

**Please cite as:**

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 (11), 1104-1109.

**Abstract**

**Objective**

To explore the health-seeking behaviours of primiparous women with Pelvic Girdle Pain persisting for more than three months postpartum.

**Design**

A descriptive qualitative design involving face-to-face semi-structured interviews following institutional ethical approval. Transcripts were analysed using thematic analysis.

**Setting**

An urban hospital in Ireland.

**Participants**

A purposive sample of 23 consenting first-time mothers with Pelvic Girdle Pain persisting for at least three months postpartum.

**Findings**

‘They didn’t ask, I didn’t tell’ was a key theme, which included emerging categories of a perceived lack of follow-up postpartum, and feeling ignored by healthcare

professionals. The theme 'Seeking advice and support' describes women's role of talking to others, and triggers and barriers to getting help. 'Coping strategies' was the third theme emerging from the interviews, whereby participants described different strategies they used to deal with their symptoms, although many expressed uncertainty about what to do or who to see.

### **Conclusion and implications for practice**

Our findings show the importance of appropriate information and follow-up care for women with Pelvic Girdle Pain and highlight barriers they encounter in seeking help. They also question the duration of postnatal care as participants felt that postnatal care was stopped too early. The findings may assist maternity care providers in addressing mothers' expectations and needs related to persistent Pelvic Girdle Pain.

### **Key words**

Pelvic girdle pain, postpartum, health-seeking behaviour, qualitative design.

### **Abbreviations**

GP = General Practitioner

PHN = Public Health Nurse

PGP = Pelvic Girdle Pain

PPGP = Pregnancy-related Pelvic Girdle Pain

## Introduction

Pelvic Girdle Pain (PGP) is common during pregnancy with approximately 23-65% of pregnant women reporting Pregnancy-related Pelvic Girdle Pain (PPGP) depending on the criteria used for assessment (Albert *et al.* 2002, Kovacs *et al.* 2012). In Ireland, where this study took place, maternity care is provided jointly by the family doctor, or General Practitioner (GP), and the maternity hospital. This scheme also includes postnatal care, which typically consists of two visits with the GP at two and six weeks' postpartum, and visits from a Public Health Nurse (PHN) within these six weeks (HSE 2013). This 6-8 week length of postnatal care is comparable to many other countries (Southfield (MI): Michigan Quality Improvement Consortium 2012, NICE 2014). Although PPGP mostly subsides after the birth, 8-10% of women continue to have persistent PGP 18-24 months after the birth (Albert *et al.* 2001, Rost *et al.* 2006). National clinical guidelines recommend out-patient physiotherapy for the management of persistent PGP postpartum with individualised assessment and treatment focussing on stabilising exercises and movement advice and possibly including multidisciplinary interventions if physical interventions fail (Hogan *et al.* 2012). However, limited resources often make it difficult for services to deliver such individual care. Moreover, PGP may persist beyond the 6-8 weeks postnatal care; yet, the health-seeking behaviours of women for whom PGP persists for many months postpartum, beyond the end of standard postnatal care, have not previously been explored. In addition, a lack of connectivity between maternity hospital records and records of any care that women might receive later on leaves a knowledge gap concerning any help women with persistent PGP may seek. In-depth information from the women's perspective concerning their health-seeking behaviours can offer useful data for addressing the needs of these women and provide a basis for

optimising maternity care related to PGP. The objective of the study was to explore the health-seeking behaviours of primiparous women with PGP persisting for more than three months postpartum.

For the purpose of this study, health-seeking behaviours were defined as any remedial actions that individuals undertake to rectify a perceived health problem (Ward *et al.* 1997). This is different from 'health behaviour', which is related to preventing health problem/disease (Kasl & Cobb 1966), and is sometimes referred to as 'health-promoting behaviour' (Lo *et al.* 2014). It is also different from 'help seeking behaviour' which Cornally & McCarthy (2011b), in a concept analysis, defined as a problem-focused, planned behaviour, involving interpersonal interaction with a selected health-care professional; also often referred to as 'healthcare-seeking behaviour' (Chowdhury *et al.* 2007). However, 'health-seeking behaviours', of interest in this study, may or may not involve a health-care professional, and can include other 'informal' actions aimed at improving or resolving the health problem they experience (El Kahi *et al.* 2012).

## **Methods**

### ***Setting and design***

This study employed a descriptive qualitative design to gain in-depth knowledge of the health-seeking behaviours from the women's perspective (Neergaard *et al.* 2009). While quantitative description is limited in learning about the meaning that participants give to events by pre-selecting variables, qualitative description allows for unanticipated themes to emerge (Sandelowski 2000). On the other hand, a descriptive qualitative design involves minimal interpretation and stays closer to the

data compared to other qualitative approaches, nonetheless, it is still interpretative (Sandelowski 2010). A descriptive qualitative design is thus particularly appropriate to obtain straight answers to questions of importance to healthcare practitioners and policy makers (Sandelowski 2000). This is in contrast to other qualitative approaches that aim to develop theory (grounded theory) or seek interpretative meaning of an experience (phenomenology) (Neergaard *et al.* 2009), which were not appropriate to address the aim of this study. This study was designed to answer the question 'What are the health-seeking behaviours of women with persistent PGP postpartum?', and the qualitative approach allowed for the participants' views and thoughts surrounding this question to be explored in depth from their personal accounts. This study took place in Ireland, and ethical approval was obtained from the site hospital and Trinity College Dublin, the University of Dublin.

### ***Sample & Recruitment***

A purposive sample of 23 first-time mothers attending one tertiary maternity hospital in Dublin was recruited based on the following characteristics: having PGP that had started during their pregnancy and persisted for three or more months postpartum to some extent and with no history of pain in the low back or pelvic girdle areas prior to becoming pregnant. Women were also excluded if they had any symptoms suggestive of nerve involvement (lumbar radiculopathy), or serious illness including infection, malignancy or traumatic injuries. Participants may or may not have sought help before the interview; this was not a criterion to participate. The participants' characteristics are presented in Table 1.

Participants were recruited from a survey-based longitudinal cohort study (the MAMMI study), which followed women from early pregnancy to a year postpartum using self-administered postal questionnaires to assess all types of morbidity. The MAMMI study involved all consenting primiparous women aged 18 years or over, booking at a large maternity hospital in Dublin with a 38% (1833/4809) response rate. Sixty-nine women who indicated they experienced persistent PGP for at least 3 months postpartum in their MAMMI study surveys were consecutively contacted by telephone. For 27 women their PPGP had resolved since their last survey, 15 did not answer, one woman had been diagnosed with postpartum osteoporosis and sacral insufficiency fractures, one woman experienced perineal pain primarily, and two women did not want to take part in an interview. Data saturation was reached after 20 interviews (Green & Thorogood 2004) but a further three interviews were conducted and a final sample of 23 women were included in the analysis. During this telephone conversation, the researcher (a qualified chiropractor) asked detailed questions regarding their symptoms to exclude serious pathology or nerve involvement. The purpose of the study and what it would involve were also explained to the woman.

### ***Data collection***

Semi-structured face-to-face interviews took place between June-October 2013, in a private location that was most convenient for the women, either at the woman's home or at the university. Written consent was obtained and women completed a short questionnaire regarding their pain levels, pain location and pain pattern prior to the interview. The interviews were guided by the following key questions: 'What do you do when you're in pain?', 'Tell me about the care/support you have been offered

since the birth', and 'Tell me about any help/advice you have sought'. All interviews were conducted by the same researcher (FW) and were audio recorded

### ***Data analysis***

Interviews were transcribed verbatim, checked twice for accuracy, and analysed by FW in NVivo software (2008) using thematic analysis (Vaismoradi *et al.* 2013). Analysis involved initial open coding of all transcripts into meaningful segments without trying to fit data into a pre-existing coding scheme (Braun & Clarke 2006). Subsequently, axial coding identified emerging themes and categories. Rigour in research is important and has been described as a way of demonstrating the legitimacy of the research process to ensure representation of reality as much as possible (McBrien 2008). Lincoln & Guba (1985) proposed the term 'trustworthiness' to describe questions of the truth value, applicability, consistency and neutrality of qualitative research. Strategies to enhance trustworthiness in this study included independent analysis of 3 transcripts by a second researcher (CB) and reflective journal entries. This ensured that the findings were clearly derived from the data and that the research process was carried out logically, thus increasing dependability and confirmability of the results. To promote the accuracy of the descriptions or interpretations of the experiences that were studied (credibility), negative-case analysis, regular peer-debriefing, and member checking took place (Lincoln & Guba 1985). All participants were sent a summary of the findings of the study and a short accompanying questionnaire to rate the extent to which these findings resonated with them. They were also given the opportunity to comment. Fourteen of the 23 participants replied and results showed high resonance of the findings with the

participants. Subsequently, no changes were required to the emerging categories and themes.

## **Findings**

Three main themes, each with several categories (Table 2), 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. These findings are described below and are supported by quotes that are labelled with the participant's number to maintain confidentiality. Quotes also include the number of days between the day that the woman gave birth and the date of the interview, for illustrative purposes.

### **'They didn't ask, I didn't tell' (1)**

#### *Lack of follow-up after birth*

Women said they would have liked 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. (16; 243 days)*

Three women said they would like to be able to go back to the maternity hospital for a longer period after the birth because of their expertise in maternity-related issues, although opinions of women who had attended postnatal hospital services for their PGP postpartum were mixed. Other postnatal support that women would like to have had, included more physiotherapy classes postpartum, specifically addressing PGP,

easier access to physiotherapy services or other practitioners such as osteopaths or chiropractors, and more structured follow-up care.

#### *Healthcare professionals ignore it*

Women said that healthcare professionals did not enquire after any persisting PGP symptoms during their postpartum visits, and expressed a need for specific questions to be asked concerning their health.

*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. (24; 364 days)*

Women thought postpartum contacts with their GP/public health nurse were primarily focussed on the baby only. Women often did not mention their symptoms either because of their own focus being on their baby's health, a perceived lack of time during the encounter, negative experiences in past encounters, or because they thought it was just part of having given birth. Others forgot to mention it during the visit because of the intermittent nature of their pain and not being in pain during the consultation.

*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. (16; 243 days)*

If their pain was mentioned, women felt their complaint was minimised with the most common advice being to 'give it time to settle'. As a result women wanted healthcare professionals to make 'a bigger deal out of it', listen to and examine their complaint carefully. One woman, however, was very pleased with her care.

## **Seeking advice and support (2)**

### *Talking to others*

Most women had mentioned their persisting symptoms to their partner but did not really talk about it much.

*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. (12; 300 days)*

Conversely, one woman did say she often complained to her husband about her PGP. Women greatly valued talking to family members or other women who had experienced persistent postpartum PGP for advice about managing their pain, but sometimes were worried after hearing others' experiences. Women often did not feel understood when talking to women without persistent PGP. Some women had mentioned it to friends; however, others kept it to themselves as they did not want it to become 'the thing', or the focus of conversation was on the baby.

### *Triggers to seek help*

Certain factors had encouraged some women to seek help including, completing the MAMMI surveys, an acute flare-up of PGP symptoms, realising the impact of the

pain after taking pain relief medication, or encouragement from family members 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. (3; 167 days)*

### *Barriers to getting help*

Women described various practical barriers to getting professional help including the cost of seeking private treatment, and finding the time and someone to care for the baby. Moreover, many women were uncertain from whom they should seek help and said that advice was often conflicting.

*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. (2; 227 days)*

Four of the six women who had contacted the physiotherapy department in the maternity hospital postpartum said they had had difficulties getting through to them by telephone but all except one woman eventually got an appointment. Three women also expressed how conflicting advice from different healthcare professionals added to their confusion.

### **Coping strategies (3)**

#### *Self-management strategies*

Most women felt they could cope with their persistent PGP, but would prefer to be pain free. They described numerous coping strategies including avoiding or adapting

provocative activities, being mindful of their posture, wearing comfortable shoes, storing items at a height, and two women tried to lose weight. Seventeen of the 23 women tried to, or believed they should, exercise regularly to improve their symptoms but had to be cautious not to exercise too intensively as this often had an adverse effect; finding this balance was challenging.

*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. (24; 364 days)*

However, four women said their main coping strategy was 'trying not to think about it'. Other strategies were stretching, applying pressure on tender muscles and resting between activities, although they had few opportunities for the latter.

#### *Pain Medication & Treatments*

Nine women mentioned using pain medication. Seven women were reluctant to take pain medication or were trying to cut down on painkillers.

*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. (17; 132 days)*

Three women said that they did not take any pain medication because they were breastfeeding. Some women used other remedies such as hot/cold packs, hot baths or supplements. Three women had attended a postnatal physiotherapy class at the hospital and four had sought advice from private physiotherapists, chiropractors or

osteopaths to help manage their symptoms, while two women said they were going to seek such help soon.

## **Discussion**

### ***'They didn't ask, I didn't tell'***

Women described limited opportunities to discuss any problems postnatally compared to antenatally. Existing literature into postnatal care highlights this challenge of giving individualised information at the right time to parents, particularly with the increasing trend of early discharge (Danbjorg *et al.* 2014), although the impact of early discharge on many maternal and infant outcomes remains unclear (Brown *et al.* 2002). Home visits seem to increase maternal satisfaction with postnatal care (Yonemoto *et al.* 2013) but some women in this study wanted to be able to go back to the hospital for a longer period of time postpartum as they experienced symptoms far beyond their 6-week check-up.

Most women said that healthcare professionals (usually GPs and public health nurses (PHNs)) did not ask any questions regarding PGP and that the focus was on the baby. PHNs and GPs are 'generalists' in healthcare practice (Hanafin *et al.* 2002); however, in the combined model of care under the Maternity and Infant Care Scheme in Ireland, they are responsible for the wellbeing of mother and child (HSE 2013). A more structured approach to postnatal consultations might address this perceived lack of attention to, and knowledge about, women's complaints.

When women mentioned their PGP symptoms during a consultation, they felt ignored. Similarly, in a study by Elden *et al.* (2014), pregnant women with PPGP

described how they were met with a lack of knowledge and understanding. Fredriksen *et al.* (2008), examined online discussions about PPGP, and Engeset *et al.* (2014), explored the lived experiences of five women with persistent PGP. Both studies reported a lack of acknowledgment as an emerging theme. In a study exploring midwives' experiences of dealing with women with PPGP, the time limit during visits was considered a restrictive factor on what issues could be addressed in relation to PPGP (Mogren *et al.* 2010). This lack of time during postpartum follow-up visits was also perceived by several women in the present study.

### ***Seeking advice and support***

Most women had mentioned their persistent PGP symptoms to their husband, although they did not often talk about it. For females with chronic pain, talking about their pain with their spouses has been associated with greater marital satisfaction, whereas this is not the case for their spouses (Newton-John & Williams 2006). The latter may explain why most women did not often speak about their pain to their husbands, if they perceived his satisfaction as more important than their own. Talking to family members and other mothers was also mostly considered helpful and was a common source of advice on self-management strategies; a finding which coincides with qualitative studies of peer support in pain management groups (Haraldseid *et al.* 2014). However, the lack of understanding by women who did not experience persistent PGP may be because PPGP subsides after the birth for many women and thus there is a lack of awareness that for some women PGP may persist.

Women who had sought additional help sometimes encountered conflicting diagnoses and advice. Similarly, in internet discussions regarding PPGP, women said that conflicting labels were given by different healthcare professionals (Fredriksen *et al.* 2008). Mogren *et al.* (2010) reported that midwives expressed doubts about whether women were sometimes falsely diagnosed with PPGP by themselves or others. Continuity and consistency of information in maternity care is important to women, especially to first-time mothers (Jenkins *et al.* 2015). When problems persist beyond the end of standard maternity care, information becomes more prone to inconsistency due to the absence of information transfer, particularly when a woman seeks help from healthcare professionals who have not been involved in the woman's care before and who do not have access to maternity care records.

### ***Coping strategies***

Chang *et al.* (2011) surveyed 183 pregnant women with low back and/or pelvic girdle pain during pregnancy regarding the coping strategies they used, and found that rest, task persistence and seeking assistance were the three most common ones. Women in this study described similar strategies and highlighted the difficult balance between continuing as normal, and adapting or avoiding activities. This uncertainty could impede self-efficacy and reduce their confidence that they can successfully execute a course of action to relieve their symptoms (Bandura 1997). Self-efficacy has an important psychological influence on chronic pain, and higher self-efficacy is associated with less functional impairment, less affective distress and reduced pain (Jackson *et al.* 2014). Addressing the need for more precise and consistent advice (theme 1) may enhance self-efficacy in women with persistent PGP postpartum.

The reason why some women sought help, and others had not, is likely to be multifactorial. Cornally & McCarthy (2011b) identified three antecedents to help-seeking including problem recognition (a), decision to act (b) and selection of sources of help (c), all of which are likely to be influenced by the advice and information that women seek or receive. This again demonstrates the close relationship between the three main emerging themes from this study.

### ***Conclusions***

Primiparous women with persistent postpartum PGP adopt several self-management strategies to deal with their symptoms. Findings from this study indicate that participants felt that their PGP was often ignored by healthcare professionals. These findings are important for those responsible for providing maternity care if women's expectations and needs are to be met. It also calls into question the timing of postnatal follow-up care, which participants felt was stopped too soon. Participant selection based on history only and no physical examination is a limitation of this study. A strength however, lies in the fact that women did not have to make contact with any health service provider regarding their PGP to participate in the study and provides a unique perspective regarding health-seeking behaviours. Future research could include similar studies in countries with different maternity care systems for comparison.

### **Author's contributions**

FW was involved in the design of the study, conducted the interviews and data analysis, and drafted the manuscript. EC and CB were involved in the design of the

study and peer-debriefing sessions, and they reviewed the manuscript. CB completed independent analysis of 3 transcripts for quality assurance.

**Competing interests**

No competing interests.

## References

- Albert H., Godskesen M. & Westergaard J. (2001) Prognosis in four syndromes of pregnancy-related pelvic pain. *Acta Obstet Gynecol Scand* **80**(6), 505-510.
- Albert H.B., Godskesen M. & Westergaard J.G. (2002) Incidence of four syndromes of pregnancy-related pelvic joint pain. *Spine (Phila Pa 1976)* **27**(24), 2831-2834.
- Bandura A. (1997) *Self-efficacy: The exercise of control*. Freeman, New York.
- Braun V. & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**(2), 77-101.
- Brown S., Small R., Faber B., Krastev A. & Davis P. (2002) Early postnatal discharge from hospital for healthy mothers and term infants. *Cochrane Database of Systematic Reviews* (3), CD002958.
- Chang H.Y., Yang Y.L., Jensen M.P., Lee C.N. & Lai Y.H. (2011) The experience of and coping with lumbopelvic pain among pregnant women in Taiwan. *Pain Medicine* **12**(6), 846-853.
- Chowdhury R.I., Islam M.A., Gulshan J. & Chakraborty N. (2007) Delivery complications and healthcare-seeking behaviour: the Bangladesh Demographic Health Survey, 1999-2000. *Health & Social Care in the Community* **15**(3), 254-264.
- Cornally N. & McCarthy G. (2011a) Help-seeking behaviour for the treatment of chronic pain. *British Journal of Community Nursing* **16**(2), 90-98.
- Cornally N. & McCarthy G. (2011b) Help-seeking behaviour: a concept analysis. *International Journal of Nursing Practice* **17**(3), 280-288.
- Danbjorg D.B., Wagner L. & Clemensen J. (2014) Do families after early postnatal discharge need new ways to communicate with the hospital? A feasibility study. *Midwifery* **30**(6), 725-732.
- El Kahi H.A., Abi Rizk G.Y., Hlais S.A. & Adib S.M. (2012) Health-care-seeking behaviour among university students in Lebanon. *Eastern Mediterranean Health Journal* **18**(6), 598-606.
- Elden H., Lungren I. & Robertson E. (2014) The pelvic ring of pain: Pregnant women's experiences of severe pelvic girdle pain: An interview study *Clinical Nursing Studies* **2**(2), 30-41.
- Engeset J., Stuge B. & Fegran L. (2014) Pelvic girdle pain affects the whole life--a qualitative interview study in Norway on women's experiences with pelvic girdle pain after delivery. *BMC Research Notes* **7**(1), 686.
- Fredriksen E.H., Moland K.M. & Sundby J. (2008) "Listen to your body". A qualitative text analysis of internet discussions related to pregnancy health and pelvic girdle pain in pregnancy. *Patient Education and Counselling* **73**(2), 294-299.
- Green J. & Thorogood N. (2004) *Qualitative Methods for Health Research*. 1 edn. SAGE Publications, London, Thousand Oaks, New Delhi.
- Hanafin S., Houston A.M. & Cowley S. (2002) Vertical equity in service provision: a model for the Irish public health nursing service. *Journal of Advanced Nursing* **39**(1), 68-76.
- Haraldseid C., Dysvik E. & Furnes B. (2014) The experience of loss in patients suffering from chronic pain attending a pain management group based on cognitive-behavioral therapy. *Pain Management Nursing* **15**(1), 12-21.
- HSE (2013) *Maternity and Infant Care Scheme*. Retrieved from <http://www.hse.ie/eng/services/list/3/maternity/combinedcare.html> [Accessed 10th July 2014].
- Hogan M., Wiseman S. & Ross L. (2012) Clinical Practice Guideline: Management of Pelvic Girdle Pain in Pregnancy and Post-partum.

- Jackson T., Wang Y., Wang Y. & Fan H. (2014) Self-Efficacy and Chronic Pain Outcomes: A Meta-Analytic Review. *Journal of Pain*.
- Jenkins M.G., Ford J.B., Todd A.L., Forsyth R., Morris J.M. & Roberts C.L. (2015) Women's views about maternity care: how do women conceptualise the process of continuity? *Midwifery* **31**(1), 25-30.
- Kasl S.V. & Cobb S. (1966) Health behavior, illness behavior, and sick role behavior. I. Health and illness behavior. *Archives of Environmental Health* **12**(2), 246-266.
- Kovacs F.M., Garcia E., Royuela A., Gonzalez L. & Abraira V. (2012) Prevalence and factors associated with low back pain and pelvic girdle pain during pregnancy: a multicenter study conducted in the Spanish National Health Service. *Spine (Phila Pa 1976)* **37**(17), 1516-1533.
- Lincoln Y.S. & Guba E.G. (1985) *Naturalistic enquiry*. 1 edn. SAGE Publications, Newbury Park, London, New Delhi.
- Lo S.W., Chair S.Y. & Lee F.K. (2014) Factors associated with health-promoting behavior of people with or at high risk of metabolic syndrome: Based on the health belief model. *Applied Nursing Research* (Epub ahead of print).
- McBrien B. (2008) Evidence-based care: enhancing the rigour of a qualitative study. *British Journal of Nursing* **17**(20), 1286-1289.
- McCracken L.M. & Eccleston C. (2003) Coping or acceptance: what to do about chronic pain? *Pain* **105**(1-2), 197-204.
- Mogren I., Winkvist A. & Dahlgren L. (2010) Trust and ambivalence in midwives' views towards women developing pelvic pain during pregnancy: a qualitative study. *BMC Public Health* **10**, 600.
- Neergaard M.A., Olesen F., Andersen R.S. & Sondergaard J. (2009) Qualitative description - the poor cousin of health research? *BMC Medical Research Methodology* **9**, 52.
- Newton-John T.R. & Williams A.C. (2006) Chronic pain couples: perceived marital interactions and pain behaviours. *Pain* **123**(1-2), 53-63.
- NICE (2014) *Postnatal Care [CG37]*. Retrieved from [www.nice.org.uk](http://www.nice.org.uk) [Accessed 20th August 2014].
- NVivo qualitative data analysis software Version 10 (2008). QSR International Pty Ltd.
- Rost C.C., Jacqueline J., Kaiser A., Verhagen A.P. & Koes B.W. (2006) Prognosis of women with pelvic pain during pregnancy: a long-term follow-up study. *Acta Obstetrica et Gynecologica Scandinavica* **85**(7), 771-777.
- Sandelowski M. (2000) Whatever happened to qualitative description? *Research in Nursing & Health* **23**(4), 334-340.
- Sandelowski M. (2010) What's in a name? Qualitative description revisited. *Research in Nursing & Health* **33**(1), 77-84.
- Southfield (MI): Michigan Quality Improvement Consortium (2012) *Routine prenatal and postnatal care*. Retrieved from <http://www.guideline.gov/> [Accessed 10 January 2015].
- Vaismoradi M., Turunen H. & Bondas T. (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences* **15**(3), 398-405.
- Ward H., Mertens T.E. & Thomas C. (1997) Health seeking behaviour and the control of sexually transmitted disease. *Health Policy Plan* **12**(1), 19-28.
- Yonemoto N., Dowswell T., Nagai S. & Mori R. (2013) Schedules for home visits in the early postpartum period. *Cochrane Database of Systematic Reviews* **7**, CD009326.

## Tables

**Table 1: Participants' characteristics**

<b>Age</b>	<b>Number of participants (n)</b>
≤ 24	2
25-29	2
30-34	12
35-39	7
<b>Country of birth</b>	<b>n</b>
Ireland	19
Other European country	4
<b>Highest qualification</b>	<b>n</b>
Upper secondary leaving cert – applied and vocation progs., A levels, National Vocational Certificate (NCVA) level 1	2
Completed apprenticeship, NCVA level 2/3, Teagasc certificate, diploma or equivalent	1
Primary degree	6
Professional qualification of degree status	2
Postgraduate certificate or diploma	6
Postgraduate degree Masters	6
<b>Time postpartum at the time of interview</b>	<b>n</b>
3 and 6 months (91-182 days)	14
6 and 9 months (183-273 days)	6
9 and 12 months (274-364 days)	3
<b>Pain pattern</b>	<b>n</b>
Constant	1
Intermittent	10
Transient	1
Constant & intermittent (day dependent)	10
Constant & transient (day dependent)	1
<b>Pain location</b>	<b>n</b>
Anterior PGP	2
Posterior PGP	14
Combined Anterior & Posterior PGP	7
<b>Pain severity at the time of interview (VAS 10cm)</b>	<b>Mean (SD)</b>
Morning	5.0 (SD 2.3)
Evening	5.7 (SD 1.9)

**Table 2: Overview of emerging themes and categories**

<b>Themes</b>	<b>Categories</b>
(1) 'They didn't ask, I didn't tell'	<ul style="list-style-type: none"><li>• Lack of follow up after birth</li><li>• Healthcare professionals ignore it</li><li>•</li></ul>
(2) Seeking advice and support	<ul style="list-style-type: none"><li>• Talking to others</li><li>• Triggers to seek help</li><li>• Barriers to getting help</li></ul>
(3) Coping strategies	<ul style="list-style-type: none"><li>• Self-management strategies</li><li>• Pain medication</li></ul>