Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review

Maryam Rouhi , Christine Stirling , Elaine Peta Crisp

PII: S0266-6138(19)30035-X
DOI: https://doi.org/10.1016/j.midw.2019.02.005
Reference: YMIDW 2420

To appear in: *Midwifery*

Received date: 10 September 2018
Revised date: 11 January 2019
Accepted date: 6 February 2019

Please cite this article as: Maryam Rouhi , Christine Stirling , Elaine Peta Crisp , Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review, *Midwifery* (2019), doi: https://doi.org/10.1016/j.midw.2019.02.005

Highlights

- Women did not seek help because they accepted problems as a part of the motherhood role or because they feared being judged negatively.
- Women most often shared their issues first with family and friends as trusted people.
- Low health literacy was a barrier to seeking help, as were 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.

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Authors

Maryam Rouhi *
PhD Candidate
BSc (Mid.), MSC (MCH)
School of Health Sciences, College of Health and Medicine, University of Tasmania
Advocate House, 9 Liverpool St, Hobart TAS 7001
+61 3 6226 5700
Maryam.rouhi@utas.edu.au
Twitter @rouhi-maryam

Associate Professor Christine Stirling
School of Health Sciences, College of Health and Medicine, University of Tasmania
Private Bag 135, HOBART TAS 7001
71 Brooker Avenue, Hobart TAS 7001, Australia
+61 3 6226 4678
Christine.Stirling@utas.edu.au
Twitter @CMStirling1

Elaine Peta Crisp
RN, BN (Hons), PhD
School of Health Sciences, College of Health and Medicine, University of Tasmania
Locked Bag 1322 Launceston 7250, Australia
+61 3 6324 3230
elaine.crisp@utas.edu.au

Conflict of Interest

None declared.

Ethical Approval

Not applicable

Funding Sources

Not applicable

Acknowledgments

This study was not funded and is part of the PhD research of Maryam Rouhi.

***Corresponding Author:**

Maryam Rouhi, Advocate House, 9 Liverpool St, Hobart TAS 7001

Phone: +61 3 6226 5700

Email: Maryam.rouhi@utas.edu.au

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 & 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 & 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 (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 (Cornally & McCarthy, 2011; Maher & 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 & 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 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 & 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 & 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, 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).

Figure 1.

The BMHSU (figure. 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 Figure 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 (Figure.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 & 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 (Abrams et al., 2009; Bell et al., 2016; Buurman & 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 & 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 & 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 2). Further analysis of the categories shaped three synthesised statements (Figure 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 (figure 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 & 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 & 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 (Bell et al., 2016; Buurman & 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 & 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:

'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 & 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).

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 & Santangelo, 2011; Rudman & Waldenström, 2007; Scrandis, 2016).

Low health literacy underpins women's lack of perceived need. The synthesized findings confirmed women (Bell et al., 2016; Buurman & 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 & 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 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 & 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 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 apparent lack of knowledge by women's family and health care providers (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).

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 (Figure 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 (Figure 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.

FIGURE 4.

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.

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 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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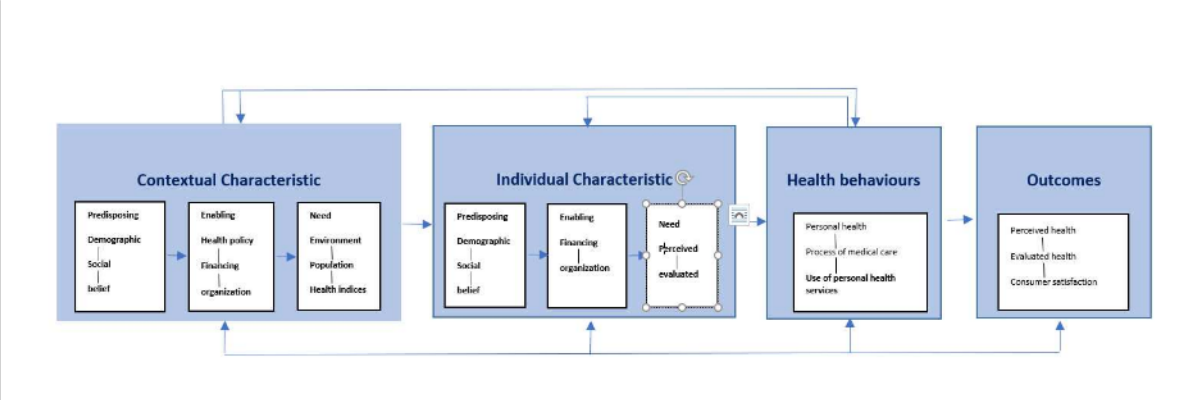
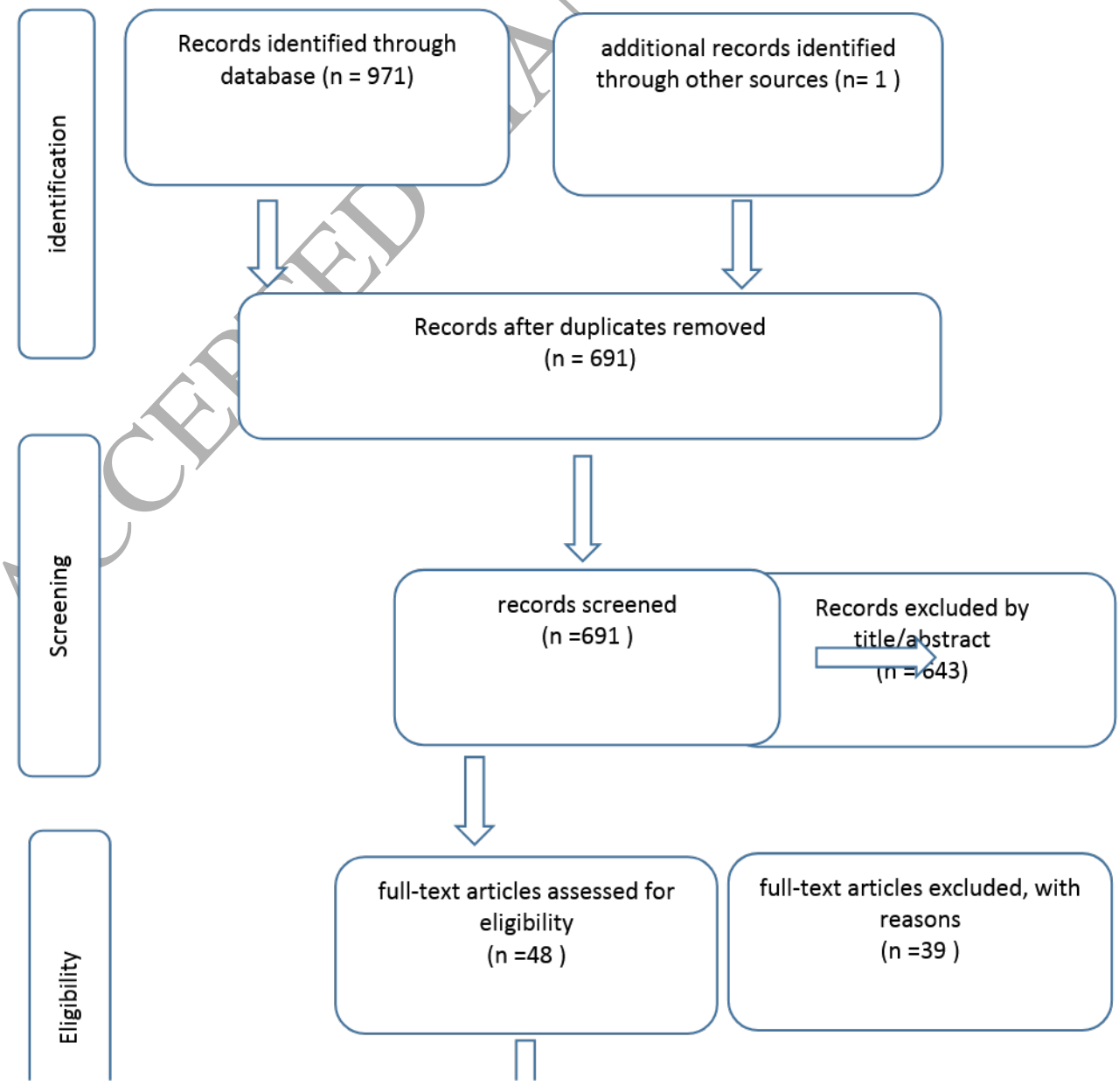


Figure 1. A Behavioural model of Health Services Use including contextual and individual characteristics. Adapted from Magaard et al. (2017)



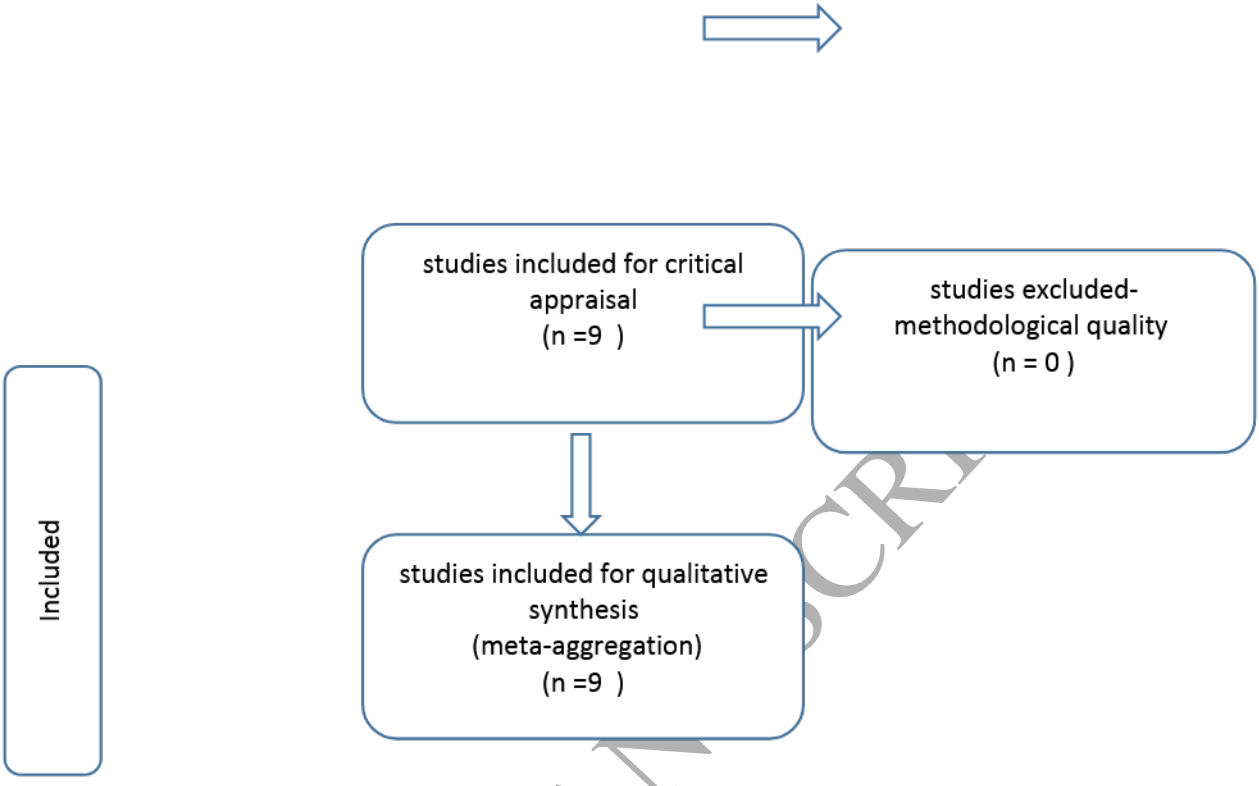


Figure 2. Flow diagram of trial.

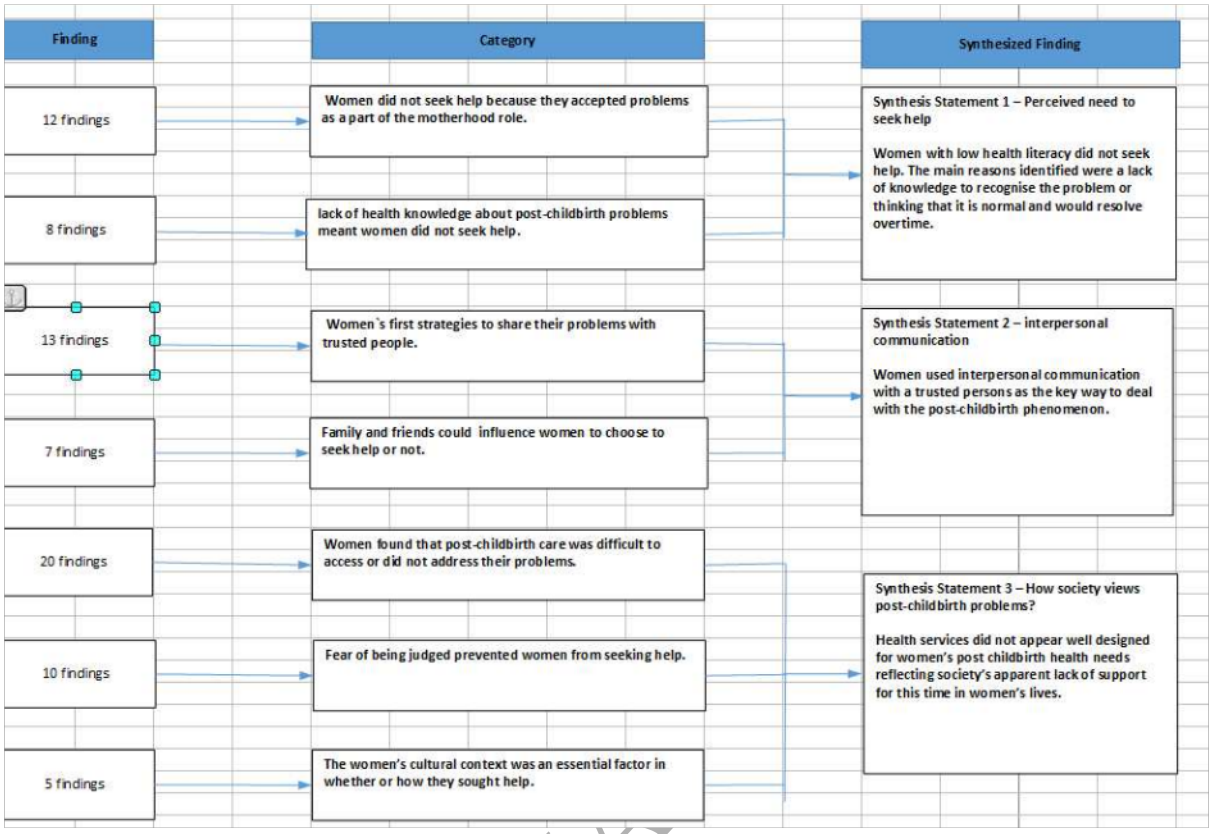


Figure 3. This figure shows a meta-aggregation of findings about barriers and facilitators that women experienced after childbirth to seek professional help.

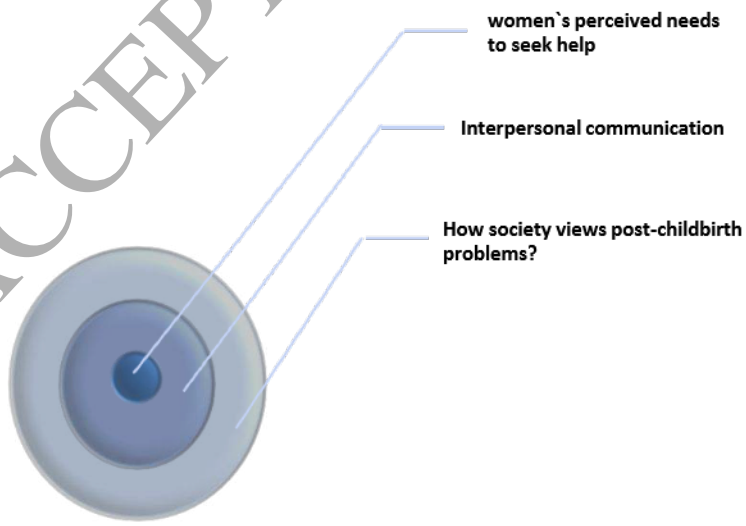


Fig. 4. A model of key influences on women's help-seeking for maternal morbidities.

Table 1. 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, 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 Mancheste r area	Women attending one tertiary maternity hospital
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. Appropriateness 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	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	Seven themes: (1) cultural identity, (2) practice and examples of postpartum traditions, (3) perception	Themes were identified that reflected three levels of influence: individual level, social network level, and health care system	The three main overarching core categories related to PND, (1) internalising misery, (2) others will judge me, and I feel on my own, and	Three main themes, each with several categories emerged from the women's accounts of their health-seeking behaviours;

			and help-seeking		psychosocial	s 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.	level. At each level, specific barriers to and facilitators of care seeking emerged from the analysis of interview transcripts	(3) I talk to my health professional and they don't understand.	(1) 'They didn't ask, I didn't tell', (2) Seeking advice and support, and (3) Coping strategies