they were able to self-manage their problems (Bell et al., 2016). Overall, women's accounts showed that their infant's health had priority over their health (Bell et al., 2016; Buurman and Lagro-Janssen, 2013).

Category – A lack of health knowledge about post-childbirth problems meant women did not seek help.

All seven studies confirmed that both women (Buurman and Lagro-Janssen, 2013; Merry et al., 2011; Sword et al., 2008) and trusted people in their lives (Sword et al., 2008) had a lack of knowledge about post-childbirth health problems: 'I just didn't know what I wanted at the time and I didn't know what I wanted to get out of it. I didn't know what was going on.' (Bell et al., 2016, p. 656)

One study showed that provision of information and guidance by health care providers to women about their issues or previously experienced problems assisted women to cope with the problems after childbirth (Sword et al., 2008).

Synthesis statement 2 – interpersonal communication

Women used interpersonal communication with a trusted person as the fundamental way to deal with the post-childbirth phenomenon. Two categories supported this synthesis.

Category – Women's first strategies were to share their problems with trusted people.

This category was supported by 14 findings in five studies (Abrams et al., 2009; Goyal et al., 2015; Merry et al., 2011; Wittkowski et al., 2012; Wuytack et al., 2015). Findings suggested that if women could not manage their health issues alone, then they shared problems as the first step in help-seeking (Goyal et al., 2015). Many women spoke to their spouse or other women about their health issues (Abrams et al., 2009; Goyal et al., 2015; Wittkowski et al., 2012). For example, one participant reported about her husband:

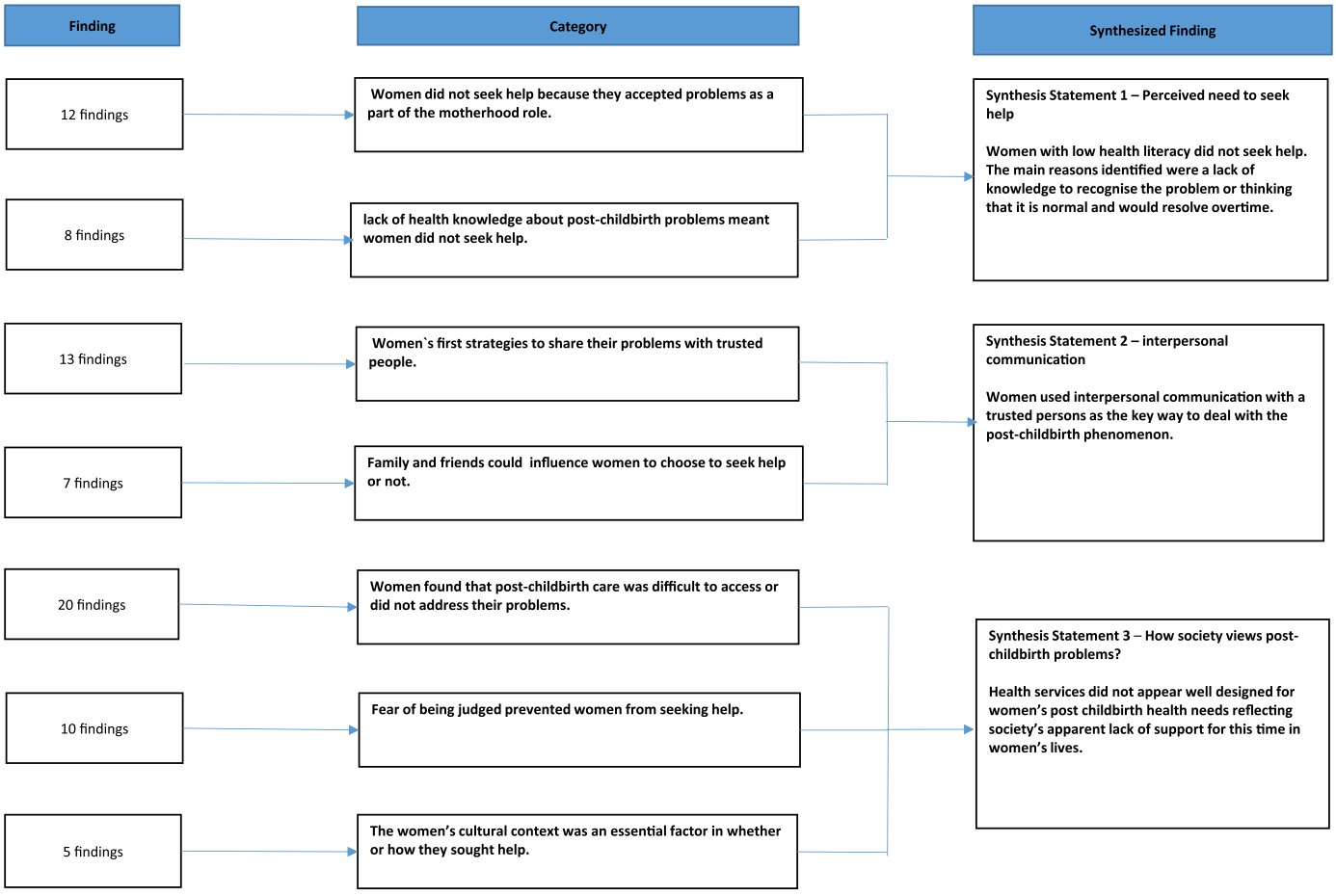

Fig. 3. This figure shows a meta-aggregation of findings about barriers and facilitators that women experienced after childbirth to seek professional help.

'He always says, "But, who do we ask? Who do we ask? Next time you go to the doctor ask him about how you're feeling (Abrams et al., 2009, p. 542).

Another study identified a preference for sharing problems with friends from the same age group (Goyal et al., 2015), or some women preferred to talk to a person who they felt was reliable and would listen carefully to their problems without any judgment (Abrams et al., 2009).

Category – Family and friends influenced women's choice to seek help or not.

Women were often encouraged by family and friends to seek help, even if their family considered the problems as a part of normal childbirth process (Bell et al., 2016; Sword et al., 2008; Wuytack et al., 2015). If there was a lack of awareness and assistances by partner and family, depressed women often did not feel motivated to seek help (Bell et al., 2016). Some of the women felt their health problems were not significant to the family (Sword et al., 2008) and were even ignored by them (Bell et al., 2016). For example, one woman reported: 'My mother doesn't want to look after the baby so I can see my psychologist. She believes I don't need it. I have no support from her for this.' (Bell et al., 2016, p. 656)

Synthesis statement 3 – how society views post-childbirth problems?

Health services did not appear well designed for women's post-childbirth health needs reflecting society's apparent lack of support for this time in women's lives. Three categories supported this synthesis.

Category – Women found that post-childbirth care was difficult to access or did not address their problems.

Many of the women reported that professional health care was unhelpful experience (Abrams et al., 2009) as this participant reported:

'I find they just like brush you off **...** my gyne doctor, I thought she would help, she would understand, cause she works in the field. And instead she just like didn't care. I honestly felt that she didn't care and I felt so alone ' (Bell et al., 2016, p. 654).

The discrepancy between antenatal and postnatal care was also emphasised by women (Wuytack et al., 2015) as health services often did not forewarn women about possible problems (Bell et al., 2016). Healthcare professionals rarely asked women about their problems during appointments such as infant checks (Wuytack et al., 2015) with consultations focused on the infant's need rather than the mother's (Bell et al., 2016).

There was a lack of psychosocial assessment or assessment of abuse or depression (Merry et al., 2011) and some women reported that they received conflicting advice from different health professionals when they discussed morbidities (Wuytack et al., 2015). Women often struggled to access professional health care as a first line of treatment (Abrams et al., 2009). Among those women who sought professional help, those services that were close to home or online were the priority (Bell et al., 2016).

Among immigrant women, Isolation and language obstacles were barriers to accessing health services (Merry et al., 2011). Some factors such as absence of knowledge about who and which services were available (Wittkowski et al., 2012), government-funded (free services) (Merry et al., 2011), and the cost of seeking

private treatment (Wuytack et al., 2015) were reported in findings as barriers to care. Continuity of care and having an established relationship with a health care provider facilitated post-childbirth help-seeking in two papers. A 'comfortable relationship' with healthcare providers was the main reason for seeking help (Bell et al., 2016; Sword et al., 2008):

'I had already established a relationship with [the clinic] so the counsellor I was seeing there was, I mean, available at any time and I felt that was good and I also had a good rapport with my doctor, so I was alright. I'm not one to easily open up, so if I don't feel comfortable with someone there's no way I'll talk about how I feel.' (Sword et al., 2008, p. 1169)

Category - Fear of being judged prevented women from seeking help.

Women's fear of being judged was a barrier to seeking help, with some women stating fears of being labelled as "crazy," "schizo," or "psycho" (Abrams et al., 2009; Bell et al., 2016) and a general worry about stigma (Goyal et al., 2015): 'I'm like I don't wanna be labelled you know. It's like you always feel like you're being labelled as a psychiatric patient.' (Bell et al., 2016, p. 655). Working women were additionally worried that being labelled as "depressed" might negatively influence their employment prospects (Sword et al., 2008). This issue was at the forefront in the rare cases were women worried about losing child custody (Sword et al., 2008).

Some women felt that openly discussing urogenital problems was "taboo" and embarrassing (Buurman and Lagro-Janssen, 2013). They expressed feelings of shame if they had to talk about these (Buurman and Lagro-Janssen, 2013). This also applied to mental symptoms (Sword et al., 2008). These barriers could be exacerbated if women experienced lack of self-esteem about body image (Buurman and Lagro-Janssen, 2013) or if there were a lack of respect for patient's privacy by health professionals (Bell et al., 2016).

Category – The women's cultural context was an essential factor in whether or how they sought help.

Culture-specific post-childbirth traditions can help family and friends to support women (Goyal et al., 2015) and conversely a lack of culturally appropriate care was a barrier to accessing care for many immigrant women (Goyal et al., 2015; Park et al., 2017).

'I think our Vietnamese never come to those services. Our Vietnamese are very strong. American always comes to see counsellors. Majority of our Vietnamese don't come to see these professions. I have a strong mind. I am sad, but I don't need to see them.' (Park et al., 2017, p. 437)

Findings showed that "familism" or cultural norms also created strong barriers as some women explained their culture banned women from talking about their mental health issues and did not encourage them to engage with their thoughts and feelings (Wittkowski et al., 2012). Some women therefore preferred to speak to strangers to protect their privacy (Abrams et al., 2009) and sometimes they preferred to get this help anonymously (Goyal et al., 2015).

Discussion

The studies included in this review only covered depression, pelvic floor dysfunction, and pelvic girdle pain. This is in contrast to reported quantitative studies which have highlighted a wide range of morbidities, and suggest the prevalence of morbidities is around 90% during the postpartum period (Cooklin et al., 2018). The limited research presenting a women's perspective on help-seeking for post-childbirth morbidities is surprising given the prevalence of morbidities and suggests a 'hidden' problem. The meta-aggregation results highlight possible reasons for the dearth of qualitative research in this area.

The key facilitators and barriers for women seeking help for health issues after childbirth were summarized as three synthesis statements covering women's perceived need to seek help, interpersonal communication, and how society views post-childbirth problems. The results extracted three coherent themes about factors influencing women's help-seeking behaviour after childbirth.

Perceived need to seek help

These findings show that women normalized, minimized or hid their health issues. This resulted in a lack of perceived need as women often did not understand the importance of their problems or could not distinguish between what is regarded as normal or abnormal when it comes to physical or mental problems after childbirth. According to the BMSHU Model, this lack of perceived need leads to less demand for services (Bradley et al., 2002). The normalizing, minimizing or hiding of problems means that women conceptualized these problems as a normal process of childbirth and subsequently did not take any action to resolve them (2008; Chew-Graham et al., 2009; Goodman and Santangelo, 2011; Rudman and Waldenström, 2007; Scrandis, 2016).

Low health literacy underpins women's lack of perceived need. The synthesized findings confirmed women (Bell et al., 2016; Buurman and Lagro-Janssen, 2013; Merry et al., 2011; Sword et al., 2008), trusted persons (Sword et al., 2008) and health care providers (Beake et al., 2010; Khalaf et al., 2009) were often unaware of potential problems deriving from childbirth. This low literacy exists across all groups despite the known high prevalence of post-childbirth morbidities during the first year (Cheng and Li, 2008; Haran et al., 2014). Others have highlighted that high-level education is a motivation to seek treatment (Dennis and Chung-Lee, 2006) and so education can be seen as an enabler for women to be empowered to seek help.

Women's perceived need to seek help are framed as individual characteristics in the model but this study suggests perceived need is also a social phenomenon. Evaluated need is categorised as professional judgments by specialist and health care providers in the BMSHU model. It also has social elements, such as access to the latest medical advances and the provision of educational brochures and medical equipment. The included papers for this systematic review showed that lack of evaluated need is one of the reasons for women's lack of knowledge about post-childbirth problems, as women felt health care providers had not prepared them for potential problems after childbirth in the prenatal period.

Interpersonal communication

The synthesized findings indicated that women used interpersonal communication with trusted persons as the fundamental way to deal with post-childbirth morbidities. Once women decided they needed to seek help, family and friends were found to be the first source of help (O'Mahen and Flynn, 2008). Scrandis (2016) showed that women notably shared their problems with trusted people through their connections with other women who have the same problem. Overall it is clear that positive interpersonal connections between women and surrounding people encouraged them to seek help.

How society views post-childbirth problems

One of the implications of this systematic review is that society's views are a barrier to women's post-childbirth problems because there is a general normalising of maternal morbidities. According to the BMSHU Model, social factors at the contextual level influence health service use. More specifically, a community's

health literacy level and ethnic composition were relevant predisposing influences found in this study for enabling of creating barriers to help-seeking.

The community-based beliefs that derive from community values and culture direct financial resources and policies for access to services and therefore can also influence evaluated need. The relevance of cultural barriers found by others, such as lack of understanding and support by society and lack of understanding of cultural background by health care providers (Sword et al., 2008) were supported by this review.

Enabling characteristics identified in the BMHS Model that could offset these elements consists of health policy, financing and organization. These factors reflect the distribution of care services in the community and the community access. As these results highlight, limitations in these services result in non-use by women after childbirth and are compounded by feelings of stigma. This review is supported by others who argue that a key way to improve post-childbirth maternal and child health is improving health care providers' awareness of post-childbirth morbidities (Cassiano et al., 2015; Mazzo et al., 2015), with a re-balancing of post-childbirth health visits towards the needs of the woman's post-childbirth health (Fahey and Shenassa, 2013).

There is little research about the knowledge of health care providers (McCauley et al., 2011). The necessity for improved education for health care providers about maternal morbidities is crucial the apparent lack of knowledge by women's family and health care providers (Khalaf et al., 2009). To provide appropriate care to women during the post-childbirth period, it is important that health care providers increase their knowledge about post-childbirth physical and mental care (Romano et al., 2010).

The BMSHU model

This systematic review applied the BMSHU model as a lens to find women's help-seeking behaviour about their health issues after childbirth (Fig. 1). We found several of the BMSHU categories more useful than others. Among contextual characteristics and individual characteristics, the predisposing factors 'social' and 'beliefs' were relevant. Health policy and organization as enabling factors were relevant to this systematic review according to contextual characteristics. Among individual characteristics financing and organization characteristics were enabling and evaluated and perceived need factors were also key findings from this systematic review (Magaard et al., 2017). None of our review papers identified relevant demographic details. The BMSHU Model does not specify health literacy. However, this review shows the importance of health literacy as a unique factor to explain help-seeking behaviour and we propose adding health literacy as a predisposing factor for both contextual and individual characteristics. Overall, the BHMSU model was overly complex for our findings.

This meta-aggregation found several pivotal obstacles to post-childbirth care, which has enabled the development of a new framework for understanding barriers and facilitators to women's help-seeking for maternal morbidities (Fig. 4). We placed women's perception of need at the centre, surrounded by interpersonal communication with trusted others, and all encompassed by society's views of women and childbirth. A comprehensive study of women's post-childbirth behavioural and psychosocial health care, acknowledging social factors is necessary to address gaps in care. The recognition of these gaps, in turn, can be helping to enhance care and meet guidelines for better post childbirth care.

Implication for practices

WHO (1998) two decades ago suggested a more comprehensive schedule for postpartum care (6–12 h, 3–6 days, 6 weeks, 6 months), with current guidelines by WHO (2015) ended by 6 weeks. Our review suggests that extending offered care by health care providers to 12 months after childbirth, might enable mothers' help-seeking for maternal morbidities and protect the women's health and consequently families' health. Our review also highlights the role for informed health care workers in routine questioning about morbidities to bypass women's lack of perceived need. This could be via a checklist to remind health care workers to collect the required information from the mother and if appropriate, their partner (Phang et al., 2015). Additionally, better educational preparation of women and their families about maternal morbidities during pregnancy or the during hospital stay could enable help-seeking behaviours.

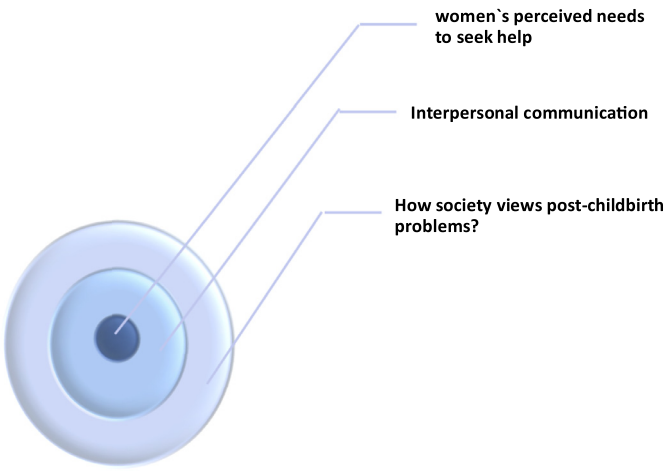

Fig. 4. A model of key influences on women's help-seeking for maternal morbidities.

Further, health service managers need to ensure that access barriers are addressed through quality needs assessment processes, particularly for vulnerable women.

Limitations

The meta-aggregation approach considers extracted themes from supporting statements such as the participant's experiences or quotes and creates new knowledge through synthesis not new analysis. This study included papers which reported depression and pelvic issues, but research addressing other common post-childbirth morbidities were not found and it is possible that we failed to identify all available literature. Given quantitative papers show a wide range of morbidities it can be assumed that there is a need for further primary research into women's experiences of post-childbirth help-seeking. Only papers written in English were included and all the studies located were conducted in developed countries, so there is limited applicability of the findings to women in developing countries.

Conclusion

This review found that women often do not recognise morbidities, or are disinclined to reveal physical and mental post-childbirth morbidities in the primary care setting. We also found that health professionals do not facilitate discussion of post-childbirth morbidities and may have a lack of awareness of evidence-based management of post-childbirth morbidities. Societal lack of knowledge about maternal morbidities was also found by this review suggesting the need for improved health literacy among family, health care providers and the community about these problems are necessary. We identified a model of women's

help-seeking for maternal morbidities that addresses our findings more closely than the BHMSU model. The review has highlighted that there is limited literature from a women's perspective about post-childbirth help-seeking and lack of research in this area may negatively influence policy. Given the identified barriers to help-seeking for women further research and review of the content, quantity and quality of care after childbirth are recommended.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2019.02.005.

References

Abrams, L.S., et al., 2009. Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. Qual. Health Res. 19 (4), 535–551.
Abushaikha, L., Khalaf, I., 2014. Exploring the roles of family members in women's decision to use postpartum healthcare services from the perspectives of women and health care providers. Women Health 54 (6), 502.
Anderson, R.M., et al., 2011. Improving access to care in America. In: Kominski, G.F. (Ed.), Changing the U.S. Health Care system: Key issues in Health Services Policy and Management. John Wiley and Sons, USA.
Ansara, D., et al., 2005. Predictors of women's physical health problems after childbirth. J. Psychosom. Obstet. Gynecol. 26 (2), 115–125. doi:10.1080/01443610400023064.
Armitage, C.J., Conner, M., 2001. Efficacy of the theory of planned behaviour: a meta-analytic review. Br. J. Soc. Psychol. 40 (4), 471–499. doi:10.1348/014466601164939.
Bell, L., et al., 2016. Barriers and facilitators to the use of mental health services by women with elevated symptoms of depression and their partners. Issues Ment. Health Nurs. 37 (9), 651–659. doi:10.1080/01612840.2016.1180724.
Beake, S., et al., 2010. A qualitative study of the experiences and expectations of women receiving in-patient postnatal care in one English maternity unit. BMC Pregnancy Childbirth 10, 70. doi:10.1186/1471-2393-10-70.
Bina, R., 2014. Seeking help for postpartum depression in the Israeli Jewish Orthodox Community: factors associated with use of professional and informal help. Women Health 54 (5), 455–473. doi:10.1080/03630242.2014.897675.
Brown, S., et al., 2015. Consultation about urinary and faecal incontinence in the year after childbirth: a cohort study. BJOG 122 (7), 954–962. doi:10.1111/1471-0528.12963.
Bradley, E.H., et al., 2002. Expanding the Andersen Model: The Role of Psychosocial Factors in Long-Term Care Use. Health Services Research 37 (5), 1221–1242. doi:10.1111/1475-6773.01053.
Bryant, A., et al., 2016. Women's use of health care in the first 2 years postpartum: occurrence and correlates. Matern. Child Health J. 20 (1), 81–91. doi:10.1007/s10995-016-2168-9.
Buurman, M.B.R., Lagro-Janssen, A.L.M., 2013. Women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour: a qualitative interview study. Scand. J. Caring Sci. 27 (2), 406–413. doi:10.1111/j.1471-6712.2012.01044.x.
Cassiano, A.D.N., et al., 2015. Nursing care to woman in immediate puerperium: a narrative description. Revista de Pesquisa: Cuidado é Fundamental Online 7 (1), 2061. doi:10.9789/2175-5361.2015.v7i1.2061-2071.
Chandrasekara, W.S., 2016. Help seeking attitudes and willingness to seek psychological help: application of the theory of planed behavior. Int. J. Manag. Account. Econ. 3 (4), 233–245.
Cheng, C., Li, Q., 2008. Integrative review of research on general health status and prevalence of common physical health conditions of women after childbirth. Womens Health Issues 18. doi:10.1016/j.whi.2008.02.004.
Chew-Graham, C., et al., 2009. Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. BMC Family Practice 10. doi:10.1186/1471-2296-10-7.
Cooklin, A.R., et al., 2018. Physical health, breastfeeding problems and maternal mood in the early postpartum: a prospective cohort study. Archives Women's Ment. Health 21 (3), 365–374. doi:10.1007/s00737-017-0805-y.
Cornally, N., McCarthy, G., 2011. Help-seeking behaviour: a concept analysis. Int. J. Nurs. Pract. 17 (3), 280–288. doi:10.1111/j.1440-172X.2011.01936.x.
Creswell, W.J., 2013. Research Design, Qualitative, Quantitative and Mixed Methods Approaches. SAGE, USA.
Dennis, C., Chung-Lee, L., 2006. Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. Birth 33 (4), 323–331.
Diefenbach, M.A., Leventhal, H., 1996. The common-sense model of illness representation: theoretical and practical considerations. J. Soc. Distress Homeless 5 (1), 11–38. doi:10.1007/BF02090456.
Dixon-Woods, M., 2006. How can systematic reviews incorporate qualitative research? A critical perspective. Qualitative Research 6 (1), 27–44. doi:10.1177/1468794106058867.
Fahey, J.O., Shenassa, E., 2013. Understanding and meeting the needs of women in the postpartum period: the Perinatal Maternal Health Promotion Model. J Midwifery Womens Health 58 (6), 613–621. doi:10.1111/jmwh.12139.
Fonseca, A., Canavarro, M.C., 2017. Women's intentions of informal and formal help-seeking for mental health problems during the perinatal period: the role of perceived encouragement from the partner. Midwifery 50, 78–85. doi:10.1016/j.midw.2017.04.001.
Foulkes, M., 2011. Enablers and barriers to seeking help for a postpartum mood disorder. J. Obstet. Gynecol. Neonatal Nurs. 40 (4), 450–457. doi:10.1111/j.1552-6909.2011.01264.x.
Glazener, C.M.A., et al., 1995. Postnatal maternal morbidity: extent, causes, prevention and treatment. BJOG 102 (4), 282–287. doi:10.1111/j.1471-0528.1995.tb09132.x.
Goodman, J.H., Santangelo, G., 2011. Group treatment for postpartum depression: a systematic review. Arch Womens Ment Health 14 (4), 277–293. doi:10.1007/s00737-011-0225-3.
Goyal, D., et al., 2015. Postpartum depression among Asian Indian mothers. MCN Am. J. Matern. Child Nurs. 40 (4), 256–261. doi:10.1097/NMC.0000000000000146.
Hannes, K., Lockwood, C., 2011. Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. J. Adv. Nurs. 67 (7), 1632–1642. doi:10.1111/j.1365-2648.2011.05636.x.
Haran, C., et al., 2014. Clinical guidelines for postpartum women and infants in primary care—a systematic review. BMC Pregnancy Childbirth 14 (1), 1–9. doi:10.1186/1471-2393-14-51.
Hardee, K., et al., 2012. Maternal morbidity: neglected dimension of safe motherhood in the developing world. Glob. Publ. Health 7 (6), 603–617. doi:10.1080/17441692.2012.668919.
JBI, 2011. Joanna Briggs Institute Reviewers' Manual: 2011 Edition. The Joanna Briggs Institute.
Kadushin, C.. Introduction to social network theory.
Khajehei, M., et al., 2015. Prevalence and risk factors of sexual dysfunction in postpartum Australian women. J. Sex. Med. 12 (6), 1415–1426. doi:10.1111/jsm.12901.
Khalaf, I.A., et al., 2009. Jordanian health care providers' perceptions of postpartum health care. International Nursing Review 56 (4), 442–449. doi:10.1111/j.1466-7657.2009.00733.x.
Korhonen, A., et al., 2013. Meta-synthesis and evidence-based health care - a method for systematic review. Scandinavian Journal of Caring Sciences 27 (4), 1027–1034. doi:10.1111/scs.12003.
Lockwood, C., et al., 2015. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. Int. J. Evid. Based Healthc. 13 (3), 179–187. doi:10.1097/xeb.0000000000000062.
Magaard, J.L., et al., 2017. Factors associated with help-seeking behaviour among individuals with major depression: a systematic review. PLoS One 12 (5), 1–17. doi:10.1371/journal.pone.0176730.
Maher, J., Souter, K., 2014. 'It's much easier to get help for the baby': women, postpartum health and maternal and child health care groups. Health Sociol. Rev. 15 (1), 104–111. doi:10.5172/hesr.2006.15.1.104.
Mazzo, D., et al., 2015. Empirical indicators of the affected human needs of puerperal women: Validation by focus group. Online Brazilian Journal of Nursing 14 (1), 41–50.
McCallum, S.M., et al., 2011. Unsettled infant behaviour and health service use: a cross-sectional community survey in Melbourne, Australia. J. Paediatr. Child Health 47. doi:10.1111/j.1440-1754.2011.02032.x.
McCauley, K., et al., 2011. Midwives and assessment of perinatal mental health. Journal of Psychiatric & Mental Health Nursing 18 (9), 786–795. doi:10.1111/j.1365-2850.2011.01727.x.
McGovern, P., et al., 2007. Mothers' health and work-related factors at 11 weeks postpartum. Ann. Fam. Med. 5 (6), 519–527. http://dx.doi.org/10.1370/afm.751.
Merry, L.A., et al., 2011. Refugee claimant women and barriers to health and social services post-birth. Can. J. Publ. Health 102 (4), 286–290.
O'Mahen, H.A., Flynn, H.A., 2008. Preferences and perceived barriers to treatment for depression during the perinatal period. J Womens Health (Larchmt) 17 (8), 1301–1309. doi:10.1089/jwh.2007.0631.
Phang, K.N., et al., 2015. Postpartum social support of women in Singapore: A pilot study. International Journal of Nursing Practice 21, 99–107. doi:10.1111/ijn.12340.
Park, V.T., et al., 2017. Postpartum traditions, mental health, and help-seeking considerations among Vietnamese American Women: a Mixed-Methods Pilot Study. J. Behav. Health Serv. Res. 44 (3), 428–441. doi:10.1007/s11414-015-9476-5.
Pescosolido, B.A., 1991. Illness careers and network ties: a conceptual model of utilization and compliance. Adv. Med. Sociol. 2 (16), 164–181.
Romano, M., 2010. Postpartum period: three distinct but continuous phases. Journal of prenatal medicine 4 (2).
Rudman, A., Waldenström, U., 2007. Critical views on postpartum care expressed by new mothers. BMC Health Services Research 7 (1), 178. doi:10.1186/1472-6963-7-178.
Sword, W., et al., 2008. Women's care-seeking experiences after referral for postpartum depression. Qual. Health Res. 18 (9), 1161–1173. doi:10.1177/1049732308321736.

Van der Woude, D.A., et al., 2015. Health status and quality of life in postpartum women: a systematic review of associated factors. Eur. J. Obstet. Gynecol. Reprod. Biol. 185, 45–52. http://dx.doi.org/10.1016/j.ejogrb.2014.11.041.

Vanderkruik, R.C., et al., 2013. Framing maternal morbidity: WHO scoping exercise. BMC Pregnancy Childbirth 13, 213. http://dx.doi.org/10.1186/1471-2393-13-213.

WHO, 1998. Safe motherhood, postpartum care of the mother and newborn: a practical guide Report of a technical working group.

WHO. (2015). Pregnancy, Childbirth, Postpartum and Newborn Care: a guide for essential practice.

Wilkie, S., et al., 2017. Assessing physical symptoms during the postpartum period: reliability and validity of the primary health questionnaire somatic symptom subscale (PHQ-15). J. Psychosom. Obstet. Gynaecol. 1–8. doi:10.1080/0167482X.2017.1289167.

Wittkowski, A., et al., 2012. The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. J. Reprod. Infant Psychol. 30 (5), 480–492. doi:10.1080/02646838.2011.639014.

Woolhouse, H., et al., 2009. Seeking help for anxiety and depression after childbirth: results of the Maternal Health Study. Arch. Womens Ment. Health 12 (2), 75–83. doi:10.1007/s00737-009-0049-6.

Wittkowski, A., et al., 2017. The Experience of Postnatal Depression in Immigrant Mothers Living in Western Countries: A Meta-Synthesis. Clinical Psychology & Psychotherapy 24 (2), 411–427. doi:10.1002/cpp.2010.

Wuytack, F., et al., 2015. The health-seeking behaviours of first-time mothers with persistent pelvic girdle pain after childbirth in Ireland: a descriptive qualitative study. Midwifery 31 (11), 1104–1109.

Appendix II. Excluded studies and the reasons for exclusion

Reference	Reason for exclusion
(Abrams & Curran, 2009)	Not outcome of interest, no help-seeking behaviour
(Agapidaki et al., 2015)	Conference paper
(Atif et al., 2016)	Not participants of interest, pregnant women and those who had a child less than 3 months old
(Ahmed et al., 2017)	Not participants of interest, 8 pregnant women and 8 postpartum
(Bilszta et al., 2010)	Not clear about participants, time frame
(Chan et al., 2002)	Not phenomena of interest
(Chan et al., 2009)	Not phenomena of interest
(Chew-Graham et al., 2009)	Not outcome of interest
(Fikree et al., 2004)	Not phenomena of interest, care-seeking behaviour
(Foulkes, 2011)	Not participants of interest, Had kid less than 24 months
(Ganle, 2015)	Not participants of interest, Pregnant and postpartum
(Ganle et al., 2014)	Not participants of interest, Pregnant and postpartum
(Gardner et al., 2014)	Not participants of interest, having had a baby in the past 24 months
(Guy et al., 2014)	Not participants of interest, Participants were 12 to 24 months postpartum, and three participants reported being pregnant.
(Hartley et al., 2012)	Not phenomena of interest
(Higgins et al., 2016)	Not phenomena of interest, Pregnancy, childbirth and immediate postnatal period in hospital.
(Hoang et al., 2009)	Not phenomena of interest, women who have had childbirth experiences within the last five years
(Holopainen, 2002)	Not participants of interest, Unknown infant age, time frame
(Jackson et al., 2016)	Not phenomena of interest, giving birth in the previous two years
(Lara-Cinisomo et al., 2014)	Not phenomena of interest, prenatal and postpartum
(Letourneau et al., 2007)	Not participants of interest, women had to report they experienced symptoms of PPD within the past 2 years
(Li et al., 2014)	Not participants of interest, maternal and child healthcare workers as participants
(Matsuoka et al., 2010)	Not phenomena of interest, barrier to access maternal health services
(Nakku et al., 2016)	Not phenomena of interest, pregnant and postpartum
(Newbrander et al., 2014)	Not phenomena of interest, Perinatal period
(O'Mahony & Donnelly, 2013)	Not phenomena of interest, within the past 5 years;
(Ong et al., 2014)	Not phenomena of interest, first-time mothers' postnatal experiences and support needs after hospital discharge
(Probandari et al., 2017)	Not participants of interest
(Renzaho & Oldroyd, 2014)	Not participants of interest, with at least one child aged 3 years
(Roost et al., 2009)	Not phenomena of interest,
(Russo et al., 2015)	Not participants of interest, required to have a child under the age of 5 years,
(Sacks et al., 2017)	Not participants of interest,
(Sampson et al., 2014)	Not participants of interest,18 months and had been screened for PPD was eligible to participate in the study
(Sharma et al., 2016)	Not participants of interest, pregnancy and/or with a child under the age of two;
(Sialubanje et al., 2014)	Not participants of interest, One mothers between 15-19 years old
(Suplee et al., 2014)	Not phenomena of interest, self and infant care
(Titaley et al., 2010)	Not phenomena of interest, Antenatal and postnatal
(Thorstensson et al., 2016)	Not phenomena of interest, professional support at the maternity ward
(Woodward et al., 2016)	Not phenomena of interest, women's experiences of the different forms of post-birth care

References

Abrams, L. S., & Curran, L. (2009). "AND YOU'RE TELLING ME NOT TO STRESS ?" A GROUNDED THEORY STUDY OF POSTPARTUM DEPRESSION SYMPTOMS AMONG LOW-INCOME MOTHERS. *Psychology of Women Quarterly, 33*(3), 351-362.

Agapidaki, E., et al. (2015). Help seeking behaviour of depressive mothers in the context of a weak primary health care system. A qualitative study. *European Psychiatry, 30*, 1558.

Ahmed, A., et al. (2017). Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy and Childbirth, 17*. doi:10.1186/s12884-017-1433-2

Atif, N., et al. (2016). Barefoot therapists: barriers and facilitators to delivering maternal mental health care through peer volunteers in Pakistan: a qualitative study. *International Journal of Mental Health Systems, 10*. doi:10.1186/s13033-016-0055-9

Bilszta, J., et al. (2010). Women's experience of postnatal depression -- beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing, 27*(3), 44-54.

Chan, S. W., et al. (2002). A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. *Journal of Advanced Nursing, 39*(6), 571-579.

Chan, S. W., et al. (2009). A comparative study of the experiences of a group of Hong Kong Chinese and Australian women diagnosed with postnatal depression. *Perspectives in Psychiatric Care, 45*(2), 108-118. doi:10.1111/j.1744-6163.2009.00211.x

Chew-Graham, C., et al. (2009). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice, 10*. doi:10.1186/1471-2296-10-7

Fikree, F. F., et al. (2004). Health service utilization for perceived postpartum morbidity among poor women living in Karachi. *Social Science & Medicine, 59*(4), 681-694. doi:10.1016/j.socscimed.2003.11.034

Foulkes, M. (2011). Enablers and Barriers to Seeking Help for a Postpartum Mood Disorder. *Jognn-Journal of Obstetric Gynecologic and Neonatal Nursing, 40*(4), 450-457. doi:10.1111/j.1552-6909.2011.01264.x

Ganle, J. K. (2015). Why Muslim women in Northern Ghana do not use skilled maternal healthcare services at health facilities: A qualitative study Healthcare availability and accessibility. *BMC International Health and Human Rights, 15 (1) (no pagination)*(10).

Ganle, J. K., et al. (2014). A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. *BMC Pregnancy & Childbirth, 14*, 425.

Gardner, P. L., et al. (2014). The experience of postnatal depression in West African mothers living in the United Kingdom: a qualitative study. *Midwifery, 30*(6), 756-763.

Guy, S., et al. (2014). Mental Health Literacy and Postpartum Depression: A Qualitative Description of Views of Lower Income Women. *Archives of Psychiatric Nursing, 28*(4), 256-262. doi:10.1016/j.apnu.2014.04.001

Hartley, S., et al. (2012). 'You're more likely to tell the GP if you're asked': women's views of care from general practitioners in the first postpartum year. *Australian Journal Of Primary Health, 18*(4), 308-312. doi:10.1071/py11111

Higgins, A., et al. (2016). Mothers with mental health problems: Contrasting experiences of support within maternity services in the Republic of Ireland. *Midwifery, 36*, 28-34. doi:10.1016/j.midw.2016.02.023

Hoang, H. T., et al. (2009). Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia. *Rural & Remote Health, 9*(1), 1084.

Holopainen, D. (2002). The experience of seeking help for postnatal depression. *Australian Journal of Advanced Nursing, 19*(3), 39-44.

Jackson, R., et al. (2016). Health Extension Workers' and Mothers' Attitudes to Maternal Health Service Utilization and Acceptance in Adwa Woreda, Tigray Region, Ethiopia. *PLoS One, 11*(3), e0150747. doi:10.1371/journal.pone.0150747

Lara-Cinisomo, S., et al. (2014). Perinatal depression treatment preferences among Latina mothers. *Qual Health Res, 24*(2), 232-241. doi:10.1177/1049732313519866

Letourneau, N., et al. (2007). Canadian mothers' perceived support needs during postpartum depression. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 36*(5), 441-449.

Li, C., et al. (2014). Coverage, quality of and barriers to postnatal care in rural Hebei, China: a mixed method study. *BMC Pregnancy and Childbirth, 14*. doi:10.1186/1471-2393-14-31

Matsuoka, S., et al. (2010). Perceived barriers to utilization of maternal health services in rural Cambodia. *Health Policy, 95*(2-3), 255-263. doi:10.1016/j.healthpol.2009.12.011

Nakku, J. E., et al. (2016). Perinatal mental health care in a rural African district, Uganda: a qualitative study of barriers, facilitators and needs. *BMC Health Serv Res, 16*, 295. doi:10.1186/s12913-016-1547-7

Newbrander, W., et al. (2014). Barriers to appropriate care for mothers and infants during the perinatal period in rural Afghanistan: a qualitative assessment. *Glob Public Health, 9 Suppl 1*(SUPPL.1), S93-109. doi:10.1080/17441692.2013.827735

O'Mahony, J. M., & Donnelly, T. T. (2013). How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing, 20*(8), 714-725. doi:10.1111/jpm.12005

Ong, S. F., et al. (2014). Postnatal experiences and support needs of first-time mothers in Singapore: A descriptive qualitative study. *Midwifery, 30*(6), 772-778. doi:10.1016/j.midw.2013.09.004

Probandari, A., et al. (2017). Barriers to utilization of postnatal care at village level in Klaten district, central Java Province, Indonesia. *BMC Health Services Research, 17*, 1-9. doi:10.1186/s12913-017-2490-y

Renzaho, A. M., & Oldroyd, J. C. (2014). Closing the gap in maternal and child health: a qualitative study examining health needs of migrant mothers in Dandenong, Victoria, Australia. *Maternal & Child Health Journal, 18*(6), 1391-1402.

Roost, M., et al. (2009). Social differentiation and embodied dispositions: a qualitative study of maternal care-seeking behaviour for near-miss morbidity in Bolivia. *Reprod Health, 6*(13), 13. doi:10.1186/1742-4755-6-13

Russo, A., et al. (2015). A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia. *BMC Pregnancy Childbirth, 15*(197), 197. doi:10.1186/s12884-015-0631-z

Sacks, E., et al. (2017). Postnatal Care Experiences and Barriers to Care Utilization for Home- and Facility-Delivered Newborns in Uganda and Zambia. *Maternal and Child Health Journal, 21*(3), 599-606. doi:10.1007/s10995-016-2144-4

Sampson, M., et al. (2014). A disease you just caught: Low-income African American mothers' cultural beliefs about postpartum depression. *Women's Healthcare: A Clinical Journal for NPs, 2*(4), 44-50.

Sharma, S., et al. (2016). Dirty and 40 days in the wilderness: Eliciting childbirth and postnatal cultural practices and beliefs in Nepal. *BMC Pregnancy Childbirth, 16*(1), 147. doi:10.1186/s12884-016-0938-4

Sialubanje, C., et al. (2014). Understanding the psychosocial and environmental factors and barriers affecting utilization of maternal healthcare services in Kalomo, Zambia: a qualitative study. *Health Education Research, 29*(3), 521-532.

Suplee, P. D., et al. (2014). Low-income, urban minority women's perceptions of self- and infant care during the postpartum period. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 43*(6), 803-812.

Thorstensson, S., et al. (2016). To build a bridge between two worlds: Mothers' experiences of professional support at the maternity ward. *Health Care for Women International, 37*(10), 1067-1081.

Titaley, C. R., et al. (2010). Why don't some women attend antenatal and postnatal care services?: a qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. *BMC Pregnancy & Childbirth, 10*, 61.

Woodward, B. M., et al. (2016). Beyond birth: Women's concerns about post-birth care in an Australian urban community. *Women & Birth: Journal of the Australian College of Midwives, 29*(2), 153-159.

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer_____Date_____

Author _____Year_____Record Number_____

		Yes	No	Unclear	Not applicable
1.	Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2.	Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3.	Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4.	Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5.	Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6.	Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7.	Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8.	Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9.	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10.	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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Appendix IV: Summary of data extraction

Author	Finding	Illustration	Category
(Abrams et al., 2009)	**Phase thinking about symptoms;**		**Women did not seek help because they accepted problems as a part of the motherhood role.**
	All participants initially minimized, normalized or hide their symptoms from themselves and others believing it was normal or demonstrated they were not good mothers or were.	`Well, that's not postpartum, you know.' . . . I guess, I couldn't decipher completely what I was going through. . . . I was thinking at first, "Well you know, you just had the baby, relax.'(p. 540)	
	Women had fears of being judged or labelled as "crazy," "schizo," or "psycho."	`I thought at a moment I might have had postpartum depression, but I jumped back into place, like I better jump into place an' get with it because I don't want anyone to think that I'm crazy or I'm incapable to raise my child.'(p. 541)	**Fear of being judged prevented women from seeking help.**
	Women asserted that being a good mother means that they didn't get depression and depression cannot happen for strong mothers.	`Well I would listen to others say that when they had a baby they would get depressed but I think no that's not true since that had never happened to me. They're exaggerating. I would think they were immature . . . that's what I thought.' (p. 541)	**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Phase seeking advice;		**Women`s first strategies to share their problems with trusted people.**
	Women after initial hesitation, asked mostly trusted family members who also normalised symptoms, most also encouraged them to seek help from professionals.	`At least my husband when I tell him, "I feel bad, I feel sad," he tells me, "You want to take a walk somewhere?" or "Do you want to do something?" or "Do you want to be alone?" He always says, "But, who do we ask? Who do we ask? Next time you go to the doctor ask him about how you're feeling.'	

	Phase seeking advice; Half of the mothers sought help from health providers (e.g. physician, nurse, gynecologist, ED doctor) but mostly perceived responses an unhelpful because 1) they advised 'wait and see' to sometimes severe symptoms or 2) prescribed medication which women felt was not a viable option.	`The doctor said . . . to wait until I come back for my six week, and if I continued to feel that way, he'll prescribe something for me.` (p. 542) `Marta: I went to the doctors and they gave me Xanax and I said, "I'm not gonna take it," and they say, "Just take when you feel like you can help things and just to relax but don't drink it all the time." And I got it but I threw them away in the toilet.'(p. 543)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Phase rejecting formal care; Women rejected professional care as `not the right help for me` and interpret the "medication first" approach as "uncaring". Past medical treatment was reminding pictures of "white coats," "clipboards," and "laboratory testing" as unhelpful experience.	`What they did was, they had you answer these questions on a clipboard of your family history, are you emotional, just like those type of questions, and of course I put it all "No" . . . to them, but I was kind of like having problems with like things that have happened in the past with my family, you know like my mom, she's used drugs—like that type of thing.'(p. 543)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Women preferred to talk about their problems with the "ideal" person to listen to their problems.	`As long as they're [providers] a person. . . . Like now, today, it's like you're here. You couldn't tell you're a psychologist you just look like a regular woman, just coming just to listen . . . and I wouldn't like somebody all dressed up and looking like, you know what I'm saying? Just looking like they're doing an experiment you know, but just look like a regular person, just to listen.'(p. 543)	**Women`s first strategies to share their problems with trusted people.**
	One of the strategies among women was `talking it out`.	`The best thing you can do to deal with depression is to talk about it. Find somebody that you trust, not just someone to be talking [to], find someone you can trust or seek professional help because it will help. Depression is really, really something that is difficult to deal with.'(p. 544)	**Women`s first strategies to share their problems with trusted people.**
	`Familism` or cultural norms banned women to talk about their mental health issues because of potential shame and fear of judgment of talking	`I don't know I think sometimes we are ashamed, for the majority of us we are ashamed to talk about a certain family problem with	**The women's cultural context was an essential factor in**

	to others about private matters. Although some mothers believed in familism but preferred to talk with `stranger`.	someone that you don't know. But sometimes it's better to talk to a stranger than to a family member that gives you bad advice. But sometimes you're not that comfortable talking to someone outside the family. But, at least when you trust a psychologist you know that information is not going to get out.'(p. 544)	**whether or how they sought help.**
	The unconditional admission of the maternal role of these mothers lead to them did not seek mental support.	`Well its people that have had hard lives, life's full of hardship that they don't feel empowered that they can change those hardships in their life, and so they do the best they can, and they just have to do it all the time. No matter how bad it gets, that's their approach to life because that's how their life is.'(p. 545)	**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Phase caring for the self; Lack of formal care leads to self-care practices such as religious practices as a source of strength, comfort, and healing.	`Some of the Christian sisters, they've had depression symptoms and the church has taken it all away. So when you start to experience the symptoms of depression, to the people who have suffered from depression, you need to start hearing Christian music and pray to God. . . . So that is what has helped me so I don't pay attention when I get those symptoms. I tell myself that this will not happen to me and it will pass. I lift my self-esteem myself.'(p. 545)	**Women`s first strategies to share their problems with trusted people.**
	In addition to religion and prayer, mothers described an array of emotional, cognitive, and behavioral strategies to manage their PPD symptoms. Consisted of crying and releasing emotions, reaching out to family members, and talking to other mothers.	`Interviewer: So tell me, what do you know about postpartum depression? Alicia: That it is real. It is real and all those men that get on TV and say, "Oh you don't need to do this," or, "You don't need to do that," or that "it's not real," I shun them. I shun them because they'll never know how somebody is feeling after everything someone has been through. It is life changing.'(p. 546)	**The women's cultural context was an essential factor in whether or how they sought help.**
(Bell et al., 2016)	**Facilitators and Barriers for Use of Mental Health Care Services**		
	The first principal: Accessibility and Proximity	`The other thing that might be a good idea ... webinars and	**Women found that post-childbirth care**

	Women preferred services that offered at home or close to their home but E-health options like Wbinar was useful for isolated mothers. The other factors experienced by women: costs related to services, a perceived health care professional shortage, time and waiting at the hospital and difficulties obtaining reliable information as a barrier to her use of services.	telediscussion ... for people who, like myself, feel isolated at home and would like to be able to at least speak to or read up on the different topics that affect new mothers.'(p. 653) `The specialist is the psychiatrist. But the psychiatrist is not readily available, and by the time you get that appointment 7-months later, things have manifested themselves to a different degree and you could have prevented the growth of whatever anxiety that the person had. You could have suppressed it earlier.'(p. 653)	**was difficult to access or did not address their problems.**
	The second principal: Appropriateness and Fit While women report the routine care that they received was mainly focused on the baby's needs and healthcare professionals did not address their mental health needs at some point during the perinatal period. Women asserted that the gynaecologist was not sensitive or responsive to her mental health status.	`I find they just like brush you off ... my gyne doctor, I thought she would help, she would understand, cause she works in the field. And instead she just like didn't care. I honestly felt that she didn't care and I felt so alone.'(p. 654)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	The physical environment was a barrier for some of women to seek help.	`I felt everyone was looking at each other, myself included. I was looking at people I felt they were looking at me. I felt like everyone is probably wondering what is this person doing here and vice-versa. When you go up, especially to where her office is, the hallways are so tiny and sterile. I feel like it's not warm and inviting.'(p. 654)	**Fear of judgment was the reason to hinder seeking help.**
	The third principal: Stigma Women who perceived being labelled with a mental health illness, it played a role as a barrier to their access of mental health services.	`I'm like I don't wanna be labeled you know. It's like you always feel like you're being labeled as a psychiatric patient.'(p. 655)	**Fear of being judged prevented women from seeking help.**
	The forth principal: Encouraged by Significant Others to Seek Help Women encouraged by family to seek a help.	`But I have even talked to my husband, I told him what they gave to me. He said, "okay, it could be good, you lose nothing, call. You don't feel good, call."(p. 655)	**Family and friends could be influenced to choose to seek help or not.**

	Women mentioned lack of understanding and support by partner and family was a barrier to seek help.	`My mother doesn't want to look after the baby so I can see my psychologist. She believes I don't need it. I have no support from her for this.'(p. 656)	**Family and friends could be influenced to choose to seek help or not.**
	Women asserted that an existing relationship with a healthcare professional was a facilitator to use mental health services.	`So we need to have a close relationship with healthcare providers, a really close relationship with healthcare providers, at least one, to have access to ... So you have a better surveillance of your health problems.'(p. 656)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	The fifth principal: personal Characteristics		
	Indecision about following through with treatment: Women noted that indecision about following through with treatment as a barrier to take care.	`I don't think I ever would have went back anyways. Not because of them, they were very nice. Maybe more because of me. I just didn't know what I wanted at the time and I didn't know what I wanted to get out of it. I didn't know what was going on.'(p. 656)	**lack of health knowledge about post-childbirth problems meant women did not seek help.**
	A belief they can manage symptoms on their own Women believed that they can manage symptoms on their own.	`I don't know. Like to start, I'm not one to go to people when I need like help in the first place. I can really just go to husband or my sister. So I won't open up to my own friends. I won't, I don't know if I'd even go to a psychologist and like freely talk about myself ... In general, I really don't think so .'(p. 656)	**Category 1 - Women did not seek help because they accepted problems as a part of the motherhood role.**
(Buurman & Lagro-Janssen, 2013)	**The first core themes: Inevitable and disappointing problems**		**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Women acquiesced in the problems and accepted the problems as normal not as ailment or disease.	`I simply thought: the urinary incontinence is just part of it. Your whole body is turned inside out after delivery anyway. So I thought it's just part of the game.'(29 years, uncomplicated home delivery, first child).'(p. 408)	
	Women asserted that the problems were worse than expected. Especially, the post-delivery genital pain was worse than they had anticipated.	'Well, actually I never knew you could have so much pain. I knew you'd have some pain. Nor did I know you'd be unable to control urine loss. I never knew that.'(19	

		years, vacuum extraction hospital delivery, first child).'(p. 408)	
	The second core themes: Natural recovery		**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Women believed that their problems gradually decreased. They hoped that their problems will be resolved spontaneously.	'It's like there's a train that's driven right through you. I understand that your body needs time to recover. If I just look after myself properly and don't neglect my body, I expect this prolapse won't be so painful after a while'. (34 years, uncomplicated hospital delivery, second child) 'I handled it [urinary incontinence] without making much of a fuss. It'll pass off, I suppose.'(34 years, uncomplicated home delivery, fourth child).'(p. 409)	
	Some of the women indicated that they have the more important thing on their mind, so their priorities are not their health.	'When you've just had a delivery, you've got a thousand things on your mind and you're a bit of a scatterbrain. So to be honest, I wasn't really thinking about my problem holding my stools in, as I had more important things on my mind. I just thought: it'll be all right.' (23 years, vacuum extraction hospital delivery, first child).'(p. 409)	**Women did not seek help because they accepted problems as a part of the motherhood role.**
	The third core themes: Feelings of shame		**Fear of being judged prevented women from seeking help.**
	Feeling of shame mentioned by women as a reason to hinder help-seeking or just talked with family and friends. Talking about pelvic issues considered as a taboo.	'You know, sometimes I'm chatting with a friend who also has young children. But still, haemorrhoids are out of bounds, you know, they're not really a topic of conversation. And I have to admit I find haemorrhoids a pretty embarrassing thing to have'. (34 years, uncomplicated hospital delivery, second child) 'So you're thinking to yourself, I hope nobody else will smell it [loss of urine]. It does make you feel uncomfortable.'(37 years, uncomplicated home delivery, second child).' (p. 409)	
	Several women declared embarrassment as a barrier to seeking help. But they agreed that if the healthcare providers asked them the direct	'I think asking direct questions about it [pelvic floor problems] is a good idea. For when they ask you an open question, perhaps it's difficult to mention the subject,	**Fear of being judged prevented women from seeking help.**

	question about pelvic floor problems, it would be helpful for women that these are a normal subject to talk about to your doctor.	especially when you're embarrassed or you're not sure whether this is normal or not.'(32 years, uncomplicated hospital delivery, first child).' (p. 409). 'I think asking direct questions about it [pelvic floor problems] is a good idea. For when they ask you an open question, perhaps it's difficult to mention the subject, especially when you're embarrassed or you're not sure whether this is normal or not.'(32 years, uncomplicated hospital delivery, first child).' (p. 409)	
	Women asserted that their self-image negatively affected and no control over their body.	'When you've just delivered a baby, you're dirty. You're losing a lot of blood, you're wearing giant nappies in your knickers, and you're wearing giant knickers for a start. You've got a big fat blubbering belly, and your self-esteem is flat as a pancake. If on top of that you wet yourself and you've got haemorrhoids, this doesn't make it any easier, you're no longer what you used to be. It really affects your self-confidence.'(31 years, uncomplicated hospital delivery, second child).' (p. 410).	**Fear of being judged prevented women from seeking help.**
	The fourth core themes: **The role played by initiates and help-seeking behaviour**		**Family and friends could be influenced to choose to seek help or not.**
	Women searched help from the group of initiates: female relatives or close female friends who had already had deliveries. They convinced by initiates that it is the normal process of childbearing.	'No, I didn't call in medical help because my relatives, especially my mum and my gran, said that it would just pass off. So I was like if my mum and my gran say so, it'll be all right'. (23 years, vacuum extraction hospital delivery, first child) 'Well, because several women told me they lose a little urine sometimes. So I feel I'm not the only one and that this is quite normal.'(28 years, uncomplicated home delivery, second child).'(p. 410)	
	The fifth core themes: **Lack of information about pelvic floor dysfunction**		**Lack of health knowledge about post-childbirth problems meant**

	Women mentioned that they did not have any information about pelvic floor problems such as the relation between vaginal flatulence, constipation, sexual dysfunction, and reduced pelvic floor support function.	'I was very happy when I read that vaginal flatulence existed because I thought it was impossible, but it was possible indeed! Well, I don't know what's causing them, but I do think they're a pretty nuisance'. (36 years, uncomplicated hospital delivery, second child) (p. 410) I don't really understand the constipation. You see, that I'm not feeling the flatulence that has got something to do with pelvic floor weakness, but why I have constipation? I don't know'.(35 years, uncomplicated home delivery, second child) .' (p. 410)	**women did not seek help.**
	They asserted that health care providers did not inform them about pelvic floor dysfunction and treatment options.	'So I think that's very odd, that this midwife told me nothing about the pelvic floor during my pregnancy. She only said something about it at a check-up visit when I mentioned that I had such a heavy feeling. So it turns out that's your pelvic floor'!(35 years, uncomplicated home delivery, second child).'(p. 410)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Some women who agreed about doing exercise to help or remedy the problems but they did not know what exercises they have to do nor did they know how to do them.	'Well, I thought to myself sometimes: am I doing this right? For you might be training as much as you like and then find out afterwards that you're not doing the right exercises. So this would have no effect at all: you'd be training the muscles in your buttocks instead of the proper ones in your pelvic floor.' (32 years, vacuum extraction hospital delivery, second child).' (p. 410)	**Lack of health knowledge about post-childbirth problems meant women did not seek help.**
(Goyal et al., 2015)	**The second themes: maternal mental health help-seeking behaviour**		
	Seeking professional help as a last resort		**Women`s first strategies to share their problems with trusted people.**
	Mothers would share their problems if they could not cope with that.	'I would talk to my husband and my family about it. … if I really felt like I wanted to harm my baby or myself, then I would definitely seek help, because that is not acceptable to me.' (p.259)	

	Help-seeking influenced by generation values		**Women`s first strategies to share their problems with trusted people.**
	Mother` the different view about mental help-seeking lead to women prefer shared the problems with their age person.	'I think friends, if they are my age group… they do understand that you need to be treated… if it is a senior family member, they would just shun it and they would say, oh, there`s nothing wrong with you. Look at someone else whose situation is much worse. I think that`s the way they look at it and I don't think take depression as something serious. They think the fault is in you.'(p.259). I think in my parents` generation, the generation born in India, I think they probably just don`t see the importance of mental health. I think in my generation we`re sort of a do-it-yourself generation, so we`ll try to do what we can on our own, and then if it doesn`t work, go and see a therapist.' (p.260)	
	Importance of mental healthcare providers who understand the culture		**Accessible appropriate care out post-childbirth morbidities**
	Women declared that it is essential to find mental healthcare providers who understand the culture.	'Yeah, I think they (the therapist) should know about our culture. Yeah. I mean, I think our culture, and how we were brought up, it plays a role in our life. So, if at all they are seeking help, I think they (therapists) should consider all those factors, how we were brought up.' (p.260)	
	Preference of social support and complementary/alternative therapies		**Women`s first strategies to share their problems with trusted people.**
	Women mentioned that they prefer try alternative ways to resolve their problems such as talking to friends or seeking non-medicine methods.	'I think it could be taking time to talk with my friends about it. I think it could also be non-medication supplements maybe, all natural supplements, Ayurcedic supplements, homeo-pathic supplements.' (p.260)	
	STigma as a barrier to obtaining mental health care		**Fear of being judged prevented women from seeking help.**
	Working women worried about the stigma to find mental health care.	'I`d think twice because there`s always a stigma, if you`re working, what if there`s a depression attached to your charts…But, you know, generally I wouldn`t like to be labelled a depressed person or	

		someone with a psych disorder.' (p.260)	
	Wanting to seek mental healthcare anonymously Women had the desire to seek mental health care anonymously.	'There are quite a few forums, I could log into (HMO) and anonymously seek some advice…But I don't want to identify myself, but I still want advice' (p.260)	**Women`s first strategies to share their problems with trusted people.**
(Merry et al., 2011)	**The first themes:** **Isolation** Women reported being separated from family and friends, felt isolated and "no one to help" her.	"She is here as a refugee. She came alone and left her husband and 2 yr old child in China. She only speaks Mandarin. Mother is living in a small apartment with 4 other families she does not know - Mom claims none of them are her friends and they do not help her. No help, not enough food and not aware of social resources." (24 y.o., China, 1 yr 4 mos in Canada)'' (p.287)	**Women`s first strategies to share their problems with trusted people.**
	The second themes: **Language barriers** Immigrant women could not communicate well in English or French and their partner wasn't flue in the second language. Interpreters were not available and women could not easily express their concerns or understand teaching and information given.	"The woman claims the social worker told her she has to research [English] classes on the internet herself. The woman paid someone to interpret at her [prenatal] visits. Public health nurse called to check on mom and baby but there was no interpreter so they were not able to communicate." (26 y.o., Mexico, 8 mos in Canada, Toronto). (p.288)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	The third themes: **Low health literacy** Women lacked knowledge about self-care and baby care due to language barriers, teaching was poorly understood or not provided.	"Mother has had no nurse [visit] yet. She is a new mother who has very little info, intensive teaching had to be done... breastfeeding…mother does not know why she has to give vitamin D." (25 y.o., Mexico, 1 yr in Canada). (p.288)	**Lack of health knowledge about post-childbirth problems meant women did not seek help.**
	The forth themes: **Lacking psychosocial assessments, support and referrals** There was a lack of psychosocial assessments and support for PPD or abuse.	"She did not mention it [skipping meals] because the [nurse] had not asked." (33 y.o., Congo, 1.5 yrs in Canada, Montreal) "She [the mother] was unaware that there are health professionals who deal specifically with this type of abuse. She has never had any	**Women found that post-childbirth care was difficult to access or did not address their problems.**

		counselling." (25 y.o., Mexico, 11 mos in Canada, Toronto)	
	The fifth themes: **IFHP is limited and confusing** It was unclear to women and health care professionals which services were covered the Interim Federal Health Program (IFHP).	The following research nurse excerpts illustrate these challenges: "The doctor sent her [mother] for blood tests and did not tell her that they are not covered by insurance…" "Mom has lost her documentation [IFHP]. Her social worker is helping her to get it replaced, but have not been successful. Mom is concerned she may not have access to healthcare for herself at present…" (30 y.o., Nigeria, 10 mos in Canada, Toronto) "Paediatrician refused to see baby because she had no medicare. One month later the paediatrician gave her an appointment but when mother said she still had no medicare then he cancelled it." (36 y.o., Mexico, 6 mos in Canada, Montreal)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
(Park et al., 2017)	**The first themes:** **perceptions of the aetiology of sadness/depression**		**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Women mentioned that the conventional gender role for the woman serves as a contributor to sadness/depression. They expected instrumental and emotional support, as well as sympathy to help alleviate the stress, and ultimately, feelings of sadness/depression.	'I think sometimes we're not allowed to express our feelings. . . . And women, even in the family life, they are supposed to be submissive. And men are the ones that are dominant. So they can do whatever they want, and for women, it's like a second class. For example, in my family ...we're supposed to be like obedient and do whatever our parents say, whatever adult people say. They're right all the time.' (p. 436)	
	Women`s role in families was prone to depression.	'Oh, that's the woman. That's the mother's job. That's why it's hard sometimes. That's why I feel depressed. . . . Because I have to take care of the baby and do all the household work. That's another thing that contributes to the depression . . . I think the men need to be more supportive.' (p. 436)	
	The second themes:	'I think our Vietnamese never come to those services. Our	**The women's cultural context was an**

	Barriers to help-seeking: cultural barriers such as stigma and the lack of culturally appropriate care Most of the women stated that the lack of culturally appropriate care is a barrier, so they culturally were "not seeking care".	Vietnamese are very strong. American always comes to see counsellors. Majority of our Vietnamese don't come to see these professions. I have a strong mind. I am sad, but I don't need to see them.' (p. 437)	**essential factor in whether or how they sought help.**
(Sword et al., 2008)	**The first themes:** **Individual-Level Barriers**		
	Normalizing of symptoms Women thought that the symptoms are relate to motherhood or baby blue.	'It [probable depression] was just a shock to me. I mean I didn't notice I had it. I was just crying. I thought I had the baby blues, that's all. I was just crying for no reason, arguing with my husband, you know, yelling at my kids for no reason, taking everything out on everybody and I just didn't know why, and so you know she gave me the test [EPDS] and she said do you know that you have postpartum depression, I'm like, oh, I didn't know that. It was shocking.' (p. 1165)	**Women did not seek help because they accepted problems as a part of the motherhood role.**
	Limited understanding Women could not understand that their symptoms are related to depression and must seek help. They found help if they had thoughts of self-harm.	'People say that after having a baby . . . the iron level is low and other things, the hormone system changes, so you are depressed and frustrated and that remains for a few days or just for 1 or 2 weeks and after that it goes by itself, you don't need to do anything.' 'Um, just I didn't understand what was going on, you know what I mean? Like I knew . . . I suffered from anxiety prior to being pregnant and I was taking medication. I came off the medication because of the pregnancy. But then at that point when we figured out that maybe I could have been experiencing it [depression] when this nurse was here, I just like, ok, so? I didn't know what it was, whether it was anxiety or depression. That's why I was confused. Do you know what I mean? The baby blues, I didn't know.' (p. 1165)	**Lack of health knowledge about post-childbirth problems meant women did not seek help.**
	Waiting for symptom improvement	'I just told him [husband] if I'm not myself within 3 weeks, you know,	**Women did not seek help because they**

	Because women regarded their symptoms as normal or limited knowledge, they talked about waiting to seek care.	back to myself, and you can let me know to do something. . . . I just let the first couple of weeks go and then I figured if it persisted after 3 weeks I'd talk to somebody else about it.' (p. 1166)	**accepted problems as a part of the motherhood role.**
	Discomfort discussing mental health concerns Women explained `discomfort' to discuss their mental symptoms with health care providers and some of them described depression make them `feel weak'.	'Well, for me it is just something very private because to me, it's just weakness. . . . And I don't like to feel weak, like I can't handle something. For myself, I'll get over it, where I know other people get into that psychosis and they can't get over it and I don't fault them for that. What I fault is myself for feeling weak. . . . I just don't like to feel this oh, I can't do it. I hate feeling like that, you know.' (p. 1166)	**Fear of being judged prevented women from seeking help.**
	Fears Women were worried future career and labelled as 'bad mother' and fear about child apprehension.	'I'm afraid if, you know, if my mental condition is not good who is going to hire me? They always take, you know, they usually take your health information from your doctor, right?"(p. 1166) I hold him and I feed him and I change him, but I'm not happy, and I felt so guilty about that and that was kind of hard to admit to people because, you know, I was so afraid I'd be seen as a bad mother, you know. And that was hard to even admit to [my] husband that I don't feel happy, I have this beautiful baby but ' I'm not happy '.(p. 1166) Well, I was nervous about it at first. I didn't really want to go because I didn't want anyone to think I was crazy. And I know postpartum depression some people get like postpartum psychosis and I was worried that they would think that that was me or that they might take my kids from me if they knew I was depressed'.(p. 1166)	**Fear of being judged prevented women from seeking help.**
	The first themes: **Individual-Level Facilitator**		**Lack of health knowledge about post-childbirth problems meant women did not seek help.**
	Symptom awareness Women who informed by care providers or the previous experience about the	'I figured I did. . . . I wasn't sleeping well. I was up most of the night even when the baby was asleep. I was getting really, really moody	

	symptoms of depression were keen to find help.	and really depressed, and really anxious and crying quite often for no really good reason '.(p. 1166) 'I wasn't surprised. . . . I knew that I was definitely high risk because of my history, I've a long history with depression. Um, and throughout the pregnancy, um, I was seeing my psychiatrist and, and I was getting ready like reading literature on it, the symptoms and everything, so I was well aware that it could happen and I knew what to expect. So I wasn't shocked or surprised '.(p. 1166)	
	Not feeling like oneself Women who felt not feeling themselves, then they sought help.	'just feeling really run down a lot and not feeling myself like, just don't enjoy a lot of the stuff that I used to do before the baby came'.(p. 1167)	**Women did not seek help because they accepted problems as a part of the motherhood role.**
	The second themes: **Social Network–Level Barriers**		**Family and friends could be influenced to choose to seek help or not.**
	Normalizing of symptoms women asserted that their symptoms normalized by family and friends or "brushed off "	'I had called my mom to tell her like I'm not feeling and I was crying and stuff, she just like brushed it off. . . . And I'm like, no, this is really bad, like I don't feel like myself. And she said, well, you'll get used to it. They kind of brushed it off. . . . So it was just even me trying to explain or trying to talk to them just didn't, they don't believe in it. Even like when someone wasn't listening to me that even added on because I'm like well, maybe I'm just crazy, like why am I not like feeling bonded with my daughter '.(p. 1167)	
	limited understanding Lack of knowledge about depression among family and friends was a barrier to seek help.	'My mom and mother-in-law, they don't really understand, especially because they're kind of old world, they would just say things like, oh how can you not be happy, look at this beautiful baby, and that would just make me feel worse '.(p. 1167) 'Like I think he [husband] understands it, you know, when	**Lack of health knowledge about post-childbirth problems meant women did not seek help.**

		you have a baby you're tired and you're up all the time and you're emotional and this and that, but I don't think he understands that those can also be symptoms of something else. I think he just thinks it's just what happens when you have a baby and that, you know, it's just, it happens to everybody, you'll snap out of it kind of thing '.(p. 1167)	
	The second themes: **Social Network–Level facilitators**		
	Encouragement to seek care Women were encouraged by partner and parents to seek help.	"Really didn't even want to tell anybody about it" but her "mom and my boyfriend talked [her] into it [seeking help]." 'Yeah, well every time I have a bad day like yesterday, my husband will say you need to call [women's health clinic], you need to call, you know. And I actually had wanted to call her yesterday because she had said if it gets bad before your appointment, come in. You know, give me a call and we'll get you in sooner'.(p. 1167)	**Family and friends could be influenced to choose to seek help or not.**
	Expressing worry and concern family and friends were concern about the women`s mental health and convinced them to seek help.	'I was a little concerned about it, because my husband really worries, and when we were, when we were looking through all the information on postpartum depression and postpartum psychosis, some of it was really scary. And we were both terrified that I would, um, have some of the psychosis in which case he certainly couldn't go to work and he'd be afraid. I was afraid, you know if I had psychosis, if I start to hallucinate or anything, I don't want to end up a headline, right? (p. 1167)	**Family and friends could be influenced to choose to seek help or not.**
	The third themes: **Health Care System–Level Barriers**		
	Offering of unacceptable interventions		
	Disconnected care pathways Women mentioned the timing issues such as long wait times and limited service availability were the reason for disconnected care pathways**.**	'The fact that it [support group] doesn't run in the summer doesn't make a lot of sense. A woman delivers in the summer and she, you know, is having the depression, is she supposed to	**Women found that post-childbirth care was difficult to access or did not address their problems.**

		wait until the fall to get help? '. (p. 1169)	
	The third themes: **Health Care System–Level facilitators**		
	Having established and supportive relationships Established relationship with health care providers helped women to seek help. The importance of comfort was highlighted.	'I had been involved with the [clinic] already. My obstetrician referred me there as I was a candidate. I had depression. I had a series of depression so she actually referred me there. So I was aware that I was already feeling that way and um, yes, blue for sure. . . . I had already established a relationship with [the clinic] so the counsellor I was seeing there was, I mean, available at any time and I felt that was good and I also had a good rapport with my doctor, so I was alright. "I'm not one to easily open up, so if I don't feel comfortable with someone there's no way I'll talk about how I feel." (p. 1169)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Outreach and follow-up Follow-up by care providers and was an important role in receiving care among women.	'She [nurse] has called on a couple of occasions. There was an appointment that I had missed that she was really concerned that I wasn't there, but I had forgotten about it. I guess they sort of worry if you're just not going because you don't want to, whatever. She's been good with following up with me and giving me possible options for help. (p. 1169)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Legitimization of postpartum depression women reassured when care providers told them it is postpartum depression and she "wasn`t crazy"	'I went in really nervous and I told her [the nurse] flat out I wasn't crazy and she kind of started laughing and she said I wasn't crazy. That means a lot. It's better when the psychiatrist said I wasn't crazy, that helps even more . . . he thought my problem was that I did have postpartum depression, but I also had severe anxiety which can make it even worse'. (p. 1169)	**Fear of being judged prevented women from seeking help.**
	Timeliness of care Women dissatisfied from the time that they must wait for getting an appointment if needed.	"[I] called them and told them I was referred by a public health nurse and she called me back like 10 minutes later and I had an appointment for me for like 3 days after that and I went" and "After she got the results of the	**Women found that post-childbirth care was difficult to access or did not address their problems.**

		questionnaire [EPDS] she said no, you need to be seen. And I can't tell you how quickly it happened. . . . I'm sure it was just a matter of days or the next day." (p. 1170)	
(Wittkowski et al., 2012)	**The first main core; internalising misery (the experience of depression)**		**The women's cultural context was an essential factor in whether or how they sought help.**
	Women`s religious and cultural practices did not encourage them to engage with their thoughts and feelings.	'Religion (Islam) says it is like Waswasah (evil satanic whispers), do you know what Waswasah is? In our religion we call it satanic whispers, and we pray to our god to make them go away. We shouldn't think about them. I pray Namaaz [a particular prayer] and I feel better for a while, and then I start thinking again'. (p. 485)	
	The second main core; Others will judge me and I feel like I am on my own		**Women`s first strategies to share their problems with trusted people.**
	Mothers illustrated concepts of the "impact of PND on others" as well as the "lack of support for the mother". Feelings of "being isolated" were also expressed.	'My parents didn't have a clue as to what was going on when it all started so it was just as frightening for them. They were not sure how best to help me or who to turn to '. (p. 486). 'My husband just don't understand how I feel, everybody just keep saying Dimaak kharaab hai [mind is not working properly], please help '. (p. 486)	
	Women felt isolation and desperate for support and did not know who to turn to or what services they could expect in the postpartum period.	'I need help and support zarroorat hey [desperately needed], my husband left me in pregnancy, and I have no-body, my family are in India. I can't speak English properly, and I can't read English to fill out forms. My GP says go the HV and HV says go to GP. I don't know what to do, I need help, don't know where to go, or who to turn to '. (p. 487)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	The third main core: I go and talk to my health professional and they don't understand		**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Women reported lack of input from services and concepts like	'I got answers from professionals like, there is nothing wrong with	

	"discrimination and stigmatisation", "language and communication barriers", and "cultural and religious insensitivity" mentioned as barriers to and from services.	you, go back home stop disturbing us, basically you are wasting our time, and they were horrible. It was a Doctor that said that to me, my husband was sat with me that day as well. I don't know if they would have said that if I was white '. (p. 487) 'In Pakistan we only saw lady professionals, but here you don't have a choice, you have to see the men as well otherwise you don't get to see a doctor. My husband is always at work so he can't come with me, I feel very uncomfortable.' (p. 487) 'There is a huge stigma of being mentally ill in the public, but for us Asians there is a double disadvantage. I really fear that work will find out'. (p. 487)	
(Wuytack et al., 2015)	**The first themes:** **'They didn't ask, I didn't tell'**		**Women found that post-childbirth care was difficult to access or did not address their problems.**
	Category one: Lack of follow-up after birth Women would like to have more support and advice in hospital after the birth and more follow-up care later on.	'Before you have the baby you have so many check-ups and you have scans and everything, there is a fantastic support system, but once you've had the baby it's like you're left to your own devices.' (p. 9)	
	Category two: Healthcare professionals ignore it Women mentioned that healthcare professionals did not ask them about their symptoms and it would be acceptable if they asked questions that are more specific about their health issues.	'I suppose the 6-weeks check; I was quite surprised by just how basic it was, and I know a lot of friends have said the same. There is no kind of like real physical proper check. But I would feel that a lot of, even friends with things that are unaddressed, because it's a fairly just 'Ok, fine, see you now'. They didn't ask specific questions and it was very quick and very minimal. If you said you were fine, you were fine..' (p. 10)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	They mentioned that health care providers did not ask anything about their problems.	'But I think, they were not conscious of me having pain and there are days I think; 'Was I stupid never to tell?', but I don't have anything to compare it to so I was like 'That's part of giving birth I presume?' because I didn't know; it's my first baby so I didn't know any different. When I went to the	**Women found that post-childbirth care was difficult to access or did not address their problems.**

		2-week and 6-week check, the doctor never asked me; he just said 'how was I?' and I said I was fine, I didn't say anything. It was all about my baby. ' (p. 10)	
	The second themes: **Seeking advice and support**		**Women`s first strategies to share their problems with trusted people.**
	Talking to others Most of the women did not seriously talk about their problem with partner. Some of them talked with family and friends and the rest did not disclose their problem with the others not want it to become 'the thing'.	'He is aware I still have pain. We don't really talk too much about it, but it's still there, and he is very supportive anyway. ' (p. 11)	
	Triggers to seek help Women were encouraged by family and friends to seek help.	'Well, I probably wouldn't have gotten help if my husband and family wouldn't have pushed it, but I'm glad they did. ' (p. 12)	**Family and friends could be influenced to choose to seek help or not.**
	Barriers to getting help Women explained some barriers to seek professional help: cost of cost of seeking private treatment, and finding the time and someone to care for the baby, uncertain from whom they should seek help and conflicting advice.	'I know I'm getting no kind of joy with my GP but I don't know what the next step could be, what I could personally do with it, who I could go to with it. So, I don't know; I'm kind of in limbo. I don't know what the next step is. ' (p. 12)	**Women found that post-childbirth care was difficult to access or did not address their problems.**
	The third themes: **Coping strategies**		**Women`s first strategies to share their problems with trusted people.**
	Self-management strategies Women applied various coping strategies: avoiding or adapting provocative activities, being mindful of their posture, wearing comfortable shoes, storing items at a height and lose weight, considered exercise, which was challenging to find balance. 'Trying not to think about it' was the main coping strategy among women.	'Exercise is good and it's not sore when I do it, well, it depends for how long. Particularly softer ground is better than concrete. I can really find it hurting when I'm walking on concrete. ' (p. 12)	
	Pain Medication & Treatments Women applied different ways to manage their pain such as took painkiller or other remedies such as hot/cold packs, hot baths or supplements, attended a postnatal physiotherapy class at the hospital and private physiotherapists, chiropractors or osteopaths.	'I cut down on the pain relief so it's not as much; I'm glad I got off Solpadine because that was quite harsh on the system. Panadol is a little bit softer but obviously if it's a bad day you still need it.' (p. 12)	**Women`s first strategies to share their problems with trusted people.**

Abrams, L. S., et al. (2009). Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. *Qualitative Health Research, 19*(4), 535-551.

Bell, L., et al. (2016). Barriers and Facilitators to the Use of Mental Health Services by Women With Elevated Symptoms of Depression and Their Partners. *Issues in Mental Health Nursing, 37*(9), 651-659. doi:10.1080/01612840.2016.1180724

Buurman, M. B. R., & Lagro-Janssen, A. L. M. (2013). Women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour: a qualitative interview study. *Scandinavian Journal of Caring Sciences, 27*(2), 406-413. doi:10.1111/j.1471-6712.2012.01044.x

Goyal, D., et al. (2015). Postpartum Depression Among Asian Indian Mothers. *MCN Am J Matern Child Nurs, 40*(4), 256-261. doi:10.1097/NMC.0000000000000146

Merry, L. A., et al. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health, 102*(4), 286-290.

Park, V. T., et al. (2017). Postpartum Traditions, Mental Health, and Help-Seeking Considerations Among Vietnamese American Women: a Mixed-Methods Pilot Study. *Journal of Behavioral Health Services & Research, 44*(3), 428-441. doi:10.1007/s11414-015-9476-5

Sword, W., et al. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research, 18*(9), 1161-1173. doi:10.1177/1049732308321736

Wittkowski, A., et al. (2012). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. *Journal of Reproductive & Infant Psychology, 30*(5), 480-492. doi:10.1080/02646838.2011.639014

Wuytack, F., et al. (2015). The health-seeking behaviours of first-time mothers with persistent pelvic girdle pain after childbirth in Ireland: A descriptive qualitative study. *Midwifery, 31*(11), 1104-1109.

Appendix V. Synthesis Summary

Author	Finding	Illustration
Category 1 - Women did not seek help because they accepted problems as a part of the motherhood role.		
(Abrams et al., 2009)	Women asserted that being a good mother means that they didn't get depression and depression cannot happen for strong mothers.	`Well I would listen to others say that when they had a baby they would get depressed but I think no that's not true since that had never happened to me. They're exaggerating. I would think they were immature . . . that's what I thought.' (p. 541)
(Abrams et al., 2009)	All participants initially minimized, normalized or hide their symptoms from themselves and others believing it was normal or demonstrated they were not good mothers or were.	`Well, that's not postpartum, you know.' . . . I guess, I couldn't decipher completely what I was going through. . . . I was thinking at first, "Well you know, you just had the baby, relax.'(p. 540)
(Abrams et al., 2009)	The unconditional admission of the maternal role of these mothers lead to them did not seek mental support.	`Well its people that have had hard lives, life's full of hardship that they don't feel empowered that they can change those hardships in their life, and so they do the best they can, and they just have to do it all the time. No matter how bad it gets, that's their approach to life because that's how their life is.'(p. 545)
(Bell et al., 2016)	Women believed that they can manage symptoms on their own.	`I don't know. Like to start, I'm not one to go to people when I need like help in the first place. I can really just go to husband or my sister. So I won't open up to my own friends. I won't, I don't know if I'd even go to a psychologist and like freely talk about myself ... In general, I really don't think so .'(p. 656)
(Buurman & Lagro-Janssen, 2013)	Women acquiesced in the problems and accepted the problems as normal not as ailment or disease.	`I simply thought: the urinary incontinence is just part of it. Your whole body is turned inside out after delivery anyway. So I thought it's just part of the game.'(29 years, uncomplicated home delivery, first child).'(p. 408)
(Buurman & Lagro-Janssen, 2013)	Women believed that their problems gradually decreased. They hoped that their problems will be resolved spontaneously.	'It's like there's a train that's driven right through you. I understand that your body needs time to recover. If I just look after myself properly and don't neglect my body, I expect this prolapse won't be so painful after a while'. (34 years, uncomplicated hospital delivery, second child) 'I handled it [urinary incontinence] without making much of a fuss. It'll pass off, I suppose.'(34 years, uncomplicated home delivery, fourth child).'(p. 409)

(Buurman & Lagro-Janssen, 2013)	Some of the women indicated that they have the more important thing on their mind, so their priorities are not their health.	'When you've just had a delivery, you've got a thousand things on your mind and you're a bit of a scatterbrain. So to be honest, I wasn't really thinking about my problem holding my stools in, as I had more important things on my mind. I just thought: it'll be all right.' (23 years, vacuum extraction hospital delivery, first child).'(p. 409)
(Park et al., 2017)	Women mentioned that the conventional gender role for the woman serves as a contributor to sadness/depression. They expected instrumental and emotional support, as well as sympathy to help alleviate the stress, and ultimately, feelings of sadness/depression.	'I think sometimes we're not allowed to express our feelings. . . . And women, even in the family life, they are supposed to be submissive. And men are the ones that are dominant. So they can do whatever they want, and for women, it's like a second class. For example, in my family ...we're supposed to be like obedient and do whatever our parents say, whatever adult people say. They're right all the time.' (p. 436)
(Park et al., 2017)	Women believed that their conventional role in families was prone to depression.	'Oh, that's the woman. That's the mother's job. That's why it's hard sometimes. That's why I feel depressed. . . . Because I have to take care of the baby and do all the household work. That's another thing that contributes to the depression . . . I think the men need to be more supportive.' (p. 436)
(Sword et al., 2008)	Because women regarded their symptoms as normal or limited understanding, they talked about waiting to seek care.	'I just told him [husband] if I'm not myself within 3 weeks, you know, back to myself, and you can let me know to do something. . . . I just let the first couple of weeks ago and then I figured if it persisted after 3 weeks I'd talk to somebody else about it.' (p. 1166)
(Sword et al., 2008)	Women who felt not feeling themselves, then they sought help.	'just feeling really run down a lot and not feeling myself like, just don't enjoy a lot of the stuff that I used to do before the baby came'.(p. 1167)
(Sword et al., 2008)	Women thought that the symptoms are relate to motherhood or baby blue.	'It [probable depression] was just a shock to me. I mean I didn't notice I had it. I was just crying. I thought I had the baby blues, that's all. I was just crying for no reason, arguing with my husband, you know, yelling at my kids for no reason, taking everything out on everybody and I just didn't know why, and so you know she gave me the test [EPDS] and she said do you know that you have postpartum depression, I'm like, oh, I didn't know that. It was shocking.' (p. 1165)

Category 2 - Women`s first strategies to share their problems with trusted people.		
(Abrams et al., 2009)	Women after initial hesitation, asked mostly trusted family members who also normalised symptoms, most also encouraged them to seek help from professionals.	`At least my husband when I tell him, "I feel bad, I feel sad," he tells me, "You want to take a walk somewhere?" or "Do you want to do something?" or "Do you want to be alone?" He always says, "But, who do we ask? Who do we ask? Next time you go to the doctor ask him about how you're feeling.' (p. 542)
(Abrams et al., 2009)	Depressed mothered suggested to "counselling with a professional," "talking to someone," or "seeing a professional"	`The best thing you can do to deal with depression is to talk about it. Find somebody that you trust, not just someone to be talking [to], find someone you can trust or seek professional help because it will help. Depression is really, really something that is difficult to deal with.'(p. 544)
(Abrams et al., 2009)	Women preferred to talk about their problems with the "ideal" person to listen to their problems.	`As long as they're [providers] a person. . . . Like now, today, it's like you're here. You couldn't tell you're a psychologist you just look like a regular woman, just coming just to listen . . . and I wouldn't like somebody all dressed up and looking like, you know what I'm saying? Just looking like they're doing an experiment you know, but just look like a regular person, just to listen.'(p. 543)
(Abrams et al., 2009)	Lack of formal care leads to self-care such as religious practices as a source of strength, comfort, and healing.	`Some of the Christian sisters, they've had depression symptoms and the church has taken it all away. So when you start to experience the symptoms of depression, to the people who have suffered from depression, you need to start hearing Christian music and pray to God. . . . So that is what has helped me so I don't pay attention when I get those symptoms. I tell myself that this will not happen to me and it will pass. I lift my self-esteem myself.'(p. 545)
(Goyal et al., 2015)	Mothers would share their problems if they could not cope with that**.**	'I would talk to my husband and my family about it. … if I really felt like I wanted to harm my baby or myself, then I would definitely seek help, because that is not acceptable to me.' (p.259)
(Goyal et al., 2015)	Women had the desire to seek mental health care anonymously.	'There are quite a few forums, I could log into (HMO) and anonymously seek some advice…But I don't want to identify myself, but I still want advice' (p.260)
(Goyal et al., 2015)	Women mentioned that they prefer try alternative ways to resolve their problems such as talking to friends or seeking non-medicine methods.	'I think it could be taking time to talk with my friends about it. I think it could also be non-medication supplements maybe, all natural

		supplements, Ayurcedic supplements, homeo-pathic supplements.' (p.260)
(Goyal et al., 2015)	Mother`s view about mental help-seeking lead to prefer shared the problems with their age person.	'I think friends, if they are my age group… they do understand that you need to be treated… if it is a senior family member, they would just shun it and they would say, oh, there`s nothing wrong with you. Look at someone else whose situation is much worse. I think that`s the way they look at it and I don't think take depression as something serious. They think the fault is in you.'(p.259). I think in my parents` generation, the generation born in India, I think they probably just don`t see the importance of mental health. I think in my generation we`re sort of a do-it-yourself generation, so we`ll try to do what we can on our own, and then if it doesn`t work, go and see a therapist.' (p.260)
(Merry et al., 2011)	Women reported being separated from family and friends leads to feel isolated and there is "no one to help" her.	"She is here as a refugee. She came alone and left her husband and 2 yr old child in China. She only speaks Mandarin. Mother is living in a small apartment with 4 other families she does not know - Mom claims none of them are her friends and they do not help her. No help, not enough food and not aware of social resources." (24 y.o., China, 1 yr 4 mos in Canada) '' (p.287)
(Wittkowski et al., 2012)	Mothers illustrated concepts of the "impact of PND on others" as well as the "lack of support for the mother". Feelings of "being isolated" were also expressed.	'My parents didn't have a clue as to what was going on when it all started so it was just as frightening for them. They were not sure how best to help me or who to turn to '. (p. 486). 'My husband just don't understand how I feel, everybody just keep saying Dimaak kharaab hai [mind is not working properly], please help '. (p. 486)
(Wuytack et al., 2015)	Most of the women did not seriously talk about their problem with partner. Some of them talked with family and friends and the rest did not disclose their problem with the others not want it to become 'the thing'.	'He is aware I still have pain. We don't really talk too much about it, but it's still there, and he is very supportive anyway. ' (p. 11)
(Wuytack et al., 2015)	Women applied various coping strategies: avoiding or adapting provocative activities, being mindful of their posture, wearing comfortable shoes, storing items at a height and lose weight, considered exercise, which was challenging to find balance.	'Exercise is good and it's not sore when I do it, well, it depends for how long. Particularly softer ground is better than concrete. I can really find it hurting when I'm walking on concrete. ' (p. 12)

	'Trying not to think about it' was the main coping strategy among women.	
(Wuytack et al., 2015)	Women applied different ways to manage their pain such as took painkiller or other remedies such as hot/cold packs, hot baths or supplements, attended a postnatal physiotherapy class at the hospital and private physiotherapists, chiropractors or osteopaths.	'I cut down on the pain relief so it's not as much; I'm glad I got off Solpadine because that was quite harsh on the system. Panadol is a little bit softer but obviously if it's a bad day you still need it.' (p. 12)
Category 3 - Women found that post-childbirth care was difficult to access or did not address their problems.		
(Abrams et al., 2009)	Women rejected professional care as `not the right help for me` and interpret the "medication first" approach as "uncaring". Past medical treatment was reminding pictures of "white coats," "clipboards," and "laboratory testing" as unhelpful experience.	`What they did was, they had you answer these questions on a clipboard of your family history, are you emotional, just like those type of questions, and of course I put it all "No" . . . to them, but I was kind of like having problems with like things that have happened in the past with my family, you know like my mom, she's used drugs—like that type of thing.'(p. 543)
(Abrams et al., 2009)	Half of the mothers sought help from health providers (e.g. physician, nurse, gynecologist, ED doctor) but mostly perceived responses an unhelpful because 1) they advised 'wait and see' to sometimes severe symptoms or 2) prescribed medication which women felt was not a viable option.	`The doctor said . . . to wait until I come back for my six week, and if I continued to feel that way, he'll prescribe something for me.` (p. 542) `Marta: I went to the doctors and they gave me Xanax and I said, "I'm not gonna take it," and they say, "Just take when you feel like you can help things and just to relax but don't drink it all the time." And I got it but I threw them away in the toilet.'(p. 543)
(Bell et al., 2016)	Women preferred services that offered at home or close to their home but E-health options like Wbinar was useful for isolated mothers. The other factors experienced by women: costs related to services, a perceived health care professional shortage, time and waiting at the hospital and difficulties obtaining reliable information as a barrier to her use of services.	`The other thing that might be a good idea ... webinars and telediscussion ... for people who, like myself, feel isolated at home and would like to be able to at least speak to or read up on the different topics that affect new mothers.'(p. 653) `The specialist is the psychiatrist. But the psychiatrist is not readily available, and by the time you get that appointment 7-months later, things have manifested themselves to a different degree and you could have prevented the growth of whatever anxiety that the person had. You could have suppressed it earlier.'(p. 653)
(Bell et al., 2016)	Women reported the routine care that they received was mainly focused on the baby's needs and healthcare professionals did not address their mental health needs at some point during the perinatal period. Women asserted that the gynaecologist was not sensitive or responsive to her mental health status.	`I find they just like brush you off ... my gyne doctor, I thought she would help, she would understand, cause she works in the field. And instead she just like didn't care. I honestly felt that she didn't care and I felt so alone.'(p. 654)

(Bell et al., 2016)	Women asserted that an existing relationship with a healthcare professional was a facilitator to use mental health services.	`So we need to have a close relationship with healthcare providers, a really close relationship with healthcare providers, at least one, to have access to ... So you have a better surveillance of your health problems.'(p. 656)
(Buurman & Lagro-Janssen, 2013)	They asserted that health care providers did not inform them about pelvic floor dysfunction and treatment options.	'So I think that's very odd, that this midwife told me nothing about the pelvic floor during my pregnancy. She only said something about it at a check-up visit when I mentioned that I had such a heavy feeling. So it turns out that's your pelvic floor'! (35 years, uncomplicated home delivery, second child).'(p. 410)
(Goyal et al., 2015)	Women declared that it is essential to find mental healthcare providers who understand the culture.	'Yeah, I think they (the therapist) should know about our culture. Yeah. I mean, I think our culture, and how we were brought up, it plays a role in our life. So, if at all they are seeking help, I think they (therapists) should consider all those factors, how we were brought up.' (p.260)
(Merry et al., 2011)	Immigrant women could not communicate well in English or French and their partner wasn't flue in the second language. Interpreters were not available and women could not easily express their concerns or understand teaching and information given.	"The woman claims the social worker told her she has to research [English] classes on the internet herself. The woman paid someone to interpret at her [prenatal] visits. Public health nurse called to check on mom and baby but there was no interpreter so they were not able to communicate." (26 y.o., Mexico, 8 mos in Canada, Toronto). (p.288)
Merry et al., 2011)	There was a lack of psychosocial assessments and support for PPD or abuse.	"She did not mention it [skipping meals] because the [nurse] had not asked." (33 y.o., Congo, 1.5 yrs in Canada, Montreal) (p.288) "She [the mother] was unaware that there are health professionals who deal specifically with this type of abuse. She has never had any counselling." (25 y.o., Mexico, 11 mos in Canada, Toronto) (p.288)
(Merry et al., 2011)	It was unclear to women and health care professionals which services were covered the Interim Federal Health Program (IFHP).	The following research nurse excerpts illustrate these challenges: "The doctor sent her [mother] for blood tests and did not tell her that they are not covered by insurance…"

		"Mom has lost her documentation [IFHP]. Her social worker is helping her to get it replaced, but have not been successful. Mom is concerned she may not have access to healthcare for herself at present…" (30 y.o., Nigeria, 10 mos in Canada, Toronto) "Paediatrician refused to see baby because she had no medicare. One month later the paediatrician gave her an appointment but when mother said she still had no medicare then he cancelled it." (36 y.o., Mexico, 6 mos in Canada, Montreal). (p.289)
(Sword et al., 2008)	Women mentioned the timing issues such as long wait times and limited service availability were the reason for disconnected care pathways**.**	'The fact that it [support group] doesn't run in the summer doesn't make a lot of sense. A woman delivers in the summer and she, you know, is having the depression, is she supposed to wait until the fall to get help? '. (p. 1169)
(Sword et al., 2008)	Established relationship with health care providers helped women to seek help. The importance of comfort was highlighted.	'I had been involved with the [clinic] already. My obstetrician referred me there as I was a candidate. I had depression. I had a series of depression so she actually referred me there. So I was aware that I was already feeling that way and um, yes, blue for sure. . . . I had already established a relationship with [the clinic] so the counsellor I was seeing there was, I mean, available at any time and I felt that was good and I also had a good rapport with my doctor, so I was alright. "I'm not one to easily open up, so if I don't feel comfortable with someone there's no way I'll talk about how I feel." (p. 1169)
(Sword et al., 2008)	Follow-up by care providers was an important role in receiving care among women.	'She [nurse] has called on a couple of occasions. There was an appointment that I had missed that she was really concerned that I wasn't there, but I had forgotten about it. I guess they sort of worry if you're just not going because you don't want to, whatever. She's been good with following up with me and giving me possible options for help. (p. 1169)
(Sword et al., 2008)	Women dissatisfied from the time that they must wait for getting an appointment if needed.	"[I] called them and told them I was referred by a public health nurse and she called me back like 10 minutes later and I had an appointment for me for like 3 days after that and I went" and "After she got the results of the questionnaire [EPDS] she said no, you need to be seen. And I can't tell you how quickly it happened. . . . I'm sure it was just a matter of days or the next day." (p. 1170)

(Wittkowski et al., 2012)	Women reported lack of input from services and concepts like "discrimination and stigmatisation", "language and communication barriers", and "cultural and religious insensitivity" mentioned as barriers to and from services.	'I got answers from professionals like, there is nothing wrong with you, go back home stop disturbing us, basically you are wasting our time, and they were horrible. It was a Doctor that said that to me, my husband was sat with me that day as well. I don't know if they would have said that if I was white '. (p. 487) 'In Pakistan we only saw lady professionals, but here you don't have a choice, you have to see the men as well otherwise you don't get to see a doctor. My husband is always at work so he can't come with me, I feel very uncomfortable.' (p. 487) 'There is a huge stigma of being mentally ill in the public, but for us Asians there is a double disadvantage. I really fear that work will find out'. (p. 487)
(Wittkowski et al., 2012)	Women felt isolation and desperate for support and did not know who to turn to or what services they could expect in the postpartum period.	'I need help and support zarroorat hey [desperately needed], my husband left me in pregnancy, and I have no-body, my family are in India. I can't speak English properly, and I can't read English to fill out forms. My GP says go the HV and HV says go to GP. I don't know what to do, I need help, don't know where to go, or who to turn to '. (p. 487)
(Wuytack et al., 2015)	Women would like to have more support and advice in hospital after the birth and more follow-up care later on.	'Before you have the baby you have so many check-ups and you have scans and everything, there is a fantastic support system, but once you've had the baby it's like you're left to your own devices.' (p. 9)
(Wuytack et al., 2015)	Women mentioned that healthcare professionals did not ask them about their symptoms and it would be acceptable if they asked questions that are more specific about their health issues.	'I suppose the 6-weeks check; I was quite surprised by just how basic it was, and I know a lot of friends have said the same. There is no kind of like real physical proper check. But I would feel that a lot of, even friends with things that are unaddressed, because it's a fairly just 'Ok, fine, see you now'. They didn't ask specific questions and it was very quick and very minimal. If you said you were fine, you were fine.' (p. 10)
(Wuytack et al., 2015)	They mentioned that health care providers did not ask anything about their problems.	'But I think, they were not conscious of me having pain and there are days I think; 'Was I stupid never to tell?', but I don't have anything to compare it to so I was like 'That's part of giving birth I presume?' because I didn't know; it's my first baby so I didn't know any different. When I went to the 2-week and 6-week check, the doctor never asked me; he just said 'how was I?' and I said I was fine, I didn't say anything. It was all about my baby. ' (p. 10)

(Wuytack et al., 2015)	Women explained some barriers to seek professional help: cost of seeking private treatment and finding the time and someone to care for the baby, uncertain from whom they should seek help and conflicting advice.	'I know I'm getting no kind of joy with my GP but I don't know what the next step could be, what I could personally do with it, who I could go to with it. So, I don't know; I'm kind of in limbo. I don't know what the next step is. ' (p. 12)
Category 4- Family and friends could be influenced to choose to seek help or not.		
(Bell et al., 2016)	Women encouraged by family to seek a help.	`But I have even talked to my husband, I told him what they gave to me. He said, "okay, it could be good, you lose nothing, call. You don't feel good, call."(p. 655)
(Bell et al., 2016)	Women mentioned lack of understanding and support by partner and family was a barrier to seek help.	`My mother doesn't want to look after the baby so I can see my psychologist. She believes I don't need it. I have no support from her for this.'(p. 656)
(Buurman & Lagro-Janssen, 2013)	Women searched help from the group of initiates: female relatives or close female friends who had already had deliveries. They convinced by initiates that it is the normal process of childbearing.	'No, I didn't call in medical help because my relatives, especially my mum and my gran, said that it would just pass off. So I was like if my mum and my gran say so, it'll be all right'. (23 years, vacuum extraction hospital delivery, first child) 'Well, because several women told me they lose a little urine sometimes. So I feel I'm not the only one and that this is quite normal.'(28 years, uncomplicated home delivery, second child).'(p. 410)
(Sword et al., 2008)	Women were encouraged by partner and parents to seek help.	"Really didn't even want to tell anybody about it" but her "mom and my boyfriend talked [her] into it [seeking help]." 'Yeah, well every time I have a bad day like yesterday, my husband will say you need to call [women's health clinic], you need to call, you know. And I actually had wanted to call her yesterday because she had said if it gets bad before your appointment, come in. You know, give me a call and we'll get you in sooner'.(p. 1167)
(Sword et al., 2008)	Family and friends were concern about the women`s mental health and convinced them to seek help.	'I was a little concerned about it, because my husband really worries, and when we were, when we were looking through all the information on postpartum depression and postpartum psychosis, some of it was really scary. And we were both terrified that I would, um, have some of the psychosis in which case he certainly couldn't go to work and he'd be afraid. I was afraid, you know if I had psychosis, if I start to hallucinate or anything, I don't want to end up a headline, right? (p. 1167)

(Sword et al., 2008)	Women asserted that their symptoms normalized by family and friends or "brushed off "	'I had called my mom to tell her like I'm not feeling and I was crying and stuff, she just like brushed it off. . . . And I'm like, no, this is really bad, like I don't feel like myself. And she said, well, you'll get used to it. They kind of brushed it off. . . . So it was just even me trying to explain or trying to talk to them just didn't, they don't believe in it. Even like when someone wasn't listening to me that even added on because I'm like well, maybe I'm just crazy, like why am I not like feeling bonded with my daughter '.(p. 1167)
(Wuytack et al., 2015)	Women were encouraged by family and friends to seek help.	'Well, I probably wouldn't have gotten help if my husband and family wouldn't have pushed it, but I'm glad they did. ' (p. 12)
Category 5 – lack of health knowledge about post-childbirth problems meant women did not seek help.		
(Bell et al., 2016)	Women noted that indecision about following through with treatment as a barrier to take care.	`I don't think I ever would have went back anyways. Not because of them, they were very nice. Maybe more because of me. I just didn't know what I wanted at the time and I didn't know what I wanted to get out of it. I didn't know what was going on.'(p. 656)
(Buurman & Lagro-Janssen, 2013)	Women asserted that problems were worse than expected. Especially, the post-delivery genital pain was worse than they had anticipated.	'Well, actually I never knew you could have so much pain. I knew you'd have some pain. Nor did I know you'd be unable to control urine loss. I never knew that.'(19 years, vacuum extraction hospital delivery, first child).'(p. 408)
(Buurman & Lagro-Janssen, 2013)	Women mentioned that they did not have any information about pelvic floor problems such as the relation between vaginal flatulence, constipation, sexual dysfunction, and reduced pelvic floor support function.	'I was very happy when I read that vaginal flatulence existed because I thought it was impossible, but it was possible indeed! Well, I don't know what's causing them, but I do think they're a pretty nuisance'. (36 years, uncomplicated hospital delivery, second child) (p. 410) I don't really understand the constipation. You see, that I'm not feeling the flatulence that has got something to do with pelvic floor weakness, but why I have constipation? I don't know'. (35 years, uncomplicated home delivery, second child).' (p. 410)
(Buurman & Lagro-Janssen, 2013)	Some women who agreed about doing exercise to help or remedy the problems but they did not know what exercises they have to do nor did they know how to do them.	'Well, I thought to myself sometimes: am I doing this right? For you might be training as much as you like and then find out afterwards that you're not doing the right exercises. So this would have no effect at all: you'd be training the muscles in your buttocks instead of the proper ones in your pelvic floor.' (32 years, vacuum extraction hospital delivery, second child).' (p. 410)

(Merry et al., 2011)	Women lacked knowledge about self-care and baby care due to language barriers and teaching was poorly understood or not provided.	"Mother has had no nurse [visit] yet. She is a new mother who has very little info, intensive teaching had to be done... breastfeeding…mother does not know why she has to give vitamin D." (25 y.o., Mexico, 1 yr in Canada).
(Sword et al., 2008)	Women could not understand that their symptoms are related to depression and must seek help. They found help if they had thoughts of self-harm.	'People say that after having a baby . . . the iron level is low and other things, the hormone system changes, so you are depressed and frustrated and that remains for a few days or just for 1 or 2 weeks and after that it goes by itself, you don't need to do anything.' 'Um, just I didn't understand what was going on, you know what I mean? Like I knew . . . I suffered from anxiety prior to being pregnant and I was taking medication. I came off the medication because of the pregnancy. But then at that point when we figured out that maybe I could have been experiencing it [depression] when this nurse was here, I just like, ok, so? I didn't know what it was, whether it was anxiety or depression. That's why I was confused. Do you know what I mean? The baby blues, I didn't know.' (p. 1165)
(Sword et al., 2008)	Women who informed by care providers or the previous experience about the symptoms of depression were keen to find help.	'I figured I did. . . . I wasn't sleeping well. I was up most of the night even when the baby was asleep. I was getting really, really moody and really depressed, and really anxious and crying quite often for no really good reason '.(p. 1166) 'I wasn't surprised. . . . I knew that I was definitely high risk because of my history, I've a long history with depression. Um, and throughout the pregnancy, um, I was seeing my psychiatrist and, and I was getting ready like reading literature on it, the symptoms and everything, so I was well aware that it could happen and I knew what to expect. So I wasn't shocked or surprised '.(p. 1166)
(Sword et al., 2008)	Lack of knowledge about depression among family and friends was a barrier to seek help.	'My mom and mother-in-law, they don't really understand, especially because they're kind of old world, they would just say things like, oh how can you not be happy, look at this beautiful baby, and that would just make me feel worse '.(p. 1167) 'Like I think he [husband] understands it, you know, when you have a baby you're tired and you're up all the time and you're emotional and this and that, but I don't think he

		understands that those can also be symptoms of something else. I think he just thinks it's just what happens when you have a baby and that, you know, it's just, it happens to everybody, you'll snap out of it kind of thing '.(p. 1167)
Category 6 - Fear of being judged prevented women from seeking help.		
(Abrams et al., 2009)	Women had fears of being judged or labelled as "crazy," "schizo," or "psycho."	`I thought at a moment I might have had postpartum depression, but I jumped back into place, like I better jump into place an' get with it because I don't want anyone to think that I'm crazy or I'm incapable to raise my child.'(p. 541)
(Bell et al., 2016)	Women who perceived being labelled with a mental health illness, it played a role as a barrier to their access of mental health services.	`I'm like I don't wanna be labeled you know. It's like you always feel like you're being labeled as a psychiatric patient.'(p. 655)
(Bell et al., 2016)	The physical environment was a barrier for some of women to seek help.	`I felt everyone was looking at each other, myself included. I was looking at people I felt they were looking at me. I felt like everyone is probably wondering what is this person doing here and vice-versa. When you go up, especially to where her office is, the hallways are so tiny and sterile. I feel like it's not warm and inviting.'(p. 654)
(Buurman & Lagro-Janssen, 2013)	Feeling of shame mentioned by women as a reason to hinder help-seeking or just talked with family and friends. Talking about pelvic issues considered as a taboo.	'You know, sometimes I'm chatting with a friend who also has young children. But still, haemorrhoids are out of bounds, you know, they're not really a topic of conversation. And I have to admit I find haemorrhoids a pretty embarrassing thing to have'. (34 years, uncomplicated hospital delivery, second child) 'So you're thinking to yourself, I hope nobody else will smell it [loss of urine]. It does make you feel uncomfortable.'(37 years, uncomplicated home delivery, second child).' (p. 409)
(Buurman & Lagro-Janssen, 2013)	Several women declared embarrassment as a barrier to seeking help. But they agreed that if the healthcare providers asked them the direct question about their problems, it would be helpful for women that these are a normal subject to talk about to your doctor.	'I think asking direct questions about it [pelvic floor problems] is a good idea. For when they ask you an open question, perhaps it's difficult to mention the subject, especially when you're embarrassed or you're not sure whether this is normal or not.'(32 years, uncomplicated hospital delivery, first child).' (p. 409)
(Buurman & Lagro-Janssen, 2013)	Women asserted that their self-image negatively affected and no control over their body.	'When you've just delivered a baby, you're dirty. You're losing a lot of blood, you're wearing giant nappies in your knickers, and you're wearing giant knickers for a start.

		You've got a big fat blubbering belly, and your self-esteem is flat as a pancake. If on top of that you wet yourself and you've got haemorrhoids, this doesn't make it any easier, you're no longer what you used to be. It really affects your self-confidence.'(31 years, uncomplicated hospital delivery, second child).' (p. 410)
(Goyal et al., 2015)	Working women worried about the stigma to find mental health care.	'I`d think twice because there`s always a stigma, if you`re working, what if there`s a depression attached to your charts…But, you know, generally I wouldn`t like to be labelled a depressed person or someone with a psych disorder.' (p.260)
(Sword et al., 2008)	Women were worried about their future career and labelled as 'bad mother' and fear about child apprehension.	'I'm afraid if, you know, if my mental condition is not good who is going to hire me? They always take, you know, they usually take your health information from your doctor, right?"(p. 1166) I hold him and I feed him and I change him, but I'm not happy, and I felt so guilty about that and that was kind of hard to admit to people because, you know, I was so afraid I'd be seen as a bad mother, you know. And that was hard to even admit to [my] husband that I don't feel happy, I have this beautiful baby but ' I'm not happy '.(p. 1166) Well, I was nervous about it at first. I didn't really want to go because I didn't want anyone to think I was crazy. And I know postpartum depression some people get like postpartum psychosis and I was worried that they would think that that was me or that they might take my kids from me if they knew I was depressed'.(p. 1166)
(Sword et al., 2008)	Women reassured when care providers told them it is postpartum depression and she "wasn`t crazy"	'I went in really nervous and I told her [the nurse] flat out I wasn't crazy and she kind of started laughing and she said I wasn't crazy. That means a lot. It's better when the psychiatrist said I wasn't crazy, that helps even more . . . he thought my problem was that I did have postpartum depression, but I also had severe anxiety which can make it even worse'. (p. 1169)
(Sword et al., 2008)	Women explained `discomfort' to discuss their mental symptoms with health care providers and some of them described depression make them `feel weak'.	'Well, for me it is just something very private because to me, it's just weakness. . . . And I don't like to feel weak, like I can't handle something. For myself, I'll get over it, where I know other people get into that psychosis and they can't get over it and I don't fault them for that. What I fault is myself for feeling weak. . . . I just don't like to feel this

		oh, I can't do it. I hate feeling like that, you know.' (p. 1166)
Category 7 - The women's cultural context was an essential factor in whether or how they sought help.		
(Abrams et al., 2009)	`Familism` or cultural norms banned women to talk about their mental health issues because of potential shame and fear of judgment of talking to others about private matters. Although some mothers believed in familism but preferred to talk with `stranger`.	`I don't know I think sometimes we are ashamed, for the majority of us we are ashamed to talk about a certain family problem with someone that you don't know. But sometimes it's better to talk to a stranger than to a family member that gives you bad advice. But sometimes you're not that comfortable talking to someone outside the family. But, at least when you trust a psychologist you know that information is not going to get out.'(p. 544)
(Abrams et al., 2009)	In addition to religion and prayer, mothers described an array of emotional, cognitive, and behavioral strategies to manage their PPD symptoms; consisted of crying and releasing emotions, reaching out to family members and talking to other mothers.	`Interviewer: So tell me, what do you know about postpartum depression? Alicia: That it is real. It is real and all those men that get on TV and say, "Oh you don't need to do this," or, "You don't need to do that," or that "it's not real," I shun them. I shun them because they'll never know how somebody is feeling after everything someone has been through. It is life changing.'(p. 546)
(Park et al., 2017)	Most of the women stated that the lack of culturally appropriate care is a barrier, so they culturally were "not seeking care".	'I think our Vietnamese never come to those services. Our Vietnamese are very strong. American always comes to see counsellors. Majority of our Vietnamese don't come to see these professions. I have a strong mind. I am sad, but I don't need to see them.' (p. 437)
(Goyal et al., 2015)	Mothers and babies were surrounded by family and friends as a culture-specific postpartum traditional (such as restriction to leave home, eating specific foods to promote breastfeeding and to return the new mother`s state of balance).	'for 28th day days back home in India you would get a massage in bed, your hair would be washed, somebody would give you a bath, the mother and the baby and you`re given very healthy meals' (Bandypadhyay, 2009) (p.259).
(Wittkowski et al., 2012)	Women`s religious and cultural practices did not encourage them to engage with their thoughts and feelings.	'Religion (Islam) says it is like Waswasah (evil satanic whispers), do you know what Waswasah is? In our religion we call it satanic whispers, and we pray to our god to make them go away. We shouldn't think about them. I pray Namaaz [a particular prayer] and I feel better for a while, and then I start thinking again'. (p. 485)

References

Abrams, L. S., et al. (2009). Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. *Qualitative Health Research, 19*(4), 535-551.

Bell, L., et al. (2016). Barriers and Facilitators to the Use of Mental Health Services by Women With Elevated Symptoms of Depression and Their Partners. *Issues in Mental Health Nursing, 37*(9), 651-659. doi:10.1080/01612840.2016.1180724

Buurman, M., & Lagro-Janssen, A. (2013). Women's perception of postpartum pelvic floor dysfunction and their help-seeking behaviour: a qualitative interview study. *Scandinavian Journal of Caring Sciences, 27*(2), 406-413. doi:10.1111/j.1471-6712.2012.01044.x

Goyal, D., et al. (2015). Postpartum Depression Among Asian Indian Mothers. *MCN Am J Matern Child Nurs, 40*(4), 256-261. doi:10.1097/NMC.0000000000000146

Merry, L. A., et al. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health, 102*(4), 286-290.

Park, V. T., et al. (2017). Postpartum Traditions, Mental Health, and Help-Seeking Considerations Among Vietnamese American Women: a Mixed-Methods Pilot Study. *Journal of Behavioral Health Services & Research, 44*(3), 428-441. doi:10.1007/s11414-015-9476-5

Sword, W., et al. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research, 18*(9), 1161-1173. doi:10.1177/1049732308321736

Wittkowski, A., et al. (2012). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. *Journal of Reproductive & Infant Psychology, 30*(5), 480-492. doi:10.1080/02646838.2011.639014

Wuytack, F., et al. (2015). The health-seeking behaviours of first-time mothers with persistent pelvic girdle pain after childbirth in Ireland: A descriptive qualitative study. *Midwifery, 31*(11), 1104-1109.

Appendix VI has been removed for copyright or proprietary reasons.

It is the following published article: Rouhi, M., Stirling, C. M., Crisp, E. P. 2019. Mothers' views of health problems in the twelve months after childbirth: A concept mapping study, Journal of advanced nursing, 75(12), 3702-3714

Healthy after Baby (HaBaby) Project

Consent form for participants

This screen allows you to choose to continue to the research task on the next page. You have been asked to participate in a web-based research task. Your participation is voluntary.

You may be asked to offer your input in three ways:

- By providing your ideas
- Rating the ideas or sorting them into groups of similar themes
- By providing non-identifying information about yourself.

You may participate in the entire research project or in any one aspect of the research depending on the point at which you enter the research sequence. Your input in this research is confidential.

ACCEPT REJECT

Researcher's institutional letterhead

Participant Information Sheet [version number] [date]

Healthy after Baby (HaBaby) Project

1. Invitation

You are invited to participate in a research study that will identify the health problems and help-seeking behaviors of Australian women in the twelve-months after childbirth (Hababy Project). This study is being conducted in partial fulfillment of PhD degree for student researcher (Maryam Rouhi) under supervision of

Dr. Christine Stirling, Associate Professor, School of Health Sciences, University of Tasmania.

Dr. Suanne Lawrence, Lecturer, School of Health Sciences, University of Tasmania.

Dr. Jennifer Ayton, Lecturer, School of Health Sciences, University of Tasmania.

This study is being funded by School of Health Sciences, University of Tasmania.

2. What is the purpose of this study?

This study will investigate:

- Mothers health problems that require help during the twelve-month period following childbirth.
- The help-seeking behavior of mothers during the twelve-month period following childbirth.
- Any barriers experienced by mothers to access healthcare during the twelve-month period following childbirth.

3. Why have I been invited to participate?

You have been invited to participate in the study because you are a mother who has given birth in the past twelve months and you gave birth to a single full-term infant (born after 37 weeks).

It is important that you understand that your involvement is this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. There will be no consequences to you if you decide not to participate.

4. What will I be asked to do?

Participation in this study will involve one of three online tasks. You may be asked to do any one of these depending on the stage of the project.

For the first task (Group 1 task), you will be asked to respond to a question about your health experiences after the birth of your child. You can give more than one answer. This could take between 10 to 60 minutes depending on how many answers you give.

The second task (Group 2 task), you will be asked to sort the answers provided (anonymously) by the first Group of mothers into group, based on your perception of the similarity of the answers. This activity takes about 15minutes.

The third task (Group 3 task) you will be asked to rate the answers sorted by the Group 2 mothers according to their importance to you. This activity takes about 15minutes.

If you wish to participate in this study please log into this web address (TBC).

All information you provide will be treated in a confidential manner, and your personal details will not be used in any publication arising out of the research.

5. Are there any possible benefits from participation in this study?

It is possible that changes or improvements to maternity care might occur as a result of the information that is gained from this survey. The results may be valuable information for other women and it may lead to a greater awareness amongst health care providers and other mothers.

6. Are there any possible risks from participation in this study?

There are no risks to participating in this study. However, due to the sometimes-emotional nature of pregnancy and becoming parent the topic of this research may evoke some feelings of anxiety, distress and painful memories. If you find you are becoming distressed, you will be advised to see such as your general practitioner, child and family health nurse, psychologist or mental health counselor. You may also withdraw from the study.

7. What if I change my mind during or after the study?

You are free to withdraw at any time, you can do this without providing an explanation. If you wish to withdraw the information you provided, this can be done with sorting or ranking activities by contacting Maryam Rouhi by email (Maryam.rouhi@utas.edu.au). But with the initial answer task, the data provided cannot be withdrawn.

8. What will happen to the information when this study is over?

Printed data will be kept at the office of in a locked filing cabinet. An electronic version of data and other project material will be stored on a secure drive that is password protected, with Faculty of Health Science at the University of Tasmanian, and only the investigators will have access to this folder. The data will be kept until at least 5 five years after publication, then they will be shredded/deleted in accordance with the national guideline.

9. How will the results of the study be published?

Once we have analyzed the information a summary of results will be provided to you through our Facebook page. We will also publish anonymous data in journal articles.

10. What if I have questions about this study?

If you would like to discuss any aspect of this study please feel free to contact

Maryam Rouhi on email: Tel: 0362265700 Email: Maryam.rouhi@utas.edu.au

Maryam will be happy to discuss any aspect of the research with you.

Dr. Christine Stirling, Tel: 03 6226 4678 Email: christine.stirling@utas.edu.au

Dr. Suanne Lawrence Tel: 03 6226 4216 Email: suanne.lawrence@utas.edu.au

Dr. Jennifer Ayton Tel: 0362264240 Email: Jennifer.ayton@utas.edu.au

"This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on +61 3 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [H0016441].

Thank you for taking the time to consider this study.

If you wish to take part in it, Please continue to the agreement to participate on the next page.

Appendix VIII

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
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Katherine.Shaw@utas.edu.au

UTAS

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

21 April 2017

AssocProf Christine Stirling
Health Sciences
Private Bag 121

Dear AssocProf Stirling

Re: MINIMAL RISK ETHICS APPLICATION APPROVAL
Ethics Ref: H0016441 - To explore help-seeking behaviours among Australian women about their health problems in the twelve-months after childbirth (Hababy Project)

We are pleased to advise that acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 21 April 2017.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.

3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Jude Vienna-Hallam
Ethics Administration Officer
Tasmania Social Sciences HREC

Appendix IX: Publication three

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The 'fallacy of normalcy': A content analysis of women's online post-childbirth health-related support

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ABSTRACT

Background: Online forums have changed traditional sources of seeking help because they provide an anonymous and non-judgemental environment particularly suited for women with post-childbirth problems.
Question: What support is given to mothers who have posted questions about post-childbirth morbidities?
Methods: A total of 333 messages posted on a post-childbirth online forum were loaded into NVIVO 12 Pro and were analysed using content and thematic analysis. Content analysis identified the major health problems, and thematic analysis was used for identifying motivations and the support offered.
Findings: Seventeen different health problems were discussed on posts, with a strong emphasis on pelvic problems, followed by mental health concerns. The key motivation for seeking online help identified using 'typology of advice solicitation' was request for opinion or information (48.85%). The two main support themes were: peer to peer support (82%) and normalisation (not always appropriate) of post-childbirth problems (18%). Most of the support offered was emotional (56.9%) followed by practical (22.7%) and informational support (20.4%).
Discussion: Postpartum adjustment of post-childbirth experiences can be supportive but if ill-informed may provide a barrier to safe and reliable health care.
Conclusion: We recommend women have access to online forums moderated by healthcare providers who can notify participants when a problem requires support from a relevant health professional opinion.

Statement of significance

Problem

Many women around the world experience physical and mental health problems after childbirth, but there is little information about how women seek help for these problems or what help they receive from outside their family and friends.

What is already known?

Peer support in the online setting is commonly used by post-childbirth women to resolve anxieties and uncertainties where family and friends cannot help them to cope with their health problems.

What this paper adds?

Normalisation of health problems after childbirth is common in online peer support settings. Women and their online supporters sometimes normalise health problems after childbirth that are not normal, or problems that are no longer normal because they have continued for too long. To ensure reliable online information, healthcare providers should provide websites with content that is monitored by professionals in this area and be able to reply to questions promptly.

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1. Background

Globally, increasing access to smartphones and tablets allows women to use technology to communicate. Among the digital platforms that have been introduced since the 1990s, forums and weblogs are the most popular sources of finding health information, especially among women [1]. Pregnant and post-childbirth women are among the highest users of formal and informal blogs [2,3]. Previous studies have shown that women use online platforms for breastfeeding or parents' concerns [4–7]. These online interactions by peer support are a way to help isolated mothers with a different socioeconomic background to achieve better adjustment where access to healthcare providers have time and cost limitations [8,9].

The postpartum period has been defined as the first 6 weeks after childbirth [10]. Traditionally it is said that during this period changes which have happened during pregnancy, will return to a "non pregnant" state [11]. Many women experience physical and mental health problems, but consider these changes as a part of the normal childbirth process or postpartum adjustment and have had this confirmed by family and friends [49].

Motherhood involves many physical and mental health changes and women need adequate knowledge to safely navigate these changes [2]. The traditional forms of getting this information, such as pamphlets or face-to-face services, have partly been replaced by online forums where women share their experiences. Online settings also provide anonymity and privacy, allowing women to talk freely about their health problems without fear of judgement and embarrassment [12,13] and giving access to global information [14,15]. This online information-seeking can affect the women's decision-making about their health and their infant's health as well [13].

Plantin and Daneback's systematic review [16] showed that many parents search the internet to find health information and advice. However, our own previous systematic review found very few studies related to the help-seeking behaviours of women in the twelve-month post-childbirth period [49]. The limited evidence base showed that women largely report relying on family and friends to seek help for their post-childbirth health problems. To build on this work, this paper describes research exploring online help-seeking discussions about post-childbirth problems among women who participate in post-childbirth online support forums. We asked three research questions: Which health problems were shared by women who seek help? What were the motivations for questions mothers posted on the forum discussion board? What support is given to mothers who have posted questions about post-childbirth morbidities?

2. Method

We applied a directed qualitative content approach, which can be used to analyse text or data gathered from audio, video, printed data such as books, papers and pamphlets or online sources to find themes or patterns [17]. The directed content method originated in the 18th century in Scandinavia [17] and is used widely as either a qualitative or quantitative method in health research [15,18–20]. While conventional content analysis looks to increase knowledge about less studied phenomena, directed content analysis helps to endorse or expand an existing theoretical framework with a more qualitative focus [17]. This method has helped to answer midwifery research questions considering why participants use a service and the nature of their concerns [15,21].

3. Online recruitment

A comprehensive online search was conducted to find a list of Australian forums which contained post-childbirth online support forums. Those forums which were active within the last 365 days, had at least 50 active individuals and more than 30 posts on the forum per day met the inclusion criteria. The moderators of these forums were contacted to explain the aim of the study and request permission to include the forum in our study. From six Australian parenthood forums only one granted permission to analyse posts. We approached moderators for consent rather than forum participants so as not to disturb participants.

We undertook an observational, passive analysis and all posts were anonymous [22]. Participants' I.D. numbers and I.P. addresses were blocked so the identity of the forums and participants were not visible to the researchers. This prevented violation of privacy, which is increasingly debated in social media research where the online personal information is released via social networking data [22].

3.1. Data management

The recruited forum website had a variety of forums about parenting from conception to children's issues, but we only analysed content from one forum, which concentrated on post-childbirth problems and covered women's health problems. This forum had 332 posts related to post-childbirth health problems. The content of messages posted to this forum by women was imported into NVivo 12 [23], a qualitative data analysis software programme, for analysis. Messages retrieved from March 2007 to March 2019 were used to catch a broad range of conversations. In the first step, 127 posts were analysed for evidence about physical and mental health problems shared by women as 'posters' (P). Of these there were 49 original posts, 21 threads (T) and 78 comments from 'commenters' (C) over the eight years. In this study a 'poster' was defined as a woman who posted the original thread, and 'commenters' as those women who responded to the original posts.

As some original posts and comments consisted of multiple questions and comments, in total 63 advice solicitations and 270 comments to original posts were identified. This data was considered adequate for the study as previous studies have analysed different numbers of interactions from 120 message posts to 921 messages [15,24]. All quotes of posts are unaltered, with no corrections for grammar or spelling, but abbreviations are defined in brackets.

4. Data analysis

To answer the first question, all health problems which were shared by women seeking help were documented and quantitatively analysed using the NVivo 12 [23] coding system. We used word clouds provided by NVivo 12 [23]. Word clouds are a tool to visually depict and interpret the findings: the more frequent the word use, the bolder the colour and larger the size. Table 1 shows the morbidities that were shared by women as motivation to seek help.

To answer the second question regarding the motivations of women posters (P) on the forum discussion board, the 'typology of advice solicitation' modified by Sillence [25] was applied as a predefined categorisation. This typology originally derived from Goldsmith [26] who evaluated oral advice interactions and identified six patterns of interaction. Sillence [25] adopted this categorisation for her study which was focused on online breast cancer support group and applied five types of advice solicitation

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Table 1
Physical and mental health problems shared by women.

Morbidities categorisation	Morbidities reported by the initial posts (21 threads), *N* (%)	How many commenters replied
Urogenital problems	9 (40)	132
Gastrointestinal problems	5 (23)	3
Breastfeeding issues	1 (5)	3
Obesity and weight loss	2 (9)	20
Mood problems	5 (23)	112

as an outcome of her analysis. This typology has been used successfully to analyse and categorise online interactions in areas as diverse as online breastfeeding advice, online support communities [15,20].

To answer the third question, a qualitative thematic analysis approach was used [27] to examine what support was given to the posters about their health problems post-childbirth. Thematic analysis is a 'careful reading and re-reading of the data' which allows identification of emerging themes and their categorisation [28]. We followed the six steps of the approach described by Braun and Clarke [27] which consist of: 'familiarising yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report'. The researchers read all extracted data to be familiar with the data and developed initial codes. The codes were then collapsed into themes. The final set of themes were checked and compared to the extracted texts and approved by the research team through discussion. Finally, the research team discussions, along with reflection on this study aims and our previous studies helped us to interpret the themes and identify the overarching themes.

5. Credibility

The intercoder reliability or reproducibility across coders is a concern in qualitative content analysis [29]. To have consistency in the coding process, one researcher codes all of the transcripts and these are double checked by the researchers with the final set of codes agreed by the team [30], with 70% agreement in coding considered reliable [31]. Credibility was ensured by the first author undertaking '. . . prolonged engagement, persistent observation, negative case analysis, [and] referential adequacy' [17]. Peer debriefing was undertaken by all authors with the team looking for negative examples or data which did not fit the categories. This resulted in adjustments to the categories and provided a balance to the position of the first author who is a midwife and has studied women's post-childbirth health problems for a long time and has an unbiased view of the results.

5.1. Ethical statement

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee H0017619 24 August 2018.

6. Findings

A total of 332 postings were collected and analysed from the forum. The results are presented in three sections answering the research questions. In addition, two overarching themes of appropriate and inappropriate normalisation that spanned both motivations and support were identified. We labelled these 'postpartum adjustment' and 'the fallacy of normalcy'.

6.1. Which health problems were shared by women who seek help?

Women shared 17 health problems, which ranged from mental health problems like depression and anxiety to physical concerns like mastitis, uterine infection, constipation, overweight and weight loss, and fatigue (Table 1). About 90% of the health problems were focused on pelvic issues. Fig. 1 is a word cloud which shows the key health problems discussed with larger words representing more frequent use in the forums; bladder problems and incontinence being prominent. However, there was a key subforum focused on women's pelvic issues which dominated this word cloud; therefore, we excluded the pelvic issues in the second word cloud which depicts the weighting of the other health problems, with depression, anxiety, sleep and fitness as key concerns for women (Fig. 2).

6.2. What were the motivations in questions women posted on the forum discussion board?

To answer the second question, we analysed the common themes in help-seeking of original posts using the 'typology of advice solicitation' modified by Sillence [25]. Each of the 63 original posts were allocated to one the following advice solicitation categories: request for opinion or information (48.85%), problem disclosure (30.23%), anyone in the same boat (13.95%), and request for advice (6.97%). Announcement of a plan of action has been excluded because no post fitted.

6.2.1. Request for opinion or information

About half of the women requested an opinion or some information (48.85%). This category defines 'questions such as

Fig. 1. Physical and mental health problems shared by women.

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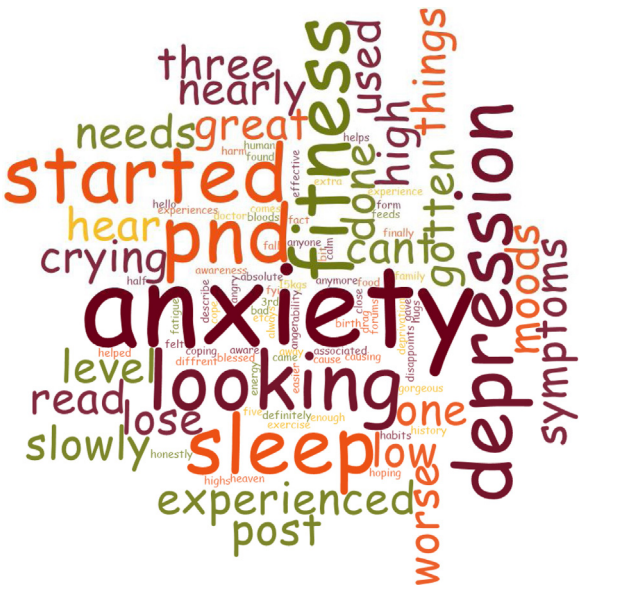

Fig. 2. Health problems excluded pelvic problems.

"What do you think?" or "What do you think of X?" as a request to get information or opinion' [25]. Included in this category is any post where it is not clear whether the poster wanted someone to solve their problem or provide emotional support.

This is demonstrated in the following quote where the poster asked about the difference between depression and postnatal depression (PND) by briefly explaining a past history of depression, which shows she knew what depression was but could not distinguish it from PND:

> "Im [I'm] just wondering what the difference is between depression and pnd [post-natal depression]? how can you tell the difference? I suffered Depression through high school and came of my meds just before I fell pregnant . . . Everything in life, besides being a mother and my babies, just feels like its crap. I just dont [don't] know how the 2 are different" (T5P).

While the poster only asks for information about depression, she also provides a lot of detail about her personal situation which suggests she is struggling with 'feeling like crap'. This was seen in many posts where a simple request for information was presented alongside disclosure of information about a difficult-sounding situation.

7. Problem disclosure

About one-third of the posters (30.23%) revealed a problem. Definition of this category means that women did not directly ask a question about their problems but appear to be trying to vent their concerns. Analysis of the posts showed they were requesting 'advice, sympathy, solidarity, etc' [25], as seen in the following quote where the poster shows her frustration about her situation and is looking for women who identify with her situation. She asked for advice about how she could "juggle everything":

> "Hi, I am new here and hoping I can find some people who understand and that i can talk to. I work full time and have 2 kids, 1 and 3. I love my kids but hate my life the way it is and just don't see anyway for it to get better. How do i juggle everything?" (T13P).

It is ambiguous for the reader to know whether she needed information or to receive emotional support as the poster only disclosed her problem. This ambiguous approach to the original post was used by about one-third of women.

8. Anyone in the same boat

About 13.95% of the original posts were in this category, and asked if others were going through the same situation, or is 'anyone in the same boat' [25]. The interactions in this category were concentrated only on pelvic issues and blood loss. In one of the threads, for example, the poster declared her concerns about incontinence as a barrier to jumping on her trampoline and asked "Anyone else struggle with bladder problems":

> "Hi sorry if TMI [too much information] but my second bub is 10 months old! I'm ok with day to day stuff but can't jump on the trampoline with my 3 year old! I go to the toilet before I get on with her but have to weans [sic] heavy pad because it just keeps coming even tho ive [sic] just emptied my bladder I stayed very fit with my second pregnancy and did lots of pelvic floor etc.! Feeling frustrated coz [sic] I love getting on the trampoline with my kids! Anyone else struggle with bladder problems??" (T20P).

It is surprising that the poster did not appear to have sought professional care for what is clearly a post-childbirth morbidity and instead had normalised her problem. However, she received replies that encouraged her to get appropriate professional health support to which she responded:

> "Thanks! I'm going to see a Physio who specializes in pelvic floor problems! Will go back to my obstetrician if that doesn't work! Been doing exercises myself too! Hopefully I won't be wearing a nappy any time soon hehe!" (T20P).

In this case, commenters' responses resulted in the poster seeking appropriate healthcare.

9. Request for advice

Request for advice accounted for 6.97% of original posts. According to Sillence [25] advice solicitation consists of messages that contains these phrases: (a) "I need your advice"; (b) "What should I do?"; and (c) "Should I do X?". In this category, posters disclosed health problems and followed up with asking for direct advice.

This poster opened her post by explaining her leaking and asking, "what should I do?"

> "Overnight I woke twice to feed my 4 month old DS [Dear son] and both times my pj [pyjamas] pants were a bit wet and I could feel myself leaking a bit (sorry, I feel like this is TMI [too much information]). Is it possible to have incontinence 4 months after having a baby?? I had no problems when I was pregnant. What should I do?? I feel too embarrassed to tell anyone!" (T11P).

While this poster is not sure about the incontinence, it is clear in this original post she was looking for any advice about the incontinence and also that embarrassment was a barrier to disclosing her problem to others.

10. What support is given to women who have posted questions about post-childbirth morbidities?

A total of 270 comments were collected and analysed. Upon coding by content analysis and thematic analysis, we found the 'peer support' offered by commenters three themes of emotional support (56.9%) followed by practical (22.7%) and informational support (20.4%).

10.1. Emotional support

The most common specific support given by the commenters were emotional support (56.9%, $n = 125$). In response to the posters' descriptions of their problems faced during the first year after

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childbirth, commenters showed their empathy, sympathy and encouragement. They tried to show that others experienced the same condition, so the posters were not alone. This commenter expressed her emotional support by providing explanations about how she managed her depression and confirmed 'how hard the road can be', and she also tried to provide a comprehensive picture of depression and solutions:

> "There are differences between PND [postnatal depression]and depression however they also share many similarities! PND usually starts a few days after birth or, interestingly in your case, many women relapse after 6 or so months of birth! Nobody can say for sure why women experience PND however having a history of depression, enviromental [sic] stressors . . . I too am a mum and suffered PND [postnatal depression]! How hard the road can be and I take my hat off to you as you have twins! – but these feelings will pass with help and time. Believe me. Be gentle on yourself too" (T5C4).

She correctly pointed out that PND and depression are the same and asked the poster to consider counselling support and be gentle with herself, and to ask for support from family and friends or any public services.

Another commenter assured a poster with a query about incontinence that 'there are lots more of us out here' and encouraged her to make a contact with a specialist clinic. At the end, she emotionally supported the poster by recommending that 'be strong and be grateful that you have this forum and people to give answers'. Interestingly many commenters believed that the previous generation suffered in silence but that discussion about incontinence is now accepted by the public:

> "You are not alone. Remember that ad in the parent's rooms that the Federal Government put out – one in three – well you are one of the one in three and there are lots more of us out here. My problems were very bad after DD1[dear daughter1] but have remarkably improved with each delivery but worsened during each pregnancy . . . In the meantime – be strong and be grateful that you have this forum and people to give answers – previous generations had to suffer in silence" (T19C5).

Commenters confirmed that many women experienced physical and mental health problems. Furthermore, the commenter believed that new generation speak out their experienced problems and there are some potential supports in the society.

10.2. Practical support

Practical support was provided by about one-fourth of commenters (22.7%, $n = 50$). This support was limited to physical health problems such as bladder issues and getting back into shape. Commenters suggested solutions like Kegel exercise or special pads for urinary incontinence or suggesting following an online group to lose weight. In Thread #9, in reply to the original poster asking for any opinion about losing weight, some suggestions like the following were provided by commenters:

> "I'm currently on keto (high fat, low carb) and have managed to lose 7.5 kg in 6 weeks with no real exercise except for a good walk once a week. It's pretty easy to stick to and even DH [dear husband] is loving the food!" (T9C4).

In reply, unlike the others, this commenter reminded her about how breastfeeding could be affected by diet and proposed an easy way to lose weight when her child got older and less reliant on breastfeeding:

> "If you are breastfeeding, I would suggest holding off on dieting for now – you will need to keep yourself well nourished so the baby doesn't deplete your nutrients. ie your breastmilk will always be fine, you need to eat well to keep yourself healthy. In terms of exercise, I found walking worked for me in the early days postpartum. I wasn't up for much else. I did join a gym when my youngest was a bit older – 12 months? and got into cardio and weight bearing exercise then" (T9C13).

Normalising bladder issues was evident among commenter's posts. However, they suggested some practical supports like Kegel exercises as the first option and then to seek professional help:

> "Its [It is] perfectly normal. The stress of the birth/s cause the pelvic floor muscles to weaken. Normally doing your pelvic floor exercises will help. If not though id me [sic] making an appointment with your gp [General Practitioner] to see a gynaecologist. I have a first degree cystocele which is a slight movement on the bladder. Meaning it has moved slightly down in the pelvic cavity which is the early stages of a prolapse. Which causes incontinence. If you feel there is something not right about your situation (only you know your body) please head to a specialist. Its worth getting these things checked sooner rather than later as if they catch it at the early stages it can ge [sic] fixed easier" (T20C2).

In this case, even though the commenter normalised the bladder issue they suggested that if they listen to their body it helps them to distinguish abnormalities in the early stages.

10.3. Informational support

The third type of support provided by commenters was informational support (20.4%, $n = 45$). The commenters replied by offering advice, recommendations and information to assist with solving any physical and mental problems raised by the original posters. In Thread #20, in reply to a poster who was seeking information on whether there were other ways to solve urinary incontinence apart from exercise:

> "I had the same problem a couple of months after having my second. I spoke to my GP [General Practitioner] who referred me to a physiotherapist at the public hospital I birthed at and she was great. She assessed the strength of my pelvic floor and gave lots of suggestions to help strengthen it. There's a machine you can hire that sends an electrical pulse that tightens up the muscles, it's a bit strange to use but I definitely felt results. If you make an appointment with your doctor they should be able to refer you to someone that can offer some more advice" (T20C2).

The commenter discussed her experience with her GP and explained the process of healing that she passed and convincing the poster to seek professional help.

11. Overarching theme: appropriate and inappropriate normalisation of post-childbirth health problems

Postpartum care in regard to maternal health problems is defined by WHO [10] as assessment of urinary incontinence, depression, postpartum bleeding and lochia by healthcare providers. A key finding from this study was 'normalisation' of health problems after childbirth. Reading through the online discussions among women, we extracted two subthemes related to the concept of normalisation. The first subtheme is 'postpartum adjustment' and the second is 'the fallacy of normalcy'.

'Postpartum adjustment' describes the process by which women perceive the discussed problems to be a normal part of adjustment after childbirth, and consequently normalise difficulties such as infant problems or managing motherhood roles, and tasks plus any physical and maternal mental health adjustment during the first six weeks after childbirth.

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However, our analysis revealed that most of the commenters tried to justify any maternal health problems as a normal process after childbirth during the first twelve months after childbirth. We called this 'the fallacy of normalcy', as any health problems that extend beyond the postpartum period of six weeks is not normal and needs professional help.

11.1. 'Postpartum adjustment'

'Postpartum adjustment' is proposed as the main reason for health problems in the first six weeks post-childbirth. Women reminded each other that during this period, they must adapt to a new role; their personal and social life have changed dramatically, with the priority being a focus on the infant's needs, like breastfeeding. They give encouragement that adjustment to the demands and burden of motherhood gradually gets easier and women should get help from family and friends as well:

> "I honestly feel that the first 6 weeks after having a baby are the most challenging weeks of your entire life. I think many people underestimate just how exhausting it actually can be. Your number 1 priority is you and bub. Housework etc. is waaay down the bottom of the list. Get out of the house. Go for a walk around the block with bub. Go out for lunch . . . Whether it's your DP [dear parents]/DH [dear husband], your GP [General Practitioner] or even someone from Beyond Blue etc. If you are really struggling there is absolutely NO shame in asking for help" (T21C6).

Another commenter tried to encourage the poster that problems get better and "Hang in there":

> " . . . With both of mine I found the first 6 weeks was soooo bloody hard! Then it started to get easier as we all got into the swing of things, feeding and sleeping got better, smiles started to appear, and I was able to get out and about a bit more. Hang in there lovely, you can do this!" (T21C21).

Commenters also remind each other that physical and hormonal changes occur and their children's problems are part of the motherhood adjustment as well. Importantly, their comments reflected the struggle with the new role as a mother and how mothers must adapt and embrace their problems in this period and be kind to themselves:

> "It definitely gets better! Those first few weeks of motherhood are hard!! It is a big adjustment, plus you are tired and have lots of hormones making things even harder. The feeding and changing etc. is also at its most demanding. I would try and get out whenever you can. A little walk or a trip to a cafe makes a huge difference. Also, don't put too much pressure on yourself. Just do whatever you need to do to get through the first couple of months and then it does get a bit better. I personally love this article about the "fourth trimester". It was the most helpful thing anyone ever shared with me as a new parent and hope it helps you too: https://pregnantchicken.com/whatyou..bout-newborns/" (T21C5).

Another commenter clearly explained there is a new lifestyle after childbirth with a dramatic change in their role and showed their sympathy as they are not alone:

> "I think there's also a process of grieving the old life you had that's now disappeared. i think there's a lot of pressure to love your new role of mum instantly and unquestioningly, and that we're supposed to be ok and even excited about the disposal of our old childless lives. it's such a silly notion when you think about it, but we accept the model that's presented to us as though it's gospel and normal. it takes a while to adjust into any new role, and it takes a while to adjust to a new lifestyle and be upset about the lives we had that we no longer have. under any other circumstance, a new job, a move to a new city/state/country, etc., we would recognize hey, . . . go easy on yourself OP, becoming a mum is a rude shock to many. you are most definitely not alone xx" (T21C29).

Commenters convinced the posters to ignore the problems as part of postpartum adjustment and their attention shifted to the infant's need and mother's new role.

11.2. 'The fallacy of normalcy'

In this subtheme posters and commenters discussed health problems which are not normal and may even require the intervention of professional healthcare providers to resolve. Some commenters normalised the problems and encouraged the posters to ignore these as part of a normal process after childbirth, but others, while agreeing the problem were normal, suggested seeking medical or family help.

In one thread, the poster was asking for practical advice about the wetness and odour originating from her incontinence. Her description showed she had severe and continual urinary incontinence. The poster appeared to accept her problem as normal and instead of seeking professional help, she sought advice on products to hide the odour of her incontinence. Concerningly, most commenters seemed to agree that it is a normal condition and advised the poster on different products to resolve the wetness and odour, suggesting "absorbent & fragranced" incontinence products:

> "I think some of them upset the natural Ph of the vagina-leaving you more susceptable [sic] to yeast infections and what not. The vagina is meant to be self cleaning. Having said that though i'm sure there would be nothing wrong with using some cleansing wipes or something-so long as you were just using it on the labia etc. and not internally IYKWIM? Perhaps you could have a look and see if they make some wipes like the ones for babies but for intimate adult use. Something for sensitive skin/unfragranced perhaps? I'm pretty sure they make some special liners for incontinence that are a bit more absorbent & fragranced etc.-to stop the wet patch problem" (T21C2).

One commenter replied by introducing a pad that she used to resolve her incontinence:

> "I use the Tena lady incontinence pads – they are especially for urine leakage and incontinence so more absorbent. You can ask the company for free samples etc. They aren't the only company that makes incontinence pads – they are located within the sanitary pad section as well" (T21C9).

A small proportion of women addressed it as normal incontinence but advised her to seek further help:

> "Also just in regard to incontinence you can see a physio about it and they can help you with advice and exercises etc. I went to one at the hospital following the birth of my bub and I had incontinence issues as well and the physio helped! Try your hospital first since they will have contacts in that specialised area" (T21C12).

Another commenter experienced bowel incontinence for a long time and encouraged the poster to check the other potential problems as well. Interestingly the commenter introduced diet modification to manage anal fissure:

> "Not as a rule . . . but if I hang on too long or bladder is too full and I cough, sneeze it can happen. I tend to put it down to old age HA HA Jax, that is tough with the other department. Do you mind me saying, are you sure that is the only reason . . . I only say that cos I had issues for the last six months (TMI warning) like leaking a bit of mucus from the bowel every time I went to

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the loo to urinate and at other times had to clench my butt . . . turns out I had rather large growth (discovered and removed when I had a colonoscopy) I don't say this to make you worry, but to heed warnings when things aren't normal. Obiviously [sic] you know your body better than me, but this is my experience and as you say, its helpful to share. Anal fissures can be managed with diet and drinking lots of water so you don't get constipated Angike" (T6C14).

Some of the commenters think that urinary incontinence is normal but faecal incontinence is not and needs professional attention, like this poster:

"Urinary stress incontinence is completely normal during pregnancy and even after, but I'd be encouraging you to seek further medical advice if there is any faecal incontinence" (T16C2).

While some of the commenters think that incontinence is normal some of the commenters considered exhaustion as "not normal" and showed their sympathy, like this mum:

"I agree with the others – definitely doesn't sound normal!! But without knowing what your psychosocial disability is, it's hard to distinguish whether it's related to that or something else?? So sorry you're going through this" (T15C8).

Some commenters reminded posters that bleeding, and fatigue are not a normal situation after birth and encouraged the others to get professional help:

"I echo everyone's sentiments. What you're describing doesn't sound 'normal', especially fatigue/tiredness that is so severe you're forgetting to go to the toilet/eat/drink etc. It may well be psychosomatic, but I would definitely be doing as others have suggested and getting full bloods done. I know that the thought of that (going to the Doctor etc.) is probably hard, but it's very worrisome what you're describing, especially feeling everything is a 'failure'. At least by getting a professional to see/hear/test you, you can find out what is really going on with your mind and body" (T15C6).

It was evident that 'the fallacy of normalcy' is found in online blogs both from posters and commenters, and while some of the commenters guided posters to ignore their problems as a normal process after birth, others recommended the poster get help from different health professionals.

12. Discussion

This study sought to provide a picture of women's online interactions by analysing the discussion boards in a post-childbirth forum.

In the current study, although women shared different health problems, pelvic issues, especially incontinence and prolapse, followed by mental health problems were the key health issues motivating women to post on the online forum. This is consistent with our previous systematic review [49]. That review showed that pelvic issues and depression qualitatively are the most researched area, which could be related to healthcare providers concentrating more on mood disorders and incontinence problems than other health issues. Recent studies highlight that women are now more informed about pelvic problems and depression [32,33]. While this fairly narrow range of health problems were found in the online forum our previous concept mapping study showed women have a much broader perception of healthcare needs after birth which include fitness and social connection [50].

To answer the second question, we analysed the common themes in help-seeking of original posts by the "typology of advice solicitation" modified by Sillence [25]. Consistent with other studies, our findings have shown that new mothers often use the online environment to get information support for their infants' problems or themselves through social networking [5,6,8,9,15,34,35]. Motherhood is a challenging time for women and studies show that they struggle to cope with the stress and demands during this time especially for breastfeeding [1,5,36,37]. Prenatal care equips women for labour and delivery topics but does not prepare them for post-childbirth problems [9,33,38]. It is possible that by accessing online platforms, women reassure the inconsistency of available information and get validation as well [35].

'What support is given to mothers who have posted questions about post-childbirth morbidities?' was the third question. In the online setting peer support was prominent among women to resolve their anxiety and uncertainties about infant care and breastfeeding concerns where family and friends could not help them to cope with these ambiguities [5,33,39]. The online forum assisted them to share concerns with other mothers who have the same problems during the transition of motherhood and make 'unique bonds' in a mutuality of endorsement, sympathy and responsiveness [40]. Furthermore, reading other posts about their post-childbirth challenges helped them to compare their problems and gave them a feeling of comfort [12].

In our study, while most of the posters asked informational support, surprisingly most of the peer support given was emotional support as women shared their stories and emphasised to posters that they were not alone [12]. A critical review by Doty and Dworkin [12] to assess online social support for parents, confirmed that there is unclear meaning for emotional support among parents but the most prevalent meanings were 'overcoming isolation, sharing experiences, building self-esteem, and empathizing' (p. 185).

This inconsistency between asking for information by posters and replying with emotional support by commenters may be explained by the theory of optimal matching described by Cutrona and Suhr [41]. They proposed two types of support: action-facilitating support and nurturant support. Action-facilitating support assists people by providing informational and tangible support, while nurturant support provides emotional, network and esteem support. In our study, most of the commenters provided emotional support by offering empathy or sympathy and did not necessarily propose solutions to the problems. Cutrona and Suhr [41] proposed that when people are in stressful situations that cannot be controlled, emotional support is adopted to help eliminate the stress. In the context of post-childbirth problems, we believe that women recognise post-childbirth health problems as stressful events so emotional support is proposed as the first nurturant support.

13. Postpartum adjustment and the fallacy of normalcy

In the current study, postpartum adjustment and normalisation of women's health problems after childbirth are proposed as the key framing of health problems. Because the first six weeks post-childbirth is widely recognised as the postpartum adjustment time when women return to a nonpregnant state [10], issues outside this period are not well supported by health care services [42].

'Normalisation' of post-childbirth health problems that are not necessarily normal emerged as a key finding during the analysis. The term 'normalisation' comes from Bank-Mikkelsen who worked with people with mental problems [43]. Robinson [44] later assessed this concept among people living with a chronic condition. She showed this group of people attempt to have a normal life with a chronic health condition by "covering up" their symptoms. This conceptualisation has been used in the area of post-childbirth maternal morbidities in our previous study and

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was a dominant issue among families that concealed health problems after childbirth [49].

In this study, we adopted the term 'the fallacy of normalcy' to describe women's perception of their health problems after childbirth when those problems were beyond normal. Both this research and our previous study [50] showed that some women assume that all morbidities are a normal part of the six-week postpartum adjustment period and will resolve on their own without the need to seek help. 'The fallacy of normalcy' hinders women from seeking professional help and family and friends contribute to this, often convincing women that even mental health or pelvic problems are normal [45]. We found that women's use of online forums where they can read and compare other's posts and comments with their own also contributes to normalisation of post-childbirth problems [12,37].

Online forums, by providing anonymity, privacy, lack of embarrassment, support, and appropriate normalisation, help women to access to information globally [14,15,46]. But consistent with the current research, women also give unauthorised medical advice to each other [13,47]. It is unknown how many of these women act according to the suggestions they receive, but there is no doubt that the post-childbirth period is a stressful time for women and to cope with this period women need to search for information about their concerns. The internet is the most used source of information to manage health problems [12,13], and the credibility of the information shared by women raises important questions within online support groups [48], The accuracy of exchanged information needs further investigation [47].

14. Strengths and limitations

The result of this study clearly showed that women use online forums as a source of information. This study only looked at one particular Australian public forum, and other forums and private online groups may have highlighted different results. Our results were restricted to Australian women who communicate in English and are computer literate, therefore it is unknown what concerns are held by those who are unfamiliar with English or using a computer.

15. Conclusion

The result of this study demonstrates that some women share their post-childbirth problems online seeking information and support. In this online setting, women access informal information and independently or as a group, make decisions about their health problems, often without reference to professional opinion.

We recommend that women be directed to high-quality health information to answer their post childbirth health concerns in addition to accessing peer emotional support through online forums. To ensure reliable online information, healthcare providers should provide websites with content that is monitored by relevant health professionals who can reply to questions promptly including notifying participants when a problem is one for which a professional opinion should be sought. The design of the websites should be provided in multiple languages to address community needs. Women should also be prepared during their pregnancy for inevitable health problems and be reminded by healthcare workers about what is normal or abnormal to meet the mothers' needs post-childbirth.

Author contributions

All authors involved in at all stages.

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Ethical statement

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee H0017619 24 August 2018.

Conflict of interests

None declared.

References

[1] D. Lupton, S. Pedersen, G.M. Thomas, Parenting and digital media: from the early web to contemporary digital society, Sociol. Compass 10 (8) (2016) 730–743.
[2] D. Lupton, The use and value of digital media for information about pregnancy and early motherhood: a focus group study, BMC Pregnancy Childb. 16 (1) (2016) 171.
[3] L.O. Walker, M.S. Mackert, J. Ahn, et al., e-Health and new moms: contextual factors associated with sources of health information, Public Health Nurs., 2017.
[4] I.V. Asiodu, C.M. Waters, D.E. Dailey, K.A. Lee, A. Lyndon, Breastfeeding and use of social media among first-time African American mothers, J. Obstet. Gynecol. Neonatal Nurs. 44 (2) (2015) 268–278.
[5] N. Alianmoghaddam, S. Phibbs, C. Benn, "I did a lot of Googling": a qualitative study of exclusive breastfeeding support through social media, Women Birth 32 (2) (2019) 147–156.
[6] A.J. Wagg, M.M. Callanan, A. Hassett, Online social support group use by breastfeeding mothers: a content analysis, Heliyon 5 (3) (2019) e01245.
[7] H. Niela-Vilen, A. Axelin, S. Salantera, H.L. Melender, Internet-based peer support for parents: a systematic integrative review, Int. J. Nurs. Stud. 51 (11) (2014) 1524–1537.
[8] S. Nolan, J. Hendricks, A. Towell, Social networking sites (SNS); exploring their uses and associated value for adolescent mothers in Western Australia in terms of social support provision and building social capital, Midwifery 31 (9) (2015) 912–919.
[9] L. Guerra-Reyes, V.M. Christie, A. Prabhakar, A.L. Harris, K.A. Siek, Postpartum health information seeking using mobile phones: experiences of low-income mothers, Matern. Child Health J. 20 (1) (2016) 13–21.
[10] WHO, Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice, WHO, Geneva, Switzerland, 2015.
[11] L.A. Leah, Health problems after childbirth, J. Midwifery Women's Health 45 (1) (2000) 55–57.
[12] J.L. Doty, J. Dworkin, Online social support for parents: a critical review, Marriage Fam. Rev. 50 (2) (2014) 174–198.
[13] J. Slomian, O. Bruyere, J.Y. Reginster, P. Emonts, The internet as a source of information used by women after childbirth to meet their need for information: a web-based survey, Midwifery 48 (2017) 46–52.
[14] S.D. Kauer, L. Sanci, C. Mangan, Do online mental health services improve help-seeking for young people? A systematic review, J. Med. Internet Res. 16 (3) (2014) e66.
[15] J. Furkin, Mom to Mom: Online Breastfeeding Advice, University of Kentucky, 2018.
[16] L. Plantin, K. Daneback, Parenthood, information and support on the internet. A literature review of research on parents and professionals online, BMC Fam. Pract. 10 (1) (2009) 34.
[17] H.F. Hsieh, S.E. Shannon, Three approaches to qualitative content analysis, Qual. Health Res. 15 (9) (2005) 1277–1288.
[18] N.S. Coulson, H. Buchanan, A. Aubeeluck, Social support in cyberspace: a content analysis of communication within a Huntington's disease online support group, Patient Educ. Couns. 68 (2) (2007) 173–178.
[19] M. Evans, L. Donelle, L. Hume-Loveland, Social support and online postpartum depression discussion groups: a content analysis, Patient Educ. Couns. 87 (3) (2012) 405–410.
[20] R.M. Smedley, N.S. Coulson, A thematic analysis of messages posted by moderators within health-related asynchronous online support forums, Patient Educ. Couns. 100 (9) (2017) 1688–1693.
[21] M. Vaismoradi, Content analysis and thematic analysis: implications for conducting a qualitative descriptive study, Nurs. Health Sci. 15 (3) (2013) 398–405.
[22] G. Eysenbach, J.E. Till, Ethical issues in qualitative research on internet communities, BMJ 323 (7321) (2001) 1103–1105.
[23] NVivo 12. QSR International Pty Ltd. NVivo QUALITATIVE DATA ANALYSIS SOFTWARE. Version 12. ed., 2018.
[24] K.C. Eichhorn, Soliciting and providing social support over the internet: an investigation of online eating disorder support groups, J. Comput. Mediat. Commun. 14 (1) (2008) 67–78.

Please cite this article in press as: M. Rouhi, et al., The 'fallacy of normalcy': A content analysis of women's online post-childbirth health-related support, Women Birth (2020), https://doi.org/10.1016/j.wombi.2020.04.007

[25] E. Sillence, Giving and receiving peer advice in an online breast cancer support group, Cyberpsychol. Behav. Soc. Netw. 16 (6) (2013) 480–485.
[26] D.J. Goldsmith, Soliciting advice: the role of sequential placement in mitigating face threat, Commun. Monogr. 67 (1) (2000) 1–19.
[27] V. Braun, V. Clarke, Using thematic analysis in psychology, Qual. Res. Psychol. 3 (2) (2006) 77–101.
[28] J. Fereday, E. Muir-Cochrane, Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development, Int. J. Qual. Methods 5 (1) (2006) 80–92.
[29] J.L. Campbell, C. Quincy, J. Osserman, O.K. Pedersen, Coding in-depth semistructured interviews, Sociol. Methods Res. 42 (3) (2013) 294–320.
[30] L. Burla, B. Knierim, J. Barth, K. Liewald, M. Duetz, T. Abel, From text to codings: intercoder reliability assessment in qualitative content analysis, Nurs. Res. 57 (2) (2008) 113–117.
[31] L.R. Frey, C.H. Botan, G.L. Kreps, Investigating Communication: An Investigation to Research Method, (2000) .
[32] F. Alderdice, J. McNeill, F. Lynn, A systematic review of systematic reviews of interventions to improve maternal mental health and well-being, Midwifery 29 (4) (2013) 389–399.
[33] M. Rouhi, C. Stirling, J. Ayton, E.P. Crisp, Women's help-seeking behaviours within the first twelve months after childbirth: a systematic qualitative meta-aggregation review, Midwifery 72 (2019) 39–49.
[34] S.K. Walker, J. Dworkin, J. Connell, Variation in parent use of information and communications technology: does quantity matter? Fam. Consum. Sci. Res. J. 40 (2) (2011) 106–119.
[35] J. Jang, J. Dworkin, H. Hessel, Mothers' use of information and communication technologies for information seeking, CyberPsychol. Behav. Soc. Netw. 18 (4) (2015) 221–227.
[36] D.C. Parry, D. Troy, Glover, C.M. Mulcahy, From 3Stroller-Stalker3 to 3Momancer3, J. Leis. Res. (2013).
[37] L. Gibson, V. Hanson, 'Digital Motherhood': How Does Technology Support New Mothers? CHI, 2013.
[38] B.L. Valtchanov, D.C. Parry, T.D. Glover, C.M. Mulcahy, Neighborhood at your fingertips: transforming community online through a Canadian social networking site for mothers, Gend. Technol. Dev. 18 (2) (2017) 187–217.
[39] C. Strange, C. Fisher, P. Howat, L. Wood, Fostering supportive community connections through mothers' groups and playgroups, J. Adv. Nurs. 12 (2014) 2835.
[40] M.L. Nolan, V. Mason, S. Snow, W. Messenger, J. Catling, P. Upton, Making friends at antenatal classes: a qualitative exploration of friendship across the transition to motherhood, J. Perinat. Educ. 21 (3) (2012) 178–185.
[41] C. Cutrona, J. Suhr, Controllability of stressful events and satisfaction with spouse support behaviors, Commun. Res. 19 (2) (1992) 154–174.
[42] E.R. Fowles, H.R. Cheng, S. Mills, Postpartum health promotion interventions: a systematic review, Nurs. Res. 61 (4) (2012) 269–282.
[43] W.P. Wolfensberger, B. Nirje, S. Olshansky, R. Perske, P. Roos, The Principle of Normalization in Human Services, University of Nebraska Medical Center, 1972, pp. 114.
[44] C.A. Robinson, Managing life with a chronic condition: the story of normalization, Qual. Health Res. 3 (1) (1993) 6–28.
[45] F. Wuytack, E. Curtis, C. Begley, The health-seeking behaviours of first-time mothers with persistent pelvic girdle pain after childbirth in Ireland: a descriptive qualitative study, Midwifery 31 (11) (2015) 1104–1109.
[46] S.Y. Schoenebeck, The secret life of online moms: anonymity and disinhibition on YouBeMom.com, AAAI International Conference on Weblogs and Social Media ICWSM 2013, Massachusetts, USA, July 8–11, 2013, pp. 2013.
[47] N.S. Coulson, N. Greenwood, Families affected by childhood cancer: an analysis of the provision of social support within online support groups, Child: Care Health Dev. 38 (6) (2012) 870–877.
[48] A. Esquivel, F. Meric-Bernstam, E.V. Bernstam, Accuracy and self correction of information received from an internet breast cancer list: content analysis, BMJ 332 (7547) (2006) 939–942.
[49] M. Rouhi, C. Stirling, J. Ayton, E.P. Crisp, Women's help-seeking behaviours within the first twelve months after childbirth: a systematic qualitative meta-aggregation review, Midwifery 72 (2019) 39–49.
[50] M. Rouhi, C.M. Stirling, E.P. Crisp, Mothers' views of health problems in the 12 months after childbirth: a concept mapping study, J. Adv. Nurs. 75 (12) (2019) 3702–3714.

Please cite this article in press as: M. Rouhi, et al., The 'fallacy of normalcy': A content analysis of women's online post-childbirth health-related support, Women Birth (2020), https://doi.org/10.1016/j.wombi.2020.04.007

Appendix X

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HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

29 August 2018

AssocProf Christine Stirling
Health Sciences
Private Bag 121

Dear AssocProf Stirling

Re: MINIMAL RISK ETHICS APPLICATION APPROVAL
Ethics Ref: H0017619 - Online help-seeking behaviours and online post-childbirth problems discussion group: A content analysis

We are pleased to advise that acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 28 August 2018.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.

3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Ailin Ding
Administration Officer
Tasmania Social Sciences HREC