

**“An exploration of the role and experiences of the postnatal
domiciliary midwife in Victoria, Australia”**

Submitted by

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degree

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Statement of authorship

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgement in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics Committee (where required) or a relevant safety committee if the matter is referred to such a committee.

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Statement of appreciation

I would like to acknowledge the “team” that has brought me to this place; it has not been a journey that I’ve had to run alone and I am grateful for all the assistance, in whatever form it has come.

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Dedication

This thesis, and the efforts that have gone into its production are dedicated to my loving mother, who recently succumbed to a four-year battle with lymphoma. Although she could not quite understand why I chose this particular adventure, Vernie resolutely believed in and encouraged me.

Gladys “Verna” Chapman

12/4/39—10/8/13

“Safe in the arms of Jesus”

Abstract

This study aimed to explore the current professional lives, roles and experiences of homecare midwives providing postnatal domiciliary care. The changing environment of maternity care in Australia, with limited resources, has resulted in a continual decrease in postnatal hospital length of stay. Early discharge has resulted in an increased number of clients requiring home visits and domiciliary midwives are attending to mothers and babies who are experiencing increased acuity.

A literature review revealed there is a paucity of research pertaining to postnatal care in the home and postnatal care is marginalised in terms of the broader context of midwifery care. There were no available studies that specifically addressed domiciliary midwives' experiences of care in the home environment.

The research design for the study was critical ethnography. There were four ethnographic methods utilised: participant observation, critical conversations, field notes and reflective journalling.

Seven domiciliary midwives participated in the study. Data analysis was comprised of three aspects: qualitative content analysis—summative, deep data immersion and qualitative thematic analysis—conventional.

The results revealed the role of domiciliary midwives was embedded in their experiences and participants were expert practitioners. Seven themes exemplified their role: relating with intention, autonomy, assessment, prediction, management, education and advocacy. The experiences were characterised by three themes: role complexity and negotiation, personal validation and satisfaction, and professional undervaluing.

This study has contributed to the existing body of knowledge by exposing the juxtaposed position of expert practitioners who are personally satisfied yet professionally undervalued. Domiciliary midwives are dedicated to excellent service provision, operating with a vast array of knowledge, skill and experience. Despite limited resources and a changing healthcare context the safety, health and well-being of mothers and babies was not compromised.

Glossary of terms

BFHI	Breastfeeding Friendly Hospital Initiative
BMS	Breast Milk Substitute (formula milk)
BOS	Birthing Outcome System (computer program)
C/S	Caesarean Section
DM	Domiciliary Midwife
Dom	Domiciliary Midwifery work
Dusky episode	A brief period of time where a neonate shows signs of apoxia. The skin of the neonate turns a bluish hue.
DV	Domestic Violence
FDIU	Foetal Death in Utero
LC	Lactation Consultant
LMC	Lead Maternity Carer (New Zealand)
LOS	Length of Stay (in hospital)
MCHN	Maternal Child Health Nurse
Multi	Multiparous woman, second or subsequent baby/pregnancy
NESB	Non English Speaking Background
NST	Newborn Screen Test
OH&S	Occupational Health and Safety
Paed	Paediatrician
Peri	Perineum
Primip	Primiparous woman, first baby
RM	Registered Midwife
SBR	Serum Bilirubin
SIG	Special Interest Group
UK	United Kingdom
US	United States of America
VBAC	Vaginal Birth after Caesarean Section
WHO	World Health Organisation

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Chapter I – Introduction

Chapter overview

This research thesis describes an ethnographic exploratory study focused on the experiences of midwives who provide postnatal care in women's homes. In this chapter I will introduce and contextualise the research study by providing an overview of the changes of postnatal care in Australia as well as the significance of care for women and their babies in the postnatal period. I introduce myself along with my professional background, providing insight into my motivation for this study. I summarise each chapter as well as describe the stylistic details I have used in this thesis.

Background

Over the last two decades maternity care provided during pregnancy, childbirth and during the postnatal period, has changed considerably in Australia. For many years early postnatal care in Australia has been managed predominantly by midwives in hospitals. Historically it has been only those mothers or babies with special needs who have been provided with a domiciliary/home midwifery visit. In the last two decades the length of hospital stay following birth has reduced significantly resulting in almost all women now having a home visit. As mothers still require care and monitoring, following discharge from hospital, the demand for home visits by domiciliary midwives has increased dramatically. Concurrently, the needs of women and babies have also changed and there is a higher acuity of home care often required for both mothers and babies. Furthermore, the workforce is shrinking and resources are limited. Therefore domiciliary midwives are required to attend more visits with higher acuity and reduced resources and also to prioritise care under pressured circumstances. The implications being that domiciliary midwives are at risk of discharging women earlier than what may be deemed clinically safe and also utilise phone consultations rather than always consulting in person on a home visit.

Although there are similarities between the postnatal care provided at home and in the hospital, there remains some uncertainty regarding the role of the domiciliary midwife. This could be attributed to their unique practice where they usually work independently, and have developed their own culture of care. My experience as a domiciliary midwife in the public sector, as well as in private practice, has given me insight into the challenges faced by domiciliary midwives. This insight

particularly concerns the changing needs of postnatal care in the current climate of early discharge. This experience has contributed to my interest and motivation to research domiciliary midwives. In this research I aim to gain a greater knowledge of the current role of domiciliary midwives and specifically, to identify what is their role, to valorise their voices, related choices, priorities and any other subsequent issues that pertain uniquely to their role.

Context of postnatal care by midwives—an overview

Midwives provide care for women during pregnancy, the birthing process and, the period following the birth of the baby, the postnatal period. Postnatal care is provided by midwives to mothers immediately after the birth of their baby and up to six to seven weeks (Australian Government, 2010). Postnatal care is an integral component of the full scope of practice of registered midwives (International Confederation of Midwives, 2007). Postnatal care is focused on ensuring the health and well-being of the mother and baby.

Postnatal care, also known as the puerperium, is the time period when the woman's body returns to her pre-pregnant state (Henderson & MacDonald, 2004). During this time domiciliary midwives support women to nurture and care for their babies and in most circumstances significant bonding occurs between the mother and baby. In the Australian context, mothers rely on skilled practitioners, particularly midwives, to educate and encourage their care during this vulnerable time, to ensure they become confident and competent to care for their newborn babies. Concurrently, midwives observe and assess women and babies for health problems that may need further management or referral to other healthcare providers.

One of the current issues facing the health profession is that the Australian midwifery workforce is aging and decreasing (Tracy, Barclay, & Brodie, 2000). Although the latest figures indicate the average age of employed, single-registered midwives has decreased from 43 to 38 years (K. Cook, 2013), in the long term, Australia is still facing a shortfall in the midwifery workforce (HealthWorkforce, 2012). The workforce shortage impacts on the workload of midwives and on strategic decision making regarding workplace shortfall. Combined with a global shortage of hospital bed availability, hospital administrators have implemented new models of care for mothers and babies to ensure there are resources available for patients with acute or complex needs. Caring for women within the community in the early

postnatal period has been a general trend world-wide, including Australia, to provide women with care in an environment of limited resources (Tracy et al., 2000; Yelland, Krastev, & Brown, 2009).

In the last 80 years, community views regarding pregnancy and birth have transitioned from belief in self to perceptions that the pregnancy and birth process is largely uncontrollable and threatening to health status. As such, pregnant women have become reliant on medical intervention to ensure predictability and safety (Fisher, Hauck, & Fenwick, 2006). The widely held belief in the superiority of the medical model of maternity care has often led people to believe that midwifery-led, or community based care is inferior, therefore, early hospital discharge is met with resistance. This notwithstanding, recent studies have shown that early postnatal discharge can be a positive experience provided it is managed well (Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010; Forster et al., 2008).

Some studies have determined the needs of postnatal women and required service provision (M. Cook & Stacey, 2003; Fenwick et al., 2010; Forster et al., 2008; Homer, Henry, et al., 2009; Homer, Passant, et al., 2009; Van Teijlingen, 1990), yet postnatal care remains consistently rated more poorly by midwives and women than any other component of maternity care (Yelland, 2009; Yelland et al., 2009).

There is an increasing interest in postnatal care due to the postnatal period of hospital stays shortening in length and dissatisfaction rates rising. Recent research has explored midwifery and women's satisfaction and experiences with postnatal care (Fenwick et al., 2010), staffing issues (Rayner, McLachlan, Forster, Peters, & Yelland, 2010), continuity of care beyond one week (Homer, Henry, et al., 2009), needs and expectations of postnatal women (Forster et al., 2008) as well as the development of national competency standards for midwives in Australia (Homer et al., 2007).

The development of postnatal care guidelines by the Victorian Government indicates recognition of the changing and growing need for attention to postnatal services (Australian Government, 2012). The delivery, however, of each service is dependent on the service provider and there remains little research contribution regarding safety and satisfactory management.

On a state level, a special interest group specifically aimed at support of midwives who provide postnatal domiciliary care in the home has been developed in Victoria. Over the last two years there have been several meetings culminating in an

inaugural conference. It is evident that the Australian maternity system is in a state of flux with midwives experiencing diverse yet challenging roles and responsibilities. It is anticipated that with strong state and national leadership, many of the issues raised in the context of this study are beginning to be addressed.

Context of postnatal care in the home

In Australia care provided at home by a midwife is termed postnatal domiciliary care, and is provided by a domiciliary midwife. Maternal and Child Health Nurses (MCHN) also provide care for women and their babies. This occurs following transfer of care from the domiciliary midwife usually one week after birth. While domiciliary midwives' responsibility for care with mothers and babies usually is completed when the baby is one week of age, midwives are educated in care provision up to seven weeks into the postnatal period.

As introduced above, throughout the world, there has been a growing shortage of midwives, which has manifested in reduced staffing levels, inadequate midwife:client ratios and limitations of care provision. The shortage of midwives, along with funding cuts and hospital bed shortages have led to women being offered shorter length of stay in hospital after the birth of their baby. It is evident that this is a strategic intervention to alleviate the over-burdened hospital system. Studies have shown that midwives and women have mixed responses to the reduced length of postnatal stay in hospital, depending on the manner in which the postnatal period is managed (Biro, Yelland, Sutherland, & Brown, 2012; S. Brown, Small, Argus, Davis, & Krastev, 2009). A shorter length of stay does not necessarily result in a negative experience or poor outcomes for mother or baby. The key to successful outcomes is management; if managed well, a shorter length of stay can be a positive experience. Studies have also shown that all women, whether having their first or subsequent baby, require adequate care in order to adjust to the birth of their baby (M. Cook & Stacey, 2003). It is evident that multiparity should not be a targeted area by hospitals and/or governments for reduction in future expenditure. Studies have shown that consistent, unrushed advice and specifically continuity of care leads to more positive healthcare outcomes for mothers and babies and greater satisfaction with services by both mothers and midwives (Fenwick et al., 2010; Forster et al., 2008; Hildingsson & Sandin-Bojo, 2011; Schmied, Cook, Gutwein, Steinlein, & Homer, 2009).

The World Health Organisation (WHO) defines the pregnancy, birthing and postnatal period as a normal life event, however, in many developed countries the process has become medicalised to the point where women and families view this time as an illness requiring treatment. Inadvertently, the reduced length of postnatal stay in hospital may positively assist women and communities in the re-establishment of their belief in the normalcy of the pregnancy and birthing process.

According to the Victorian Maternity Performance Indicators, every woman who births in a public hospital in Victoria, Australia, should be offered a domiciliary midwife visit after the birth of their baby (Victorian Department of Health, 2010b). This service is in recognition of the reduced length of stay for women after the birth of their baby, which averages two-three days, but is often less than 24 hours. This service places more pressure on midwives to perform more domiciliary visits with women and babies experiencing higher acuity.

Furthermore, Maternal and Child Health Nursing services are also experiencing workplace pressure, and on some occasions a mother may not receive her first MCHN visit until her baby is eight weeks old, although most visits occur within two weeks (Homer, Henry, et al., 2009). While both domiciliary midwives and MCHN have been adequately educated to care for mothers and babies in this time period, scarcity of resources negatively impacts on the quality of care provision.

Due to the increased needs for domiciliary services, and the higher acuity of care provided for women and babies at home, it could be theorised that the role of the domiciliary midwife is in a state of transition. However, little is known about the precise role of the domiciliary midwife or how they gauge their significance in maternity services. Postnatal care has not traditionally attracted the same attention and funding as other areas of maternity care, and has been referred to as the “poor cousin” of maternity services. Therefore, research into the role and experiences of the postnatal domiciliary midwife in Victoria, Australia, is a valuable tool for understanding and improvement of these services.

Motivation for study

My interest in this field of study, postnatal domiciliary care, arises from both my personal and professional experience. As a new mother, during my own postnatal period in hospital, I received advice from midwives that whilst kind, was also often

inconsistent. This inconsistent advice related to breastfeeding issues, mothercrafting and recovery from my labour and birth.

Whilst in hospital, I also found the hospital environment challenging. I shared a room with several other women, and it was difficult to rest. I decided that being in hospital is helpful should emergencies arise, however, it is not a positive environment for rest or immediate postnatal advice. Both at a personal level and later on, at a professional level, this experience stimulated my interest regarding the benefits of early discharge as well as antenatal education, continuity of carer and the benefits of consistent advice.

Professionally my main motivation for this study arose from my varied and extensive experience as a midwife. Since registering as a midwife I have worked in a variety of healthcare settings, including working with women birthing in hospitals in both the public and private sectors. The hospitals where I was employed were small, medium and large tertiary facilities that offered both medical and midwifery-led models of care. I have also worked as a private midwife where I cared for women throughout their pregnancy, labour and postnatal period. I have observed that the postnatal period may be managed in very different ways, depending on the model of care.

In my experience, the majority of domiciliary work is carried out by a core group of midwives who enjoyed working in women's homes. They enjoyed the autonomy and had confidence in their abilities to carry out their job well with little direction. While the postnatal care followed hospital guidelines there was a significant degree of autonomy in the actual role of the domiciliary midwife. These visits continued until their care was transferred to the Maternal and Child Health Nurse (MCHN) at approximately one week into the postnatal period. It appears the domiciliary midwives role had evolved and they had developed their own culture devoid of any guiding research.

Although continuity of care is a "buzz" term, a desired concept, attempted through models such as team care (McLachlan et al., 2013), I observed that many of the midwives that provided home visits had not met the women antenatally or in labour. Whilst there was continuity of philosophy, continuity of care was limited. There are many factors that contribute to continuity of care. The result is however, that after a woman has had her baby in hospital, a midwife whom she may not have met before, who clearly specialises in domiciliary care, often visits her. Further, these

midwives who have provided domiciliary care for long periods of time will have experience and skills to teach less experienced domiciliary midwives.

This study focuses on postnatal care provision in the home by a domiciliary midwife with a mother following a hospital birth. My research interest encompasses the effects of the current changes and experiences of care given by domiciliary midwives with a particular focus on the public healthcare system. In my experience I have observed that the powerlessness and marginalisation midwives experience is pervasive, and significantly, there is limited research regarding domiciliary care.

The researcher's position

I am strongly aware as a qualitative researcher that my presence is not value-free. Therefore, my own philosophical stance and the choice of philosophy to underpin the research are critical to the success of this study.

During my training a senior midwife pointed out to me that postnatal care received less attention, funding and research than other areas of midwifery care. She indicated there is a general lack of enthusiasm about this area of midwifery because it lacks the intensity and the profile of antenatal emergencies, labour care or even neonatal issues. I also identified this by the lack of attention to training in postnatal care as a student, and when I worked in hospitals midwives often referred to postnatal care as “boring”. Postnatal care can be arduous, repetitive and frustrating. However, as it has not been taught, researched or managed as well as it could be, this has contributed to its negative standing. Yet, this should not justify the alienation of domiciliary midwives. It is evident that continuity models have contributed to minimising negative attitudes, because midwives are working across the full scope of practice and therefore develop a better appreciation for each of the areas of care. However, in practice there remain problems regarding skill level, follow-up of issues, depth of experience and transition to maternal and child healthcare. In this research, therefore, I am strongly motivated to illuminate skills as well as the frustrations experienced by postnatal domiciliary midwives.

Creswell (2007) maintained that researchers need to acknowledge their own power, engage in discourse, and use social theory to interpret or illuminate social action. Therefore I believed I needed to explore and reflect upon my own philosophical stance initially and throughout the study.

My area of research interest was always centred on midwifery postnatal care because I constantly questioned training, education, care delivery, clinical support and autonomy. The specific question that eventually arose emanated from hours of reading, reflecting and discussion with my peers and supervisors and my own considered mental processing.

Midwifery is perceived “less than”, and therefore in submission to, nursing and the medical model (Fahy, 2007). In my experience I have witnessed midwives working within disempowering frameworks, subservient to a culture of medical hierarchy. Many of the idealistic ideas of autonomy learned in midwifery education have been cast aside as the realities of fear, submission and busyness underpin much of midwifery work. As I have reflected on my experiences I have been both infuriated and spurred into action. I decided that the option to become an agent of change was more attractive than “sitting” with frustration and powerlessness. I realised I could be a part of the change in the status quo, by researching, perhaps providing evidence of the need for change and mostly by supporting midwives to have a voice.

I strongly believe in the plight of domiciliary midwives. I consider their work to be of great value and they are working under difficult circumstances. I wanted to give midwives in my research an opportunity to be validated and in terms of the proposed research outcomes, provide a path for improvement. I relate to their frustrations, busyness, fears and triumphs because I too, have performed a domiciliary role and I recognise the need to honour their work. Integral is my desire to highlight their expertise and ability to practice effectively in a challenging health system. I fear that a consequence of their busyness and increased responsibility is ironically, less voice. Therefore they have less time for standing their ground and demanding their rights.

With these issues of powerlessness and distinct culture, the choice of critical theory and ethnography seemed congruent with my research inquiry: An exploration of the role and experiences of the postnatal domiciliary midwife in Victoria, Australia.

Significance of the study

While there is an increased interest in postnatal issues, much of the scholarly focus is on postnatal hospital care. With the known state of transition of the midwife providing postnatal care in women’s homes, there is little documentation regarding

what it is that midwives are actually doing in their care provision, and what their experiences are within their role.

Research question and aims

The question and aims that arose, in addressing the gap in the literature were these:

‘What is the role and what are the experiences of homecare midwives providing postnatal domiciliary care in Victoria, Australia?’

The broad and specific research aims are:

Broad aim:

- To explore the role and experiences of homecare midwives providing postnatal domiciliary care in Victoria, Australia.

Specific aims:

- To illuminate the contextual issues contributing to the role and experiences of postnatal domiciliary midwives.
- To highlight the complexities of the role and experiences of the postnatal domiciliary midwife.
- To acknowledge the unique stories of postnatal domiciliary midwives.

Research approach

The need for further investigation about the role and experiences of postnatal domiciliary midwives became apparent following a comprehensive literature review. A qualitative approach in the form of a critical ethnography was chosen for the research design. The pivotal reason for this choice relates to the importance of domiciliary midwife participants sharing their views in conversation and my observation of their practice. Qualitative epistemology, or “ways of knowing”, assumes that knowledge is context-driven, therefore the “truth” is dependent on a plethora of factors such as, but not limited to, socio-politics, values and personal experiences. Qualitative studies value the subjective ideas, experiences and voices of the group being studied (Creswell, 2007; Grbich, 1999).

Further to this, critical ethnography was chosen to inform my method selection. It has been documented that midwives are an oppressed group, in subordination to both medicine and nursing (Fahy, 2007). Critical theory asserts that

knowledge is power (Creswell, 2007; Kincheloe & McLaren, 2002), therefore, by increasing knowledge and understanding of the domiciliary midwife's circumstances, and the contributing factors, there are possibilities for change in the status quo. Critical theory has an emancipatory intent. I seek to examine social conditions, so that hidden structures contributing to oppressed states may be uncovered. With knowledge of the dominating themes in a social context, any group of people, consequently, has the ability to transform their social environment (Creswell, 2007).

This study will utilise ethnography as both methodology and methods. Ethnography is the study of culture and a group of people within that culture. Therefore the people are studied within the context of their common patterns of behaviour (Roper & Shapira, 2000; Van Maanen, 1988). Domiciliary midwives share specific, common goals, experiences, beliefs and values not necessarily shared by midwives who work within a hospital environment. Therefore this unique midwifery culture was researched within the context of the domiciliary midwife's daily workplace. Ethnographic methods such as participant observation, field notes, critical conversations and reflexive journalling were used to collect data most appropriate to generate an accurate portrayal of the role and experience of the postnatal domiciliary midwife in Victoria, Australia.

Explanation of grammatical styles

The following is an explanation of the grammatical styles used to present this thesis. The American Psychological Association (APA) (6th ed.) style of referencing and presentation has been used in accordance with the expected requirements of the Australian Catholic University (ACU). Examples of the styles are outlined in Table 1.1.

Style	Example
Level one headings: Gill Sans font 16 bold, black	Title page
Level two headings: Gill Sans font 14, black	The midwives
Level three headings: Gill Sans font 14, indented one centimetre	Inclusion criteria
Level four headings: Gill Sans font 14, indented two centimetres, italic, black	<i>Relating with intention</i>
The main body of text: Arial, 12 font, black with 1.5 line spacing	In this research I aim to gain a greater knowledge of the current role of domiciliary midwives and specifically, to identify what it is their role . . .
Journal: Papyrus font 12, black, indent 1.25 cm, 1.5 spacing Quotations from the reflective journal and field notes will be written in Papyrus font 12, black, indented one centimetre from the margin, double line spacing, as per ACU requirements.	I have learnt an important lesson about grasping the deeper meaning and applying the theory to my findings. I wanted to go and read every methodology article again, with my new “glasses”. In fact, I did read over quite a lot of them with my new understanding, I felt like I better understood how the critical lens filtered my data.
Table text: Calibri font 10	Women’s experience of domiciliary postnatal care in Victoria and South Australia: a population-based survey.
Table and Figure Titles: Georgia font 12, black, bold, Italic, flush with left side of table.	<i>Table 2.2 Recent Australian Literature</i>

Table 1.1 Grammatical styles used in this thesis

In this research quotations from the data will not adhere to English grammatical rules. Colloquial language and structure of language will be used as a faithful representation of the participants' experiences and personal pronouns will be used to indicate my own opinions about postnatal care or the experience of researching "in the field".

Summary of thesis structure

This thesis has five chapters. Chapter one introduces the background, aims and context for the study. The significance of postnatal care has been reviewed, as well my motivation and choice of research approach. A brief description of the grammatical styles used in this thesis is provided.

The second chapter presents the scholarly literature review conducted to gather current information about postnatal domiciliary care. I have described the strategies used to search the appropriate literature as well as a search summary. The chapter will proceed with a discussion regarding the findings including clarification of a definition for domiciliary midwives used in this study. Following this, there will be a discussion about the differing global approaches to domiciliary care, then findings regarding the role and experience of postnatal domiciliary midwives. I will identify knowledge gaps in the literature that contribute to the significance of this research study.

Chapter three discusses the methodology, methods and processes by which data was to be collected for analysis. I discuss critical and ethical processes used in this study, as well as a description of the data analysis approaches employed.

The fourth chapter presents the work and results of this qualitative study. I discuss the manner in which I collected and analysed data. Following thematic analysis of the data, discussion of role and experiences of the domiciliary midwife will be presented.

Chapter five presents the conclusion of the study where the research questions and aims will be revisited. This will be followed by an exploration of the research significance, clinical implications, recommendations, validity, limitations and reflections of this.

Chapter summary

Chapter one has provided background information for this study by discussing the maternity care context in Australia. I focused on postnatal care provided by midwives and the context of postnatal care in the home. I described my personal and professional motivations for this study and my researcher position. Next, the significance of this study was highlighted, followed by the research question and aims. A description of the research approach and explanation of grammatical styles was outlined followed by a summary of the thesis structure. The following chapter is a review of the literature.

Chapter 2 – Literature review

Chapter overview

This chapter describes the literature pertinent to my research study of postnatal domiciliary midwife's role and experiences. First I will identify the questions and search strategies used to investigate the context and specific information surrounding postnatal domiciliary care. I will then discuss the findings of the literature searches beginning with various definitions ascribed to midwives who provide care to women in their homes.

I have categorised the literature into general and specific findings on postnatal domiciliary care. In relation to the general findings, I have differentiated national and international literature. The specific literature has been addressed by seven predominant postnatal issues. These are: early postnatal discharge; midwives' views regarding postnatal care; mothers' views regarding postnatal care; breastfeeding and the midwife; mental health and well-being; miscellaneous domiciliary roles and other assistance at home in the postnatal period. These issues combine national and international research. The chapter concludes by addressing the gap in the literature regarding postnatal domiciliary care.

Literature search strategy

The literature regarding home-based postnatal care was primarily obtained by searching electronic databases using a variety of keywords, wildcards and combinations of each. The initial search undertaken in August 2010, utilised the electronic databases British Nursing Index, Cumulative Index to Nursing and Allied Health (CINAHL), Google Scholar and Wiley Online. These were searched and repeated in February 2012 to ensure that the most recent articles would be included as well as any material overlooked in the early candidature search.

The search was further extended to include articles obtained from journal article reference lists as well as specific documents recommended by professional advisors. Automatic alerts related to postnatal midwifery care were established on Google Scholar to ensure inclusion of new or newly published information. I regularly continued to search CINAHL, Wiley Online and Google Scholar for any new publications relevant to this study up to October, 2013.

Much of the information reviewed has been based on postnatal care in hospital, as there were a minority of studies that encompassed domiciliary homecare. Table 2.1 outlines the search results conducted in February 2012.

Database searched	Time period	Keywords	Results
British Nursing Index	2000-2012	postnatal care	1300
CINAHL			1574
Maternity and Infant Care			1524
Wiley Online Library			24,809
British Nursing Index	2000-2012	midwife* role	993
CINAHL			330
Maternity and Infant Care			66
Wiley Online Library			12,663
British Nursing Index	2000-2012	midwi* experience postnatal	965
CINAHL			153
Maternity and Infant Care			1796
Wiley Online Library			4206
British Nursing Index	2000-2012	midwife* role AND postnatal care	96
CINAHL			380
Maternity and Infant Care			360
Wiley Online Library			1667
British Nursing Index	2000-2012	midwife* AND postnatal care AND home visit OR domiciliary	7
CINAHL			265
Maternity and Infant Care			27
Wiley Online Library			2929
British Nursing Index	2000-2012	midwi* AND early discharge	1
CINAHL			21
Maternity and Infant Care			7
Wiley Online Index			3116
British Nursing Index	2000-2012	midwi* role AND early discharge	1
CINAHL			0
Maternity and Infant Care			0
Wiley Online Library			2506
British Nursing Index	2000-2012	postnatal AND early discharge AND midwife AND home visit OR domiciliary	1
CINAHL			0
Maternity and Infant Care			25
Wiley Online Library			5141
British Nursing Index	2000-2012	Australia* AND fund* AND postnatal AND homevisit	-
CINAHL			1
Maternity and Infant Care			0
Wiley Online Library			1557
British Nursing Index	2000-2012	Australia* AND government AND postnatal AND homevisit	-
CINAHL			1
Maternity and Infant Care			1
Wiley Online Library			973
British Nursing Index	2000-2012	midwi* AND role AND postnatal depression OR postpartum depression	29
CINAHL			2430
Maternity and Infant Care			0
Wiley Online Index			187
British Nursing Index	2000-2012	midwife AND role AND breastfeed	5

CINAHL			59
Maternity and Infant Care			7
Wiley Online Library			851
British Nursing Index			6
CINAHL	2000-2012	midwi* AND neonat* AND examin*	1
Wiley Online Library			12
Maternity and Infant Care			2

Table 2.1 Literature search strategies and results

Findings

Although Table 2.1 indicates an extensive amount of literature on postnatal issues, the majority of articles were unrelated to postnatal care of humans and/or highly scientifically technical. Therefore most articles in the above table were not helpful for this study and were disregarded.

The results of the search therefore revealed a paucity of literature regarding the experience of the postnatal domiciliary midwife, although there was slightly more regarding the role of postnatal midwives working in a hospital context. In terms of my chosen research approach, there was one critical ethnographical study that pertained to the postnatal context, however, it was focused on breastfeeding in hospital. There was also some definitional confusion in the literature regarding domiciliary midwives, therefore it is important to discuss definition.

The searched articles provided a background of information, context and issues surrounding postnatal domiciliary care. The literature findings have been identified into several categories. These are outlined in Table 2.2. I will begin with a discussion of definitions, then follow with the national and international literature of postnatal domiciliary care. I will then discuss the specific categories of the literature.

Literature subject area	Category type
Definitions	Broad
Approaches to postnatal care: National and international literature	Broad
Early postnatal discharge	Specific
Midwives' views of postnatal care	Specific
Mothers' views of postnatal care	Specific
Breastfeeding and the role of the midwife	Specific
Mental health and well-being	Specific
Miscellaneous midwifery roles in postnatal care	Specific
Other assistance at home in the postnatal period	Specific

Table 2.2 Categories of literature

Literature categories: Broad

Definitions

The literature revealed there are different terms used to refer to midwives who provide postnatal care in the home. In some spheres the term “domiciliary midwife” was used to indicate antenatal care or care for a woman in labour in the woman’s home (Banks, 2007; Blondel, Breart, Llado, & Chartier, 1990; Dawson et al., 1999) as well as postnatal care. Some articles also used the term “community midwife” when referring to midwives who visit clients at home (Baston & Green, 2002; MacArthur et al., 2002). The term “community midwife” was also used to indicate midwives who provide postnatal care in a clinic that was not located at a hospital. For the purposes of this research, the term “domiciliary midwife” is used for the provision of postnatal care at home.

Approaches to postnatal care: National and international literature

While midwives are educated to care for women from early pregnancy to the postpartum period, education varies across countries. The following provides a global perspective of the ways in which different countries provide postnatal midwifery care within community settings.

National literature

The Australian studies have provided a broad context of postnatal care. While research studies have not extensively explored or investigated the role and experiences of postnatal domiciliary midwives in Australia research has revealed the complexity of postnatal issues. Arguably there is an increased interest in Australian postnatal care provision. The studies have indicated that domiciliary care needs to be taken more seriously, primarily because it has become a more significant area of maternity care in the last 5-10 years.

Literature specifically regarding domiciliary care remains sparse. Table 2.3 outlines 30 studies regarding postnatal care that have been conducted in Australia over the last eleven years. Most of the studies include postnatal care within a hospital

setting, rather than domiciliary care alone. Contextually these studies are important as they assist in outlining care for mothers and babies and as such are integrally linked.

Of the thirty studies outlined, twelve were carried out from a quantitative perspective, eight were a mixed method design and ten studies used qualitative approaches. The research regarding postnatal care, whether in hospital or home-based is heavily reliant on quantitative methodology. Many of the articles have highlighted the challenging context of postnatal care provision and the need for research and improvement to postnatal service, either implicitly or explicitly stating the invisibility of postnatal care in planning, research and resourcing. However, most did not differentiate between postnatal care in the hospital or home and there remains a gap in the literature regarding experiences of postnatal domiciliary care from the perspectives of both midwives and mothers.

Of particular note, postnatal care is consistently rated more poorly than any other maternity episode (Brown, Davey, & Bruinsma, 2004; Yelland et al., 2009). According to Fenwick et al (2010), a greater understanding of women's needs regarding postnatal care is required to improve satisfaction rates. It was identified that consistency of information, availability of professional advice and assistance, attention to emotional care, provision of information regarding other health resources and practical education were key issues of importance for postnatal mothers.

In relation to research on postnatal domiciliary midwives Homer and colleagues (2009) investigated the role of the postnatal domiciliary midwife in Australia. The study was a multi-method, qualitative design. Their findings highlighted the barriers to effective and satisfactory domiciliary practice, which include: the invisibility of midwifery regulation and role, domination of medicine, workforce shortages, institutionalised care and a lack of clear community expectations of the midwife. This was an important study and contributed to the development of my research wherein I explored effective practice.

Additionally some of the discourse includes current birthing practices and recommendations for domiciliary visits. In Australia most women currently birth their babies in hospital, therefore immediate postnatal care is provided by midwives within

the hospital setting, under a variety of models of care. As the current postnatal length of stay in Australian hospitals is approximately two-three days (S. Brown, Darcy, & Bruinsma, 2002), the majority of their postnatal period is spent at home.

As introduced in the first chapter, every woman who births in a public hospital in Victoria, Australia should be offered a domiciliary visit (Victorian Department of Health, 2010b). The Victorian government has an expectation that women will be offered two or more domiciliary visits if the need arises.

Recent literature (Kruske, Schmied, & Homer, 2013; Psaila, Schmied, Kruske, & Homer, 2013) has indicated that the transfer from domiciliary care to MCHN lacks consistency in timing and that the midwives delivering postnatal care are uncertain regarding the management of basic cues in postnatal care. These findings point to the invisibility of postnatal, and therefore domiciliary needs, education and resourcing. They further highlight a gap in care with uncertainty of management and the inconsistency of transfer timing.

Author, Year	Research Topic	State	Methods	Contribution to this research
Kruske, Schmied & Homer (2013)	Midwives' confidence in the skills required for postnatal care: Results of a national survey	AUST	Three-phase, sequential mixed methods	Midwives in postnatal care have skills yet low confidence in specific skills e.g.: Maternal/infant attachment, reading infant cues, supporting breastfeeding with unwell women/babies, using EPDS, screening for DV issues.
Psaila, Schmied, Kruske & Homer (2013)	Transition of care . . . How well is it done? Findings from the CHoRUS study	AUST	Three-phase, sequential mixed methods	Described patterns and processes of transition of care between maternity services and child and family health services. Transition somewhat effective. Strategies to improve: co-location, collaborative relationships & joint service re-design.
Biro, Yelland, Sutherland & Brown (2012)	Women's experience of domiciliary postnatal care in Victoria and South Australia: a population-based survey	SA & VIC	Population-based survey—quantitative	Majority of women in the public maternity system in VIC and SA received at least one domiciliary visit in their first week after leaving hospital. Victorian women least likely to receive a visit; rated visits less positively than SA. Women who would have benefited most were least likely to receive visits. More work on policy and guidelines needs to be done.

Author, Year	Research Topic	State	Methods	Contribution to this research
Fenwick, Butt, Downie, Monterosso & Wood (2012)	Priorities for midwifery research in Perth, Western Australia: A Delphi study	WA	Two-round Delphi study	Midwives most concerned about the delivery and organization of maternity services, the invisibility of the postnatal experience and how to operationalise evidence-based clinical care.
Ford, Algert, Morris & Roberts (2012)	Decreasing length of maternal hospital stay is not associated with increased readmission rates	NSW	Longitudinal, population quantitative	Length of postnatal stay in hospital does not appear to be having serious adverse effects of the health of women and babies—as measured by readmission rates.
Hoban & Liamputtong (2012)	Cambodian migrant women's postpartum experiences in Victoria, Australia	VIC	Ethnography	Migrant women benefit from a midwifery-led model of care, supported by interpreters and other health professionals from antenatal to postnatal care, in hospital/home for up to 6 weeks postpartum. Mothers often have a gap of care from 10 days to 4-6 weeks, left feeling lonely, anxious.
Morrow, McLachlan, Foster, Davey & Newton (2012)	Redesigning postnatal care: Exploring the views and experiences of midwives	VIC	Cross-sectional surveys	Focus on in-hospital care: Midwives state postnatal care needs to be redesigned. Required changes: documentation and communication. Midwives and mothers should be involved in the changes.
Rayner, McLachlan & Forster (2012)	Care providers' views and experiences of postnatal care in private hospitals in Victoria, Australia	VIC	Qualitative Semi-structured interviews	Two global themes: constrained care and consumer care. Postnatal care: complex, characterized by many barriers which impact on quality service provision. More in-depth studies required in public and private sectors.
Fenwick, Butt, Dhaliwal, Hauck & Schmied (2010)	Western Australian women's perceptions of the style and quality of midwifery postnatal care in hospital and at home.	WA	Cross-sectional, self report survey. Quantitative	Greater understanding regarding what women want from their postnatal care: consistency; availability; emotional care; resource information; education about practical matters. Women satisfied with domiciliary care—the traditional model of hospital postnatal care is not a necessity for satisfaction.
Rayner, McLachlan, Forster, Peters & Yelland (2010)	A statewide review of postnatal care in private hospitals in Victoria, Australia.	VIC	Mixed method design.	Recommend further research to provide evidence-based postnatal care.

Author, Year	Research Topic	State	Methods	Contribution to this research
Brown, Small, Argus, Davis, Krastev (2009)	Early postnatal discharge from hospital for healthy mothers and term infants	AUST	Literature Review	Variation in the definition of <i>early discharge</i> , antenatal preparation and care at home. Early discharge does not necessarily have harmful effects on mother/babies provided that there is adequate domiciliary care.
Homer, Henry, Schmied, Kemp, Leap & Briggs (2009)	Transitions of care between midwives and child and family health nurses in New South Wales	NSW	Descriptive Study	There is no overlap of care from DM—MCHN. Scope for DM to care for longer (continuity of carer). How does the culture/beliefs of the DM contribute or not) to the role?
Homer, Passant, Brodie, Kildea, Leap, Pincombe & Thorogood (2009)	The role of the midwife in Australia: Views of women and midwives	AUST	Multi-method Qualitative data=32 midwives interviewed Women's descriptive surveys=28	Barriers to practice: Invisibility of midwifery regulation and role; domination of medicine; workforce shortages; institutionalised care; community lacking clear image of expectations and role of midwife.
McLachlan, Gold, Forster, Yelland, Rayner & Rayner (2009)	Women's views of postnatal care in the context of the increasing pressure on postnatal beds	VIC	Focus groups, interviews	Consideration for women's concerns about reduced LOS. LOS should be well evaluated. Must acknowledge individual needs of women.
Schmied, Cooke, Gutwein, Steinlein & Homer (2009)	Evaluation of strategies to improve quality and content of hospital-based postnatal care in a metropolitan hospital	NSW	Pre/post test design Key test—"one to one time".	Hospital routines difficult to change. Midwives require skill development and time to listen adequately.
Yelland, Krastev & Brown (2009)	Enhancing early postnatal care: findings from a major reform of maternity care in three Australian hospitals	VIC	Pre/post test surveys. Key test—implementation of postnatal care initiatives.	Postnatal care rates consistently lower than other episodes of maternity care, What is it about the midwifery culture that can be explored and addressed in order to improve the outcomes of postnatal care?
Forster, McLachlan, Rayner, J., Yelland, Gold & Rayner (2008)	The early postnatal period: Exploring women's views, expectations and experiences of care using focus groups	VIC	Exploratory study	Contributes to our understanding of what women need and expect from their postnatal care.

Author, Year	Research Topic	State	Methods	Contribution to this research
King (2008)	Midwives' and mothers' perspectives of postnatal care: A phenomenological approach	NSW	Interviews	Provides understanding of the nature and effects of postnatal care from the perspective of midwives' who provide that care, and from women who had received that care.
Rayner, Forster, McLachlan, Yelland & Davey (2008)	State-wide review of private hospital postnatal care in Victoria, Australia: The view and experiences of midwives	VIC	Semi-structured interviews	Recommendations: Review of staffing levels, development of alternative postnatal care arrangements, further research to provide a greater evidence-base for postnatal care provision.
Schmied, Cooke, Gutwein, Steinlein, Homer (2009)	Strategies to improve hospital-based postnatal care	NSW	Action research	Midwives designed and implemented strategies to provide better postnatal care within a hospital setting. Important principles: relationship, individualised care, flexibility and continuity.
Homer, Passant, Brodie, Kildea, Leap, Pincombe & Thorogood (2007)	The development of national competency standards for midwife in Australia	AUST	Multi-method, staged approach. Purposive sampling	National registration and regulation of midwives.
Yelland, McLachlan, Forster, Rayner, & Lumley (2007)	How is maternal psychosocial health assessed and promoted in the early postnatal period?	VIC	Mixed methods: Interviews Postal survey	Implement strategies which give care providers quality guidelines and skills for problem detection. Requirements: reorganisation of care, time provision, individualized care, continuity of carer.
Forster, McLachlan, Yelland, Rayner, Lumley & Davey (2006)	Staffing in postnatal units	VIC	Mixed Methods Questionnaire Interviews	Future research on postnatal care provision should include consideration of staffing issues.
McKellar, Pincombe, Henderson (2006)	Insights from Australian parents into educational experiences in the early postnatal period	SA	Action research	Window of opportunity for education whilst still an inpatient is significant, despite reduced length of stay postnatally. Family centred, individualized care is valued. Fathers have different learning needs, direct education of fathers reported as lacking.

Author, Year	Research Topic	State	Methods	Contribution to this research
Zadoroznyj (2006)	Surveillance, support and risk in the postnatal period	SA	Review of two services provided by SA government.	Contributes to the understanding of the “normal” process of pregnancy, birth and postnatal period, Health outcomes are better support in this period. Requiring good support is not an indication of ill-health. What else do domiciliary midwives’ need to learn in order to observe and refer more effectively. Contributes to the understanding of the possible scope of practice of a domiciliary midwife.
Forster, McLachlan, Yelland, Rayner, J. & Lumley (2005)	A review of in-hospital postnatal care in Victoria. Final report.	VIC	Mixed method	Review staffing ratios and mix. Review postnatal care design.
Brown, Davey & Bruinsma (2004)	Women’s views and experiences of postnatal hospital care in the Victorian Survey of Recent Mothers 2000	VIC	Survey	Postnatal care rated less favourably than other episodes of maternity care. Interactions with caregivers, communication, listening, staffing levels, leadership are key and should be taken into consideration when restructuring care.
Brown, Bruinsma, Darcy, Small, Lumley (2004)	Early discharge: No evidence of adverse outcomes in three consecutive population-based Australian surveys of recent mothers, conducted in 1989, 1994 and 2000	VIC	Surveys	Shorter length of stay does not appear to have an adverse impact on breastfeeding rates or length, or women's emotional well-being.
Cooke & Stacey (2003)	Evaluation of postnatal midwifery support by multiparous and primiparous women in the first two weeks after birth.	NSW	Quantitative Self-report questionnaires	All mothers who have just birthed require care. It is a fallacy to think that women who have had babies previously do not need assistance. Ignoring the needs of multiparous women is not a good way to reduce spending.

Author, Year	Research Topic	State	Methods	Contribution to this research
Brown, Darcy & Bruinsma (2002)	Having a baby in Victoria 1989-2000: continuity and change in the decade following the Victorian Ministerial Review of Birthing Services.	VIC	Population Surveys x 3	Maternity care is in a state of flux, therefore the role of midwives is in transition, including midwives who provide postnatal care at home. There is an increasing need for DM care due to the decreased LOS of women after birth in hospital. There are positive attitudes in the community to midwifery-led units.

Table 2.3 Australian postnatal studies

International literature

There were thirty-two research articles identified that related to general postnatal care and these are outlined in Table 2.4. As there is a dearth of available scholarship the literature spans a twenty-five year period. Of the studies accessed, twenty-one of the studies were quantitative in design, one was a mixed method design and ten were qualitative. There were no studies that explored the role and experiences of the postnatal domiciliary midwife from a critical perspective or were ethnographic in design.

Global literature has revealed that postnatal care has not been well researched, and is indicative of higher levels of dissatisfaction than any other episode of maternity care, similarly reflected in Australian literature (Ching-Yu, Fowles, & Walker, 2006; Lindberg, 2007). The literature has revealed a similar trend to Australia, with growing interest in the need to research and improve postnatal care, particularly in the light of reduced resources, staffing shortages and the impact this has on decreased length of stay in hospital following childbirth. The literature has demonstrated an enforced shorter length of stay does not necessarily lead to poor outcomes, and can result in positive outcomes and greater rates of satisfaction if managed well.

Postnatal care in the home and hospital has not always been differentiated in the literature, however, in some cases home care has been specifically targeted. For instance that has been in recognition of it being a specialty area and the strategies that are effective in hospital, may require adjustment to be effective in domiciliary settings (Johansson, Aarts, & Darj, 2010; Kronborg, Vaeth, & Kristensen, 2012).

Lindberg (2007) even trialled videoconferencing as a form of managing domiciliary postnatal care with mixed satisfaction rates.

Mothers and midwives were sought regarding their views about postnatal care, with the repeating view that continuity of carer, individualised care, emphasis on practical skills and empathy from the carer are significant for the effectiveness of postnatal care (L. Hunter, 2004; Johansson et al., 2010; Smythe, Payne, Wilson, & Wynyard, 2012; Tarkka, Paunonen, & Laippala, 2000).

Below I have outlined the literature from several countries that highlight the differences in postnatal care and the particular central focus for each country.

New Zealand

The New Zealand government currently provides an example model of care that offers routine, funded, domiciliary antenatal, labour and postnatal care for normal pregnancy and birth, should a woman wish to access it (New Zealand College of Midwives Inc., 2010). A midwife may be employed by the woman as her Lead Maternity Carer (LMC) where the full scope of care and continuity of carer may be provided in her own home, a clinic or a hospital or a mixture thereof. The employment of LMC's are accessed by 75% of women in New Zealand (New Zealand College of Midwives Inc., 2010). All residents of New Zealand are entitled to receive at least 5 postnatal domiciliary midwife visits after they leave hospital. However, most usually receive up to 10 visits at home or in a nearby clinic in a 4-6 week period after the birth of their infant (New Zealand Primary Maternity Services, 2007).

According to global findings, effective postnatal care is important for mothers and maternal health. Early discharge with midwifery home visits can be a positive experience for midwives and babies provided that the care is well planned. Further study is required to improve current levels of dissatisfaction with postnatal care.

Europe

The role and circumstances of midwives varies throughout Europe. In Denmark the vast majority of midwives are autonomous and are employed by a

national health service (Malott, Davis, McDonald, & Hutton, 2009). Most babies (97%) are born in a hospital setting where midwives attend the birth if this is low risk. The average postnatal length of stay is two days with women being offered home visits for up to five days by midwives (McKay, 1993).

Since the 1950's most Swedish babies have been born in hospital. The average postnatal length of stay in hospital is two-three days, however this is decreasing due to a high demand for early discharge after giving birth. Commonly women are offered as many visits as required until the fourth postnatal day at home (Johansson et al., 2010; Malott et al., 2009). Alternatively, they are offered a brief stay in a "family suite", which is similar to a home-like environment where midwives provide care and education, situated close to a hospital (Ellberg, 2008). Malott et al (2009) reported that midwives may provide postpartum care for up to ten weeks within a community setting, as a woman or baby requires. Midwives' duties included observation for women's physical recovery from birth, breastfeeding assistance, education in mothercrafting skills and observation for the health and well-being of the neonate.

Three quarters of Dutch midwives are in independent practice, and more than 30% of Dutch women give birth at home (DeVries, 2005; McKay, 1993). Midwives provide the full scope of care from antenatal, labour and postnatal care in Denmark, Sweden and Holland. Community midwives provide the primary care for healthy pregnant women and are considered essential to the high percentage of positive outcomes of this country. Postnatally, women in Holland receive visits at home from midwives for six weeks, but also receive help from a "Kramzorg", a maternity home care assistant (Van Teijlingen, 1990).

In Finland, approximately 97% of babies are birthed in hospital, with midwives attending 80-85% of those births (Benoit et al., 2005; Callister, Sirkka, & Vehvilainen-Julkunen, 2000). The typical length of stay after a vaginal birth in Finland is two-four days, while the length of stay after a caesarean section is five-seven days. The newborn is assessed at two weeks of life by the midwife, then both mother and baby are assessed twice in the first three months. The nurse midwife may conduct a home visit as indicated, and mothers are encouraged to contact the nurse midwife by

phone as needed. Nurses provide health education, family planning counselling, and treat gynaecological infections. Reunion childbirth classes are offered, so new parents have the opportunity to reflect on their birth experiences and share their perspectives on early parenting (Callister et al., 2000).

United Kingdom

The United Kingdom (UK) has seen significant adjustments in postnatal care from homebirth and all postnatal care provided in the home before industrialisation to a rise in hospital births and ten day “lying in” period in hospital after World War II (Reid, 2005). An increase in hospital births and a shortage of availability of hospital beds meant that by the 1980’s the length of stay had decreased to a five-six day hospital stay. According to the National Health Service (NHS, UK), 80% of women who birth in NHS hospitals stayed in hospital for two days or less during 2009-10 (Department of Health, 2011). MacArthur (1999) stated that midwives are expected to visit women in their homes up to the tenth postnatal day, or even up until the twenty-eighth day, as required. Consistent with the highly influential “Changing Childbirth” (Department of Health, 1993) report, the content and frequency of these visits are based on women’s individual needs, rather than a prescribed list of observations. Provided that women are well, all of their antenatal, labour and postnatal care may be performed by midwives in a variety of models of care including home (Dowswell, Renfrew, Hewison, & Gregson, 2001; Ralston, 1998; Spurgeon, Hicks, & Barwell, 2001).

United States of America (USA)

Most babies are birthed within a hospital setting, with midwives attending only 10% of vaginal births. Albers and Williams (2007) stated that most women’s health insurance cover provides for one home visit that is usually by a doctor, and a doctor’s visit at a clinic at four-six weeks. Most postnatal care (90%) is provided in a clinic by a doctor, however there have been some midwives who have initiated alternative models of care which include scheduled phone calls, home visits and/or additional clinic visits (Albers & Williams, 2007). Cheng, Fowles and Walker (2006) revealed

that, postnatal visits by a midwife in a woman's home are largely dependent on her ability to obtain health insurance. Even with health insurance, there is no guarantee of a domiciliary visit, and it may not be until three-four weeks postnatally.

In summary the international literature has revealed there are a variety of ways to deliver domiciliary and postnatal care management. I have focused on first-world countries because specific resourcing and context aligns mostly closely with Australia. Some of the literature accessed is more than two decades old; this was deliberate because of the paucity of available recent literature.

It is strongly evident that resources are becoming more limited and every country is confronted by the increasing needs for safe, satisfying, evidence based domiciliary care. The overwhelming feature of this component of the literature review is that it is necessary to profile domiciliary postnatal research, policy and management if midwives and women are to demonstrate evidence of satisfaction and safety in the domiciliary postnatal period.

Author, Year	Research topic	Country	Methods	Contribution to this research
Bick, Murrells, Weavers, Rose, Wray & Beake (2012)	Revising acute care systems and processes to improve breastfeeding and maternal postnatal health	UK	Continuous Quality Improvement Quantitative	Improvement of postnatal outcomes and satisfaction with care is possible (initiation, duration and exclusive breastfeeding rates and physical well-being) through continuous quality improvement.
Kronborg, Vaeth & Kristensen (2012)	The effect of early postpartum home visits by health visitors: A natural experiment	Denmark	Observational cross-sectional study	Nonstandardised home visits by health visitors were associated with a longer breast-feeding duration. The postnatal visits depended on parity and unmet needs increased the use of medical services.
Smythe, Payne, Wilson & Wynyard (2012)	The dwelling space of postnatal care	New Zealand	Qualitative interpretive	Women's ability with on-going mothering is influenced by the presence of a "dwelling space" provided by healthcare workers. Women need to be listened to, anticipatory needs addressed and cared for in a "loving" manner.
Johansson, Aarts & Darj (2010)	First-time parents' experiences of home-based postnatal care in Sweden	Sweden	Explorative study—interviews	Outcomes for healthy mother/baby good and satisfaction high provided that women were supported with home visits, ease of contact, encouragement and appropriate education.

Author, Year	Research topic	Country	Methods	Contribution to this research
Ellberg (2008)	Postnatal care— Outcomes of various care options in Sweden	Sweden	Cross sectional	Provides a general description of postnatal routine of care in hospital— varies between health facilities. Dissatisfaction evident with decreased length of hospital stay. More research required to improve postnatal satisfaction and mother/baby outcomes,
Gibb & Hundley (2007)	What psychosocial well-being in the postnatal period means to midwives.	Scotland	Naturalistic enquiry. Convenience sample.	Midwives are well placed to contribute to the emotional and mental well-being of women postnatally. Attention should be given to providing continuity of carer. It is important to question the current culture of care provided by midwives in the postnatal period. How has this culture contributed to less than satisfactory outcomes?
Lindberg (2007)	Postpartum care in transition	Sweden	Mixed methods	Explored mothers' and midwives' experiences of decreased length of postnatal stay in hospital, especially using videoconferencing to assist with care. Overall mixed satisfaction rates regarding postnatal care whether hospital, home or use of videoconferencing.
Banks (2007)	The personal mandate to practise midwifery by midwives of the domiciliary midwives society of New Zealand (Inc), 1974-1986	New Zealand	Historical— domiciliary midwives in NZ	Contributes to definition, perceptions, role and scope of practice for domiciliary midwives.
Rudman & Waldenstrom (2007)	Critical views on postpartum care expressed by new mothers	Sweden	Population based, longitudinal study	Increasing dissatisfaction with hospital- based postnatal care, especially regarding lack of rest, reduced length of postnatal stay in hospital, inadequate education. Need for further discussion and development of effective needs-based aims in postnatal care programs.
Ching-Yu, Fowles & Walker (2006)	Postpartum maternal healthcare in the USA critical review	US	Literature review	Current models of postnatal care, have unsatisfactory outcomes for mothers and babies. Reconsider scope, duration and models of care for improved outcomes including longer term emphasis on education, and parenting skills.
Lof, Svalenius & Persson (2006)	Factors that influence first-time mothers' choices and experiences of early discharge.	Sweden	Descriptive	Early discharge from hospital after having a baby can be a positive experience provided that women have adequate support.

Author, Year	Research topic	Country	Methods	Contribution to this research
Reid (2005)	Midwifery in Scotland 4: the shaping of postnatal care	Scotland	Historical Interview and literature review	Postnatal care is a significant part of the midwife role. Increased medical control, decrease in bed availability has changed the postnatal role, including need for home visits. Home visits by midwives until the 28th day postnatal are an integral part of women's and babies' health.
Boulvain, Perneger, Othenin-Girard, Petrou, Berner & Irion (2004)	Home-based versus hospital-based postnatal care: A randomized trial.	Switzerland	RCT Home or hospital based care	Early discharge does not have to lead to poor outcomes (i.e. Early weaning, low satisfaction) provide that adequate follow-up at home is provided.
Bull, McCormick, Swann & Mulvihill (2004)	Ante- and post-natal home-visiting programmes: a review of reviews	UK	Literature review	Mixed findings regarding home visiting and improvements to child health. Home visiting improves outcomes for mothers . Mixed findings about effectiveness of current models of care. Recommend further research
Hunter (2004)	The views of women and their partners on the support provided by community midwives during postnatal home visits	UK	Semi-structured interviews—Grounded theory	Parents want more practical help, especially with breastfeeding. Parents would like more continuity of carer and care. Suggestion that parents should assist design their own care in order to meet their needs.
Bick (2003)	Strategies to reduce postnatal psychological morbidity: the role of midwifery services.	UK	Critical Review—postnatal “debriefing”	Highlights what can happen to women if postnatal care is not adequate.
Baston & Green (2002)	Community midwives' role perceptions	UK	Qualitative Cross-sectional study using a grounded theory approach	Contributes to definition and role of midwife. Specifies values which are important to midwives in their delivery of care. What are the cultural mores that shape midwives' decisions, behaviour and role? Can these beliefs be address to improve midwives' and women's situations?

Author, Year	Research topic	Country	Methods	Contribution to this research
Lugina, Johansson, Lindmark & Christensson (2002)	Developing a theoretical framework on postpartum care from Tanzanian midwives' views on their role.	Tanzania	Grounded theory	Describes some of the frustrations of midwives as they struggle with under-resourcing. Are midwives powerless to change the current community attitude toward the early postnatal period? What is it about our midwifery culture that prevents us from getting politically active? How does our midwifery culture prevent us from changing policy to improve women's care and our satisfaction with our care?
MacArthur, Winter, Knowles, Lilford, Henderson, Lancashire, Braunholtz & Gee (2002)	Effects of redesigned community postnatal care on women's health 4 months after birth: a cluster randomized controlled trial.	England	Cluster RCT	Extended, individualized care by midwives increases satisfaction for women. What is it about our culture of "production line care" that can be addressed and challenged to improve outcomes for women? Are we only reliant on increased economic attention for better care?
Young & Bennett (2002)	Visiting women after a termination.	UK	Qualitative. Semi-structured interviews.	Contributes to the understanding of the broad nature of the scope of practice of midwives. Contributes to our understanding of the changing nature of midwives' roles as technology advances, increasing the workload of maternity services.
Crowther, Spiby & Morrell (2001)	Community midwifery support workers.	UK	Qualitative. Surveys and focus group.	One way of validating and supporting women in that early postnatal period is to provide home assistance for
Dowswell, Renfrew, Hewison & Gregson (2001)	A review of the literature on the midwife and community-based maternity care	UK	Literature review	Postnatal care in community settings (not necessarily women's homes) is safe and acceptable. Little is known about the role and contribution to women's care. More studies required.
Spurgeon, Hicks & Barwell (2001)	Antenatal, delivery and postnatal comparisons of maternal satisfaction with two pilot "Changing Childbirth" schemes compared with a traditional model of care	UK	Retrospective between-group questionnaire	Midwifery-led care was preferred to obstetric led care, showed higher rates of satisfaction by women. Clinical outcomes were identical whether midwifery or obstetric provision.

Author, Year	Research topic	Country	Methods	Contribution to this research
Callister, Sirkka & Vehvilainen-Julkunen (2000)	A description of birth in Finland	Finland	Report Literature review	Postnatal visits within the community, and continuity of carer improve mother/baby outcomes and satisfaction with care.
Nyberg & Sternhufvud (2000)	Mothers' and fathers' concerns and needs postpartum.	Sweden	Qualitative	Contributes to the understanding of needs and concerns of parents in the postnatal period.
Tarkka, Paunonen & Laippala (2000)	How first-time mothers cope with child care while still in the maternity ward	Finland	Quantitative Questionnaire	First time mothers require support from both midwifery staff and close relatives in order to trust their own abilities to cope better with parenting and mothercraft skills in the postnatal period.
Dawson, Cohen, Candelier, Jones, Sanders, Thompson, Arnall & Coles (1999)	Domiciliary midwifery support in high-risk pregnancy incorporating telephonic foetal heart rate monitoring	UK	RCT	Contributes to the definition of DM and our understanding scope of practice—providing high risk antenatal care at home.
Temkin (1999)	Driving through: postpartum care during World War 11	USA	Literature review	Historical context of medicalisation of maternity care in the USA. Need for research and revision of services, including postnatal care, which currently has less than optimal mother/baby health outcomes.
McKay (1993)	Models of midwifery care: Denmark, Sweden and the Netherlands.	Denmark Sweden, Netherlands	Qualitative, description of maternity services in these countries.	Contributes to the understanding of scope of practice of a midwife. Contributes to the understanding of the capabilities and autonomy of midwives.
Van Teijlingen (1990)	The profession of maternity home care assistant and its significance for the Dutch midwifery profession.	UK/Netherlands	Descriptive	Good postnatal care is normal and essential for healthy women and babies. Midwives are not the only supports important to women. In a world where people often live away from traditional networks of support, what else can be done to provide support at this important time? This government attaches a high level of importance on the immediate postnatal period.
Blondel, Breart, Llado & Chartier (1990)	Evaluation of the home-visiting system for women with threatened preterm labour	France	RCT.	Highlights scope of practice for domiciliary midwife (antenatal care).

Author, Year	Research topic	Country	Methods	Contribution to this research
Waldenstrom (1988)	Early and late discharge after hospital birth: fatigue and emotional reactions in the postpartum period.	Sweden	RCT	Early discharge after birth, with adequate domiciliary midwife follow-up shows decreased rates of depression at 2 and 3 weeks post birth.

Table 2:4 International postnatal studies

Literature categories: Specific

There were many articles located by search that potentially seemed significant to review for specific categories. However the majority were not directly relevant to my study. I chose to review key articles of direct relevance to my study. Most were recent and published in peer-reviewed journals.

Early postnatal discharge

Increasingly, in Australia over the last two decades, women have been discharged earlier after giving birth. The length of stay in hospital has reduced from an average of ten-fourteen days to two-three days, and often within one day. There has been research that has measured postnatal outcomes, particularly breastfeeding, and postnatal depression rates, to identify or quantify risks or benefits of early postnatal discharge. The literature has demonstrated that discharge planning should be individualised, multidisciplinary and flexible. Early discharge, provided that the needs of the women and neonates are met, have the same outcomes as a longer stay in hospital. Midwives and women have shown mixed responses as far as satisfaction, based on the individualisation of the care and the preparedness of the family involved. Early discharge has been highlighted as a positive experience, despite misgivings based on traditional models. Parents have indicated their satisfaction if they have ready access to advice by phone if necessary and have flexibility should more acute needs arise. Table 2.5 lists national and international articles related to early discharge.

Author, Year	Research topic	Country	Methods	Contribution to this research
Brown, Small, Argus, Davis, Krastev (2009)	Early postnatal discharge from hospital for healthy mothers and term infants	AUST	Literature Review	Variation in the definition of “early discharge”, antenatal preparation and care at home. Early discharge does not necessarily have harmful effects on mother/babies provided that there is adequate domiciliary care (at least one visit).
Bernstein, Spino, Finch, Wasserman, Slora, Lalama, Touloukian, Lilienfeld, McCormick (2007)	Decision-making for postnatal discharge of 4300 mothers and their healthy infants: the life around newborn discharge study	USA	Prospective observational cohort study.	Hospital discharge decision should be made jointly, to ensure mother-baby readiness. Flexibility of discharge dependent on needs.
Cargill, Martel (2007)	Postpartum maternal and newborn discharge	Canada	Literature Review	Early discharge increases the risk of neonatal mortality and morbidity. Early discharge should be well planned taking many factors into consideration, health, social setting, age. Current community support programs are appreciated but the community needs more.
Brown, Bruinsma, Darcy, Small, Lumley (2004)	Early discharge: No evidence of adverse outcomes in three consecutive population-based Australian surveys of recent mothers, conducted in 1989, 1994 and 2000	VIC, AUST	Surveys	Shorter length of stay does not appear to have an adverse impact on breastfeeding rates or length or women's emotional well-being.
Lieu, Braveman, Escobar, Fischer, Jensvold, Capra (2000)	A randomized comparison of home and clinic follow-up visits after early postpartum hospital discharge	USA	RCT	Home visits by either midwife/nurse/doctor after early discharge displayed no difference in outcomes to women who visit their local clinic on day 3 or 4 postnatally. Home visitation service was more costly, but women's satisfaction rates were higher.

Table 2.5 Early postnatal discharge

Midwives' views of postnatal care

Ten articles were reviewed regarding midwives' views about postnatal care. This aspect of the literature provides some insight into the experience of the postnatal midwife, however, does not always include the experience of domiciliary

midwives. The postnatal care provided and studied was usually within the context of hospital, therefore it did not comprehensively represent postnatal care in the home. Of the ten articles reviewed, two were based on quantitative methods, three were based on qualitative methods, four were mixed methods and there was one review. Nine of the articles were based on data from Australia and one of the articles originated from the UK.

The literature in Table 2.6 has demonstrated there were mixed satisfaction levels with the provision of postnatal care in Australia and the UK. Postnatal care provided in hospital was perceived as important in both countries, however, there was a reported need for improvement with the care in a few areas. Areas such as communication, documentation, routine, individualisation of care and reduced length of postnatal stay were raised as significant areas for further research. Issues such as skill and staffing mix, visiting hours were also deemed important, as midwives indicated issues with safety and efficiency were a problem.

The research by Hunter (2006) involved an ethnographic study of community-based midwives in the UK. The focus was on the reciprocity of the relationship between postnatal women and the midwives providing care within the community. This study highlighted the emotional work of which the community midwives may be involved. It was inclusive of positive and negative aspects that were dependent on the interactions between the midwife and the mother. As indicated above, the context of postnatal care within the community is different in the UK to Australia. Midwives in the UK may provide care at a clinic or in the home, and generally provide care for up to four weeks postpartum.

Australian studies indicated that midwives were concerned with current care outcomes and involvement in future postnatal care. In relation to early postnatal discharge, midwives were concerned with safety issues, continuity of care, breastfeeding and mothercrafting outcomes. There was recognition that adequate support especially in the first week was essential for a good start for mother and baby. There was concern expressed regarding the lack of adequate overlap of services between the hospital and community nurses. Zadoroznyj (2006) addressed this issue by reviewing two services that provided extra care, which revealed good

health outcomes. Furthermore, Morrow (2012) believed midwives should be involved in redesigning postnatal care, along with mothers, to increase satisfaction levels for all, as well as better health outcomes.

Author, Year	Research topic	Country	Methods	Contribution to this research
Morrow (2012)	Redesigning postnatal care: Exploring the views and experiences of midwives	VIC, AUST	Article based on cross-sectional surveys	Focus on in-hospital care: Midwives agree that postnatal care needs to be redesigned. Most crucial changes revolve around documentation and communication. Midwives and mothers should be involved in the changes.
Homer, Henry, Schmied, Kemp, Leap & Briggs (2009)	"It looks good on paper": Transitions of care between midwives and child and family health nurses in New South Wales	NSW, AUST	Descriptive Study	There is no overlap of care from domiciliary midwife—MCHN. Scope for DM to care for longer (continuity of carer).
Rayner, Forster, McLachlan, Yelland, Davey (2008)	A state-wide review of private hospital postnatal care in Victoria, Australia: The view and experiences of midwives.	VIC, AUST	Article based on semi-structured interviews	Midwives positive about hospital-based postnatal care. Midwives expressed dissatisfaction with barriers to quality care: time, LOS, staff ratios, consistent advice. Recommendations: Review of staffing levels, development of alternative postnatal care arrangements, further research to provide a greater evidence-base for postnatal care provision.
Schmied, Cooke, Gutwein, Steinlein, Homer (2008)	Time to listen: Strategies to improve hospital-based postnatal care	SYD, AUST	Action research	Midwives designed and implemented strategies to provide better postnatal care within a hospital setting. Important principles: relationship, individualized care, flexibility, continuity
Homer, Passant, Brodie, Kildea, Leap, Pincombe, Thorogood (2007)	The development of national competency standards for midwife in Australia	AUST	Multi-method, staged approach. Purposive sampling	Minimal competency standards to be implemented within Australia, to contribute to accountable, safe and effective practice.
Yelland, McLachlan, Forster, Rayner, J., Lumley (2007)	How is maternal psychosocial health assessed and promoted in the early postnatal period? Findings from a	VIC, AUST	Mixed methods: Interviews Postal survey	Various methods of assessment, skills range mix. Implement strategies that give care providers quality guidelines and skills for problem detection. Requirements: Reorganisation of care, time provision, individualized care,

Author, Year	Research topic	Country	Methods	Contribution to this research
	review of hospital postnatal care in Victoria, Australia			continuity of carer.
Forster, McLachlan, Yelland, Rayner, Lumley, Davey (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	VIC, AUST	Mixed Methods Questionnaire Interviews	Issues with staffing ratios and mix, patients mix, prioritization of labour ward over birth suites, use of agency/casual staff. Impacts on continuity of care. Recruitment and retention are problems.
Hunter (2006)	The importance of reciprocity in relationships between community-based midwives and mothers	UK	Article based on ethnographic study	Four key relationships identified: balanced, rejected, reversed and unsustainable. Understanding the concepts enhances will assist in improving outcomes given the increased focus on professional/client centred care. Further education and research is needed.
Zadoroznyj (2006)	Surveillance, support and risk in the postnatal period	SA, AUST	Review Of two services provided by SA government.	SA attempt at caring for women with early PN discharge: Home carer—good outcomes. “One off” visit by Child & Youth Nurse, with follow-up as necessary. Recognition that supporting women in the early postnatal period emphasizes the normal birth process. Early intervention for “at risk” women available, due to surveillance.
Forster, McLachlan, Yelland, Rayner, J. & Lumley (2005)	PinC. A review of in-hospital postnatal care in Victoria. Final report.	VIC, AUST	Mixed method	Postnatal care diverse and complex. Staffing constraints, visitors contribute to not providing women-centred care. Review staffing ratios and mix and postnatal care design.

Table 2.6 Midwives’ views of postnatal care

Mothers’ views of postnatal care

There were seventeen available articles that comprehensively explored this category. Of these articles outlined in Table 2.7, eight were based on qualitative studies, eight were based on quantitative research and one study was based on a mixed method study. The studies originated from Australia, Norway, Sweden and the UK. Many of the studies included hospital and home care in their field of enquiry, so the results are based on the broad range of postnatal care, not specifically focused on domiciliary postnatal care.

Postnatal care generally rated less favourably than other episodes of maternity care (S. Bailey, 2010; S. J. Brown et al., 2004; Yelland, 2009). Interactions with caregivers, communication, listening, staffing levels, leadership and empowerment of women are key and should be taken into consideration when restructuring care (Cooper & Lavender, 2013). Yelland et al (2009) affirmed although there have been strategies to improve postnatal care, such care still requires restructuring if it is to meet the needs of mothers in the community. Issues such as antenatal education, skill enhancement, improved communication for midwives and continuity of care were cited as the main areas requiring improvement. A study conducted in 2012 revealed that mothers were happy with their postnatal care at home, in a non-medicalised environment, taking a more active role in their postnatal care (Hocking, 2012). Cooke and Stacey (2003) reiterated that mothers who have given birth previously still require care, and their multiparity is not an excuse to provide less or inferior care.

Author, Year	Research topic	Country	Methods	Contribution to this research
Cooper & Lavender (2013)	Women's perceptions of a midwife's role: an initial investigation	UK	Qualitative, focus groups	Themes: empowerment influence of midwives; influences of media, friends and family; role of monitoring and technology; and influence of doctors. Model of care and care provider influence women's perceptions of midwife role.
Hjalmhult, Lomborg (2012)	Managing the first period at home with a newborn: a grounded theory study of mothers' experiences	Norway	Article based on grounded theory	Due to early postnatal discharge trends, Knowledge is lacking in how mothers deal with the first period at home with the baby. The idea that giving birth is a simple and normal situation may obscure the importance of seamless healthcare and the need for professional support and information.
Hocking (2012)	Exploring women's experiences of postnatal care at home	VIC, AUST	Phenomenological	Women were positive about home-based postnatal care provided by hospital midwives. Overall global theme of "my space" where are takes place in a de-medicalised environment where women and families can participate more fully.

Author, Year	Research topic	Country	Methods	Contribution to this research
Hildingsson, Sandin-Bojo (2011)	"What is could indeed be better"—Swedish women's perceptions of early postnatal care	Sweden	Quantitative, longitudinal study. Questionnaires	Mothers were generally dissatisfied with the various models of care, did not meet their expectations. Further study needed to asses the best model of postnatal care that provides the best opportunity to give satisfactory care.
Bailey (2010)	Postnatal care: exploring the views of first-time mothers	UK	Report based on qualitative research, interviews	Visits by healthcare workers at home are valued. Care provision varies in content, setting and pattern. Even mothers with no provable problems require support. Need to rethink the factors that motivate care provision from organizationally driven to mother-baby centred.
Fenwick, Butt, Dhaliwal, Hauck & Schmied (2010)	Western Australian women's perceptions of the style and quality of midwifery postnatal care in hospital and at home	WA, AUST	Cross-sectional, self report survey. Quantitative	Contributes to our understanding of what women want from their postnatal care: Consistency Availability Emotional care Information about other resources Education about practical matters Women have been satisfied with their care when received as domiciliary care—the traditional model of hospital postnatal care is not a necessity for satisfaction.
Rayner, McLachlan, Forster, Peters & Yelland (2010)	A statewide review of postnatal care in private hospitals in Victoria, Australia.	VIC, AUST	Mixed method design.	Recommend further research to provide evidence-based postnatal care.
Homer, Passant, Brodie, Kildea, Leap, Pincombe, Thorogood (2009)	The role of the midwife in Australia: Views of women and midwives	Each state and territory, AUST	Multi-method Qualitative data=32 midwives interviewed Women's descriptive surveys=28	Barriers to practice: Invisibility of midwifery regulation and role Domination of medicine Workforce shortages Institutionalized care Community lacking clear image of expectations and role of midwife.
McLachlan, Gold, Forster, Yelland, Rayner, J., & Rayner, S. (2009)	Women's views of postnatal care in the context of the increasing pressure on postnatal beds in Australia	VIC, AUST	Focus groups, interviews	Women expressed preference for the familiar not responding well to redesigned postnatal care packages.

Author, Year	Research topic	Country	Methods	Contribution to this research
Schmied, Cooke, Gutwein, Steinlein & Homer (2009)	An evaluation of the strategies to improve the quality and content of hospital-based postnatal care in a metropolitan Australian hospital	NSW, AUST	Pre/post test design Key test—“one to one time”.	Hospital routines difficult to change. Midwives require skill development and time to listen adequately.
Yelland, Krastev & Brown (2009)	Enhancing early postnatal care: findings from a major reform of maternity care in three Australian hospitals	VIC, AUST	Pre/post test surveys. Key test—implementation of postnatal care initiatives.	Postnatal care rates consistently lower than other episodes of maternity care. What is it about the midwifery culture that can be explored and addressed in order to improve the outcomes of postnatal care.
Forster, McLachlan, Rayner, J., Yelland, Gold & Rayner, S. (2008)	The early postnatal period: Exploring women’s views, expectations and experiences of care using focus groups in Victoria, Australia.	VIC, AUST	Exploratory study	Themes: fear/anxiety, transition to motherhood/parenting. Availability of professional to alleviate anxiety is essential, also the ability to deliver individualized care.
McKellar, Pincombe, Henderson (2006)	Insights from Australian parents into educational experiences in the early postnatal period	SA, AUST	Action research	Window of opportunity for education whilst still an inpatient is significant, despite reduced length of stay postnatally. Family centred, individualized care is valued. Fathers have different learning needs, direct education of fathers reported as lacking.
Brown, Davey, Bruinsma (2004)	Women’s views and experiences of postnatal hospital care in the Victorian Survey of Recent Mothers 2000	VIC, AUST	Survey	Half of participants rate postnatal care as “very good”. Midwives too rushed, busy. Staff not always sensitive. Support, advice not very helpful. Adverse view of short LOS. Lack of continuity of carer.

Author, Year	Research topic	Country	Methods	Contribution to this research
Ockleford, Berryman, Hsu (2004)	Postnatal care: What new mothers say	UK	Semi-structured interviews	Low staffing levels apparent to mothers, who at times discharged themselves early. Mismatch between expectations of postnatal care provided in hospital and actuality. Midwives provide care at home, recommendation for research regarding the support provided for women in the home. Issues similar across two cultures.
Cooke & Stacey (2003)	Differences in the evaluation of postnatal midwifery support by multiparous and primiparous women in the first two weeks after birth.	SYD, AUST	Quantitative Self-report questionnaires	Primips require wider range of care. Multis also require care, in spite of widely held belief that they don't require care. 1/5 of women didn't have their postnatal needs met. 40% did not have their health needs met.
Brown, Darcy & Bruinsma (2002)	Having a baby in Victoria 1989-2000: continuity and change in the decade following the Victorian Ministerial Review of Birthing Services.	VIC, Australia	Population Surveys X3	Vast changes to maternity care in that period. Positive attitudes to midwifery led units. Increasing number of women accessing shared care. Increased need for domiciliary midwife due to decreased LOS.

Table 2.7 Mothers' views of postnatal care

Breastfeeding and the role of the midwife

The literature search identified a heavy emphasis on breastfeeding in the role of the domiciliary midwife. Following an electronic literature search using *breastfeeding* and *midwife* as cue words, twelve articles were identified as relevant to this study. These are outlined in Table 2.8. Five articles were based on quantitative research, five were based on qualitative methods and two were peer-reviewed articles for a textbook and a journal. In all they represented six countries.

Midwives are trained and well placed to provide breastfeeding education and support at all stages of the pregnancy, birth and postnatal continuum. Some midwives advance their training to become Lactation Consultants (LC), but LC's do not have to be midwives. Midwives may provide education antenatally and in the

postnatal period for up to six or seven weeks (Australian Government, 2012; Australian Government, 2010), however, this is unusual. The literature has confirmed the significance of the midwifery role in the adherence to successful breastfeeding rates, with combinations of education, advice, encouragement, consistent advice, continuity of care and practical support.

The World Health Organisation has recommended (World Health Organisation, 1996) that babies are exclusively breastfed for six months or at least four months following birth. Midwives are in a position to support that recommendation, and many hospitals have employed a “baby-friendly” initiative whereby guidelines are visible and reinforced to encourage adherence to exclusive breastfeeding (Finigan, 2010).

McKeever, Stevens and Miller et al (2002) identified a list of duties to be carried out at each postnatal visit, to improve breastfeeding rates, to ensure that each task could be quantified. This had relevance to my study in relation to area of research, however it was not based on a critical perspective, nor conducted in an environment where a culture of home visitation is the norm.

An extensive critical ethnography on the organisational culture within a postnatal ward was conducted by Dykes (2005) focusing on breastfeeding initiation and adherence. The study revealed midwives were kept “profoundly busy” and unable to establish relationships with their clients, leading to unmet needs by the mothers and dissatisfaction for the midwives (Dykes, 2005). Although it focused on care within the hospital grounds, this study was of significance to my research. Specifically it was insightful regarding the oppressed nature of midwives and women in this cultural setting.

Author, Year	Research topic	Country	Methods	Contribution to this research
Henderson, Redshaw (2011)	Midwifery factors associated with successful breastfeeding	UK	Article based on quantitative data collection (survey)	Antenatal decision about infant feeding method is the most powerful predictor of breastfeeding, but midwives also may influence the decision. Continuity, consistent advice, practical help and encouragement are important.

Author, Year	Research topic	Country	Methods	Contribution to this research
Backstrom, Wahn, Ekstrom (2010)	Two sides of breastfeeding support: experiences of women and midwives	Sweden	Article based on a qualitative study (interviews)	Midwives aim to give individualized care to women. Important to spend time watching women BF to correctly assess and advise. Continuity of care important for the women and consistency of advice between colleagues.
Burns, Schmied, Sheehan, Fenwick (2010)	A meta-ethnographic synthesis of women's experience of breastfeeding	AUST	Meta-ethnographic literature review	Contrasting themes emerged: Connected vs. disconnected and expectation vs. reality. Provides insight into subtle ways that health professionals can build maternal confidence and improve the experience of early mothering.
Finigan (2010)	Baby-friendly hospitals: What can they achieve?	UK	Midwifery Textbook chapter. Peer reviewed	Implementation of baby-friendly hospitals improve breastfeeding outcomes. Midwives have a significant role to play by implementing "ten steps" to successful breastfeeding.
Sheehan, Schmied, Barclay (2009)	Women's experiences of infant feeding support in the first 6 weeks post-birth	NSW, AUST	Article based on grounded theory	Good support is achieved through more than good education. Sensitive individualized care is paramount for improvement in BF outcomes.
Bashour, Kharouf, AbdulSalam, Tabbaa, Cheikha (2008)	Effect of postnatal home visits on maternal/infant outcomes in Syria: A randomized controlled trial	Syria	RCT	Postpartum home visits significantly increased breastfeeding rates but did not change other morbidities or outcomes.
Hannula, Kaunonen, Tarkka (2008)	A systematic review of professional support interventions for breastfeeding	Finland	Systematic Review	Interactive conversation important for BF rates. BFHI and "hands off" teaching significant. Home visits, telephone support and BF centres with peer support helpful.
Blincoe (2007)	Advice about infant nutrition: A vital role for the midwife	UK	Scholarly article Peer reviewed	Midwives are well placed to give advice about breastfeeding and appropriate breast milk substitute, as required.
Furber, Thomson (2007)	Exploratory study of providing newborn feeding support for postpartum mothers in the hospital	UK	Grounded theory	Midwives were time-poor in hospital setting. Rationed time and resources to cope, thereby impacting on success of breastfeeding.

Author, Year	Research topic	Country	Methods	Contribution to this research
Forster, McLachlan, Lumley (2006)	Factors associated with breastfeeding at six months postpartum in a group of Australian women	VIC, AUST	RCT	Use of predictive model: breast or formula at six months. Hospitals to address: Formula in hospital High body mass index Maternal depression. Consider interventions for women who display risk factors, but have expressed their desire to BF.
Dykes (2005)	A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England	UK	Critical ethnography	The organizational culture of the hospital within the postnatal ward kept midwives profoundly busy and unable to establish relationships with women. This in turn led to unmet needs (emotional, esteem, information, practical support).
Hunter (2004)	The views of women and their partners on the support provided by community midwives during postnatal home visits	UK	Qualitative, interviews	Themes: experience of the parents, support needs, structure of visits,. Need more practical help especially breastfeeding. Continuity of carer important.
McKeever, Stevens, Miller, MacDonell, Gibbins, Guerriere, Dunn, Coyte (2002)	Home versus hospital breastfeeding support for newborns: A randomized controlled trial	US	RCT	More mothers of term babies were breastfeeding following early discharge with home visit follow-up, than mothers who received standard length of stay. Home visits were attended by certified LCs/midwives.

Table 2.8 Breastfeeding and the role of the midwife

Midwifery role and women's mental well-being in the postnatal period

A further aspect of the role of postnatal midwives that repeatedly appeared in the literature searches was the mental well-being of women in the postnatal period. Electronic searches that included women's mental health following childbirth and the role of the midwife revealed just over 2,500 articles. Most of the articles did not include the midwife's role in their field of interest, and many were aimed at a different stream of academia, with much discussion about medical management. I reviewed thirteen more closely because they specifically assisted me to understand the postnatal context and the role the midwife may undertake in this period.

Of the thirteen articles outlined in Table 2.9, three were based on quantitative studies, two were mixed methods, one was based on qualitative studies and seven

were non-research peer reviewed scholarly articles. Four countries, Australia, France, UK and US were represented.

Postnatal depression (PND) affects 10-15% of women in the postnatal period (Bick, 2003). Post-traumatic stress disorder affects 2-6% women post birth (Gutteridge, 2007) thereby posing a significant problem. The literature reflects that midwives are well placed to recognize mental health issues both in the antenatal and postnatal periods, therefore it seems reasonable that this forms part of their role.

The literature recommended that the midwife's role with regard to mental health is in antenatal screening for increased risk factors, as well as recognition of changes or deterioration in mental health, especially in the postnatal period. Many of the articles discussed midwives' use of tools for detecting or predicting PND, and recommend further training in counselling skills to assist midwives with their care of women.

The literature differentiated between "baby blues", postnatal depression, post-traumatic stress disorder, puerperal psychosis and other health problems and stresses that midwives should refer clients on to other health professionals when out of their scope of practice.

Some of the literature has suggested that providing a woman a "one off" opportunity to reflect on her birth may be of assistance. While this may be of benefit if done well, others (M. Bailey & Price, 2008; Bick, 2003) reiterated that if "debriefing" is conducted ineffectively, it may be further detrimental to the woman.

The articles that focused on the midwife's role in care of women with regards to PND did not differentiate between care within the hospital or home. The literature discussed the necessity for postnatal midwives to be able to screen, detect, manage and counsel as part of that which forms the role of the domiciliary postnatal midwife (Gamble & Creedy, 2009; Jardri et al., 2010; Leach, 2010; Posmontier, 2010).

It was evident that a widespread assumption in most of the articles was that postnatal care is carried out in hospitals, not the home. These studies did not identify or discuss the changing face of postnatal care and specifically the new reality of early discharge. Most articles were focused on terminology, timing of emotionally laden discussions, tools for screening and detection, and further education of midwives.

Although Bick (2003), Madden (2002), Driscoll (2006), Gamble and Creedy (2009) provide thoughtful frameworks for service provision, these articles do not explore the role of domiciliary midwives in relation to women's mental health, when domiciliary midwives visit women in their homes.

The literature (Bick, 2003; Gutteridge, 2007; Madden, 2002; Tully, Garcia, & Davidson, 2002) has reiterated that midwives need further training to be effective in caring for women's mental health needs.

Author, Year	Research topic	Country	Methods	Contribution to this research
Jardri, Maron, Pelta (2010)	Impact of midwives' training on postnatal depression screening in the first week post delivery: a quality improvement report.	France	Article based on original mixed methods research	Screening used by midwives improved early detection of PND.
Leach (2010)	Postnatal debriefing: not just for traumatic births	UK	Scholarly article review	Benefits of midwives debriefing birth. Reduction of risk of postnatal depression.
Posmontier (2010)	The role of midwives in facilitating recovery in postpartum psychosis	US	Scholarly article	By using the Recovery Advisory Group Model as a framework for caring for women with postpartum psychosis, midwives can facilitate empowerment, provide emotional presence, provide psychoeducation to decrease the fear of the illness, and decrease barriers to recovery. Midwives can be instrumental in assisting patients through a psychiatric crisis while under the care of mental healthcare professionals.
Gamble, Creedy (2009)	A counselling model for postpartum women after distressing birth experiences	NSW, AUST	Article based on original research	Midwives well placed to provide a counselling intervention. Focuses on growth through adversity, midwives don't need extensive psychotherapeutic training.
Bailey, Price (2008)	Exploring women's experiences of a birth afterthoughts service	UK	Grounded theory	Women who have unresolved issues from birth can benefit from a "one off" discussion with a midwife.
Gutteridge (2007)	Making a difference	U K	Scholarly article	Increase in mental health issues postpartum. Midwives well placed to provide care. Need more training. Role of midwife expanding as public health issues becoming more prevalent.

Author, Year	Research topic	Country	Methods	Contribution to this research
Yelland, McLachlan, Forster, Rayner, Lumley (2007)	How is maternal psychosocial health assessed and promoted in the early postnatal period? Findings from a review of hospital postnatal care in Victoria, Australia.	VIC, AUST	Mixed Method Postal Survey Interviews	Although postnatal maternal mental well-being is a stated aim, midwifery practice is diverse and sometimes haphazard.
Rothman (2006)	The health visitor's role and postnatal depression: an overview	UK	Scholarly article Peer reviewed	Role of midwife antenatally to detect risks, history of depression or mental health problems. Focuses on first visit at home (10-14 days post birth) to support, detect, refer as necessary.
Driscoll (2006)	Postpartum depression: How nurses can identify and care for women grappling with this disorder	US	Scholarly article Peer reviewed	Provides strategy for nurses (and midwives) to identify and manage PND
Sanders (2006)	Assessing and managing women with depression: a midwifery perspective	US	Scholarly article Peer reviewed	PND a significant problem. Midwives should be adequately trained to screen, diagnose, refer and manage to improve outcomes.
Bick (2003)	Strategies to reduce postnatal psychological morbidity: The role of midwifery services	UK	Scholarly article	Management of mental well-being is necessary. Midwives are well placed but need more training to detect and refer.
Madden (2002)	Midwifery debriefing- in whose best interest?	UK	Interviews, theory development	Midwives well placed to debrief or listen to women's story following childbirth. Mostly done in hospital setting. Requires rethinking to become more effective.
Tully, Garcia, Davidson, Marchant (2002)	Role of midwives in depression screening	UK	Article based on original quantitative research	Maternity units are involved in PND screening but training, referral and support systems appear inadequate.

Table 2.9 Midwifery role and women's mental well-being in the postnatal period

Miscellaneous other roles of midwives

There were many responses to the search words *role* and *postnatal midwife*, and most were focused on medical management and other technical information beyond the scope of this study. Table 2.10 outlines sixteen articles that were specifically reviewed because they related to areas of care provided by postnatal

midwives and they highlighted the multitude of tasks in midwives' scope of practice in the postnatal period. Of the sixteen studies selected, nine were scholarly articles, four were based on qualitative study, one report to a health service, one systematic review and one quantitative study. The articles were generated from the UK, Australia, Canada, South Africa and the US.

The literature indicated that the role of the postnatal midwife, and often the domiciliary midwife, is to conduct the following services in management and education of mothers and babies: midwifery care of mother and baby and mothercrafting skills (Hawkins, 2010; Nyasulu, 2012; Shaw, Levitt, Wong, & Kaczorowski, 2006), public health issues such as education and referral (Biro, 2011; Byrom & Symon, 2011), maternal obesity challenges and dietary advice (Keating, 2011; Venter, Clayton, & Dean, 2008), newborn examinations and hearing screening (Biernath, 2009; Mitchell, 2003; Niccoll, 2009; Townsend et al., 2004), engaging with fathers to promote breastfeeding (Sherrif, 2011), contraception and sexual health advice (Norris, 2007), and, midwives caring for women with special needs such as asylum seekers and adolescents (Dunkley-Bent, 2006). Additionally, one article highlighted the teaching role that midwives play, modelling midwifery skills to students and junior midwives (Bluff, 2003). It is strongly evident that domiciliary midwives have varied and complex skills to utilise however current practice dictates a specific skill base to each care provider.

Author, Year	Research topic	Country	Methods	Contribution to this research
Nyasulu (2012)	Community-based, family-centred postnatal care: The midwives' role	South Africa	Scholarly article	Midwives should take a lead in providing postnatal care. Frustrations with dominance of medical model. Continuity of care is critical. Work with communities and families for effective care. Offer: practical, emotional and cognitive support. Timely decisions.

Author, Year	Research topic	Country	Methods	Contribution to this research
Biro (2011)	What has public health got to do with midwifery? Midwives' role in securing better health outcomes for mothers and babies	VIC, AUST	Scholarly article	Midwives are well placed to have a profound effect on the health of mother and babies. It is important for midwives to recognize this and take up the challenge by re-defining and extending boundaries of care.
Byrom, Symon (2011)	Developing the midwife's role in public health.	Scotland	Report	Prevention Education Recognition Referral to improve maternal/infant outcomes.
Keating (2011)	Using the postnatal period to help reduce obesity: The midwife's role.	UK	Scholarly article Double blind peer reviewed	Midwives may use their postnatal relationship to educate and support women regarding obesity. Visit at 6 weeks to obese women to slow the epidemic. Develop plan, offer support, assess feelings and reflect on problems obesity presents.
Sherrif (2011)	Engaging and supporting fathers to promote breastfeeding: a new role for Health Visitors?	UK	Qualitative interviews	Fathers are interested in breastfeeding and want to be more involved and prepared to support. They want more relevant and accessible information and details about practical support.
Hawkins (2010)	The midwife's role in facilitating maternal-infant bonding and attachment.	UK	Scholarly article based on published theories and literature.	Midwife's role in improving bonding and attachment in perinatal period is significant. Listening, recognition of problems, support groups, one-on-one time, referral, empathy, skin to skin contact with baby, breastfeeding.
Lawler (2010)	Women with disabilities: the midwife's role and responsibilities	UK	Scholarly article	Maternity services are not meeting the needs of pregnant women with disabilities. Describes specific issues needing to be addressed and how the role of the midwife in this.
Biernath Holstrum Eichwald (2010)	The midwife's role in infant early hearing detection and intervention	US	Scholarly article	Midwives have a role to play in detection and diagnosis of hearing problems in infants.
Niccoll (2009)	Examination of the newborn: The innocent heart murmur	UK	Case study	Midwife's extended role of the examination of the newborn. Discussion about the need, timing, competencies, mothers' satisfaction.

Author, Year	Research topic	Country	Methods	Contribution to this research
Venter Clayton Dean (2008)	Infant nutrition part 2: the midwife's role in allergy prevention	UK	Scholarly article	Midwives are the first point of information regarding allergy prevention. Identify children at risk of developing allergies. Relate current recommendations re: food, breastfeeding, weaning, BMS.
Norris (2007)	Is there a role for the midwife in contraception and sexual health services?	UK	Scholarly article	Currently contraceptive "talk" is given postnatally, hurried, non-specific. Midwives could include more extensive family planning and sexual health in their scope of practise but are already weighed down with other roles. They would need specialized training. Includes antenatal screening.
Dunkley-Bent (2006)	Reducing inequalities in childbirth: the midwife's role in public health	Scotland	Scholarly article	Discusses midwife's role in caring for asylum seekers and adolescents.
Shaw, Levitt, Wong, Kacorowski (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	Canada	Systematic review	In spite of programmes addressing the need for timely postnatal follow-up following discharge, no RCT's had been carried out to address success or outcomes of these.
Townsend, Wolke, Hayes, Dave, Rogers, Bloomfield, Quist-Therson, Tomlin, Messer (2004)	Evaluation of an extension of the midwife role including an RCT of appropriately trained midwives	UK	RCT	Trial of midwives carrying out neonatal screen at 24 hours show that it would be cost effective, safe and improve mother's satisfaction. Midwives would require suitable training.
Bluff (2003)	Learning and teaching in the context of clinical practice: the midwife as a role model	UK	Grounded theory	Discusses the differing ways that midwives model their work. Obstetric nurse to autonomous midwife.
Mitchell (2003)	Midwives conducting the neonatal examination: Part 2	UK	Article based on unstructured interviews	Midwives carry out the routine examination of the neonate prior to discharge. Mothers and midwives both satisfied with the expertise as well as the opportunity to educate women.

Table 2.10 Miscellaneous other roles of midwives

Other assistance at home in the postnatal period

In an attempt to ensure that women are adequately cared for, studies have investigated working with non-professional carers, such as doulas and also support groups. Table 2.11 summarises three articles reviewed in this category. The respective studies were: an ethnographic study; mixed-method and a quantitative based study. In each of these studies, non-professional yet trained assistants were evaluated for their effectiveness working alongside or adjunct to midwives. The focus was on mothercrafting skills, especially breastfeeding in the postnatal period, in the woman's home. Non-professional yet trained supporters increase breastfeeding rates and duration of breastfeeding.

It was reported that recognising the scope of the midwife's role is diverse and as there is a shortage of midwives, the use of support groups and trained assistants should be taken seriously to decrease the midwife's workload and ensure best outcomes for women and babies (Ingram, Rosser, & Jackson, 2005; McCormish & Visger, 2009). One of the recommendations was that midwives could be better educated to refer women to these services or groups, as available, in order to improve outcomes. At times, midwifery roles overlap with a doula's role, so there is the possibility of enlisting support from these services, provided that values and goals are congruent with current midwifery policies (Moran, Dykes, Edwards, Burt, & Whitmore, 2005).

Author, Year	Research topic	Country	Methods	Contribution to this research
McCormish, Visger (2009)	Domains of Postpartum Doula Care and Maternal Responsiveness and Competence	US	Article based on ethnographic study	Eleven domains of care emerged which included the whole family, household organization, referral, education, self/infant care, emotional support and advocacy.
Ingram, Rosser, Jackson (2005)	Breastfeeding peer supporters and a community support group: Evaluating their effectiveness	UK	Mixed Method. Focus groups, questionnaires	Peer supporters combined with a breastfeeding support group are an effective way of increasing length of breastfeeding where previously BF duration rates have been low.

Author, Year	Research topic	Country	Methods	Contribution to this research
Moran, Dykes, Edwards, Burt, Whitmore (2005)	An evaluation of the breastfeeding support skills of midwives and voluntary breastfeeding supporters using the Breastfeeding Support Skills Tool (BeSST)	UK	Article based on quantitative surveys of midwives and BF supporters	The non-professional support group has the breastfeeding support skills necessary to provide adequate assistance for breastfeeding mothers. Midwives require further education to improve outcomes.

Table 2.11 Other assistance at home in the postnatal period

Chapter summary

Appropriate postnatal care is necessary for healthy outcomes for mothers and babies. Transitions in postnatal healthcare service provision have been largely haphazard, with very little evidence-based research informing significant decisions in postnatal care, particularly domiciliary care.

There are suggestions for possible expansions of the domiciliary scope of practice. While there has been renewed interest in postnatal care, there is a paucity of literature informing the direction of home-based care, even though there is an increased need for domiciliary care. Much of the literature reviewed has combined hospital and domiciliary postnatal care in their study, assuming that the needs of women and role of domiciliary midwives are the same as in hospital-based care.

The literature that discusses the role of the postnatal domiciliary midwife discusses that role in general terms, and does not provide in-depth information regarding the role and experiences of the postnatal domiciliary midwife. Part of the issue is that most of the research is quantitative.

Consistently, the studies have recommended that further research is required to ensure evidence-based care. Yet there remains a paucity of research that considers the perspectives of the practitioners. A research study, conducted from a critical ethnographic perspective will provide much needed information regarding the current role and experience of the postnatal domiciliary midwife.

Chapter 3 – Methodology, Methods and Processes

Chapter overview

Chapter three explores the methodology, methods and processes that underpin this research study. I begin with introducing the research design, specifically, qualitative methodology and critical ethnography. I follow with a detailed discussion of the research methodology and methods inclusive of the choices for the research design. I address the significance of the choice of methodology, and provide an overview of the main tenets of critical ethnography. I provide distinct explanations of the choices of qualitative, critical theory and ethnography, highlighting the contribution that each theory brings to the study and the way in which, when entwined as a methodology, they are complementary.

The research processes to ensure consistency within the critical paradigm are then addressed. I first discuss the ethical processes and then the critical processes.

Methodological considerations: An overview

The choice of theoretical approach is crucial to generate and therefore capture rich data. As Silverman (2006) and Taylor and Roberts (2006) have stated it is critical there is congruency between the research, research paradigm and the research question therefore this discussion begins with addressing the links between the choice of methodology and its congruency with the research question.

Therefore, in order to explore the role and experiences of domiciliary midwives, a qualitative epistemology with a critical ethnographic methodology has been chosen. There are three components of the methodology, they flow and link to each other as conceptualised in Figure 3.1. The following is an explanation of these choices.

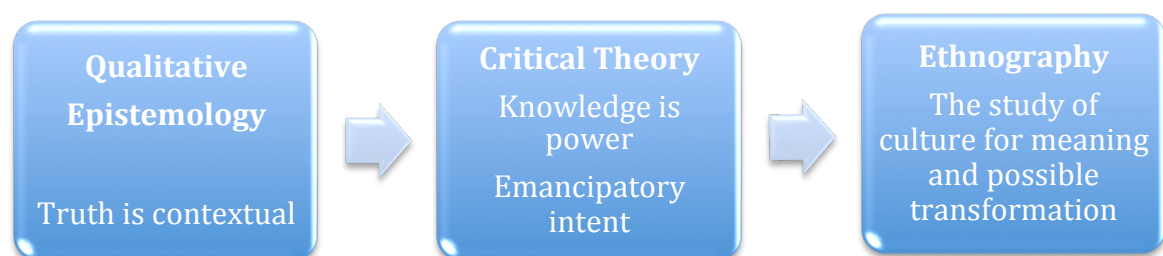


Figure 3.1 Research methodology

There are three philosophical components that form my research methodology; these are the choice of a qualitative epistemology, critical theory and ethnography. This is visually represented, to emphasise the flow from qualitative epistemology to critical theory and ethnography. The following is a discussion of the three philosophical components that have been highlighted in figure 3.1 and comprise “critical” rather than traditional or conventional ethnography. I have also included an explanation of critical science and feminist theory to enable the reader to follow my thought processes of choice and inclusion or exclusion methodology.

Qualitative paradigm

In order to faithfully undertake and present the findings of this research study, it was necessary to explore qualitative and then critical philosophical assumptions. The exploration of research paradigms enabled me to place this research study within the chosen philosophical framework. An important aim was to ensure the selection of an appropriate ontological and epistemological paradigm, which enabled congruency between the research question and methodological choices (Walter, Glass, & Davis, 2001).

To begin with, it was necessary for me to explore and understand several theoretical concepts that subsequently impacted on my choice of methodology. I was conscious that these following concepts were significant for how I conducted the research, “lived” and thought about my professional being.

The first concept is ontology. Ontology, which is the study of “being”, of existence, is focused on the question of what is “real” and was important for my research. My ontological view is a philosophical assumption regarding the nature and construction of reality. The second concept was epistemology. Epistemology, the study of knowledge, what it is and how we come to know, was also important. Specifically I focused on what it is, and how this knowledge can be explained. I viewed knowledge as related to one’s beliefs and also considered how one might discover knowledge about the world (Crotty, 1998; Grbich, 1999).

A qualitative approach recognises that for each person, the truth may be different. Meaning and context are significant in that they influence our understanding

of the social world. A qualitative researcher believes that the truth lies in gaining and understanding of the behaviour, beliefs and values of others, from within the participant's context (Creswell, 2007).

Therefore in qualitative epistemology, truth is contextual. To consider this I needed to further reflect on two broad categories of thought and approaches to research: qualitative and quantitative. I shall now discuss the qualitative paradigm together with the ontological and epistemological premises, to support my choice for that approach. This is followed by a brief description of the quantitative approach, as a way of justifying my reason for its exclusion as a methodology for this research study.

Qualitative epistemology accesses knowledge "embedded ontologically in life experiences" (Walter et al., 2001, p. 267). Therefore to gain an understanding of an individual's experiences required an understanding of their lived context in their words. Subjectivity is of utmost importance because of the value placed on the participant's lived experience. The "truth" of any situation is integrally linked to the person's experience of a situation, circumstance, occurrence and/or phenomena.

Qualitative epistemology places the researcher at the centre of the research addressing "the relationship between the researcher and that being studied as interrelated, not independent" (Creswell, 2007, p. 247). The researcher is not an objective information gatherer. Therefore by utilising a qualitative epistemology I will be focusing on methods and processes that utilise and highlight individual's reflections on their unique experiences.

Qualitative research is a broad area of research that values the lived, unique experiences of individuals and therefore places the researcher in the natural setting of the person being observed (Creswell, 2007). Importantly, context and people's voices cannot be separated. This may be in conjunction with any number of other social theories and a variety of methods, however they have commonalities: Qualitative epistemology assumes that knowledge is context-driven, therefore the "truth" is dependent on a plethora of factors such as, and not limited to, socio-political values and personal experiences. Qualitative studies value the subjective ideas,

experiences and voices of the group being studied (Grbich, 1999; Taylor & Roberts, 2006).

Qualitative research may be expressed in many different ways. Dependent on the theoretical perspective of the researcher, the research may be informed by feminist, postmodern or critical theories then applied through ethnographical, action research or discourse analysis methodologies. The methods qualitative research uses allow for scope to capture context; they may be questionnaires, interviews, focus groups, participant observation, narrative or journalling (Crotty, 1998; Taylor, 2013).

The strength of qualitative research is its ability to study individual perspectives or situations in a manner that honours the individual's unique situation. It was therefore intentional in this research to listen to domiciliary midwives' experiences of their professional lives and as such, place value on their opinions and portrayed stories. This inquiry focuses on subjective, human experience, and so a qualitative research philosophy was chosen.

Alternatively, a quantitative epistemology presumes there is a single truth and this can be found by carefully measuring and observing variables (Grbich, 1999). Research findings are presumed to be predictable and generalisable to all members of society in a value free manner. Quantitative epistemology does not take into account meaning or context or the influence of the social world. In quantitative research, the researcher is seen to be independent of the research, value-free. Studying the roles and experiences of domiciliary midwives from a quantitative perspective would not have revealed the depth or richness of data that would have been possible in a qualitative study. There would not have been the scope for the stories and experiences to be showcased, and significant themes may have been overlooked because the theoretical assumptions of quantitative research are significantly contrasted. Quantitative studies do not necessarily validate the participants' lives or contexts, as there is very little opportunity for individuals' experiences to be heard or told. Validation of the participants, through listening to their unique stories as well as utilising empathetic engagement (Glass, 2010) with their experience were important actions for me to express through my research.

Therefore a quantitative approach was considered inappropriate and was excluded for this research question.

Given that the focus of the research is on the role and the experiences of postnatal domiciliary midwives, and that their working lives are unique and subjective, the application of a qualitative epistemological and ontological paradigm was selected. A discussion of critical perspectives in research particularly focusing on possible emancipation by increasing knowledge for participants follows.

Critical perspectives

Critical social science is a broad umbrella term for theories that are focused on social change and emancipatory intent. It encompasses critical theory as well as feminist theory. The term *critical social science* may be used to encompass qualitative methodologies that are focused on emancipatory aims. Critical social science often refers to critical theory as well as feminist theories. Feminist theories observe, analyse and highlight the lives of women, in a given context, with the explicit aim of liberating women from their oppressed circumstances (Rose & Glass, 2008), whereas critical theory aims to increase knowledge of participant oppression irrespective of gender, to create opportunities for liberation from unequal power relations (Creswell, 2007).

At times I have drawn on knowledge derived from feminist theorists. This is because it is emancipatory in its approach, and aligns with my research aims. I also acknowledge that domiciliary midwives are predominantly female, thereby proposing that feminist theory could have been an appropriate possibility for this research methodology. However, I have been mindful of the constraints of a Master's degree and believe that even at its earliest inception, the selection and application of critical theory would appropriately highlight many of the issues and inequalities that I particularly wanted to illuminate.

Critical theory is the name of a tradition of critical reflection of society inspired by Marx and previously, Hegel and Rousseau. Critical theory reflects on the practices of society; it critically analyses social structures and social institutions from the point of view of their dominating effects on individuals within that society (Haugaard &

Cooke, 2010). This term has become most recognised for the theory developed in Germany from the 1920's onwards, which arose from the Frankfurt School.

The members of the Frankfurt School emphasised sociological research to develop a critique of power, as opposed to a long line of positivist thinking that focused on facts, measurements and objective data. Critical theory argues that society, and the forces of power within it must be examined and understood within the context of its own history—political, social, economic and sociological. It presupposed the right, liberty, individuality and equality of a person or group of people (Kaplan, 2003). Further, the integration of understandings should provide the opportunity for society to improve its situation and rearrange the power structures within it. Critical theory falls within emancipatory paradigmatic research.

Two other seminal theorists whose critical and/or postmodern theories have influenced the development of social critique, are Foucault (1977) and Freire (2006). The seminal work of Foucault and more specifically, his theories regarding governmentality, power and the co-determinants of power (Lemke, 2002; Schirato, Danaher, & Webb, 2012) have demanded the questioning of embedded, and often, legitimised power structures within society. Brazilian philosopher and educator Paulo Freire also developed pivotal critical theories regarding oppression and liberation (Freire, 2006) that have influenced the dialogue contributing to social critique and humanisation of the oppressed. The following is an overview of critical theory.

Critical theory seeks to change power structures by understanding the experiences of real people in context, it interprets the acts and symbols of an observed society in order to understand why they may be constrained or oppressed. Critical theory also seeks to examine social conditions, so that hidden structures contributing to oppressed states may be uncovered. With knowledge of the dominating themes in a social context, any group of people, consequently, have the ability to transform their social environment.

Oudshoorn (2005) has succinctly summarised Agger's tenets of critical theory on oppression, exploitation and domination. Critical theory presents a possibility for a future free of oppression, exploitation and domination. Oudshoorn (2005) explained that domination is structural and that these structures are reproduced through a

false-consciousness. If people become aware through knowledge and illumination of the structures and false consciousness, they have the power and responsibility to discontinue perpetuation of dominating circumstances.

In relation to midwives, it has been documented that they are an oppressed group, in subordination to both medicine and nursing (Fahy, 2007). Historically, nursing and midwifery in Australia came under the legal and disciplinary control of medicine during the period 1886-1928, which diminished any self-determining power held by midwives. Currently, many decisions regarding care provided by domiciliary midwives are determined by government policy, medical opinion, and availability of resources and midwives' own beliefs regarding their abilities and scope of practice. Critical theory has asserted that knowledge is power (Creswell, 2007; Kincheloe & McLaren, 2002), therefore, by increasing knowledge and understanding of the context of domiciliary midwifery practice there are possibilities for change in the status quo.

Embedded within critical theory is the process of analysis, sometimes also referred to as critical social science that is necessary to transform research enquiry from description to an emancipatory paradigm (Fay, 1987). Critical theory refers to the outcome that is the liberation or improvement of human circumstance, however it is the process of analysis and critical reflection of knowledge, which then leads to the possibilities of improved circumstances.

As previously mentioned, the process of critical theory involves critique of the structures that lead to the dominating themes in people's lives. The following are significant concepts and tenets underpinning critical theory process: knowledge, oppression/emancipation, power/empowerment, marginalisation and silence/vulnerability. These concepts are entwined, and although I will address them separately, in fact, each concept is dependent on the knowledge of each other concept.

Critical theory and knowledge

Critical theory has an interest in generating and utilising knowledge with an orientation toward freedom. Knowledge is not gathered for its own sake, as a bank of

stored data; instead critical theory espouses “the human capacity to be self-reflective and self-determining” (Kendall, 1992, p. 6) with the new information gathered. Critical reflective knowledge, once acquired, is considered liberating. Once this emancipatory knowledge is acquired, the focus becomes the power relationship between theoretical knowledge—what I now know—and the objective domain of practical social life—what life actually is—due to distorted systematic communication (Kendall, 1992). Emancipation is not always a product of enlightenment, however it increases the possibility of freedom from a constrictive context. It was aimed that knowledge gained through this research would provide a means to reconsider the position of domiciliary midwives, thus provide the impetus for action, leading to a shift in power.

Critical theory and power (empowerment)

Much of our understanding about power is influenced by the definitive work of Foucault (Foucault, 1977, 1979; Lemke, 2002), who was concerned with how people or groups wield power over another person or group, especially minority groups. Power has been defined as “the ability to do or act” (Oudshoorn, 2005), however, he conceded that this definition lacks the complexity required to capture the many aspects that explain power. He theorised that power is the ability to change circumstances, to produce a specific effect and is therefore the possession of control, influence or authority. With power, one may achieve one’s desired, planned goals and objectives with the use of resources at one’s disposal. It may be seen as an energy that enables individuals to do or achieve what they want (Fahy, 2007). In the midwifery context, resources may take the form of physical or intellectual property as well as emotional energy.

Power may take the form of having “power over” other people either to influence decisions or outcomes—known as oppression. It may take a legal form or a disciplinary form (Fahy, 2007). Legal power is that which is used by the police and courts, whereas disciplinary power is that which may be used in a more subtle or manipulative approach, to persuade people to submit to one’s demands in a voluntary manner (Fahy, 2007).

However, power has been conceptualised as having a non-zero sum (Oudshoorn, 2005) which means that when someone gains power (that is, empowerment) it does not imply that someone else is losing it. Theoretically, there is enough power for all parties to experience a self-determining level of control, with an infinite quantity available. When empowerment occurs, all who are involved gain from the process because there is a collective gain of power (Oudshoorn, 2005), therefore power may be seen as a positive concept.

Empowerment is the gaining of power. Kaplan (2005) expands on the main tenets of empowerment as follows: it may be considered both an outcome and a process, or a form of intervention. As an outcome, empowerment is seen as producing a positive self-concept, self-efficacy, a sense of hopefulness, well-being and good health. As a process, empowerment is a partnership between individuals that strengthens individuals' positions, giving them more control over their circumstances. The possibility of domiciliary midwives gaining power in the workplace is therefore a positive concept for all involved in the institution, as there would be a collective increase in self-determination, professional and personal satisfaction, therefore it may be an intervention. Empowerment addresses the problem of oppression and marginalisation.

Critical theory and oppression and emancipation

Critical theory also uses the theoretical lens of oppression and emancipation to process and analyse research data. The outcome of a group or an individual exerting power over another group or individual is oppression. Emancipation is freedom from that oppression with a redistribution of power so that a person or individual will have the power to achieve the goals they aspire to, and the ability to self-determination (Freire, 2006). Glass (1998) speaks of the "double whammy" of oppression where nurses are oppressed as nurses and as women. Similarly, midwives are also effected by a "double whammy" of oppression due to their oppression by both medical and nursing agendas (Fahy, 2007). Due to the fact that the critical researcher's area of interest is in power relations within a society, their focus is often on those people who are "on the margins", or those who are

marginalised irrespective of being on the margins, such as midwives in a respected profession.

Critical theory and marginalisation

Marginalisation and the factors that contribute to that experience are therefore central themes when carrying out critical theory based research. The aim is to raise understanding and awareness of people's conditions and create opportunities for correction of oppressive situations (Freire, 2006; Rose & Glass, 2008) so that there is minimisation of oppressive and marginalised experiences.

Marginalisation stems from our understanding that there are dominant themes or socio-political positions operating with a group of people. There may be many dominant themes operating, and it is the analysis or critique of the dominant marginalised power relationship which forms the basis for critical theory (Kincheloe & McLaren, 2002). Analysis of power relations and the marginalised must come from the voices and experiences of those who are oppressed. Marginalised people may reflect on their own situation, and develop their own language and symbols, which is why they should be given the opportunity to express their stories, opinions and experience. The language may not be easily understood by others (Meleis, 1996), however a researcher has the task of co-presenting the marginalised voice in a manner that is enlightening to all who read it. Vocalisation of the experiences of the oppressed is imperative to ensure that changes in power relations emanate from accurate, contextual knowledge imparted by the person(s) being oppressed. Marginalised people often have difficulty in vocalising or being heard. They often lack the opportunity and resources.

Critical theory and silence/vulnerability

Vocalising one's needs and opinions is usually equated with self determination and self expression, whereas silence is often associated with passivity, acquiescence and powerlessness (Gardezi et al., 2009). When individuals or groups experience marginalisation, they are often silenced; their thoughts are "unsaid" (Glass, 2003a,

2003b) and consequently they experience a loss of their power and their rights to resources (Oudshoorn, 2005).

Silence does not always indicate a lack of understanding or passivity; Gardezi et al. (2009) and Glass (1998) have contended that silence is not a straightforward reflection of powerlessness. Silence may be a form of resistance, or it may be defensive or strategic.

As I gather and analyse data, I will be cognisant that silence could mean many things, and not take for granted that silence is agreement with the status quo or lack of understanding of circumstance.

Moreover, I am aware that vulnerability can be a positive experience for individuals, particularly when it is verbalised. A critical and postmodern analysis of research on nurses explored the importance of a cognitive reframing of vulnerability (Glass & Davis, 2004). In this research discussions on the concepts of silencing and vulnerability were articulated as positive experiences for participants (Glass & Davis, 2004).

As it has been documented that midwives are oppressed (Fahy, 2007), my aim is to give voice to the previous held silences that may be apparent for my research participants. This is intentional to provide a means for shifting the power relations by highlighting and therefore valorising the voices of the domiciliary midwife participants.

Ethnography

Ethnography may be used as a methodology and a method. For the purposes of this research study, it was, indeed, employed as both. Ethnography is the study of culture and a group of people within that culture. Therefore the people are studied within the context of their common patterns of behaviour, (Creswell, 2007; Grbich, 1999; Roper & Shapira, 2000; Van Maanen, 1988). Domiciliary midwives share specific, common goals, experiences, beliefs and values not necessarily shared by midwives who work within a hospital environment. Therefore a unique midwifery culture will be researched within the context of the domiciliary midwife's daily workplace.

Ethnography has its roots in early 20th century anthropology. Creswell (2007) explained that the traditional approach was observational, with the researcher reporting dispassionately about their findings. Anthropologists such as Boas, Malinowski and Mead collected data through first-hand experience, however reports of the culture were given in third person, with no attempt to portray the culture from the participant's point of view, and with no intent for change or emancipation. Ethnography has developed from solely traditional interpretative perspectives to now also include critical and postmodern emancipatory approaches.

Critical ethnography has developed from an advocacy/participatory approach (Creswell, 2007; Francis, 2013), whereby people and their culture are studied and the researcher becomes a voice for advocacy and change. The end result is a portrait of a people expressed in written or visual forms that can often be recognised by the individual participants and, subsequently, can provide possibilities for transformation of their circumstances. Critical ethnography requires that the researcher is actively participating within the context of the interactions and experiences of the participants, not merely listening to stories out of context. The researcher is then able to get close to the participants and portray accurately and authentically, the issues and experiences that are integral to the participants (Glass, 2007) .

Leninger and McFarlane (2006) argued that understanding of culture within a group of people has been the missing link toward comprehensively understanding health and healthcare. Therefore, a critical ethnographic study that focuses on context including political, economical, resources, belief systems, patterns of behaviour and relational issues has the ability to increase our understanding of any group of people. It may powerfully influence the choices they make, the factors that influence those choices and provides some means to improve the situation in which they find themselves (DeLaine, 1997; Glass, 2007; Kincheloe & McLaren, 2002).

Qualitative methods

Methods design

Within this section I will discuss the choice of methods, including an in-depth discussion of the four chosen methods. One of my main priorities and responsibilities as a researcher was to accurately and safely represent the voices of the domiciliary midwives who carry out postnatal care in women's homes. The methods were specifically chosen to ensure congruency between the research question, the critical ethnographic methodology and the collection and analysis of data. Furthermore, the methods were chosen to ensure that by observing, participating, recording and reflecting upon the culture of the domiciliary midwife, their role and experiences were faithfully represented. With these principles in mind, these were the chosen methods:

- Participant observation
- Field notes
- Critical conversations
- Reflective journalling

These methods have been regularly and successfully applied in previous qualitative research studies, (DeLaine, 1997; Green & Thorogood, 2004; Taylor & Roberts, 2006) and are dependent on each other for their rich development, as conceptualised in figure 3.2. In a critical ethnography, participant observation creates an environment for critical conversations, as well as field notes and reflective journalling. The circular quality of the four methods indicate that this process of observing, writing, reflecting and conversing keep informing each other. As the researcher's understanding and expertise changes, and rapport with the participants grows, so will data become rich, leading to a more accurate representation of the role and experience of the postnatal domiciliary midwife. I will now explain more fully the selection of these methods and the value they bring to this qualitative study.

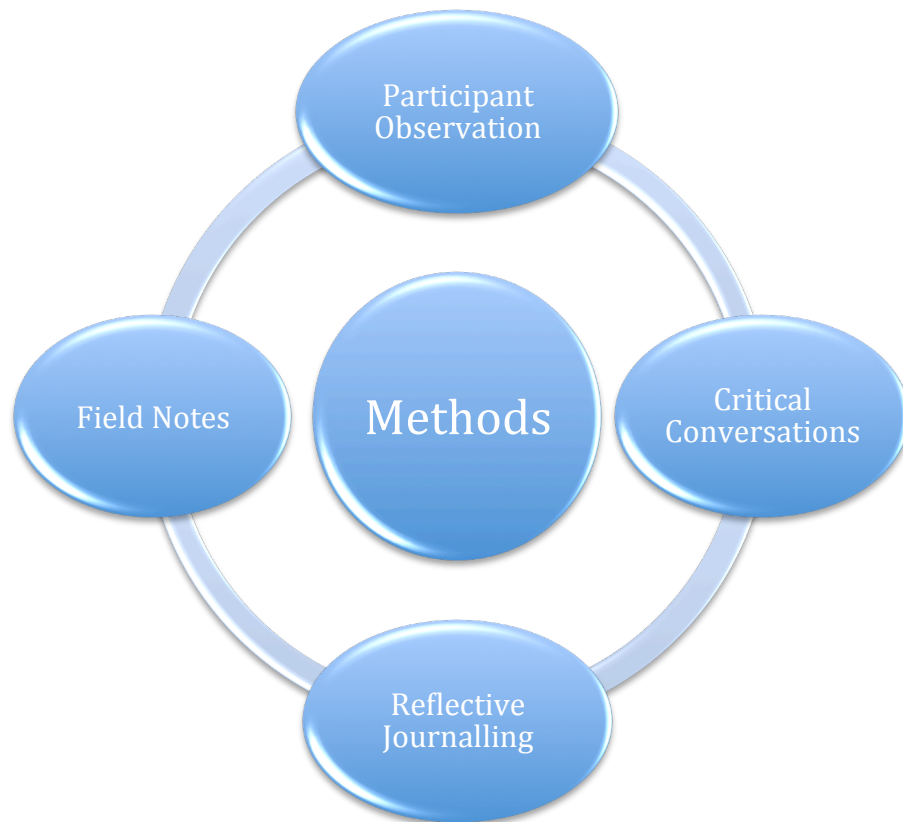


Figure 3.2 Research methods

Participant observation

One of the values that underpinned my choice of methods was the belief that domiciliary midwives were a distinct sub-cultural group within midwifery and as such, conducted their work in unique ways to their colleagues. Therefore participant observation of their work context and approach to caring for mothers and babies would provide me with a greater in-depth understanding of their role and experiences.

It has been previously stated that researchers are able to more faithfully represent and empower the participants if they are active participants in research (Davis & Taylor, 2006), Therefore by being directly involved, my aim was to capture several visual “snapshots” of the role and experience of domiciliary midwives.

By utilising participant observation, much of the information gathered will be obtained by intensive contact and immersion in the culture (Roper & Shapira, 2000; Van Maanen, 1988). Such a method will provide me with many opportunities to

observe and engage with the participants for an extended period of time. I reflected on the amount of time required to develop a rapport with my participants, be immersed in the environment and also gather accurate data for analysis. Due to my professional employment as a midwife and my higher degree study commitment, my supervisors and I determined that approximately 16 hours would be spent with each participant in their normal workplace. As this time period was planned to be over several days or weeks, the aim was that this would provide for opportunities to build rapport, have critical conversations and observe participants in the many circumstances that comprise their work life. Furthermore it was agreed that the time frame of 16 hours was only a guideline, and could be adjusted depending on the progression of the research project.

Participant observations would include behaviour and conversations in the context of real life situations such as managing client loads, engaging with clients in the hospital and at home, liaising with colleagues in a variety of situations, travelling to and from client homes, liaising with other allied health professionals and other supportive skills regarding mobility and occupational health and safety issues. It was further proposed that the intense and extensive time would also allow me to more fully understand the significant issues in their world, providing an opportunity for more detailed questioning and clarifying any uncertainties. These informal yet significant conversations are known as critical conversations, (Davis & Taylor, 2006) and will be examined more comprehensively in the ensuing sections.

My aim was to enter the field as unobtrusively as possible, therefore I considered my clothing and research “equipment”. I was not sure if a uniform was worn, however I knew that if I looked “smart-casual”, I would not stand out too much, or put undue pressure on anybody as I shadowed participants in their work.

Located onsite as a participant observer would also place me, the researcher, in the midst of the field research. A central tenet of critical theory is that the researcher is able to experience rapport and empathy with their participant through immersion in the context. There has been much discussion about the role of participant observers in ethnographic literature. Mere observation belongs to traditional ethnography, dispassionately reporting on research findings. Critical

ethnography encourages participation of the researcher in their study, by immersion in the culture. However, it comes with a warning that “going native” may also be problematic if the researcher is not wary. Therefore, after each observation I planned to put in place strategies to ensure self-reflection, frankness and self-disclosure of bias (Walsh, 1998). The complex threads that influence my experience as a researcher and findings, needed to be transparently processed. Frequent discussions were planned with my supervisors along with my researcher reflective journaling, the latter being an additional research method.

There are two bodies of written data generated from participant observation and critical conversations—that of field notes and that of researcher reflective journaling. I shall now discuss field notes, critical conversations and reflective journaling, which form the remaining three methods.

Field notes

Field notes are literary snapshots of the behaviour, situations, interactions and environment observed by the researcher with the participants (Creswell, 2007; Francis, 2013). Grbich (1999) emphasised the importance of meticulous primary data in the form of stories and quotations. Importantly, the significant amount of time spent with the participants is crucial to the analysis. These quantities of time would allow me to observe many interactions, to feel familiar with the participants and their context.

I shall observe for cues such as body language, facial expressions, interactions with clients and colleagues, which provide rich information, not otherwise gathered from interview-only style data collection. The aim is to put into words the meaning of experiences that domiciliary midwives find in their workplace.

My intention was to take some written notes at the time of participant observation, however not to the detriment of my observation and involvement. Making decisions regarding whether to take notes in the field would depend largely on the responses I received from the participants. Therefore I planned to be flexible and be responsive to their preferences regarding note taking and voice recording. I planned to record more detailed observations and interactions as field notes, from

memory, within 24 hours of the interaction, to ensure accuracy. These field notes, written from my experience of participant observation and critical conversations were to provide raw data for my research analysis.

Critical conversations

Participant observation, trust and rapport with the participants enabled me to carry out critical conversations. Vital information may be gleaned through informal conversations that Davis and Taylor (2006) describe as “akin to friendship” (p. 201). These informal conversations are known as the research method “critical conversations”. I recognised that my ability, as the researcher, to promote critical conversations would be dependent on my ability to ensure the participant feels safe and comfortable to share their views. Having worked as a domiciliary midwife, I was aware of some of the mores of the culture and I anticipated I would be able to move within the work cultures with opportunistic sensitivity and without causing offence. Furthermore it was planned with the consent of participating midwives, recordings of these critical conversations were to be made for further analysis and reflection. Critical conversations were expected to occur during participant observation, both onsite at the hospitals, “on the road” to and from domiciliary visits and off site during meal breaks. The majority of critical conversations were anticipated to occur “one-on-one”, however there may be some that eventuate while in the company of other midwives or colleagues on site.

I developed a list of possible questions that I may ask participants (Appendix 1), as submitted to the ethics committee at the health network. The questions, while reflecting my aim to explore the role and experiences of the postnatal domiciliary midwife, were at no point designed to be used in a formal interview style. They would be informal and reflexive, open to explore the issues that the participants appear to want to share and also dependent on the direction that our conversation would take. These conversations, whilst allowing the participant to share, would also be influenced by our interactions. I was hoping that although they would share facts about their role, its breadth and depth, they would also share their experiences and feelings about the diversity and complexity of their role. I assumed these

conversations might include positive and negative aspects of their work. I was hoping to hear stories that signpost their journey, assisting me to understand their experiences and views of being a postnatal domiciliary midwife. My aim was to use a variety of questioning techniques from open-ended and closed-ended questions, probing and expanding questions to ensure the generation of rich, meaningful and accurate data (Grbich, 1999).

Researcher reflective journalling

This method would provide an opportunity to record my thoughts, experiences, feelings and reflections gathered through the course of this research study. It may include reflections on conversations with other researchers, midwives and relevant informants. It was hoped that as other researchers have found, reflective journalling will assist in providing signposts along the way of how my thoughts would change, when I had dilemmas to process or when I had illuminating moments (Delgado-Gaitan, 2002).

Journalling would also provide a process to record input from other research writings either in the form of research articles or text, which may be used to develop themes or approaches in the research journey. The process of reflecting and continually modifying one's understanding incorporates reflexivity. This method situates the researcher directly within the research and subsequent research process, while also providing an avenue for the researcher to expose and question their own influences and power issues in the attempt to accurately represent the culture under research (Finlay & Gough, 2003; Grbich, 1999; Shakespeare, Atkinson, & French, 1993). Rather than denying the researcher's own biases or emotional responses to the process, I planned to embrace the subjective nature of the research process thereby enhancing the data (Rose & Glass, 2008). I will discuss reflexivity in more detail later in this chapter.

In order to gather significant information, it is important to carefully recruit and select the participating domiciliary midwives. The participants will be a purposive selection of between six and ten domiciliary midwives working within a government

health network within Victoria, Australia. The following is a discussion of participants and their selection.

Participants and their selection

In order that the observation is truly representative of the culture, it is recommended using informants who have experience with, and who are part of the culture being studied, in order to gather rich, informative data (Green & Thorogood, 2004; Speziale & Carpenter, 2007). The following is a discussion regarding the development of participant inclusion criteria and recruitment strategies developed to enhance my participant selection process.

Inclusion criteria

It was my aim to recruit experienced midwives, immersed in the domiciliary culture. The criteria for inclusion was based on much thought surrounding my own experience as a domiciliary midwife and discussion with my supervisors. However I also had three conversations with domiciliary midwife managers at the health network I hoped to access, and following these I developed criteria for inclusion that I believed would provide the possibility of rich and representative data. The following are the criteria I submitted to the university human research ethics committee in November 2011.

- The recruitment of between six and ten domiciliary midwives who work for a government hospital within metropolitan Melbourne.
- Domiciliary midwives who work at least five shifts per fortnight.
- Domiciliary midwives who have provided domiciliary care for at least two years, to ensure experience and significant enculturation to this unique environment.

Participant recruitment

The recruitment of participants should be carried out in a manner that is both effective and appropriate for the possible research design and setting. Sometimes it is necessary to collaborate with significant people in the field, to gain insight into the

available resources, settings and manner in which participants may be effectively recruited. Roper and Shapira (2000, p. 34) have referred to people who hold significant information and control of information as “gatekeepers”.

The possibility of a research study was to be discussed with two midwife managers within a tertiary network to see if they would be supportive of the research study. At this time information about the purpose, methods, ethical issues and recruitment was to be provided and discussed with the gatekeepers. Based on my midwifery experience, discussion with my supervisors and preliminary discussions with the ambulatory manager in particular, the following strategies were to be used in the recruitment of participants for research regarding the role and experiences of the postnatal domiciliary midwife in metropolitan Melbourne. A strategy to alert potential participants at the target hospital was to be submitted to the ethics committee for approval, it included the following features:

- Posters were to be placed throughout the maternity sections. The poster would include a brief description of the study and researcher contact details.
- Several ten to fifteen minute information sessions regarding the project would be run at the commencement of domiciliary shifts, to raise awareness and provide opportunity to participate in the study.
- Participants could freely contact the researcher should they wish to participate. Once a midwife contacts the researcher they would be given a plain language statement and consent form and any questions would be answered. A mutually convenient time for their period of clinical observation (two or three shifts each) would be made.

An important group of people indirectly involved with this study was the mothers and their families. While they were not research participants, I would require their verbal consent in order to observe and record interactions of the domiciliary midwives who were delivering care. Verbal consent would be requested by the attending domiciliary midwife, clearly stating that the midwives are the object of the study, not the mothers or babies. As mothers give consent, their initials were to be placed on a master sheet with verification initials by the midwife and myself as

researcher. Mothers consenting to involvement in the study were to be given an information sheet and contact information should they require clarification. If any mothers were to decline the request, the domiciliary midwives will not be observed during those specific care episodes.

I have discussed methodology and methods as separate entities, for ease of understanding. However, I have consistently pointed to the fact that much of the philosophy and methods are entwined by the critical processes that underpin and flow through the critical ethnographic paradigm. Ethical and critical processes will now be discussed.

Ethical and Critical processes

Ethical process

In order to protect research participants and other significant groups of people (mothers and non-participating midwives) I developed and submitted an ethics application for approval to an identified government health network and Australian Catholic University. Gaining ethics approval is more than obtaining permission to move ahead with a research study, without regard for human dignity or respect. It is a process that is undertaken to ensure that researchers are “acting in the right spirit, out of an abiding respect and concern for one’s fellow creatures” (National Health and Medical Research Council., 2007, p. 11) (NHMRC). The values that underpin the NHMRC guidelines are research merit and integrity, justice, beneficence and respect. These values are to stay with me during the planning, gathering, analysis and presentation of information in this research study. The health network and ACU guidelines for the ethical approval process are derived from the NHRMC statement.

The committees would review the application with its associated supportive documentation to determine whether the project will be safe for participants and researchers and whether the benefits of the project outweigh any risks associated with it. I estimated that data collection would be completed by December 2012 and applied for approval to that end, however I also clarified that the completion of the study may not be until March 2014.

I submitted my application to the health network where I planned to conduct the research in November 2011. Following some minor changes, I received authorisation to commence data collection in the health organisation in April 2012 (Appendix 2 with identifying information removed). The approval was given for as long as required provided an annual progress report would be submitted. Subsequently an ethics application was submitted and approved at ACU (Approval No. 2012 145V). Although both of the HREC committees deemed this research study “low risk”, I identified that the participants may feel vulnerable when they were being observed and sharing their personal and professional lives. I had a strong desire to honour the importance of their stories and ensure any vulnerability was minimised. For instance I upheld ethical values and protocols as outlined by the health network and the university, to protect and honour the participants. Congruent with the qualitative values of respect and beneficence, ethical considerations of confidentiality and sensitivity will be adhered to (Glesne, 1989; Olsen, 2001).

Integral to critical ethnographical research is the relationship between the researcher and participants. This may be seen in a number of processes that flow concurrently with the study and reflect the ethical process and values previously mentioned. The following outlines significant processes of critical theory, in line with critical and ethical principles to ensure that critical ethnographic values are upheld.

Critical process

An important aspect of the research study to consider throughout the study is the research process. The research process is a description of how the information will be gathered and assembled (Taylor, 2013; Taylor & Roberts, 2006). The research process aims to be transparent and respectful as well as remaining congruent with the critical methodological intent of emancipation. These qualities ensure the plausibility (Koch & Harrington, 1998; Meleis, 1996) or rigour of the research process, contributing to academic integrity and standing up under academic scrutiny.

It is imperative that the qualities and values underpinning the research process have strong epistemological links with the critical methodology chosen

(Taylor, 2013). The values must not only reflect the critical intention of emancipation, but also enhance the process of transformation and emancipation. The following skills and qualities used in the process should all be in operation at the same time, without one quality becoming more important than another. Through transparency, rapport, empathy, giving voice, the value of multiplicity of roles of the researcher and reflexivity, the domiciliary midwives may be given the opportunity to reflect on, and improve their experiences. I begin with a discussion about the value of transparency.

Transparency

Transparency of the research process refers to the researcher's open communication of method, intent and process. This researcher may have certain advantages with prior knowledge of the domiciliary midwife culture. However, this may also be seen as a disadvantage with an inability to recognise issues due to familiarity. Prior work environments will be honestly disclosed in order for readers of the research to put the findings in context. Additionally, any political or philosophical agendas will be made apparent regularly throughout the research findings, to ensure honesty. In addition the quality of transparency is congruent with the critical intent, in order to reduce power issues between researcher and participants (Creswell, 2007).

The value of transparency may also be exemplified in communication styles (Meleis, 1996). Whether communicating verbally, or through the use of written material, it will be important for me to ensure that the midwives and mothers have a clear understanding of the study and their right to participate or decline participation. Similarly, using language that is unfamiliar to them will possibly increase their sense of marginalisation through lack of understanding and a sense of alienation or disempowerment. Using plain or lay language is important to equalise the potential power struggle between researcher and participant. I have developed a plain language statement for both the midwives and women as an explanation of the goals and course of the research study and I will provide space for discussion and explanation of the study. Further, as I progress in the study, I will be prepared to adjust or clarify explanations as required, dependent on the needs of the participants. This reflection and adjustment process is called reflexivity and is discussed more fully

further in the text. I will now discuss the value of rapport, which includes actively seeking the opportunity to provide participants with the ability to gain feedback through discussion between us about the field notes, their biographies and the themes that are developing.

Rapport

Glesne (1989) and Creswell (2007) discussed the significance of rapport in qualitative research. It is integral for gathering of rich data to develop rapport with the participants. Rapport is instrumental in building confidence and trust so that participants are more likely to be comfortable to share information. Significant time spent with the participants is important, because this displays that these people are important, and their stories are of value. Qualities such as warmth, friendliness, approachability, interest, trustworthiness and concern should be evident in the interactions. Importantly, culturally appropriate behaviour is also integral to allay anxieties, reduce distances and build trust between researcher and participant.

When I examined the process of rapport, it sounded very much like friendship, and I asked myself “does this mean I have to befriend my participants?” This led me to reflect on the difference between rapport and friendship. Glesne (1989) described rapport as a relationship characterised by harmony, accord or affinity with a confidence and willingness to cooperate within that relationship. Whereas in friendship, people seek the welfare or company of another because they are held in affection and respect, and because the time spent together is pleasurable. The difference lies in the fact that rapport is a relationship marked by confidence and trust, but not necessarily by like for a person. Glesne (1989) explained that a researcher is possibly able to learn just as much from a person they like, as one that they do not like. The researcher therefore does not have to like or befriend their informant; one may glean much significant data on the basis of rapport rather than friendship, and friendship may well be a result of the time spent with the participants. It will be my intention to develop rapport, rather than friendship, with my participants through honesty, warmth, empathy and cultural respect.

The literature has warned researchers about the hazards of friendship (Glesne, 1989; Van Maanen, 1988), due to the risk of compromised objectivity. As a

critical researcher I will be located within the research and empathy and rapport are values that I will aspire to. However the use of my reflective journal and regular opportunities to discuss my research progress with my supervisors will ensure that I maintain appropriate professional relationships with my participants. Closely linked with the process of rapport is that of empathy, which I shall now discuss.

Empathy

Olsen (2001) described the importance of empathy by the researcher in the research process. Empathy in the context of research is the ability of the researcher to project one's personality into the object of participant reflection. Empathy involves listening to the participant and also understanding their story in the context of their unique situation. The quality of empathy is supportive of the critical intent. Empathy implies that the life and experience of the participant is of value. The existence of an empathic relationship based on effective interpersonal skills has the ability to provide a space for healing by giving voice and valuing the participant's research experience (Glass & Ogle, 2012, 2013). The critical intent of the research study is to liberate and bring about change, therefore the possibility of restoration due to empathy on the part of this researcher is congruent with the critical methodology.

However, Holloway (2011) reflected that we need to show empathy without being sentimental—to show concern in a detached manner, in order avoid over romanticising the story. She warned that we, as qualitative researchers, need to be accountable not only for the choice of data, but also the interpretation of that data, and this could be clouded if we do not effectively process our emotions. This processing is called reflexivity, and will be discussed further in this chapter section.

One of the ways that I will be able to display empathy as a researcher is by “making space” for the domiciliary midwives to share their stories.

Making space

Making space is metaphorical language that sends an evocative picture of a time and place especially set aside for somebody. It has the strong intention to make

sure that person or people have prime position and that all other distractions are swept aside, because at this time and place their story is of the utmost importance.

Ogle (2004) explained the use of “making space” as creating opportunities and giving permission for her nurse participants to find validation in voicing their own experiences. She further highlighted the concept of the researcher and participant jointly voicing this story, rather than the researcher “doing” it for them or “to” them. This concept implies a shift in power base from the researcher to a joint venture, where the marginalised are empowered, where power is equally distributed between researcher and participant. Oftentimes participants have never been asked their opinions or their experiences even though they are participating in research studies and are often curious (Glass & Ogle, 2013). Furthermore researchers have the written skills to project into the professional domain the voice of participants who may not have the confidence or academic skills to present and publish.

Domiciliary midwives providing postnatal care have long been considered “poor cousins” of maternity care (Schmied et al., 2009); they have been marginalized within the medical and midwifery model. With growing need for domiciliary services, these ethnographic research methods provide the means to give domiciliary midwives the space to articulate their experiences, their concerns, as well as their triumphs. This may be also known as “giving or reclaiming voice” (Glass, 2001). It is possible that some of the domiciliary midwife participants may not have been given the opportunity to reflect at length about their circumstances, and as a trusting relationship grows between participant and researcher, more in-depth data, rich with significant information, will be made apparent. It is also hoped that by providing a supportive, safe and collaborative environment, participants will want to share their stories also recognising opportunities for reflection and transformation (Davis & Taylor, 2006). The researcher recognises that while it is desirable that participants are given the space to reflect and possibly transform their circumstances, it may be that participants choose not to take the opportunities for this change. The value of the research is not merely for the potential readers; it is for the participants as they are heard and respected for their experiences (Olsen, 2001).

As the researcher I wear multiple “hats”. I will be observing, listening and interacting from different perspectives, not merely as a researcher. The following is a discussion about the benefits and problems of wearing multiple “hats” when involved in research.

The multiple roles of the critical ethnographer

Ng (2011) illustrated how the oscillation between multiple roles whilst conducting fieldwork enhances the data collection. She identified that her data collection is in fact improved by her multiple identities through her understanding and vulnerability due to these roles. As an ethnographer I will carry multiple roles into the field: a woman, nurse, midwife, lactation consultant, mother, researcher and student. Glass and Ogle (2012) revealed that the multiple roles of researcher, academic and person can enhance interactions in clinical research with participants as well as the broader team who facilitate health related research .

However, the multiplicity of roles and experiences may be perceived as conflicting and potentially inhibiting to the data collection process. Therefore, identification and reflexive processing will be utilised while I am in the field and interact with the participants. This is necessary to successfully accommodate my multiple roles, thereby enhancing the possibilities of collecting rich data. Being an experienced midwife will enable me to gain a sophisticated level of understanding making it possible to communicate easily without needing long technical explanations. However ensuring my assumptions are tested will be necessary. Understanding the nuances of the field and being able to assist is also important so that I do not become a nuisance or liability.

Reflexivity

Reflexivity in critical research refers to the researcher turning a critical gaze on themselves in order to make clear any biases, judgements or beliefs that may be embedded, therefore hindering an honest research process (Koch, 1998; Koch & Harrington, 1998). One of my aims is to address power relations between the researcher and participants, and to equalise these (Finlay & Gough, 2003; Grbich,

1999). Reflexivity is ongoing; it is a dynamic process that is fuelled by data and analysis. As the gathering of new data arouses new emotions, they will be displayed honestly. Therefore the voice of the researcher will be interwoven throughout the research study (Grbich, 1999), rather than reported separately or hidden away.

Koch (1998) suggested that reflexivity becomes a series of “signposts” that assist both the researcher and the reader to understand how the researcher came to their conclusions. Reflexivity recognises that there are multiple realities in our complex world and that the final research product will become a roadmap to many different understandings and participant experiences. The key element is that the reader can see where and why the researcher made certain decisions. Reflexivity is as much as about the researcher bias and experience as about the participant data, therefore it exposes not only the participant, but the researcher too. Koch (1998) also maintained that in raising situations to our consciousness, we are able to monitor the way we deal with tradition, experience and the text.

Holloway and Biley (2011) agreed with the need for researcher reflexivity however they also warned against “narcissism and self-absorption” (p. 971). They identified a balancing act that qualitative researchers are involved in with regard to transparency about self and focusing on participant’s perspectives.

The vulnerability of the researcher, transparency, reflexivity and rigorous analysis of data are congruent with critical theory’s focus on power balance.

Data analysis

The overriding goal of critical ethnography is to emancipate those who are in a state of oppression, strongly influenced by the critical theory component of this methodology. Analysis is to revolve around the thesis question, regarding role and experiences, but this will be filtered through the lens of power imbalance, marginalisation and oppression.

However, the ethnographic component of this methodology also plays a significant role because the domiciliary midwives are seen as a distinct and valid culture within midwifery. The analysis of their stories and experiences through field

notes, critical conversations and reflective journalling entries will provide a unique view of this area of midwifery practice.

My intention is to develop themes that explain the role and the experiences of the postnatal domiciliary midwife as separate categories, however, as the themes emerge, I will be open to reframing this intention if necessary.

There are three main approaches I will take to analyse the raw data for themes that indicate critical issues and any possible links between the role and experiences of the postnatal domiciliary midwife. I have been informed by Hsieh and Shannon's (2005) model to guide my analysis. The three components are: qualitative content analysis—summative; deep data immersion; and qualitative thematic analysis—conventional. However reflections while conducting the research and reviewing field notes form a preliminary component of the data analysis.

First, data analysis will begin when I commence data collection. As I collect and reflect on the data, I will begin to compare what I am observing with literature I have read to see how it compares and contrasts with what I am observing (Grbich, 1999). Additionally, I expect my observations to highlight new information, because of the gap I exposed in my literature review pertaining to the role and experience of the postnatal domiciliary midwife. The themes that begin to emerge during data collection will be preliminary, and open to re-interpretation as new information is gathered. I will also take the opportunity to check some of the emerging themes with the participants for validation and stimulation of further critical conversation. In this sense, critical research is collaborative, and a faithful representation of the experience of the participant and the researcher (Grbich, 1999).

Next, when data collection is completed, I will perform a qualitative content word content analysis, or summative analysis. Due to my familiarity with the field notes, critical conversations and reflective journal entries, I will use a word application to perform specific word counts, to search for repeating words or themes within the raw data. This search will be tabulated.

The second approach is deep data immersion. While this will occur throughout the data collection and analysis, I will be focused at this stage on reading and re-reading my field notes, and additional notes from participant observation and critical

conversations. It is hoped that the process will further immerse me in the data and assist with my understanding of deeper meanings and themes for these domiciliary midwives.

The third approach, qualitative thematic analysis—conventional analysis, will be based on my immersion in the field, and the data. It will involve “sifting and sorting through pieces of data to detect and interpret thematic categorisations, search for inconsistencies and contradictions, and generate conclusions about what is happening and why” (Thorne, 2000, p. 69). Following discussion with my supervisors, it is likely I will initially develop many specific themes, but as I read and re-read, then listen and re-listen to my data there will be a refining process where broader themes emerge to incorporate more definitive themes.

Chapter summary

This chapter has explored the critical ethnographic methodology underpinning this research study, and its selection for congruence with the research question and consistency with my personal ontological and epistemological position. The methodology was followed by a detailed discussion of the methods of ethnography I will utilise to gather data for analysis. The four data collection methods were outlined. A rigorous discussion of the ethical and critical research processes utilised to ensure consistency within the critical paradigm was examined. Finally data analysis utilising qualitative content analysis, deep data immersion and thematic analysis was discussed

The following chapter will discuss the findings of my research study, based on methodology, methods and processes that I described in chapter three and employed in the research study.

Chapter 4 – Results

Chapter overview

This chapter comprises the results of the research study. The chapter commences with the findings and processes related to my entry into the field and the integral interpersonal communication with the gatekeepers.

The midwife participants are then introduced and I reveal a brief biographical portrayal of each person. The significance of the mothers indirectly involved in this study, is then addressed, specifically acknowledging the challenges associated with their involvement and strategies developed to overcome these challenges.

Following this a detailed discussion of the analysis methods will be given followed by the results of analysis. The analysis will reveal a global theme and themes for both role and experiences of being a domiciliary midwife.

The global theme, themes and sub-themes will be discussed in thematic succession as well as a final discussion of the totality of the results, highlighting the complexities and juxtaposed positions of domiciliary midwives. I will conclude this chapter with a summary of the chapter.

Entry into the Field

The field that I chose to study was that of domiciliary midwives, who are employed in a public hospital system. The midwives visit mothers in their homes, following the birth of their babies in a hospital setting. Some of these were only involved in domiciliary care; others work between the maternity units, such as labour ward, postnatal ward and antenatal clinic. Due to the hospital structure, my planning, and specifically, the fact that the gatekeepers were managers of all of these areas, it was within this level of hierarchy that I made my first inquiries.

As with all research the site approval occurred before the selection and determination of the number of participants. There were two sites from which the midwives worked. Both sites were medium sized metropolitan hospitals, however one site had a larger capacity and more services than the second site. The first site was centrally located and the other had a slightly more “rural feel”. In general terms, my data collection began in the public hospital facilities, in the domiciliary offices, and

then progressed to other areas of maternity care in the hospital. However most of the field data was collected “on the road” and visiting women’s homes with the midwives.

Communicating with the gatekeepers

I made some initial inquiries before I entered the field to ascertain whether the health facilities would consider my research project worthwhile. As the website for the health organisation documented commitment to research I was hopeful my research would be perceived positively. Initially I made phone calls to the first site to establish the name of the unit and the title of the manager’s position with whom it was appropriate to liaise. This manager had jurisdiction over three sites. This in itself was challenging because I was required to have several conversations with other staff members before I was eventually led to the appropriate senior manager.

I explained my study in a phone conversation, and at the manager’s request, sent a proposal for her perusal. The senior manager showed a great deal of support for the research project and commented that it would be interesting to hear reflections from the staff of the domiciliary department. She suggested that I would probably recruit enough participants from the largest site, therefore, my ethics application reflected this intention.

Initial contact was made with this manager in November 2011 with eventual entry into the field for data collection in June 2012. Ethics approval from the health network and the university was gained in April 2012, with a modification to multiple site visits in August 2012 (Appendices 2 and 3).

Following ethics approval from the health network and Australian Catholic University, I then emailed a copy of the ethics approval from the health network as well as templates of other supportive documentation to the manager. The required documentation sent was:

- Participant Information and Consent Form version 4, dated 19 March 2012 (Appendix 4)
- Advertising Poster version 2, dated 08 January 2012 (Appendix 5)
- Woman’s Information sheet version 2, dated 19 March 2012 (Appendix 6)
- Client Consent List version 1, dated 08 January 2012 (Appendix 7)

- Plain Language Statement Version 5, dated 19 July 2012 (Appendix 8)

The next step in the process was for the manager, my gatekeeper and I to discuss details of the possibility of a brief first visit to the unit at the first site. Accordingly an email was sent to the managers with the supporting documentation required by the ethics committee. My gatekeeper also sent an introductory email reminding the managers about my research study and requesting time to present information about the study in order to recruit participants.

The email—trepidation and gaining trust

At this stage I was apprehensive due to my novice researcher status. I reflected on several issues: whether my research would be welcomed, whether I would be able to recruit enough participants, if those participants would share their world and experiences freely, and if I would accurately and faithfully portray their stories.

However, feeling somewhat buoyed by the positive nature of my conversations with my gatekeeper, I was surprised to receive a joint email from the domiciliary managers at the site where I was to begin my recruitment and data collection. The following is my reflection on this particular email:

Prior to my first visit with the domiciliary team . . . I received an email from two of the three co-ordinators. They were worried that they were being pushed into participating by their manager and cited “informed consent” as a concern. Also [they were] concerned that their jobs might be in jeopardy if something was reported that the establishment didn’t like. (Journal, 4/6/12)

I also journalled my response:

thank you for your email. I am really glad that you raised your concerns and am happy to chat with you about them before our meeting on Monday. Let me reassure you that before we can carry out any research we would require fully

informed consent from any participants and I envisaged that our meeting on Monday was a preliminary discussion only. I will have participant information and consent forms with me for you and any other midwives to peruse, and will leave them at the hospital to look over at your convenience.

There is no obligation to take part in this study, and should you change your mind about participation, you are free to withdraw at any time without any reprisal from employer or university. Although you have asked . . . [the manager] about indemnity, let me also reassure you that the sources of information are treated with confidentiality and all of the data will be de-identified before analysis and dissemination.

If you would like to discuss this further, or want to know anything else about me before Monday, feel free to call me on [my phone number]. (Journal, 4/6/12)

Although surprised and concerned with the email from the midwives, I was glad that they had asked for clarification. At the very core of critical theory research is respect for each person's truth and transparency of research process. I was able to clarify and allay their fears regarding the research, as well as provide permission to question the research process. Furthermore, coercion or bullying contravenes any ethical research approval that I may have gained. If my research was based upon "standover" tactics, the results would be skewed and inadmissible according to HREC guidelines of integrity, respect for person or beneficence (National Health and Medical Research Council., 2007). The response from the domiciliary midwives after my email of 31/5/12 expressed reassurance and welcome. I was very relieved. I thought my research was over before it was begun!

Building trust

In order to gather rich data, it was important that I gain the participants' trust. Although the email from the managers caused me some consternation, it was, in fact a great tool for building trust. I was able to reassure each potential participant about confidentiality and that the freedom to be included in the study and also withdrawal without consequence is a necessary condition.

There were other issues that I reflected upon which signified my commitment to the critical ethnographic process and therefore the relationship of rapport between myself and the participants. For instance, I pondered what I should wear to each site visit and what I should bring. I was convinced I should blend in, rather than look like a manager with a clipboard. I have been witness on numerous occasions throughout my nursing and midwifery career, to a slightly caustic conversation about managers. In my journal I reflected on a conversation that I've heard many times before:

There she is . . . [the manager] clicking around in high heels and with her clipboard . . . does she actually do anything? Cushy job . . . telling people what to do but not really doing any work. (Journal, 4/6/12)

I choose a neutral and practical look, a shirt and pants, flat shoes, light make-up and to carry a slimline folder as well as my handbag. When I entered the field, I could see that the midwives did not wear a uniform, they wore pants, casual attire, and I believed I fitted right in! My journal entry outlines this reflection:

I pondered on what to wear, do they wear a uniform? From experience, the government sector nurses and midwives tend not to worry about what they wear too much. It wouldn't be like going to a private hospital where there is a more strict uniform code. However, I don't want to stand out, so no skirts, high heels, big clipboards, heavy make-up or heavy perfume. (Journal, 4/6/12)

Another way that I tried to build trust was by respecting their cultural mores and the busy nature of their work. For example, if I could see that a midwife was busy

sorting through paperwork and information to organise her day, I would acknowledge that and give them space to do so. In fact, very early on in the research project, I offered to have coffee while they finished that part of their work, because I could see that one of my midwife participants was a bit flustered:

Shae wasn't expecting me until 8am which put her off guard a little [when I arrived a little early], once again I worried that I'd goofed. We established that I could wait until she'd "sorted out her day" (I knew what she meant, ensuring that the midwives coming in to do home visits for the day were organised) otherwise they'd be delayed in going out "on the road". . . . I waited back in the labour ward tea room. (Journal, 4/6/12)

I only had to do this on one occasion, because the midwives were aware that I understood and was sensitive to their culture. The co-operation went both ways. I was silent when they were busy, however they volunteered information to explain their duties and feelings about their duties.

I believed the participants developed trust in me as they began to let down their guard. They spoke with me and behaved openly, enabling me to gather rich, informative data. Their vulnerability was quite humbling, and as our time progressed together, they expressed a level of excitement to be able to contribute to improvement in their circumstance and overall working lives. We shared humorous stories and I shared some of my own life stories and related to their grumbling and triumphs.

Another way that I expressed my commitment to critical ethnography was the manner in which I spoke with everybody I met. I was conscious of speaking in friendly tones, on an equal footing with both participants and others with whom I came into contact. I was conscientiously aware of being positive in my interactions and specifically, not showing any negative criticism of their work.

One of the most significant ways that I validated the midwives, at the suggestion of my supervisor, was to write a short biographical piece on the participants. Once again, this provided a vehicle for reassessing and reflecting on the

data I had collected and what I knew about the participants, deepening my grasp of the data. The effect of the biographies was twofold: the midwives were curious to know what I had thought of them as people and as midwives. Therefore, these reflections sated some of that curiosity, as well as showed the positive aspects of their unique styles of caring for women and their babies. Secondly, in the context of sharing these biographies, we spoke over a cup of coffee and I either read or showed them a list of provisional themes “whirling around in my head”. They had the opportunity to contribute further and some agreed, questioned, explored and clarified issues further. While I did not record these comments it was similar to a “member check” of my observations. Importantly this checking process enabled the sharing of power regarding what would be uncovered and presented for public scrutiny.

Insider/outsider issues and reflexivity

Ethnographic literature has described the experience of the participant observer as an “insider” and an “outsider” (Allen, 2004; Burns, Fenwick, Schmied, & Sheehan, 2012; Holloway & Biley, 2011; Ng, 2011; Van Maanen, 1988) and there has been much debate regarding the benefits and risks. After reading this literature, this “insider” description told me there were qualities about being a domiciliary midwife and therefore being familiar with the domiciliary culture that would benefit my research. Firstly, being a domiciliary midwife provided much of the impetus for this study. Next, my insider status gave me ideas about the issues that may unfold as the study progressed. Significantly, the insider role often assists the researcher to build rapport and trust with the participants because they know that you have some understanding of their issues, behaviours and cultural mores, and can proceed sensitively into data collection.

The “outsider” title referred to my researcher role, and the ability to collect data without bias. Allen (2004) observed that the literature has polarised insider/outsider debates, however it does not need to be this way. In fact, the skill of reflexivity provides an avenue for transparency and reflection, a process that weaves its way throughout the entire research process from beginning to end. Allen (2004) also stated that in qualitative research, there is always going to be an element of

subjectivity; because the “results” are collected through the eyes of the researcher there is no avoiding the researcher filter. This was my experience. As I prepared, planned, communicated, observed, recorded, reflected and analysed data through this process, I was constantly battling with my place and as such, “my fit”. I had opinions regarding working in hospitals versus independent practice, oppression by the medical model, horizontal violence and my own demons of inadequacy that I had to juggle. All of this was coupled with my strong drive to succeed in this endeavour and to “give voice” to midwives whom I believe have been ignored within their own midwifery system for too long. Further, I had worked in healthcare systems for a considerable time and I felt the pressures of conforming to the well-travelled structures and thought patterns.

I continually reflected, made entries in my reflective journal and dialogued with supervisors in an effort to be transparent about my place in this research process. Sifting through this process was foundational in my thinking and attempting to stay strong in my career. The following journal entry exemplifies the struggle I had to give myself permission to be a researcher:

I have been feeling guilty because I realised that I was thinking like a worker and that if I didn't turn up I'd be letting the team down, and if I don't put in all the hours I'd be shirking my responsibilities. After chatting with Nel and Robyn I realise that I was thinking from the “insider” perspective. I don't have to be “in the fray” because I am observing. I can make some rules of my own. I am REALLY not used to that. For thirty years I have been a part of the hospital establishment in one form or another and it feels almost lazy to be picking and choosing times for data collection. Maybe they are also caught in the system at times and don't realise that some of the decisions they make are because of habit, tradition, obligation. (Journal, 15/6/13)

The following also exemplifies my challenge not to “over-identify” with my participants:

The other day I was talking to somebody about my study. I was pointing out the lack of facilities and apparent disinterest in DOM care. I found myself saying “do you realise we don’t even have a fax machine in our office?”

What is this “we”? I realised I had been identifying VERY strongly with my participants . . . The reluctance I had in gathering data of a sensitive nature was once again, about ME. If I put the midwives in a tricky place, I would be putting ME in a tricky place. Although I don’t want to betray their trust, I also have been reluctant to put myself “out there”. What happens if I get into a confrontation? What happens if somebody questions my research?

Need to find a way to step back a bit from my participants and findings. I think that Nel’s strategy of only going for shorter periods of time will help me to be a bit more objective. (Journal, 6/9/12)

As previously discussed in chapter three, Ng (2011) and Glass and Ogle (2012) oscillation between multiple roles while conducting fieldwork enhances the data collection. As an ethnographer I carried multiple roles into the field: a woman, nurse, midwife, lactation consultant, mother, researcher, student. This multiplicity of roles and experiences while resulting in considerable reflections and moments of reflexivity also enabled me to collect rich data, because they gave me a springboard for more conversations with the participants.

Security issues

I had to address security issues as a researcher at the hospital site. I had to sign in at hospital reception at each site each day I went to “the field”, collect a visitor name badge and then sign it out again. My first day at the hospital I was unaware

that there was a visitor protocol, however I thought I could sort it out with my first visit. Yet, it went a little differently than planned. Shae was not quite ready to see me, so she took me to a staff tearoom to wait for her.

While I waited back in the labour ward tearoom, I felt uneasy. Any moment somebody would question my presence. I tried to pre-empt it by saying “hi” to anybody that walked in; some people asked me who I am and were happy with my answer. After 15 minutes two women, obviously [from] management, came in to look at the whiteboard which listed the names of women admitted to labour ward; they started talking about them then one of them looked at me and said “I’m sorry, who are you?” I told her I am a midwife researcher, studying postnatal care in the home.

“Oh, I can’t see your ID badge”. Whoops, that’s because I don’t have one. She told me where to get one and that I should get one now! She asked me who was my liaison person, I told her the name, really trying not to dob anybody in . . . the woman rolled her eyes “Oh her”. How embarrassing. So much for ethical entry into hospital grounds! And what sort of communication was going on at managerial level that they so obviously disrespected one another? (Journal, 4/6/12)

The midwives

Seven domiciliary midwives chose to participate in this qualitative study: four midwives from the first site and three midwives from the second site. They averaged 15 years of midwifery experience each, with the lowest level of experience at 3 years and the highest at 30 years. Six of the midwives are only involved in domiciliary care within the hospital, with the other midwife working across the full scope of practise. Two of the midwives work as nurses in other settings, part time, and two of them are

studying to become maternal and child health nurses. None of the domiciliary midwives work full time.

Reason for choice of pseudonyms

For reasons of confidentiality, and in keeping with critical and ethical processes, I assigned pseudonyms to the participants. This initially came about suddenly for me, even though I knew I would eventually have to assign pseudonyms. The following is a journal entry:

I had to give a presentation to Uni about my study. I had to come up with a pseudonym for one of the participants because we were to use a quote from her in the presentation.

I quickly came up with “Christie”. Not even sure why except that when I thought about it I had read a book many years ago about a teacher called by that name. A good woman who worked in the wilds of America and taught in a poor village.

Then I got to thinking about more names. How should I choose them? Will I even keep “Christie”, it was after all chosen under duress! I thought about female adventurers or explorers names and looked them up. I wasn’t all that inspired. I’ve gone for some cheeky, quirky names instead [because] these participants have wonderful idiosyncrasies, and in spite of wishing that many things weren’t changing as they are—they are adapting and working well under difficult circumstances. I wanted to give them buoyancy, an up-beat feel. So after much deliberation these are the names I think I will use: Christie, Charli, Shae, Delia, Portia, Ingrid and Giselle. (Journal, 30/12/12)

In spite of the brief journal entry, I spent a long time pondering the choice of pseudonyms. The process of choosing pseudonyms provided a vehicle for reflecting on the characters, roles and experiences of the domiciliary midwives. I was once again “playing” with the data, immersing myself in the minutiae of detail and also, the larger political contexts where the domiciliary midwives find themselves.

I constructed two lists. One of them included the names of seven female sleuths that represent my favourite literary genre, “medieval mysteries”. In fact, one of the names “Delia”, I did change to “Adelia” in deference to one of these medieval characters. As I thought about the personality traits of my fictional characters and my participants, I couldn’t match them flawlessly, and that was not a good enough result for me. In the end, I liked the mixture of old and new names, the loose associations in my imagination between name and participant, which led to my choice of pseudonyms. They represent for me modern, graceful, learned, flowing, investigative and cultural traits.

These reflections built on my understanding and analysis of the data and assisted in laying foundations for the development of themes that I will explore shortly. First, I will introduce the midwives.

Introducing the midwives

1. Shae—The detective

Shae is a wonderful, kind, competent midwife—from the very beginning I became aware that she is on a quest for the truth. Clearly, before we even met, she had been thinking about the information that she thought would be important to share, in an effort to present to the world what it is that domiciliary midwives do . . . She finds great satisfaction in treating women holistically, never settling for the “tick the box” approach. I see this in her questions about the birth, women’s support at home, breastfeeding issues, women’s physical recovery and development of the baby as well as detailed

and appropriate referrals to other health professionals. There is a question behind every question. Shae believes that for women to flourish, and babies to thrive, the home visiting midwife should provide holistic care—as part of a continuum of care provided by the hospital and council . . . Shae also shows great care for her colleagues with her words of caution, experience and advice to keep them safe, it appears that there is a great sense of fulfilment in knowing that her junior colleagues have learned “the ropes” that will keep them safe. Shae’s own personal contribution of playing “detective”, discovering significant information that contributes to women’s well-being seems to give her a huge sense of fulfilment and pride in a job well done. (Journal, 2012)

2. Charli—A well polished sense of humour

It became clear very quickly that although Charli is one of the newer midwives to home visiting, her personal and professional life experiences have given her a special “edge”. Charli not only recognises that the huge variety of circumstances in which women and families live, but also seeks to provide appropriate and individualized care. I appreciated Charli’s honesty about her own personal struggles with health and family issues . . . I think her own struggles have only made her a better midwife, rather than overwhelmed her.

Charli has a great sense of humour, but also the ability to “call a spade a spade”. There are times when the workload of the day, the frustrations of the job and the intensity of the care could be very overwhelming, but Charli carries it all off with a sense of dignity, earthiness and calmness. I am sure that her

ability to find humour under very real pressure helps her to maintain her consistent, thorough approach. I enjoyed my data collecting days with Charli because she has the ability to tell a good story and make me laugh! (Journal, 2012)

3. Portia—*The gatekeeper*

My first impressions of Portia were that she was friendly, competent and approachable. Her long experience in midwifery and specifically DOM, have given her a unique approach to caring for women. Her personal approach also sets her apart, Portia also manages other midwives with competence and an “unflustered” approach, a ready laugh and understanding—which is so important to have in this job . . . Portia displays that characteristic ability to “read between the lines” when a woman’s story unfolds and she is able to grasp a bigger picture of what a woman needs, rather than taking everything on face value . . . But don’t let that friendly face fool you!! Portia is a fierce advocate for women. In fact, she described her role as a “gatekeeper” . . . Portia works very hard with the postnatal staff to ensure that women don’t get caught up in the system’s treadmill. (Journal, 2012)

4. Christie—*The teacher/educator/scholar*

It became apparent fairly quickly that Christie had put a lot of time and energy into not only providing high quality care for women and their families, but that she also has some research-based insight into the need and mechanics for change within domiciliary care. . . . She expressed delight in (at times) seeing

women in hospital and as a domiciliary midwife—then having the pleasure and satisfaction of seeing them as clients in her MCHN role—and the women have expressed their satisfaction in having the continuity of care. She notes that the insight of “knowing” these women for longer than a visit, assists her in providing better care. . . . This insight, in turn, leads her to provide detailed and appropriate handover of care to MCHN, knowing how beneficial it is for both the women and the subsequent MCHN. Both practitioners and women are winners in the long run . . . I can see that she puts her knowledge in to practice: when we spoke about the frustrations of the system, Christie seemed to have a deep understanding of the pitfalls of the system, such as lack of communication and on many occasions has asked insightful and difficult questions of the management in an attempt to bring about better communication and therefore improvement in staff morale and services . . . An empathic confidence in her approach and understanding of broader family issues is her hallmark. (Journal, 2012)

5. Giselle—Experience counts

Giselle is an experienced, senior midwife who is committed to the health and well being of the women and families she cares for. She holds a middle management position at the second site that entails both a significant amount of paperwork, but also home visits. Describing her job as “hands on”, Giselle loves this autonomous aspect of the role and the sense of satisfaction that she gains from her competency. When asked what she enjoys about her job, this was her response, recorded in the field notes:

Well, the ward is “too medical”. I love the independence of the job, and I feel good that anything out there that happens “I can deal with”. I love seeing women in their homes; you meet an array of people that you wouldn’t normally meet and they (mostly) welcome us into their homes. (Field Notes, 30/11/12)

Yet Giselle experiences the frustrations of reduced resources and increasing pressure on the staff to spread themselves thin in order to get women through the healthcare system. I noted that she said:

In the last 6 months we have more people going home with breastfeeding issues, babies with large weight loss—requiring more visits. There are no more midwives to cover the visits . . . and somehow we “just cope”. (Field Notes, 30/11/12)

Giselle spoke of the role of education of women and other midwives, especially junior midwives and how this makes up a significant portion of their work. Giselle talked about “transparency” of information and that she does not perceive herself as an expert with “special” knowledge. She believed that the knowledge and skills should be made accessible to the women so that they are empowered to care for their babies. Giselle said emphatically that she is careful to use positive and encouraging language in her interactions.

6. Adelia—The cyclist-midwife on call

Working with Adelia was a privilege and a pleasure. Her kind and non-threatening manner worked magic with her nervous mothers.

I felt like I had been taken back in time as I travelled around the countryside with her—five minutes after leaving the hospital I was “lost” in a maze of backstreets and unmarked roads. I saw that Adelia enjoyed her knowledge

(geographically) of the area and her independence to get there however she pleased. When I found out that she is an avid cyclist, I couldn't help but compare her to the old fashioned midwife . . . in the recent teleseries "Call the Midwife" that winds her way through narrow streets, seeing women in all sorts of situations and tending kindly (and competently) to whatever situation may be thrown at her.

Adelia likes the autonomy of her work in DOM, she likes being able to assess and make judgement calls on her own and loves the peace and quiet of driving to the next visit. She is a reserved person and I suspect she enjoys a lot of "thinking time" that goes on in the car, especially when the trips are long . . . I saw the difference she made to several women who were anxious about all sorts of issues from breastfeeding to normal baby behaviour and health issues. She calmly "normalised" lots of baby behaviour, physical recovery and breastfeeding issues by using gentle, encouraging language and showing with her body language that she was, indeed, intent on women's concerns. (Journal, 2012)

7. Ingrid—The enthusiast

Ingrid's competency was obvious, matched only by her enthusiasm for looking after woman and babies with complex needs in their own homes.

Ingrid is a friendly, gentle and enthusiastic midwife. Her love for her work as a midwife in women's homes was apparent very quickly. Her face lit up as she spoke to me about her almost incidental journey into midwifery, and subsequent love affair with the women and the work . . . She laughs as she tells

me how she begged the senior midwives to let her do “DOM”, but they kept putting her off because she was not experienced enough. “Now they’ll take anybody—it’s so unfair”! She applied many times before she got her present job and stated “I have the best job in the hospital”. . . . Ingrid loves the insight into people’s lives and the contexts in which they mother. She has her own family to raise and at times has wondered why she spreads herself so thin, but the love of caring for women and helping them to be strong and skilled keeps her coming back. (Journal, 2013)

She says:

When I meet somebody at the door—crying—and by the time I leave they are smiling and hopeful—well, that keeps me coming back, I am reminded that my job is important. (Field notes, 25/11/12)

The mothers

Significance of their involvement

Although the focus of this study was the midwives, the study could not have been carried out as an ethnography if the clients of the midwives did not give permission for me to observe them interacting. It was imperative that I observed the midwives in their interactions with the women and their families to provide a full and rich picture about their role. Furthermore, observing their interactions, preparation for care and management of the women and families enabled me to generate more probing questions that may not have occurred had I not immersed myself in the field. Many of the critical conversations were held in the car, between clients, and as a response to client interaction. It enabled me to compare their stories with their work, to observe and analyse for hidden themes.

Ethics—appropriate documentation for the mothers

In order to meet ethical standards, it was important for these women to have full knowledge of the presence of the researcher even though they were not the focus of the study. Furthermore, having chosen critical theory as a theoretical framework to underpin this research study, it was imperative that transparency and respect of all those involved in the study was seen to be of prime importance. In order to fulfil the HREC guidelines of informed consent, two documents were generated to assist in this process: a client consent form and a women's information sheet. The health network and university ethics committees approved both of the documents.

The client consent form was designed to provide evidence of a conversation where the woman was invited to participate in the study, with clear knowledge of the focus, as well as permission for the researcher to be present at their home visits. The form had provision for the woman's initials, to identify her on the visit list, as well as the signed initials of the midwife who sought permission and the researcher. The woman may have been asked a day or two before she was visited, or on the day of the visit and it may have been in person, or on the phone. Sometimes, while permission was granted, the allocation of visits did not match the researcher's schedule on the day. This possibility was also explained to the women, so they would not be surprised or concerned if the researcher did or did not attend. To my knowledge, no woman declined to be of assistance with the study. If the women were of a non-English-speaking background, this information was relayed through an interpreter, along with the other clinical information the midwives needed to impart.

The client consent list was only used when the woman received a postnatal visit at home, or as an outpatient at the hospital. The midwives performed brief ward rounds at the beginning of the shift, where an introduction, explanation of the domiciliary service and a possible date for a home visit was arranged. It was arranged with the midwives that they would explain the aim and focus of my study then gain permission for my attendance as they spoke briefly. Each woman agreed with my presence as a researcher, especially when they realised that it may assist in the improvement of services.

The woman's information sheet provided a plain language statement of the study and an invitation to participate. It was offered to each woman with whom we came into contact, however a copy was always left with those who were seen in the home setting. The information sheet carried the official logos of both the health network and the university as well as a brief description of the researcher and her professional qualifications. The document assures women of confidentiality and the right to refuse participation, or to withdraw from the study. The information sheet included researcher contact details, in case of any further questions. A sample of this information sheet and the client consent form is in Appendix 4.

The following is a description of how I collected my data using the chosen methods.

Data collection

Data was collected across two sites. Although I initially only gained ethics approval for site one, it became apparent that I would need to go to site two to recruit enough participants. Following ethics modification, I was also able to enter the second site for data collection.

Data collection was based on four ethnographic methods as detailed in chapter three. The following details how I engaged with each research method.

Participant observation involves shadowing or walking alongside the participants while they work. I met each participant in their office, walked with them to the postnatal ward, met with women to organise future visits, visited the special care nursery to see if there were any new clients coming home. I then travelled with each participant in their cars, visited women and families in their homes, listened to phone conversations with clients and other health professionals and even had lunch with them. They were very full field days. Field days were organised between the participants and myself, at a mutually convenient time. A schedule of participant observation and critical conversations is in Appendix 9.

In order to observe and engage with the participants for an extended period of time much of the information gathered was in the form of intensive contact (Roper & Shapira, 2000). I spent approximately 12 hours with each participant in their

workplace, observing their behaviour in the context of real-life situations. Researchers are able to more faithfully represent and empower the participants due to their active participation with the people involved in research (Davis & Taylor, 2006). I approached informants who had experience with, and who were part of the culture being studied, in order to gather rich, informative data (Green & Thorogood, 2004; Speziale & Carpenter, 2007).

The following table provides an overview of the engagement with mothers and the midwives. I have detailed the broad demographics related to the mothers while ensuring I have preserved anonymity.

Types of visits to mothers	Number of visits	Duration of visits
Hospital pre-discharge assessment	28: 7 participants x 2 occasions x 2 mothers.	5-10 minutes
In mothers homes	42: 7 participants x 2 occasions x 3 mothers.	50-60 minutes
Reason for home visit	Caring for mother and baby	Counselling mother following death of baby
	40	2
Parity	First time mothers	Multiparity
	21	21
Ages	Under 20 years	Over 20 years
	4	38
Living arrangements	With partners	With mother's parents
	40	2
Cultural origin of mothers	Australia	Overseas
	28	14
Engagement with participants related to mothers	Hospital	"On the road" and in homes
	7: 1.5 hours for each hospital assessment in postnatal ward and special care nursery x 14 occasions.	42: 3 hours x 14 occasions.
Engagement with participants away from mothers	Hours	Environment
	14	Cafes and car parks

Table 4.1 Overview of conversation details

Whilst I sought permission to voice-record time with the participants, they were all uncomfortable with this and declined. They cited privacy issues of their clients as their major concern. However, they also said they felt vulnerable and thought the conversations would be stilted if recorded. At first, they were cautious of my note

taking in the field. Therefore initially, in participant observations sessions, I observed and wrote only meagre notes. This was deliberate to visibly demonstrate my flexibility and be responsive to the participants' needs. They considered if I was writing "everything" the clients may feel unsafe, and they did not want me to be perceived negatively as a recorder and writer of vital client information.

In relation to data recording, I was disappointed the participants chose to decline this approach. Their data was rich and candid, however, I was aware that the authenticity of the data could be questioned because I would be reliant on my memory and interpretation of events, even though I did subsequently "member-check" my written notes. When the participants stated they would not approve any recordings, I was concerned about whether the absence of verbatim data signified the end of the research project, or at least there would need to be a modification. I was apprehensive about the implications. However, after discussion with my supervisors, it was decided to continue with my own verbatim recording observations for each day in the field, along with notes taken during participant observation. Therefore I actioned this plan: initially, when I had finished the conversations with meagre "on the spot" note taking, I would immediately voice record as much as I could remember on my iPhone, then transcribe and add to those recordings within 24 hours to ensure accuracy.

It was evident that the participants began to relax and settle into the ethnographic process early into the research. It took a couple of visits with the midwives and they realised I was not a threat to their job or their clients. They quickly became comfortable with my presence and in fact enjoyed having company "on the road" and expressed pleasure in having somebody show some interest in what they do. They clearly discussed my presence with each other, and I did not have to repeat the cautious behaviour of the first sessions with the other participants because the groundwork had been laid with the first two midwives. In fact, Christie, commented that she thought I should be taking more notes!

As I became more comfortable as a researcher, and I developed rapport with the participants, I developed greater awareness of the evolving rich conversations. The data told me stories, and gave my information and opinions. However my

reflections were critical particularly when I took these thoughts back to the participants for confirmation. This, combined with the participant biographies, my reflections of each person and their personalities, as well as a list of developing themes, confirmed that I was not omitting key ethnographic data.

Although the participants indicated I was free to take as many notes as I considered necessary, I was never given permission to voice record, and if the subject ever arose, they expressed horror at the thought. In fact, one midwife saw me moving a baby monitor in a mother's lounge room, so that I could sit down and this was initially misinterpreted. This was my reflection of the event:

When we first arrived at this woman's house, it had clothes, toys and papers all over every horizontal surface. The couch only had room for the mother and midwife to sit. I cleared a small patch on a solid coffee table, and asked if I could sit on it. The woman didn't mind, but Charli gasped as I moved a baby monitor from the coffee table to a TV cabinet, Charli said "are you recording me?" I explained that it was a baby monitor. She said, "Oh I got a fright, I understood I wasn't being recorded, then I thought you were." (Field Notes, 29/6/12)

The bodies of data developed from the field comprised participant observations and critical conversations. These included typed written notes and my voice recordings. My researcher reflective journal was the final data component.

Critical conversations were mostly carried out while travelling in participants' cars to and from visits. Importantly, however, I also had a long critical conversation with each participant over coffee, off-site, for further uninterrupted discussion. In these sessions, my aim was to make space for them to tell their stories, to listen to their experiences of being a postnatal domiciliary midwife. Most of them expressed, at first, that they had nothing much to say, however, even the quietest participant had stories and opinions to share. Sometimes I prompted the conversations with a question such as, "How long have you been doing this work?" Other times, I

commented on a visit we had just had and asked how the midwife felt about it. There were other times when it was clear that they had things on their minds that they wanted to share and I did not have to do much prompting at all.

In keeping with critical theory, I was mindful that these midwives were opening their vulnerable selves. Therefore in an attempt to equalise the power relations of the moment, on occasion I would share a story of my own thereby sharing the vulnerability.

My own personal journey of this research process was recorded in my reflective journal. I found that it was a place where I could record facts, reflect on my concerns, challenge my views, reframe my worries and celebrate new strategies. I journalled about my data collection, analysis, the participants, the system, conversations with participants and supervisors, my own professional history and how my career came to influence my worldview. Looking back, I can see when something “clicked” for me, there were moments of illumination about my methodology or an emerging theme. The following is an excerpt from my journal, indicating the journey-like quality of the research process:

I realised that although Nel and Robyn have been giving me really pointed and specific articles to increase my understanding and knowledge base, there was a level of understanding that I hadn't reached. On Thursday I felt like some blinkers fell off and I internalised the critical theory message a bit more. But the article would have meant very little to me had I not dialogued and read all of the previous stuff. The process of understanding the story takes time. . . . I have learnt an important lesson about grasping the deeper meaning and applying the theory to my findings. I wanted to go and read every methodology article again, with my new “glasses”. In fact, I did read over quite a lot of them with my new understanding, I felt like I better understood how the critical lens filtered my data. (Journal, 11/5/13)

Data Analysis

The process of qualitative data analysis relies on developing familiarity with the data in order to illuminate the context and meaning of the participant's "world" and to identify themes. Critical ethnography filters the analysis through the lens of marginalisation. An explicit aim in this process is to validate the participants by "making space" to analyse their stories. The themes will reflect critical theory concepts. Although the complete data was analysed following data collection, the process was iterative and did begin at the commencement of the ethnography. For instance, following each ethnographic observation, I became immersed in listening, reading and reflecting on the data collected and began to identify possible pertinent links to other data. I made a running list of critical theory concepts at the front of my field notes to remind me of the filter I would be using for analysis.

I did not choose to include a qualitative analysis software program, such as NVivo. I considered deep immersion in the data was essential to my methodology and this was possible by listening, re-listening and reading and re-reading the data. I did utilise a function in Microsoft Word that enabled me to perform selected keyword counts. The repeated manual handling of the manuscripts both in computer and hard copy form enabled me to immerse myself in the data, contributing to a deeper understanding of the information and themes embodied within the data.

The three components I used to analyse the data were:

- Qualitative content analysis—summative
- Deep immersion in the data
- Qualitative thematic analysis—conventional

Qualitative content analysis—summative

I carried out a qualitative content analysis, searching for key words using Microsoft Word. Qualitative content analysis is a research method that has been widely used in health studies in recent years (Hsieh & Shannon, 2005) and covers a family of analytical approaches including conventional, directive and summative methods. The analysis I used for this component was summative, with a focus on exploring underlying meanings flowing from textual analysis.

One of my supervisors recommended this as an initial process to uncover themes that I had either not realised were present, or might confirm an evolving theme. Among other things, she referred to it as “getting into the data/playing with the data”. Although I understood what she was saying, I was a little sceptical about the process because I believed this would be telling me something I already knew. I reflected:

Wasn't I already familiar with the data? Didn't I already know what was emerging from the data? Is “playing” with data a serious enough business? Were we going to make “themes” out of the words from the field notes?

Initially, “counting” words seemed a bit too much like quantitative analysis, however I became aware that this data component assisted with progression to analysing the contexts within which the words were set. The words I chose to count were those regularly spoken and/or emphasised.

The key word analysis allowed me to reflect on the data in three main ways. Firstly, I became further immersed in the raw data. Through this analytic process, I became more familiar with what I had seen, heard and written, and I believed I had a more comprehensive grasp on the context for the domiciliary midwives' working environment. I was like a novice akin to a beginner in a language where I considered I could “get by”, however now my fluency was improving. Eventually I enjoyed “playing” with the text! Secondly, in relation to the identified key words, *breast* and *check* appeared regularly throughout the documentation. However, other words that I thought would appear frequently, such as *undervalue* and *listen* did not. When I listened to the content I was increasingly aware that such issues were implied rather than explicitly stated. For instance “undervaluing” was discussed in terms of lack of resources and the feelings related to it, rather than stated as a term by participants. I was aware that themes could be developed as much by an absence or silence, as well as something continually explicitly stated. Thirdly, in order to faithfully answer the thesis question, I divided the significant words into the categories “role” and “experiences”. Most of the repeated words were attributed to the role, yet the words categorised for “experiences”, although fewer, seemed to permeate the role of the

domiciliary midwife. I had begun to answer my question with two distinct categories, however I began to waver about this choice because the categories were overlapping and appeared to be “blurring”.

The following are two tables of the keywords, first presented in alphabetical order, then divided into categories of “role” and “experience”, listed from most to least repeated within the field notes and journal entries.

Keyword	Repetition	Keyword	Repetition
Advi(se/ce)	15	Humour/laugh/smil(ed,ing)	28
Advoca(cate/cacy)	2	Important(ance)	32
Alone	6	Inform(ed/ing/ation)	42
Autonom(y/ous)	4	Junior	11
Breast(s)/Breastfeed(fed)	75	Limited resources	22
Busy(ness)	28	Listen(ed/ing/s)	9
Care(ing)/kind	14	Power/(Em)power(ed/ment)	37
Check (ing/s)/Checklist	37	Physical exam	60
Communica(te/tion/tes)	8	Refer(red/ral/s)	31
Confiden(t/ce/tly)	15	Safety	13
Cultur(e/al/ally)/Specific cultures	19	Satisf(y/ying/ed)	6
Detect(ive)	4	Staff(ing)	35
Document(s/ation)	5	Story	22
Domestic violence	11	Teach(es/ing)	10
Educate(d/s/ation)	23	Tick box(s)	12
Frustrat(ed/ion)	29	Travel/Car	25
Gate(keeper/ing)	4	Value (s/d)/Undervalue(s/d)	21
		Worr(y,ied)	16

Table 4.2 Qualitative content analysis—Alphabetical

Keyword—Role	Repetition	Keyword—Experience	Repetition
Care/ing	151	Staff	44
Physical examination	102	Busy(ness)	36
Inform(ed/ation)	62	Frustrat(e/ion)	32
Breast(s)	50	Power/Empowerment	26
Importan(t,ce)	44	Resources	25
Check	41	Worr(y,ied)	21
Refer(s/ral)	36	Value	20
Story	33	Laugh	17
Breastfed(feed)	31	Smile	12
Educate(e/ion/s)	24	Alone	9
Car	22	Autonomous	8
Advise/advice(s/d)	18	Undervalue(d)	8

Confiden(t/ce)	18	Satisf(y/ying/ied)	6
Safe(ty)	17	Advocate	6
Cultur(e/al)Specific cultures	27	Humour	4
Listen	14		
Tick(box)	14		
Junior	13		
Communicat(e/s/ion)	12		
Domestic violence	12		
Teach(es/ing)	12		
Document(s/ation)	11		
Kind(ness)	11		
Detect(ive)	6		
Informed consent	6		
Caring	5		
Gatekeep(er/ing)	4		
Travel	3		

Table 4.3 Qualitative content analysis—role and experiences

The analysis at this stage prompted me to create an initial model that I believed encapsulated the issues and themes that were whirling around in my head and emerging from the data. I initially developed perceived connections between role and experiences by concentric circles, arrows, concepts and divided spaces. I was conscious that the midwives were constantly moving between their idealised and actual work life. What became apparent was that the role and experiences were intricately linked, and that the remaining two components of the data analysis process were essential in developing a model for this research.

Deep immersion in the data

Deep immersion in the data was achieved in a number of ways. Firstly, collecting data ethnographically, immediately placed me in the data. Whenever I read the data I am reminded of a context, people, smells, sounds and environment (Madison, 2012).

Second, the data was summarised as it was collected (Grbich, 1999), in the form of tentative themes, so that each set of data collected, informed the next. I was constantly reflecting on what I had seen and heard. If I sensed a theme, it would prompt me to look for further indicators within the field, particularly in the light of critical theory underpinnings of oppression, marginalisation and disempowerment.

Third, deep immersion also consisted of “handling” and becoming highly familiar with the data. Qualitative content analysis—summative was one portion of immersion, however I read and re-read the texts, then listened and re-listened to the voice recordings so that I could see the words, people and places in my mind’s eye. I constantly asked myself “what is happening for them and how are they being marginalised?”

After collection I printed out 200 pages of text and physically read and marked each page with a highlighter. This contributed to my familiarity significantly. For me, putting the text on paper was more helpful than just reading data from a computer screen. The combination of touch and sight further assisted me to remember and reflect on the data.

Finally, I moved toward the development of themes that would reflect the participants. I searched for significant stories and interactions, not merely the obvious, repeated themes, so that vital information was analysed and represented in the thesis.

Qualitative thematic analysis—conventional

Conventional qualitative content analysis or thematic data analysis was the third component used to analyse this ethnographic data. Conventional qualitative content analysis or thematic data analysis is the process of taking raw data, then translating it into systematic, meaningful translations of the culture (Creswell, 2007; Hsieh & Shannon, 2005). As I collected data, I made notes about possible themes in the margins of my notes. These were thoughts made “on the run”, and although they did not all become dominant themes, they were initially helpful as a sifting through process, to make sense of what I observed and heard.

Thematic analysis is a frequently used method to analyse ethnographic research; it has proved to be appropriate and illuminating (Creswell, 2007; Hsieh & Shannon, 2005). I resonated with the description of data analysis that Thorne (2000) playfully described as having an air of “mystery and magic”. Thorne (2000) discussed researchers who claim their conceptual categories “emerged” from the data, and she indicated this was as if researchers left the raw data out overnight and awoke to find

that the data analysis fairies had organised the data into a coherent new structure that explained everything! Nothing is further from my experience although I can identify with the importance of taking time away from the handling of the data to reflect on the “emerging” themes.

After completion of my participant observation, at my supervisors’ advice, I made hard copies of my field notes as well as my journal. Following data immersion I initially developed twenty categories, further condensing these into two main categories: role and experiences, each with three sub-themes. I was looking to identify similar phrases, relationships, patterns, themes and contrasting behaviour between subgroups and eventually finalising themes that capture the meaning and issues as experienced by that culture. I used the process of inductive reasoning, whereby the data informs the theme-making rather than starting with themes or categories (Creswell, 2007; Thorne, 2000). I then made separate computer files and put the data into each category and theme. These themes stood for a few months however as I agonised at their interconnectedness and knew that I needed a different way to describe their relationship.

The aim of this final data analysis component is to compare and contrast the information, and then develop it into a full, rich literary portrait of my environment. Creswell (2007) indicated that after themes and patterns have been established, the next task for the researcher is to interpret these themes and make sense of the culture. He suggested that as one reviews events chronologically, the themes should repeat themselves within those events and situations. However, my themes did not arise just from chronological verbalisations; rather it was that they were pervasive throughout all of the data.

Thorne (2000) stated that researchers should be engaged in “active and demanding” (p. 68) analytic process throughout the whole of the research process, not merely assigning analysis to one portion of the study. For me this involved further reflection on my own values and assumptions that contribute to analysis. For instance, I had my own fears about repercussions after realising the extent of marginalisation the midwives experienced even though each of the participants said that they were happy for me to tell their complete story inclusive of pleasant and

unpleasant aspects. Once I had named this fear, I was able to move on to thematic analysis of the experience of the domiciliary midwife. Having immersed myself in the text and also used some personal “soul searching” the following are the themes that emerged from the data.

Results—the embeddedness of role in experience

The analysis revealed a global theme: *The role of domiciliary midwives was embedded in their experiences and participants were expert practitioners.*

When I commenced analysis I anticipated considering the role and experiences separately however the data indicated that the role was deeply embedded in experiences. The midwives’ role arose from the context of their experience, and the experiences of the midwife were affected by the complexity of the role. Furthermore, it was evident that domiciliary midwives were expert practitioners and this was exemplified in their diverse roles and the complexity of their experiences. The embedded nature of the role in experiences is depicted in figure 4.1

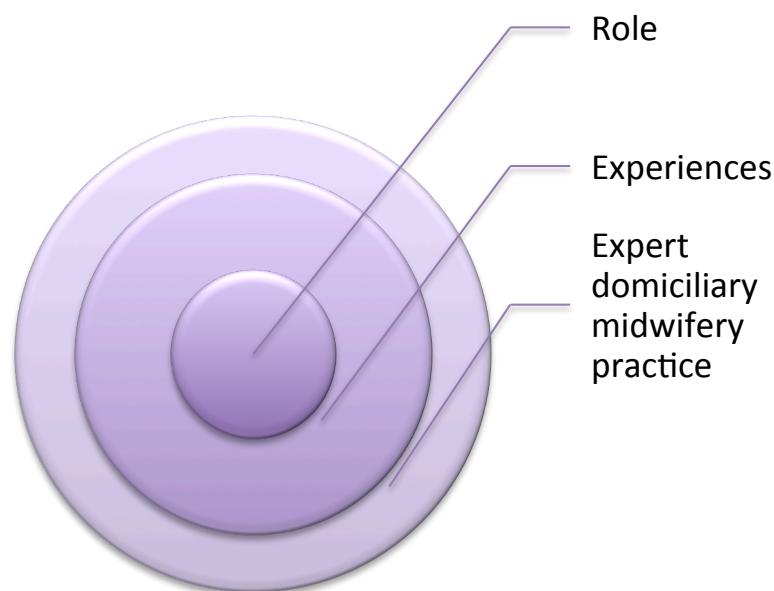


Figure 4.1 Role: linked and embedded with experiences

There were seven themes that characterised the role of the domiciliary midwife: relating with intention, assessment, education, autonomy, prediction,

management and advocacy. This role characterised by seven themes is embedded in the experience of the midwives.

The experiences of the midwives are characterised by three key themes: role complexity and negotiation of change, personal satisfaction and validation and undervaluing of professional role. The themes for role and experiences are depicted in figure 4.2.

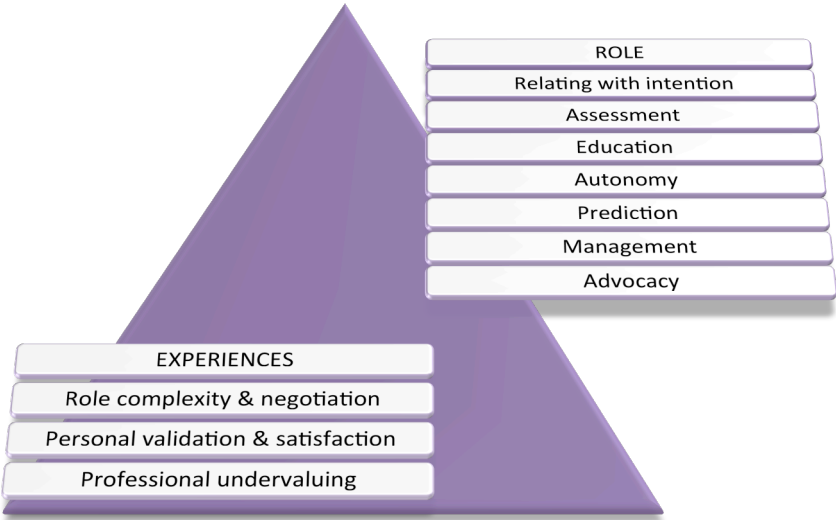


Figure 4.2 Themes of the role and experiences of the domiciliary midwife

Additionally, there were several sub-themes for the experiences of the domiciliary midwives. The following table, 4.4, outlines the global theme, themes and sub-themes from the research.

'The role of domiciliary midwives was embedded in their experiences and participants were expert practitioners.'	
<i>Themes of role</i>	
1. Relating with intention	
2. Assessment	
3. Education	
4. Autonomy	
5. Prediction	
6. Management	
7. Advocacy	
<i>Themes of experiences</i>	
1. Role complexity and negotiation of constant change	
<i>Sub-themes of role complexity and negotiation of constant change</i>	
1. Midwifery care	
2. Management	
3. Communication	
4. Geography	
5. Workforce	
6. Expectations/Culture	
7. Environment	
2. Personal satisfaction and validation	
<i>Sub-themes of personal satisfaction and validation</i>	
1. Autonomy	
2. Working in women's homes	
3. Contributing to positive results	
3. Undervaluing of professional role	
<i>Sub-themes of undervaluing of professional role</i>	
1. Physical environment	
2. Staff comment	
3. Staff issues/Resourcing	
4. Future directions and decision making	
5. Fears about employment	

Table 4.4 Global theme, themes and sub-themes

Seven themes of midwife role

Analysis of the role revealed there were seven themes which all contributed to their expertness as practitioners. The seven characteristics of their expertise will now be highlighted linking my observations and current literature.

Relating with intention

The first theme related to the role of the domiciliary midwife that emerged from the data, was that of intentional relating. This was deeper than effective communication. It was evident that the midwives held significant interpersonal

expertise and this was apparent whenever they interacted in their role. Arguably, the midwives' interactions with women, midwifery colleagues and other health professionals were not a haphazard means to an end. They displayed a sense of self-awareness, which according to Glass (2010) is the beginning of a professional, therapeutic relationship. The literature confirmed it is important to develop self-awareness to enhance one's own sense of personal self as well as one's professional capabilities. It was evident that it was in their best interests to "own [their] humanness, and especially individual emotional reactions to work practices" (Glass, 2010, p. 77).

The participants' role exemplified interpersonal relations that were characterised by skilfully sharing complex information competently and empathetically. They had extensive experience and well developed interpersonal skills to care for women and babies, yet they were aware of their limitations. I observed collaborations with other midwives and doctors to ensure the best care. In relation to Portia I wrote:

When Portia answers the phone, or engages with any other colleague, she is warm and friendly. She obviously has a great relationship with MCHN, council co-ordinators, doctors, midwives and women. It's part of her job as she sees it, and described to me on the first day I worked with her. It makes people willing to engage with her. (Field Notes, 19/6/12)

Participants relayed the intent to respect all clients and healthcare professionals. Much of their respect and compassion was motivated by their personal circumstances, and the ability to empathise with the other person's issues. Their empathy was not overwhelming, rather it appeared to contribute and illuminate their expertise. They used a variety of communication styles, matching the circumstances, skilfully moving between styles as the need arose. I observed exchanges that were information sharing, the use of humour, reinforcement, assertiveness and gentleness.

In spite of the lack of instinctive connection and her concerns about this young mother, I saw Charli treating this mother and partner with respect and kindness. Her body language was open and honest. She used humour along with important information to ensure that the young woman had knowledge to keep her baby safe and seek help if she needed it. I asked Charli how she felt after this second visit and she said she felt it satisfying to see that she had connected to a certain degree but still worried that some of the information she had given had not “sunk in”. (Field Notes, 29/6/12)

Current literature also places the relationship between professional and client as central to the therapy being offered and integral to the professional intent of health and well-being of the client (Hargie, 2011). Hargie further argued that historically people have pointed to the health benefits of a good “bedside manner” of a health professional. There is now extensive research that supports this understanding (Cahill, Paley, & Hardy, 2013; du Plessis, 2005). The following is an example from my data displaying Shae’s intention of developing a relationship with a client as part of her therapeutic care:

Shae handles the baby with confidence and kindness. She takes the opportunity to make complimentary comments about the care of the baby, encouraging the woman and building a relational bridge. (Field Notes, 21/6/12)

Participants displayed the ability to form relationships with women and their families at short notice as well as continue extended relationships with work colleagues. Developing appropriate and respectful relationships assisted participants in portraying their intended messages. This formed an intentional and integral part of their role as a domiciliary midwife, as portrayed in my conversation with Portia:

Portia pointed out that doing domiciliary work, especially on a more constant basis requires a “type” of personality, somebody who develops rapport with

women well, and is kind and gentle. Not somebody who is abrupt, pushy and lacks tact. I see that with the three midwives I have work with already. (Field Notes, 12/6/12)

The participant midwives recognised the significance of relating intentionally and practised it skilfully.

Assessment

Each of the midwives had strong expertise in the skill of assessment. Assessment in this context involves observation and precise questioning. In particular, Shae displayed this skill in her role and promoted this in her colleagues and student midwives. Often she was called “Poirot” because of her astute assessment abilities. An excerpt from my field notes reflected Shae’s thoughts on skilful assessment and thorough care:

She [Shae] believes that in order to be an effective DOM midwife, you need to know how to ask the right questions—to ask the questions behind the questions. It’s all very well to “tick the box” off a care plan, but when you start delving into people’s lives, they are far more complex. Shae wants to ensure that the correct information, education, referrals and advice are given so that mothers, babies and partners are well supported. (Field notes, 11/7/12)

Further, one of the critical conversations with Charli exemplifies specifically what happens if the “right” questions are not asked:

Charli told me how she doesn’t just ask if a woman is using her bowels and bladder. She asks how about stream flow and pain with urine and fully emptying bowels. It seems that some time ago, a woman went home . . . after a caesarean section . . . and had acute . . . [urine] . . . retention, resulting in a 5

litre bladder and ended up with renal failure. Another time, Charli asked a woman whether she had emptied her bowel after birth. The woman said “yes” and whispered “if you could call it that” . . . upon further questioning it seems for two years she had needed to disimpact her bowel vaginally before she could fully empty her bowel. Charli is quick to make referrals to physio[therapist] and peri[neal] clinic as necessary. (Field Notes, 6/6/12)

Assessment also includes being an expert questioner and listener. Listening and assessing involves being able to sift through information so that priorities can be made and the correct management plan is formed. Literature has indicated (Shiple, 2010) that while listening has been acknowledged as an important concept in nursing and midwifery, it has not received the same consideration as other skills of communication, yet it was apparent that these domiciliary midwives displayed appropriate silence, prioritising, non-judgement, empathy as well as appropriate verbal and non-verbal cues as key components of their role.

The more “glamorous” tasks of a midwife such as technical skills in the labour ward may gain more attention, yet these midwives displayed a high level of ability to assess their vulnerable clients. The following is a literary picture of a typical entry into a woman’s home:

When we walk in to a woman’s home we are hit with a barrage of information, usually about breastfeeding. Sore nipples, lumpy breasts, sleep deprivation, baby’s health, nappies, length of feeds, spacing of feeds, should I use a dummy? There is so much information, sometimes a woman will tell them a number of things in one sentence. Charli sorts through the issues one by one to follow them up and answer questions, reassure the woman, give advice about what to do or look for. (Field notes, 6/6/12)

Christie highlighted the effects of strain on the healthcare system and its snowball effect on domiciliary midwives. In this story it is evident that amongst the strain she is still acutely aware of the importance of assessing her client. Her expertise in her role is revealed by this recollection:

We visited a primip who had a 2 litre PPH [postpartum haemorrhage] . . . second visit. Christie had seen this story in the hospital, and had heard the midwives express frustration with this woman—she wouldn't have a transfusion in spite of a low Hb [haemoglobin], declining assistance newborn screen testing (NST) and hepatitis B testing for her newborn. Christie said that she realises that at times when you spend a long shift with a woman who is “challenging” that the compounded effect of her attitude, midwife's frustration and frustrated handovers can make things worse. Midwives (on the ward) had described her as a “princess”, unable to change nappies, or look after herself. She had really alienated the staff. So she saw this woman in hospital and sat on the bed and spent a bit of time with her, listening. She validated the woman's experiences and feelings. She asked “why don't you want the NST?” It turns out she didn't understand what it was all about. Christie said, it was like she was in shock from the trauma of the birth and anything they'd said hadn't really sunken in. Also, she just needed some time and connection with a caregiver and Christie realised that she could do that in her role at that time. She also reiterated that there have been times when she's “been that midwife—frustrated and worn out, fed up”, so there was no criticism of the midwives, just criticism of the system which puts everybody in a difficult situation. (Field Notes, 10/10/12)

Education

I observed the participant midwives using their expertise in their role to educate. I witnessed this particularly in relation to mothers and families. However in the critical conversations they explained their role also encompassed educating junior and student midwives.

The group of skills I observed in the participants that support the theme of education are those of explaining, reinforcing and persuading. Hargie (2011) explained these are important communication skills for successful education.

The following is an example of an explanation to a woman who has come home from the hospital after birthing her first baby. She told me about the importance of using plain language with women, because they often do not fully realise what has happened to them in the hospital.

Second visit . . . to a . . . primip [first baby]. She [Shae] typically goes through a woman's birth if it's the first day out of hospital. Explains treatment, gives opportunity to talk about the birth, she said she uses language that they understand, sometimes they don't understand what has happened to them. Shae avoids or explains the use of words like "gravid, para, epis, sutures". The care was given so that the woman understood about blood loss, perineal care and care of her baby. (Field notes, 21/6/12)

Further, the midwives shared they would often need to reinforce what has been said to these women many times because they often didn't take the information in first time around. We visited women who had been given information, for instance regarding breast engorgement, yet when we arrived, they seemed not to know what to do. The following data highlights their compassion and their appropriate response to the situation:

And women forget things, they're tired, forgetful and can't think, so repetition is good. (Giselle, Field notes, 30/11/12)

Hargie (2011) also listed the skill of persuasion as integral to that of successful communication. I observed that the midwives used the skill of persuasion on a number of occasions. The midwives had the ability to help the women to see that they could benefit from a different outlook or a different way of managing this early postnatal period. The following is an example from my field notes:

Shae sees that an important part of this role is to give women permission to “slow down”. She tells them that she likens the birth process (especially c/s) to a triathlon. . . . [Shae asks them], “Would you expect to do night shift after a triathlon. In the same way you’ve grown this baby, birthed, breastfeeding. Be kind to yourself.” Shae sees that the birth midwives are under pressure to birth, do first breastfeed, tidy, observations, paperwork (BOS) and so they are “rush, rush, rush” too. So they don’t reinforce the need for rest, or have time to emulate it. Even family members have higher expectations of women these days. So many women that Shae visit have “gone out” for the day or to the shopping malls by day 3 or 4. She also tries to change the expectations of the partners by reinforcing the “permission to rest”. (Field Notes, 11/07/12)

Autonomy

The expertise of the domiciliary midwives was witnessed in the autonomy of their role or their ability to work independently. In an attempt to differentiate between the plethora of titles used to describe advanced clinical nursing, Daly and Carnwell (2003) discussed the skills required to practise at a senior level. The ability to practise autonomously, they argue, develops after at least three years of clinical experience and further specialist education. All participants had at least that much experience, had further education and were in the process of further study when this research was conducted.

They were expert in their role in relation to making decisions that kept women and babies safe. They illuminated expert skills and experience that supported their abilities to work, for the most part, alone. Further, they enjoyed the ability to be able to make evidence-based, safe plans for women and babies, and voiced a sense of fulfilment at the responsibility. Yet, there was acknowledgement that, at times, it was important to share their concerns, or review a care plan with their colleagues because they recognised their limitations too. The following is an example reflecting the weight of responsibility they often experienced:

I visited a woman whose baby had had a huge weight loss (over 10% of body weight)—she seemed oblivious that this was NOT normal and that this baby could “go downhill” very quickly. I spent a lot of that visit making a plan and reiterating the severity of the situation. Clearly she was unhappy with my insistence, no eye contact and her back toward me . . . I went back the next day and the baby had put on weight (due to the plan we made) and the father said “she was not happy with you yesterday”. But I have to come on strong sometimes—that’s my job. I went home and worried about that baby—should I have insisted on admission? Would the mother follow the plan? That’s the responsibility of working autonomously. (Ingrid, Field Notes, 27/11/12)

Prediction

The ability to make educated predictions within the context of any nursing or midwifery arena is highly valued as an attribute of critical thinking (Khosravani, Manoochehri, & Memarian, 2004; Scheffer & Rubenfeld, 2000). I witnessed prediction, in a number of ways in the field. The experience that these midwives possessed with the way mothers and babies progressed positioned them well to make accurate decisions regarding the timing and amount of domiciliary visits. They always made contingency plans just in case things went awry. Therefore prediction was evident when participants ensured there were emergency phone numbers

available to the mothers and they empowered the mothers by encouraging them to ring if they observed any problems. Their predictions were accurate. In relation to organising the visit lists for the next few days, I documented Shae's prediction skills:

We go to special care nursery, [Shae] chats with midwife in charge. There are no nursery babies going home today but there is one potential in the next few days, she makes a note of this . . . Shae picks up referrals from other hospitals from the PN fax machine . . . She looks at yesterday's lists and reads notes/emails sent from yesterday's co-ordinator . . . sorts out list for all midwives visiting (about 12 visits) . . . she asks herself . . . what would the women be needing today/tomorrow . . . when do they need a visit? When would a visit most benefit the women and babies? . . . [Shae] predicts and prioritises geographical location, acuity, special needs. (Field Notes, 21/6/12)

When the ability to predict the course of recovery or illness is not accurate, the consequence of this may be that women receive unnecessary visits and in turn this contributes to the burden of an already overloaded system. Alternatively, the more worrying thought is that if they do not provide adequate care due to a lack of understanding of how unwell a woman or baby can become, then the outcomes may be less than optimal. This is an example in relation to Christie of when the "system" broke down:

Junior midwives seem less and less able to [predict] because they don't see women for more than 2 days in hospital unless there is something wrong—so they are not familiar with usual or normal patterns of illness or wellness. (Christie, Field Notes, 19/10/12)

Management

Another expert theme of the role was management. It was apparent that the participants' role incorporated managing a multi-levelled workload in a number of senses. They carry a patient load and manage each client, not just follow instructions or a care plan. They manage staffing levels, as best they can, which can be challenging when the number of home visits can change fairly spontaneously. Additionally, other ward staff were often reluctant to "help out" when domiciliary care is busy. Furthermore, participants managed junior and student midwives to ensure they work within their safety capabilities as well as oversee their work. Overseeing is to ensure that the women and babies are safe and to observe specific learning needs that may arise.

These midwives also manage an administrative role. They document statistics, initiate referrals, ensure care plans and patients' notes are up to date and liaise with other units regarding patient care. Participants had to ensure the infrastructure to keep themselves stocked and mobile—including facilitating the maintenance of the cars was factored into their work role.

Managers also have the task of looking ahead to provide educational opportunities for the staff and perhaps alternative ways to make their role run more efficiently. Five of the participants expressed their frustrations at having expressed their concerns and hopes to management to discuss the need for changes and said they felt undervalued at being ignored.

Advocacy

Advocacy was witnessed in many ways; one in particular was gatekeeping. Portia provided many examples of time when the postnatal ward was overwhelmed with women and a shortage of bed space. In an attempt to alleviate the problem, women and babies are sometimes discharged while they still require a higher level of care. In this case, Portia described how she would fight for the right of the women to be hospitalised for an extended stay until they were safe to go home.

Advocacy also included being responsive to women who became ill. Participants perceived another component of their role was to arrange for women to

be readmitted if their condition worsened. At times the midwifery staff on the postnatal ward were more difficult to convince than the doctors. This field note entry exemplifies this point:

Over the weekend there were two women who were day 2 or 3 who had problems that required medical attention and antibiotics. Home care midwives recommended readmission, postnatal wards said “send to GP”. Homecare midwives spoke with obstetricians (who share their office) who also recommended readmission . . . the women did indeed have problems which required treatment as in-patients. (Field notes, 19/6/12)

Experiences of domiciliary midwives

As indicated above there were three themes identified in the experiences of the participants. These were intertwined and as such impacted on each other. These are represented figuratively below in figure 4.3:

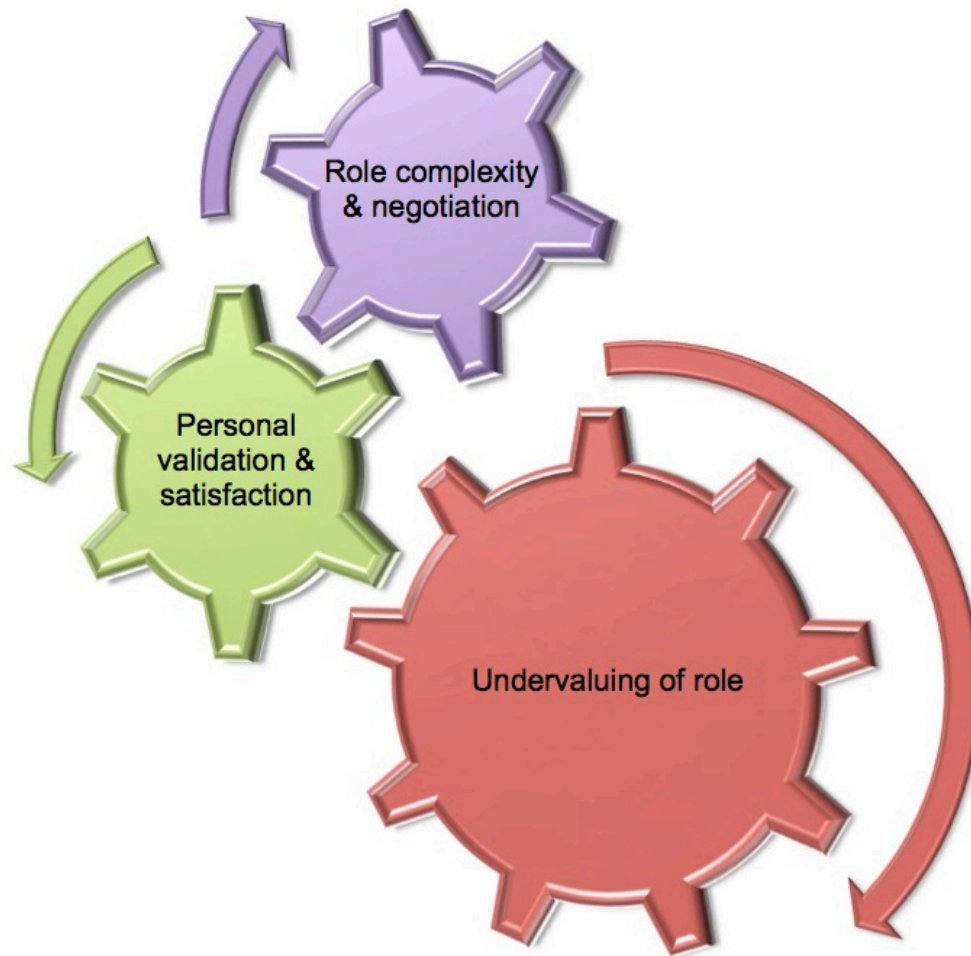


Figure 4.3 Themes of the experiences of domiciliary midwives

Furthermore there were several sub-themes embedded in the three themes and these were previously outlined above in Table 4.4. Experiences of the domiciliary midwives is discussed below.

Role complexity and negotiation of constant change

Midwifery care

The complexity of the role is seen repeatedly as women's needs are made up of their birth stories, social circumstance and postnatal issues. It is highlighted in midwifery care and reflected in the following field note entry:

There is so much information, sometimes a woman will tell us a number of things in one sentence. Charli sorts through the issues one by one to follow them up and answer questions, reassure the woman, give advice about what to do or look for. One of the issues was really tricky. Neither her nor I knew why this baby's nappies had reverted back to black poo! (Day 6, they'd already gone yellow). There was no obvious reason. Charli continued the conversation but was obviously mulling over it while she spoke about other things. She came back to it a few times and asked more questions ?medication, ?illness, ?breast milk substitute, ?foremilk, ?hindmilk. The baby had put on weight, fed well, attached well, no urates in nappy, looked healthy. Advised to go to doctor if things changed, condition deteriorated. We asked the midwife back at the hospital upon return, she said she's seen it quite a few times before, no reason, no problem—just happens! Sometimes related to phototherapy but not in this case. Lots of advice about engorgement, storage of breast milk, sore or damaged nipples. Charli gave out photocopied leaflets about these subjects if she saw that the woman required it. She also talked about management of these issues. (Field Notes, 6/6/12)

On such a busy day with five visits, the pressure of using an interpreter is added to when a baby at an early visit needs an SBR. We can't carry the blood around for the rest of the day, so we arrange to do two more visits then go back and take the blood. It seems so small, but it really adds another 30-40 mins on to the day that is already full. She tries to get back to the hospital by 4, but it's closer to 4.30. I asked if she ever gets paid overtime—Charli laughs.

Once! . . . Also, one of the mother's notes indicated that she'd been on antidepressants and to look out for signs of depression. No sign. Charli said she is surprised at how many young women are on antidepressants. (Field Notes, 6/6/12)

Management

The domiciliary midwives in this study were engaged in their work at a management level, as well as a clinical level. They co-ordinate the visits, educate junior midwives, attend to administration as well as caring for the mothers, babies and families. Yet, they expressed the frustration that although they have this high level of responsibility, they don't have the support to do it well. This has supported current literature. It has been stated that: "nurses and midwives are expected to fulfil a leadership role at all levels, yet efforts to strategically support them are often unfocused" (McNamara, Fearly, & Geraghty, 2011). I continually observed that the midwives were highly capable to carry out their work responsibilities; they knew what needed to be done, yet they continued to experience professional undervaluing. The following field note entry on Christie exemplified capability with multi-tasking:

She spends some time co-ordinating inexperienced midwives (taking phone calls, reviewing their care after the rounds). The phone rings a few times throughout time in the office, other hospitals, MCHN's, she takes it all in her stride. In all of her interactions, Christie has a smile in her voice. She clearly enjoys her job. She takes time to make sure that her information is thorough and respectfully makes suggestions to junior midwives about any tricky management of mothers or babies on their visits. (Christie, Field Notes, 25/6/12)

Communication

Communicating without words, skilled nonverbal behaviour was continually explicit in the midwives' interactions. The following field note excerpt on Charli's use of non-verbal cues at one of her visits highlights this point:

She knew the first [client]. Multi 2 [second baby]. Breastfeeding issues. Not able to fix them in this visit, but the woman had been to the lactation clinic and was being visited by the maternal and child health nurse on Monday. Charli leans forward as she takes in the information; she shows clear interest and validation of any issues that arise with her body language.

Second visit, a young mother, second baby. Charli knew this woman briefly from the ward and a previous visit. She didn't really "connect" with her, felt like she was more interested in her hair than the needs of the baby . . . The baby had experienced a significant "dusky" episode in hospital and had a brief admission to Special Care Nursery (SCN). The tests had all come back clear yet Charli visited this mother the first time and found the baby with significant discolouration around the mouth. Mother didn't seem to grasp the potential problems . . . In spite of the lack of instinctive connection I saw Charli treating this mother and partner with respect and kindness. Her body language was open and honest. (Field notes, 29/6/12)

Each of the midwives, related stories about themselves with me and it was evident that they were comfortable to share their own vulnerabilities and the impact of empathy at that time. Each disclosure was brief, however it highlighted the mutual trust between the midwives and myself. Furthermore they spoke of times they shared a component of a personal stories with a mother and the degree to which it is strategic as a helpful intervention. The following is an example from my field notes:

[Giselle says:] “At times I use personal experiences to help with education of women, but you have to be careful about how and when you do that. Some women may feel very encouraged if I’ve got twins and therefore I know how they feel, but for others that wouldn’t help and they wouldn’t care. So I modify how I help women, what I tell them and how I impart knowledge. Individualise the care depending on the woman and how she’s responding at the time.” (Giselle, Field notes, 30/11/12)

Charli utilised humour to diffuse a potentially difficult situation and combined this with disclosing personal information. In my field notes I documented this communicative action:

She [Charli] described how she uses humour in a situation where she was going out straight after work (to watch a filming of a session of “The Block”). She visited a woman who was crying and upset about breastfeeding issues, and as she expressed this woman with engorged breasts, she made a joke about not getting in the “line of fire” because she’s going out and she didn’t want breast milk all over her clothes. She used humour to soften difficult situations, and recognises women’s vulnerability, so instead of the woman feeling terrible because she was feeling incapable (somebody doing it for her), they had a laugh together, as well as problem solved. (Charli, Field notes, 1/10/12)

Detailed communication regarding clients and day-to-day running of the department was a priority for the participants. They had a few different ways to ensure that information was passed on in detail. The following exemplifies how all of the participants view the transfer of information between the staff:

Christie sees teamwork and communication as important. They rarely actually see the other co-ordinators but they consistently and deliberately leave details about client care so that communication is smooth and details are conveyed accurately, therefore care is optimal. (Field Notes, 20/6/12)

Geography

Visiting women in their homes was a two-edged sword. The domiciliary midwives love to see women in their own environment and enjoy the travel. However, the driving time and, sometimes, long distances between homes adds to their working day.

At times, there is an expectation that they will visit women on the other side of a town. This comes about because an obstetrician takes a private client who then requires domiciliary visits in their home. Where possible, the midwives try to refer these visits to other hospitals, yet at times these referrals are rejected. Although the midwives understand the reason for refusal of reciprocal referral such as busyness, they believed they make more effort to accommodate other hospitals than vice-versa. These long trips also put increased pressure on their already busy days.

Adequate stocking of cars and workbags was imperative. When a midwife realised that she has forgotten something of significance for a visit, recovery was time consuming. For instance:

We stop in at the storeroom that Charli had shown me previously, it's shared by the ward and at times is not stocked very well. Portia says she likes to make sure that the car is well stocked because there is nothing more frustrating than getting to a visit and not having the equipment; "you can't just run to the storeroom and get it, it's really inconvenient". (Field Notes, 12/6/12)

Timing of blood tests in a day's work adds to the complexity of configuring a travel route for the day. Neonatal blood tests for jaundice (Serum Bilirubin or SBR) must be taken back to the hospital for testing within two hours. Midwives try to leave

the SBR's until the end of the day, however, at times they found themselves taking early tests, going back to the hospital, then out on the road again. This back-tracking complicated their day. The following data is reflective of this problem:

Portia took an SBR, dropped it back to the hospital, and on the road again. It adds around 40 minutes to her day. She will call the woman back in the afternoon with the result and any other management issues. (Field Notes, 19/6/12)

As a result of the complexity in roles the domiciliary midwives were constantly negotiating change. These changes were reflected in the data in three ways and became the additional sub-themes for the theme.

Workforce

Recent statistics have shown that the average age of newly trained midwives in Australia has decreased from 43 to 38 years of age, (K. Cook, 2013). While this is an encouraging trend, Australia still has a midwife shortage, with many midwives heading toward retirement (Government, 2004). Research has also shown that many midwives are not satisfied with their work arrangements and are considering moving within the next five years. Additionally, many midwives are close to retirement age. With all of these factors at play, midwives must negotiate working with new colleagues, with a variety of experience under a variety of changing models of care. This can be challenging to negotiate, especially when the senior staff were expected to supervise inexperienced, junior staff as well as carry their own workload. I had written this in one of my field entries:

She spends some time co-ordinating inexperienced midwives. (Christie, Field Notes, 25/6/12)

It worries me that younger, inexperienced midwives will miss these things . . .

You used to have to have had lots of experience to work in DOM, now they'll take anybody . . . and don't provide enough educators to make it workable.
(Shae, Field Notes, 1/10/12)

Expectations/Culture

The expectations on the role of the domiciliary midwife have increased as women go home earlier, with higher acuity for women and babies. The participants noted that they are being expected to care for smaller babies in domiciliary care more than ever before. They suggested this change has not arisen because they are such experts in care; rather it is due to a shortage of hospital bed availability and staffing. They were very proud of their efforts and of the successes of their care, however, once again felt undervalued and not recognised regarding the extra stresses and responsibilities that they carried.

Domiciliary midwives are under pressure regarding the "extended time" that the mothers are in their care. Transition of care to the Maternal and Child Health Nurses (MCHN) is supposed to occur after one week however it commonly occurs that the MCHN do not visit mothers until three weeks. Therefore the domiciliary midwives experienced many situations of extended care because they believe they should continue visits for the safety of their clients. Furthermore, it must be acknowledged that the MCHN's are also under pressure, with a shortage of nurses for this area of care. I reflected on Giselle's experiences:

Giselle expressed frustration and annoyance and a lack of appreciation of the value and the extent of the job they do. She commented on the increased acuity, the increased visits, the (sometimes) extended time that it takes to handover to the MCHN (one woman wasn't seen until day 19) and the impact that has on their work. (Giselle, Field Notes, 20/11/12)

Adelia raised the cultural issue of decreased length of hospital stay and the impact of multi-health issues on her workload:

Adelia commented on the busyness of DOM now because of the decreased [hospital] LOS, the increased acuity and the need for so much more education at home. They see a lot more continence issues, these days where as once upon a time, women would be sorted in hospital (with referrals) before they got home. (Adelia, Field Notes, 20/11/12)

Portia spoke of not getting caught up in the culture of moving women and babies through the system quickly to make room for the next client. This journal entry reflects her thoughts; equally she felt the pressure of holding up the healthcare system:

Ensure that you're making sound clinical decisions based on clinical presentation, resources, likely consequences—in best interest of women and babies. Don't get caught up in the culture of "move em on and get em out". Keep vigilant because the consequences can be dire. (Portia, Journal, 21/6/12)

There have also been changes in expectations due to the changing needs of the public. The participants reported more non-English speaking background (NESB) clients and more incidents of domestic violence. They expressed their frustration of trying to care for women via a telephone interpreter. Although it seemed like a good idea, and was mostly helpful, they were also suspicious that their message was not relayed or comprehensively understood. The following is an example of this issue:

Charli also said that she is a bit suspicious of interpreters because she once had an interpreter and a student working with her. The interpreter was talking to the woman and the woman was crying. The student could speak the language and said that the interpreter was "telling her off for being in Australia, she was of lower caste and didn't deserve any good things in life . . . or words to that effect". She also said that often when she asked questions,

the answers that came back indicated that the subject and the information had been lost in translation. Charli felt that often the care was substandard due to language barriers, in spite of the interpreter's help. (Field Notes, 6/6/12)

Additionally, the care of NESB clients took more time, which was not taken into account with the organisation of staff:patient ratios. The domiciliary midwives, were undervalued:

[Ingrid said:] "You put such a lot into the visit, the eye contact, body language, speaking clearly, slowly, using the interpreter, watching out for the student with you' . . . its exhausting. You spend far more time with these women because of the language barrier because you realise how isolated they are." (Ingrid, Field Notes, 25/11/12)

There has been higher emphasis placed on occupational health and safety issues too which although necessary have added to the role of the domiciliary midwife. Domestic violence (DV) issues have risen. Domiciliary midwives are vigilant for signs of DV within family situations and are heavily reliant on antenatal care and hospital staff to highlight any problems. If domiciliary midwives have any concerns, they may offer a postnatal visit in the hospital, but not in the woman's home. Sometimes, they see that the staff may have actually escalated a situation in the hospital, and the home situation is quite safe. What they were telling me was that DV incidence has risen, they are very cautious, and mostly the system (at site two) is thorough, but they also make judgement calls based on the story. This is time-consuming and increases their workload, which once, again, they feel is undervalued by midwifery staff in the hospital. I recorded the following in my field notes:

"Do you feel that the problems of DV within the community are picked up adequately?" She said, "yes, mostly". The DOM midwives go through a checklist on the ward with the women before they visit them, so they

understand the importance of answering the questions accurately. Also, there is a team meeting with all of the allied health staff, (dietician, social worker, physio and postnatal manager) where any issues that are picked up antenatally are then passed on to the DOM staff. Ingrid said the communication is great and there is a mechanism for reporting. She said the social worker in particular really has a handle on the women, particularly those “at risk”. If there is any danger to the midwife for a home visit, the woman is offered a hospital postnatal visit. Ingrid said, “in the old days, 2 of us would go out, but that doesn’t happen any more”. Recently a man became angry and threatening on the ward because they wanted to go home but the discharge process was taking a long time. Jo said, “it sounds like the senior midwife on at the time escalated the situation too . . . it’s really important to listen to the people’s side of the story, get context”. (Field Notes, 1/2/13)

Environment

The environment in which the domiciliary midwives work has been under constant change over the last few years. They reported changes to models of care used to provide service to clients, physical space of the maternity section and the supportive infrastructure as funding changes and the constant change of staff. These changes have provided a backdrop of uncertainty yet in spite of this, they have tried to remain safe and effective. Marginalisation may be seen in the unpaid overtime they do; to them it signifies undervalue of their work. The following is an example of the change and knee-jerk response of management:

According to Portia, at first homecare wasn’t overseen by anybody in particular, but management realised that if nobody is “in charge”, then loose ends aren’t followed up, nobody is accountable, nobody takes ownership and

the care that is given is inferior, consequently the management role was developed and shared between three domiciliary midwives. There is a lot of liaising between the managers so that good care is given, the small details are followed up on. They all do unpaid overtime on a regular basis because they take pride in their work and the “good name” that this unit has in the community. (Field Notes, 20/6/12)

The literature confirmed (Sullivan, Lock, & Homer, 2011) that the top three reasons why midwives continue working is because they enjoy their job, they are proud to be a midwife and they have job satisfaction. The following is a discussion about the ways that the participants in this study found pleasure in their work.

Personal satisfaction and validation

Autonomy

The participants enjoyed the ability to be able to make evidence-based, safe plans for women and babies, and voiced a sense of fulfilment at the responsibility. They also enjoyed the “alone time” on the road and expressed pleasure at being able to escape the chaos of the wards:

Adelia met me in her usual shy style, I gave her the bio I had done for her and she smiled—expressed surprise and gave a laugh at the link I had drawn between the “midwife on call” and her own situation. She says, “yes, you wouldn’t look at me and think I ride so much”. She agreed that my reflections were accurate—especially the one about “thinking time”—“yep, that’s definitely me, the ward is so noisy and busy”. (Adelia, Journal, 20/12/12)

Working in women's homes

These participants consistently stated that they enjoyed going to women's homes. They enjoyed seeing women in their own environment where they felt they were more relaxed. It also helped the midwives understand how life really is for their clients, and to tailor their management to the women so that it was more helpful and more realistic. As one midwife wryly put it:

"We spend a lot of our lives in women's bedrooms." (Giselle, Field Notes, 30/11/12)

Many of them enjoyed the cross-cultural aspect too. Even with the difficulties of translation at times, they enjoyed learning new ideas and being exposed to different ways of doing things:

"I love seeing the different cultures—what they do." (Giselle, Field Notes, 30/11/12)

Contributing to positive results

Participants consistently indicated being a domiciliary midwife gives them meaning and pleasure in their everyday worklife. It was reflected in their decisions to stay on in their work, to persevere with the difficulties that present themselves and the smile on their faces when they shared their stories of helping women to be good mothers. They understood that looking after women in their own home environment is unique, and provides insights that midwives working in a hospital are not privy to, and it is this unique aspect that they value. Ingrid's thoughts typified this:

"I love going to their environment, seeing them in their own homes. At hospital, you don't really grasp the whole picture and when you see them at home you realise why they act like they do. And they are usually more relaxed at home too, so you get to see the women how life really is for them. I think sometimes the midwives on the ward don't realise the other issues that effect women (like

toddlers) and so it's really good for midwives to at least have a go at doing home visiting. One midwife said to me that it changes the way she practises because now she understands that there are larger contexts than just breastfeeding in hospital." (Ingrid, Field Notes, 25/11/12)

Another aspect that the participants found satisfying was the autonomy of the role, in combination with the teamwork amongst the domiciliary members.

"I love the independence of the job, and I feel good that anything out there that happens 'I can deal with' . . . We are very proud of the management we have provided to the 1.8 and 1.9 kilo babies. Once upon a time they wouldn't have gone home but now they do. We liaise with the paedcs [paediatricians] well. The mums feel good, they do amazingly well, they work really hard for those little babies. . . . But it is a huge responsibility and sometimes we second guess ourselves. You never know everything, so we ring each other and run the story by another midwife. Usually you've got it right, but a bit of reinforcement is nice. Sometimes tho', you forget the really obvious!! You can always ring back and review it with the mum." (Giselle, Field Notes, 30/11/12)

This data quotation sums up the passion that these midwives have for their role as a domiciliary midwife:

"I put everything into visits, I'm wrecked and depleted by the end of the day but I love the challenge and the variety." (Ingrid, Field Notes, 25/11/12)

Undervaluing of professional role

One major theme of the experiences of domiciliary midwives was that irrespective of enjoyment and satisfaction they were undervalued. Furthermore, participants perceived their professional undervaluing arises from several sources.

The following model represented the groups from which domiciliary midwives experienced professional undervaluing. While there is a hierarchy of influence regarding how “the healthcare system” undervalues all of those groups, the domiciliary midwives experienced undervaluing by all of groups in one form or another, represented in figure 4.4:

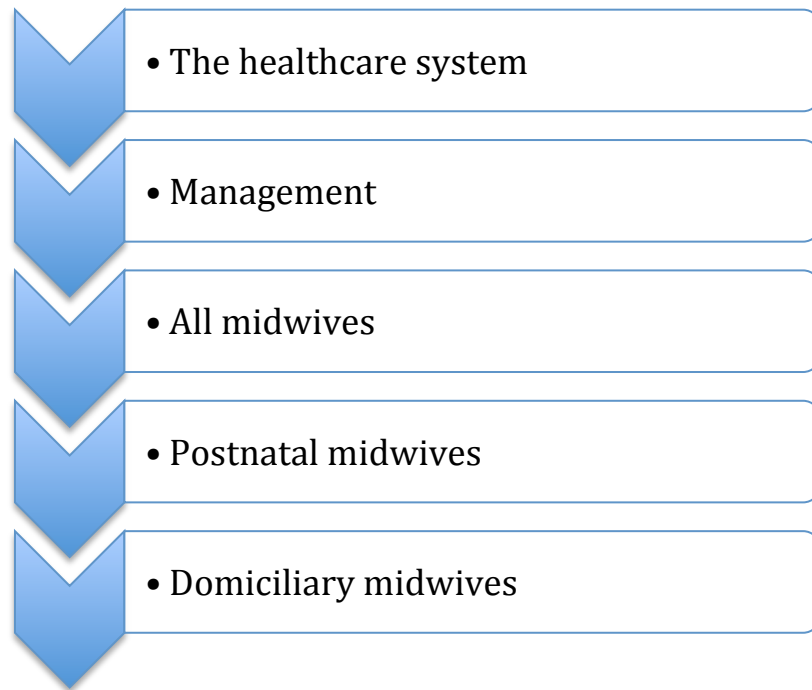


Figure 4.4 Aspects of professional undervaluing of domiciliary midwives

The following is an excerpt from the field notes highlighting undervaluing from the healthcare system, management and midwives and its effect on postnatal care provision:

Charli says that she believes that postnatal care in the home is of significant importance. She says that recently in the wards, there was discussion about postnatal care, one of the midwives was heard to comment, “oh, it’s only postnatal care”. Charli said that is typical of the attitude of the hospital system, and it shows with the low resources, low funding and that they’ve been

relegated to the dungeon out the back of the maternity ward. (Field Notes, 6/6/12)

Christie feels that the MCHN study and role enhances her role as a DOM midwife and she values the dual role. At times she sees women both as a DOM midwife and then as a MCHN. In her words she doesn't feel that her dual training is valued by "the hospital", in fact, nothing they do in PN care is valued by management. We are the dumping ground for all the clients and "midcare will sort them out". (Field Notes, 20/6/12)

Physical environment

Undervaluing of domiciliary midwife role was witnessed in their physical work environment. At the first ethnographic site, the office was shared with many other health professionals and was separate from the postnatal ward, creating much inconvenience for transfer of information. The following highlights my reflections and observations from my first visit to this area:

I walk to the maternity section and ask about the domiciliary department. The receptionist looks blank, I rephrase, "midwife homecare...". "Oh they've changed offices, they're out the back now." So I am pointed in the direction of the birth suites and get to the reception area there . . . it doesn't feel very friendly. "You need a swipe card, I'll let you in." So we walk through the birth suites area, through one heavy door requiring a swipe card for entry, through an echoing stairwell and then another heavy door requiring a swipe card. It feels a long way from anywhere. It's the size of a lounge area. All the walls are lined with supplies, books, clothes, baskets of paperwork, computers. It feels busy and slightly disorganized. It's empty, the midwife says, "are they

expecting you?” “Yes,” I say. So I’m left alone feeling rather like I’m intruding. There are three round tables where the three midwives and student midwife have spread their paperwork around. Then a midwife walks through the door, with a worried look on her face. (Field Notes, 6/6/12)

At the second site, Ingrid showed me the six places that had been used as offices in the last few years. She indicated that they felt “shunted” around, to make sure other units were catered for but that they were the expendable staff that had to accommodate the needs of the other units or staff. With each of these offices, until recently, there were either privacy issues, lack of workspace or storage issues.

Ingrid showed me the rooms that they’ve been put in “shunted around over the years to some tiny places”. I was shown 6 places (including the current one) that “Dom” . . . had operated . . . out of. One of them was a desk in the middle of another ward—with serious privacy issues.

Ingrid said, “We’ve felt neglected, de-valued.” One of the rooms was a tiny office, with no window . . . one of the midwives put a poster up “you can take away our view but you can’t take away our spirit,” or something to that effect. Remembering it had to fit four midwives in there and all their stuff. (Field Notes, 27/11/12)

Arguably, the fact that domiciliary midwives spend time “on the road” and have “hidden” offices even when on site, lends itself to the irresistible metaphor of invisibility. The work of domiciliary midwives is almost invisible to their colleagues, management and “the healthcare system”. The apportioning of hidden areas to work keeps these midwives invisible and this adds to their perception of being undervalued.

Undervaluing of their work was seen in the lack of time to be able to pay attention to the details that provide a level of satisfaction. For instance, the midwives

on site one showed me piles of notes that are case notes of referrals from other hospitals. On a day spent with Portia I noted this in my field notes:

The information about referrals taken has to be kept for three years. Currently there is no formal way to keep the information. It's kept in a pile in the dom. office, not at medical records, no hospital UR number. The midcare midwives have brought this to the attention of management, and have been told that something will be done but as yet nothing has been put in place. The midwives who co-ordinate the program find this (among other things) very frustrating. The paperwork takes up valuable space and is unprofessional. (Portia, Field Notes, 19/6/12)

Staff comment

The participants reported that on many occasions they heard the staff make derogatory comments about postnatal care in general but also domiciliary care specifically. Interestingly, two of the participants admitted to feeling exactly the same way about domiciliary care before they began working in this area. This entry has reflected this issue:

Shae said she was forced to do it [domiciliary care] at first, didn't want to because she was a "labour ward" midwife, back in the day where labour ward was "the place to be", now realises how important it is. She knows that what she says to women in the home will be repeated to mothers, sisters, friends, partners and that the women mostly hang onto every word you say, and your words and management can make a difference. (Field Notes, 4/6/12)

At first [Portia] missed labour ward and didn't care much for postnatal care but now sees postnatal care in the home as important and doesn't want to work anywhere else. (Field Notes, 12/6/12)

In fact, what these staff reported was that they had a good idea what many staff thought about postnatal domiciliary care because they had previously thought that before they were in this position. Charli and Shae's commented on what hospital midwives say and therefore these are reflective of this point. This opinion is backed up by the comments they hear when they are in the other wards:

"It's only postnatal care." (Charli, Field Notes, 6/6/12).

"Don't worry about that . . . the domiciliary staff will fix it." (Shae, Field Notes, 4/6/12)

At times, it was not what was said directly to the midwives, but actions that were taken, contributing to their view that their work is unseen and unvalued. For example, the posters that I had pinned up, in consultation with the domiciliary staff, in the postnatal ward and labour wards were taken down within a week. Other posters and information pamphlets were still there, and when I drew attention to this, Shae commented that it is "typical", because postnatal care is not seen as important as the other care in the hospital, "especially domiciliary care". Why this act of indifference, almost hostility toward a research project for domiciliary midwives? Certainly it was interpreted by the domiciliary midwives (who share this space—it's a tea room) as "get out of my space, we are more significant than you".

Staffing issues/resourcing

Another issue that frequently arose was staffing. The midwives expressed a feeling of undervalue because they were often understaffed. They expressed frustration that they always had to work at full capacity and make difficult decisions about prioritising due to being short-staffed. They were worried about client safety:

“Don’t get me started. On the wards they are 1:4, why is it then that out here on the road where it takes us sometimes 40 minutes to get to women is it 1:5? They think we sit around at McDonald cafes all the time. We’re supposed to be a team, and we rarely get breaks. I’ve been caught out before—I decided to have the luxury of a half hour break then the last visit turns out to be a lengthy 2 hour visit and I end up working late!” (Ingrid, Field Notes, 25/11/12)

Their feeling of being undervalued is evident in the way they are given extra tasks to perform when they are less busy, yet the conundrum is that if they are not busy, staff get reassigned to other units, this therefore means that they are never “not busy”. Consequently extra tasks are not getting done well or frequently enough. The following is an example of this issue:

Another task, which is part of the job, is looking out for the cars and getting cars serviced. A note was left in the diary, “keep an eye on the front left tyre”, it was fine—did it have a slow leak? Once a month they have to allow for taking cars to be serviced. The cars are not cleaned regularly, because they have to find time between visits. Management say, “when you’re not so busy”. The midwives are rostered as such that if they aren’t busy, they are redeployed to other areas of midwifery, so in fact, they aren’t “not busy” as a unit. They feel undervalued, but the core midwives work together well as a team and this is where they find some of their fulfilment and value. (Portia, Field Notes, 19/6/12)

Giselle said, “The work we do and who we are, is not valued. If the wards are busy, the DOM staff get taken, but if the wards are quiet, nobody ever offers to come around and help ‘tidy’ up our paperwork.” (Field Notes, 20/11/12)

Future directions and decision-making

The midwives expressed helplessness at the inadequate attention to training and upskilling, in spite of their recommendations. Although they said they understand that the budget is stretched, still they perceive this lack of attention and redirection to funding to other maternity areas as undervaluing of their expertise and opinions. As an example, Christie expressed the opinion that domiciliary midwives should be given training and time to assess the women within the hospital, before they go home and without the partner present to assess domestic violence (DV) issues. Apparently 1:4 homes in the local council have DV issues. Apart from safety and care for the women, it is an occupational, health and safety issue for the midwives too:

Christie has written long, detailed letters to management about the ways in which women are cared for and her concerns, but has not seen any changes or been given opportunity to implement change. She feels that many of the decisions come down to economic issues, and the lack thereof. Once again referred to postnatal issues as the “Cinderella” of maternity care. Very frustrated and discouraged. (Christie, Field Notes, 20/6/12)

The midwives expressed frustration that their opinions about the direction of the domiciliary unit are undervalued because more emphasis is placed on their shortcomings:

Christie would like to celebrate the things that have been achieved by the Dom staff, such as implementing good BF/feeding plans for women with small babies, babies that have lost more than 10% of their birth weight and have therefore avoided readmission and all of the angst that this brings to the family . . . More focus is placed on what they (Dom) do wrong, rather than all the things they get right. (Christie, Field Notes, 20/6/12)

Fears about employment

The marginalisation that domiciliary midwives experience may be seen in the perceived stability of their jobs and the ease with which they may be dismissed. Due to the miscommunication between manager and midwives, the potential participants asked for written confirmation that they would be professionally indemnified for any actions that might emanate from the research exercise. The instability of their jobs may or may not be a reality, but the culture of fear created an underlying experience in their role as domiciliary midwife. The following is an example from my journal of the email I received:

Prior to my first visit with the domiciliary team, I received an email from two of the three co-ordinators. They were worried that they were being pushed into participating by their manager and cited “informed consent” as a concern. They were also concerned that their jobs might be in jeopardy if something was reported that the establishment didn’t like. (Journal, 4/6/12)

Additional reflections on role and experiences

A time of transition

This study has occurred in a time of transition for the maternity concerns in general. Budget constraints, staff shortages, limited resourcing and a move toward continuity models of care have had their impact on all areas of maternity care including domiciliary services.

Domiciliary care may have evolved from expediency rather than developed from research-based evidence (Fenwick et al., 2012). There are scant directions providing support and value to the role and experiences of domiciliary midwives and their clients. Old care pathways have been used as a basis for new models with little research or consideration, therefore most studies carried out with postnatal care, particularly domiciliary care highly recommend further study in order to provide evidence-based practice.

Furthermore, it is evident that some of the “quick fix” solutions to problems have lacked research or thought. This was seen in the development of a management team at the health network, which was established out of a need, in an effort to ensure thorough follow-up of clients. Yet these domiciliary managers do not feel empowered to have any say over the direction or upskilling of the unit. Domiciliary midwives shoulder significant amount of responsibility yet have limited power. Studies recommend that more work around policy be done, increasing visibility of postnatal and domiciliary concerns and providing adequate resources for those midwives to work under reasonable, evidence-based conditions (Biro, 2011; Fenwick et al., 2012).

The domiciliary mandate is increasing

Women and babies are going home sooner than ever before, with higher acuity. Women and babies require more visits because their length of stay in hospital is also decreasing. The responsibilities of domiciliary midwives are increasing and changing as clientele is changing. Furthermore, many more junior midwives are required to carry out a role that has been traditionally filled by experienced midwives. If this is to continue, in order that safe care is delivered, both the junior staff and the senior staff need training and updating on current research and practice. Both junior and senior staff should be supported in their roles.

The results have highlighted the juxtaposed position of satisfaction that the domiciliary midwives experienced on one hand, yet their professional undervaluing of role and experiences was persistent and all-encompassing. The role of the domiciliary midwife requires a great deal of expertise to perform it safely and effectively yet it is carried out under complex and difficult circumstances.

Undervaluing of domiciliary midwives’ professional role is a significant theme that has pervaded the results of this research. It is explicit in the way domiciliary midwives are allocated isolated, challenging visits and often, inappropriate space within their hospital organisations. It is somewhat “palpable” in the comments other midwives have said about postnatal care in general and domiciliary work in particular. Domiciliary midwives feel that they have to continually justify their allocation of time

and even their right to have a tea break. They demonstrated their need to fight for their right to appropriate levels of staff and they carry a huge emotional load due to harsh prioritising of care. Although they recognise that the whole maternity system is under pressure, they do not feel that this emotional or clinical load that they carry is recognised adequately. What they would like to see are more appropriate staff:patient ratios, time put aside to keep up to date with infrastructure needs, value put on educating and upskilling both junior and experienced staff, and a voice in the direction of domiciliary care within the network.

Chapter summary

Chapter four has discussed the results of the research in conjunction with pertinent literature. The first section of this chapter traces my experience of entry into the field, meeting the midwife participants and mothers then developing trust with my participants. First, the global theme: “the role of the domiciliary midwife was embedded in their experiences and the midwives are expert practitioners”, was introduced and discussed throughout this chapter. Following this, the role and experiences were further discussed in the light of critical theory, focusing on themes and sub-themes that highlighted the ways in which domiciliary midwives are marginalised. The role identified seven themes and the experience identified three themes that emanated from the data.

The discussion throughout the chapter has emphasised that these challenging times are ones of transition within the maternity culture and that domiciliary management is focused on expediency. The mandate for domiciliary midwives is increasing; more emphasis should be placed on ensuring that management and care is evidence-based. I discussed the juxtaposed positions of personal satisfaction: working under difficult circumstances, and being highly skilled: undervaluing of the professional role. Finally I emphasised undervaluing of the professional role because it has been so pervasive in the results of this study.

The following chapter will present the implications, limitations and conclusion of the study.

Chapter 5 – Conclusion

Chapter overview

This chapter, being the final chapter of this thesis, has six distinct sections. First, I revisit the research question, its broad and specific aims and review the extent to which they have been addressed. Second I will discuss the significance of this research to domiciliary midwives and the midwifery population in general. Third, I will expand on the implications of the study with recommendations inclusive of areas for further research.

In the final three sections, I will elaborate on the ways in which the validity of this study has been maintained. Next I will provide a discussion regarding the limitations of the study. Finally, I will conclude with my reflections on the research, and a chapter summary.

Reflecting on the research question and aims

The research question of this critical ethnographic study was: “what is the role and what are the experiences of homecare midwives providing postnatal domiciliary care in Victoria, Australia.” The broad aims and specific aims were derived from the question and were focused on exploration of role and experiences.

The broad aim of this critical ethnographic study was:

- To explore the role and experiences of the postnatal domiciliary midwife in Victoria, Australia.

The specific aims:

- To illuminate the contextual issues contributing to the role and experience of domiciliary midwives.
- To highlight the complexities of the role and experience of the postnatal domiciliary midwife.
- To acknowledge the unique stories of the domiciliary midwives.

In order to ensure that the broad aim was achieved, the work life of seven domiciliary midwife participants was investigated. While the role and experiences were explored as possible separate entities, the thematic findings revealed they were integrated and a global theme was developed. The global theme was, “the role of the domiciliary midwife is embedded in their experiences and domiciliary midwives are

expert practitioners.” Their role impacted on their experiences, and their experiences impacted on their role. Seven themes were identified for their role and these were: relating with intention, assessment, education, autonomy, prediction, management and advocacy. These seven themes were embedded in the three themes of experience. Three experiential themes identified were: role complexity and negotiation of change, personal satisfaction and validation and undervaluing of the professional role.

My first specific aim was to illuminate the contextual issues contributing to the role and experiences of domiciliary midwives. I was able to deepen my understanding of the role and experiences of the postnatal domiciliary midwife by two comprehensive literature searches and reviews, and most importantly by engaging with my participants. In terms of the latter, my engagement was characterised by extended periods of time in participant observation, observing their roles and embedded experiences and by critical conversations. Furthermore, I gained understanding regarding their workplace context, the pivotal issues of concern and the meaning ascribed to their role. Maternity care is in transition, with changing availability of resources, transitioning models of care, styles and expectations of management. The midwife participants demonstrated an understanding of the governmental forces that influence bed availability, staff shortages, decreasing resources, increased acuity of women and babies, and the change in focus from service to “corporatisation”. However, the increased pressure that it brought to their working life is perceived as an undervaluing of their role and experiences.

The second specific aim was to highlight the complexities of the role and experiences of the postnatal domiciliary midwife. By spending extended lengths of time with the participants, in their workplace, I was able to observe their role, providing rich data about the expertise and complexity required by the role and how deeply their role was influenced by their experience in the workplace. Although initially, I wanted to separate the role and experiences to be faithful to my thesis question, I realised that these were intricately linked, each dependent on the other. The role entailed an ability to perform a multiplicity of tasks and skills, but further to this, the role was embedded in the experience, which itself is complex and pervasive.

The third and final specific aim was to acknowledge the unique stories of the domiciliary midwives. This aim was well addressed, as I made space for the participants to share their stories, perceptions and experiences, in other words, to valorise the voices of the domiciliary midwives. The data revealed that they experienced undervaluing in their professional role, by midwives throughout the hospital, management and “the healthcare system”. It explicitly demonstrated that for these midwives, the experience of this role led to dissatisfaction and marginalisation. It was seen in their interactions with the midwives on the postnatal wards who were at times unhelpful, misinformed and even hostile in regard to workload and staffing issues. It was seen in their interactions with management, where emails and concerns have gone unattended and the non-consultative attitude toward future directions and vision for the maternity unit. The lack of attention to education and upskilling along with their increased workload has also been a point of dissatisfaction that translates, in their experience, to undervaluing of their professional role. The data also revealed that their undervalue lies in the emphasis on any negative events which might occur in their role, rather than in celebration/recognition of the skilful and effective work they achieve.

In a somewhat juxtaposed position these midwives enjoyed being able to relay details of their professional lives, finding satisfaction in sharing their experiences with “somebody who is interested”. After developing rapport with these midwives, they shared rich data with gusto and enthusiasm, because they did experience some validation and hoped for change.

Significance

This study has highlighted the significance of the postnatal period, which has previously been overlooked in research, funding and resourcing for the more “immediate” and emotive areas of maternity care, such as labour ward or intensive neonatal care. Further, it has highlighted that the studies which have been done previously have predominantly concentrated on postnatal care within the hospital, rather than care in the home, or domiciliary care. Domiciliary care is an area that requires a high level of skill, especially with an increasing mandate and reducing

resources. If domiciliary care is to be valued, and outcomes for mothers and babies are to reflect WHO standards, then the postnatal period, in this Australian context, should be taken more seriously.

The research also enabled the numerous experiences of domiciliary midwives to be voiced and valorised when prior literature in this area has largely reflected quantitative methodologies. Quantitative methodologies do not allow for the rich descriptions and complexities that make up the experiences of participants. Therefore this study provided not only validation for the domiciliary midwives, but the collection of valuable data for analysis, and an accurate portrayal of the role and experience of postnatal domiciliary midwives in metropolitan Melbourne.

The significance of these research findings are firstly of concern to the midwifery profession. If the concerns of domiciliary midwives are heard and actioned, their sense of marginalisation will be decreased. Their concerns include the general attitude of other areas of maternity care, ongoing education (both undergraduate and ongoing), resourcing, staffing issues and being valued for their opinions with regards to future directions of healthcare services.

Second, these findings are significant for women and their families. The literature reminds us that women still require care in the postnatal period, even though resources are limited. The continual reduction in services may well lead to poor outcomes. Finding ways to ensure high quality care and maintain a skilled, valued and satisfied workforce will impact on the health and well-being of women, babies and their families.

Third, these findings should be significant for the governments and policy writers who are trying to predict healthcare workforce numbers for the future. If midwives were treated with more respect and value there may be better recruitment and retention rates within midwifery generally, but postnatal care in particular. For example, attention to education, both at undergraduate and postgraduate levels, in a variety of forms sends a clear message that this work is valued, and that the role of the domiciliary midwife is valuable.

In a time of midwifery shortages, this is an obvious strategy to address this problem.

Implications and recommendations for further research

The major implications from this study for domiciliary midwives in particular relate to the significance of postnatal care, the value of critical ethnography, the culture of midwifery and the transitional state of maternity services at present.

This study addressed a gap in the literature by exploring the role and experiences of being a domiciliary midwife in Victoria, Australia. A literature search and review confirmed that although there is a growing interest in the postnatal period, there is still a paucity of research related to this period of time both from the midwives' or mothers' perspectives. Therefore, this study will contribute to the body of knowledge about postnatal domiciliary midwives, the care they provide and the issues of pivotal concern to domiciliary midwives.

To my knowledge, this study is the first critical ethnography specifically to be carried out on the role and experience of domiciliary midwives. This method proved to be an appropriate and useful design for this study. It provided the process and methods necessary to gather data that answered the thesis query. Further, it provided a process that highlighted the skill of domiciliary midwives and the marginalisation and powerlessness that typified their professional experience. This methodology respectfully gave voice to and validated their professional role and experiences.

The use of critical ethnography has highlighted the need for domiciliary midwives' voices to be heard, so that their skills, experiences and opinions are not lost in the transition to changing models of care, or an under-resourced system attempting to provide services for a growing community.

This research has highlighted the long-standing culture of marginalisation embedded within postnatal care. Arguably, changing a well worn, ingrained culture of undervaluing postnatal care is a difficult task to address. While undervaluing of postnatal care has not been previously acknowledged, the data demonstrated that in many ways it is clearly an issue and it impacts on both women and midwives. It is this culture that must be addressed. Increased priority on the profile of postnatal care, including domiciliary care through research, education and re-distribution of resourcing may well assist to address this cultural issue.

The research has highlighted the transitional period that maternity care is experiencing and the need for further research to ensure that quality care or midwife satisfaction is not a victim of expediency. It also specifically highlighted the need for further and ongoing education for junior and senior midwives to maintain currency with higher acuity needs and recent research in the face of change.

This study illuminated the meaning that domiciliary midwives derive from working with women in the postnatal period, in their homes. While there were difficult circumstances that the participants experienced, high level of satisfaction also “sat” within their work experiences. The satisfaction and validation they derived from working with women at this significant time mediated their workplace frustrations.

From the findings of this study, it is evident that the role and experiences of the domiciliary midwife needs to be fully acknowledged and valued by the midwifery community, management and the health system in general.

Domiciliary midwives have a unique position that requires a high level of skill that they practise under difficult circumstances. The findings have revealed that they feel largely unacknowledged and disempowered to improve their situation. The findings showed that the participants were marginalised in many, small ways. Marginalisation needs to be brought out in the open, because naming this oppression is the first step in changing circumstances. Keeping the marginalisation of domiciliary midwives unacknowledged perpetuates the problem.

Furthermore, economic and political constraints have impacted on the role and experiences of the domiciliary midwife, as with all other areas of healthcare. However, this time of transition may be the very time for change and improvement for domiciliary midwives. Highlighting the impact of these issues and constraints could provide impetus for the development of innovative strategies, so that domiciliary postnatal care remains safe, effective and meaningful. Improving the satisfaction of work roles and experience might also improve the workforce shortage by improving nurse/midwife recruitment and retention rates.

It would be fitting for “the healthcare system” to engage with domiciliary midwives, acknowledge their expertise and ascertain the skills required to provide safe care to women and babies. Domiciliary midwives could be sourced for

information about the aspects of their care that they see waning due to changes in acuity, in junior staff being accessed, and in limited access to current research. Giving the midwives a “voice”, listening to their stories, ideas and opinions places palpable value on their professional role and experience. But more equally, this sharing of information would improve the skill and understanding of all midwives, increasing satisfaction and improving outcomes for midwives, mothers and families.

Following the research and findings of this study, the use of critical ethnography in other areas of maternity or nursing care can be recommended. It is an illuminating and respectful method of data collection as it showcased the voices of the participants by making space for their rich experiences. This study has also highlighted inequalities and provided a social critique of issues, context and meaning for the participants. The methodology, methods and process could be transferred to other settings within nursing, maternity, in Australia or overseas.

The current complexities affecting the role and experiences of domiciliary midwives may be expanded on due to the findings of the research. The following are examples of areas for further exploration:

- The use of standardised care plans in the home; are they based on evidence-based research?
- The most appropriate days for visiting women.
- The degree of necessary undergraduate education focused on postnatal care/domiciliary care.
- Safety issues regarding domiciliary midwives’ clinical practice.
- The relationship between limited resources and coping strategies.

Validity

In this section I address the concept of research validity and the processes engaged within this research that ensured it was rigorous. Across the disciplines, rigour is recognised as being of prime concern, however, traditional methods of measuring rigour have been queried, particularly within qualitative methodologies (Koch & Harrington, 1998). Further, there has been much debate between the use of tools or means to measure rigour across paradigms, as opposed to those

measurements that are methodologically specific or consistent. Scholars argue that the measurements cannot be used interchangeably. Therefore alternate terminology has been employed to capture the integrity of findings and analysis such as validity, reliability, objectivity, subjectivity, confirmability, trustworthiness and ethics (Creswell, 2007; Lincoln & Guba, 1985). Grbich (1999) has suggested that the triangulation of several techniques would assist in improving the validity of qualitative studies.

The following are the strategies I employed to ascertain validity in this research study. Initially, ethics approval was obtained, from both the university and the health network, with guidelines about participant information, data collection, data storage, confidentiality, dissemination and complaint mechanisms. The ethics approval is reviewed each year while the research is active, ensuring that I am accountable to HREC standards.

The method of participant observation entails spending extended periods of time with the participants. There is the possibility that I could misunderstand and misrepresent their story (Lincoln & Guba, 1985) however, the extended length of time spent “in the field” assists in ensuring accuracy.

The combined methods of participant observation, field notes, critical conversations and the reflective journal contributed to the internal validity (Lincoln & Guba, 1985) of the data collection. As I observed the participants moving in their workplace, I was able to verify and clarify by conversation, that the issues I saw arising were accurately noted. Conversely, as the participants shared critical conversations with me, I was able to verify emerging themes with their behaviours, context and interactions within the workplace. I looked for a “match” between observation and behaviour.

The practice of reflexivity in my reflective journal (or audit trail) and with my supervisors enabled me to sift through any biases, agendas or strong feelings that arose as I immersed myself in the research process (Roper & Shapira, 2000). Further, it assisted me to reflect on the milestones when my understanding deepened or changed direction (Grbich, 1999; Koch & Harrington, 1998; Madison, 2012).

The process of data collection, which included transparency, rapport, and empathy ensured that at all times I was consistent with critical theory intentions. My

aim was that we were on an equal footing as researcher and participants, with mutual trust and respect flowing between us (Glesne, 1989; Holloway & Biley, 2011; Olsen, 2001).

Toward the completion of data collection, I reviewed my emerging themes and characterisations of the participants, providing them with the opportunity for a “member check” (Grbich, 1999). The participants expressed delight in the accuracy of my perceptions of their professional role and experiences.

The strategies of analysis were also faithful to critical ethnography, as identified in the global theme, themes and sub-themes that emerged. Using the voices of the domiciliary midwives, they highlighted the skill, context, marginalisation and meaning that the domiciliary midwives find in their professional role and experience.

In the final stages of writing up this thesis, I presented this study and its findings at a three-day national midwifery conference (Heyward, Glass, & Ogle, 2013). The study and findings were enthusiastically received and I received a peer-reviewed nomination for best presentation at the conference. It was clear that the content “spoke” to the national midwifery delegates. Clearly the study and findings were timely, providing information regarding domiciliary care that has not been researched, and much needed information regarding the role and experiences of the postnatal domiciliary midwife. I was encouraged to publish the findings and I will be presenting the study and findings to the participants in the near future.

Limitations of the study

There are some limitations to this study. This study was carried out in a health network in metropolitan Melbourne. While many of the findings will resonate with domiciliary midwives in other settings, I am not espousing these to be generalisable to the entire population of domiciliary midwives, and also these may not even reflect the experiences of other midwives.

The methodology was critical ethnography; I gathered my data by spending many hours with the participants. I used my reflective and reflexive journal, and supervision to openly reveal and make transparent my thoughts.

The number of participants was seven, and although they had similar concerns and stories, it was a small number and may not represent a larger body of domiciliary midwives.

Other methodologies may contribute other findings related to the role and experience of postnatal domiciliary midwives. Critical ethnography is not a design that measures the outcomes of interventions. The use of quantitative methodology or other qualitative methodologies such as feminist thought would illuminate alternate aspects of midwifery or nursing professional life.

Reflections on the research journey

On a personal note, one of the joys of this study, was to spend time with the domiciliary midwives, “on the road”, observing their work, and getting to know their perceptions of their everyday work experiences. I enjoyed developing rapport and it was humbling to be part of hearing their unique stories. I also valued the opportunity to reflect on this vital work, without the responsibility of being a carer. It is a privileged and fascinating position in which to “sit” and experience. This privilege has become one of the driving forces for the completion of the thesis, as an honouring and repaying of debt to the participants who gave their time and selves generously.

As I reflect on this research process, I can see that I have learned skills as a researcher in critical analysis, but also personally as I learn to persevere through the set tasks, often alongside personal loss. It has been a time when I have learned resilience through hardship. I am sure this lesson will be of good use in the future!

I have learned the value of being mentored and this culminated with my recent experience of presenting at a national conference. My skills were honed through the careful mentorship of my supervisors and I have learned as much by my challenges as I have by my victories; my supervisors have taught me to overcome rather than be overwhelmed.

It is quite apparent that domiciliary midwives perform a highly skilled role in difficult circumstances. They find meaning and satisfaction in their work despite the undervalue they feel is inherent in their role.

While the findings regarding postnatal care may be perceived as “gloomy” it is important to reflect on this as a judicious time for midwives and women to speak up and implement more positive changes. Midwifery peak bodies and women are finding their “voices” and this is an opportune time for the development of better strategies of managing postnatal care in general, and domiciliary care in particular.

It is planned that continued dissemination of this information in Australian settings will promote interest in possibilities for improvement both in the experiences of the domiciliary midwife, but also in healthcare provision. The thesis will be made available for interested parties and the findings will contribute to the body of midwifery knowledge through new understanding of a familiar situation and generation of new information.

Chapter summary

Chapter five has been presented in six sections. First, the research question, broad aim and specific aims were reflected upon, reviewing the extent to which they have been addressed. The following section discussed the significance of this research to domiciliary midwives and the midwifery population in general. The third section expanded on the implications of the study with recommendations inclusive of areas for further research. Next, the validity of this study was discussed and justified. The fifth section provided a discussion about the limitations of the study. Finally, I concluded with my reflections on the research.

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Appendix I—Critical conversation questions exemplar

How did you feel about that visit(s)?

Do you enjoy your work?

Could you tell me what it is that you enjoy about your work?

What is the scope of your role?

Would you like to see that scope changed?

What gives you the most satisfaction/frustration about your work?

Why have you chosen to be involved in home care?

How did you gain your education, skills and expertise to deal with this type of clinical practice?

Do you perceive yourself as adequately skilled for this position?

What would you like to have as additional resources and/or training?

Appendix 2—First approval from health network

(Note: All references to the health network in the following documents are de-identified.)

Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research : _____
has been authorised

02 April 2012

Professor Nel Glass
Australian Catholic University
Locked Bag 4115
Fitzroy MDC
Fitzroy Vic 3065

Dear Prof Glass

LR51/1112 An exploration of the role and experience of the postnatal domiciliary midwife in Victoria, Australia

Principal Investigator: Prof Nel Glass

Associate Investigators: Dr Robyn Ogle & Ms Karen Heyward

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. Project has been reviewed by Research and Ethics Committee. The project is considered of negligible risk in accordance given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:

Low Risk & Negligible Risk Research Application Form
Project Proposal version 2 dated 08 February 2012
Participant Information and Consent Form version 4 dated 19 March 2012
Advertising Poster version 2 dated 08 January 2012
Woman's Information sheet version 2 19 March 2012
Client Consent List version 1 dated 08 January 2012
Curriculum Vitae – Nel Glass
Curriculum Vitae – Robyn Ogle
Curriculum vitae – Karen Heyward
Email response to ethics dated 08 February 2012
Email response to ethics dated 22 March 2012

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months an annual progress report should be submitted in **April 2013**. Continuing approval is subject to the sul be downloaded from our web-page: [ht](#)

Please quote our reference number **LR51/1112** in all future correspondence.

Yours sincerely

Copy to:

- Dr Robyn Ogle, Ms Karen Heyward & Ms

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval at . lices.

Publications

Appendix 3—Ethics Amendment

15 August 2012

Professor Nel Glass
Australian Catholic University
Locked Bag 4115
Fitzroy MDC
Fitzroy Vic 3065

Dear Prof Glass

LR51/1112 An exploration of the role and experience of the postnatal domiciliary midwife in Victoria, Australia

Principal Investigator: Prof Nel Glass

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission for the above project for review.

The following documents have been **reviewed** and **approved** by the Research and Ethics Subcommittee Chair on 9 August 2012.

- Request For Approval of Amendment form dated 12 July 2012
 - Plain Language Statement Version 5 dated 19 July 2012
 - Proposal Version 2 dated 18 July 2012

Yours sincerely



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Appendix 4—Participant Information and Consent Form (PICF) for Clinical Non-Drug/Device Research Projects



Full Project Title: An exploration of the role and experiences of the postnatal domiciliary midwife in Victoria, Australia.

Principal researcher: Prof Nel Glass

Co-researcher: Dr Robyn Ogle

Student researcher: Karen Heyward (RM)

Introduction

You are invited to take part in this research project following your expression of interest in the study. Your qualification as a Registered Midwife and experience as a postnatal domiciliary midwife is crucial for our data collection. The research project aims to explore the role and experience of postnatal domiciliary midwives in Victoria, Australia.

This Participant Information and Consent Form tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or colleague.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- .Understand what you have read;
- .Consent to take part in the research project;
- .Consent to be involved in the procedures described;

- Consent to the use of your personal and professional information as described

You will be given a copy of this Participant Information and Consent Form to keep.

What is the purpose of this research project?

The broad aim of this study is to explore the role and experience of postnatal domiciliary midwives in Victoria, Australia.

Women are leaving hospital earlier after giving birth than traditionally expected. They still require postnatal care to assist them with their mothercrafting skills, to observe for normal recovery following pregnancy and birth and to make referrals to other health professionals as necessary. Therefore, midwives are required to make more visits to women's homes than ever before.

There is a paucity of literature about the role and experience of the postnatal domiciliary midwife, in spite of the rising need for their services in maternity care. There has been no research carried out which has specifically researched the role and experience of the domiciliary midwife. Past studies have included the work of domiciliary midwives in their field of interest, but have often included them with postnatal care in hospital, or where care was provided by a community nurse or non-professional carer. Past studies have concluded that there is need for further research in the area of midwifery postnatal domiciliary care provision, since we are not sure that the care being provided at home currently is helpful, timely or appropriate.

Experienced domiciliary midwives who provide this care should be given the opportunity to have input into research regarding this care.

There will be 6-10 domiciliary midwives involved in the project, with the aim of recruiting solely from [REDACTED] Hospital.

You will be observed, individually, in your usual daily work routine in preparation at the hospital, postnatal home visits, travel time and communication with other health professionals. Semi-structured interviews between yourself and the researcher will also provide critical data to form a better understanding of your role and experience.

This is a stand-alone study. The results of this research will be used by the researcher Karen Heyward to obtain a Master of Midwifery (Research) degree.

This research has been initiated by the investigator, Karen Heyward (RM)

This research is being conducted by Australian Catholic University.

The researcher has been granted an academic scholarship by Australian University, but no other sponsorship is related to the study.

What does participation in this research project involve?

Involvement in this project requires that you spend time with me in the normal postnatal domiciliary work environment. The work environment will include the hospital, in preparation for the day's events, travel to client's homes and attendance of postnatal home visits, communication with other health professionals as necessary.

In addition to being observed, you will also take part in informal, semi-structured interviews with the researcher to share your thoughts, experiences and views about your work.

The time spent with you may include entire or partial shifts not necessarily on consecutive days. The times will be negotiated between you and the researcher, and will be dependent on circumstances and mutual convenience. Approximately 2-3 partial or whole shifts will be spent with each participant, over no more than three months.

Written field notes will be taken about the researcher's observations of work, environment and interactions. The researcher may also include a request that voice recordings be made of informal conversations between you and the researcher, these will be transcribed (with your permission) and used for analysis.

Participation in this project is considered "low risk", however, if there are any issues that arise as a result of participation, contact details will be made available for debriefing and/or counselling.

Copies of the final results will be made available for the participants.

There is no payment for your participation in this research.

What are the possible benefits?

We cannot guarantee or promise that you will receive any benefits from this research however, possible benefits may include satisfaction from participating in a study that improves circumstances for domiciliary midwives and their clientele. Further, many previous study participants have found the opportunity to voice their views and opinions in a safe, empathic environment and validating experience.

What are the possible risks?

Possible risks, side effects and discomforts include feelings of vulnerability. The researcher will aim to be sensitive at all times with the researcher's presence and dealings with you, the other hospital staff and clientele. Your participation in this study is confidential, the researcher will not be informing or confirming other people of your participation in the study.

Privacy for women and their babies may also be an issue. You are the focus of the study, not the women or babies, therefore verbal consent will be obtained by you from the families before any interaction is observed by the researcher.

If you become upset or distressed as a result of your participation in this research, the researcher is able to arrange for counselling or other appropriate support. Any counselling or support will be provided by staff who are not members of the research team. In addition, you may prefer to suspend or end your participation in the research if distress occurs. There may be additional risks that the researchers do not expect or do not know about. Please tell the researcher if you are concerned about anything that arises as a result of this study.

What if new information arises during this research project?

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information and the researcher will discuss whether this new information affects you.

Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part you don't have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with [REDACTED].

What if I withdraw from this research project?

If you decide to withdraw, please notify a member of the research team before you withdraw. This notice will allow us to inform you if there are any special requirements linked to withdrawing.

If you decide to leave the project, the researchers would like to keep the information that has been collected. This is to help them make sure that the results of the research can be measured properly. If you decide to leave the project once it is underway, it is your decision as to whether we keep or destroy the data that you have generated. There will be no penalty or consequence to your employment at [REDACTED].

Could this research project be stopped unexpectedly?

It is unlikely that this project will be stopped for any clinical reasons unexpectedly.

How will I be informed of the results of this research project?

A summary of the findings will be sent to you electronically at the conclusion of the project.

What else do I need to know?

- **What will happen to information about me?**

Data will be stored in a locked filing cabinet in a locked office on secure premises. Transcripts will be checked and all identifying features will be removed and anonymised by the project coordinator. Investigators will sign a confidentiality agreement regarding security of information and usage. No other staff will have access to the data.

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law.

Data will be stored for five years after publication of the project, after which time, transcripts will be shredded and electronic data will be deleted. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission.

- **How can I access my information?**

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information, with which you disagree, be corrected. Please contact one of the researchers named at the end of this document if you would like to access your information.

- **What happens if I am injured as a result of participating in this research project?**

If you suffer an injury as a result of participating in this research project, hospital care and treatment will be provided by the public health service at no extra cost to you if you elect to be treated as a public patient.

- **Is this research project approved?**

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of [REDACTED] and Australian Catholic University.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Consent

I have read, or have had read to me in a language that I understand, this document and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed)
.....

Signature

Date

Name of witness to participant's signature (printed)
.....

Signature

Date

Declaration by researcher: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed)
.....

Signature

Date

Note: All parties signing the consent section must date their own signature.

Who can I contact?

Who you may need to contact will depend on the nature of your query, therefore, please note the following:

For further information or appointments:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact me on:

0438 950 246 or any of the following people:

Name: Professor Nel Glass

Role: Principal Researcher (and supervisor)

Telephone: 03 9953 3478

Name: [REDACTED]

Role: [REDACTED] Manager

Telephone: [REDACTED]

For complaints:

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

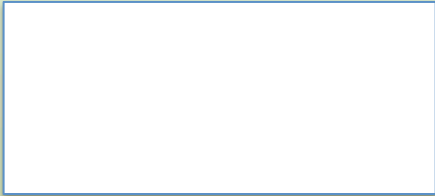

Name: Ethics Chair [REDACTED]

Telephone: [REDACTED]

Appendix 5—Advertising Poster—placed at field sites

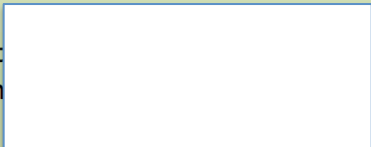
Are you interested in participating in a
postgraduate research study on...

POSTNATAL CARE IN THE HOME



This research study will explore the role and experience of the
postnatal domiciliary midwife in Victoria, Australia.

Information sessions (10 mins duration)
hospital maternity wing



If you are interested in participating in this project, please
contact me on the following details:

Mobile: 0438 950 246
heywardkaren@gmail.com

KAREN HEYWARD (RM)
Master of Midwifery (Research)
Principal Supervisor: Prof Nel Glass: nel.glass@acu.edu.au
Co-supervisor: Dr Robyn Ogle: robyn.ogle@acu.edu.au

Advertising Poster
Version Two
8 January 2012

Appendix 6—Women’s Information Sheet

██████████ and Australian Catholic University are working on a research project together to provide better services for women and their families using maternity services within Victoria.

Currently, a research study is approved at ██████████ that looks specifically at the role of midwives who provide care to women in their homes after they’ve had their babies in hospital. As you are probably aware, the length of stay after giving birth in hospital has shortened over the last two decades, yet research about the way in which hospitals provide care has been lacking and this study is attempting to address that shortcoming.

The research project is focused on midwives at work, observing their skills and interactions with postnatal women in hospital and at home. The researcher needs to spend time with midwives as they work to get a clear picture of their role, skills, choices, resources, interactions and perceptions of their role.

The researcher (Karen Heyward) collecting the information is a qualified and experienced midwife/Lactation Consultant who is working toward a Master of Midwifery. Karen has a keen interest in quality care as well as an understanding of issues related to postnatal care. At all times privacy, dignity and respect of women and midwives will be observed by the researcher. Although the researcher’s role is primarily observation, you may feel free to involve her in the visit and ask questions about the study if you wish.

You have been invited to participate in this study, by consenting the researcher to accompany the midwife at their home postnatal visits. Whilst the focus is on the midwives, your issues and participation are integral to the data collection. Your identity will remain completely anonymous, each client will be assigned a number. Once you have consented to being involved in the study, you may withdraw at any time without any consequence.

If you agree to participate, a verbal consent is all that is required, the midwife who organizes your visit will make a note of your consent.

If you have any further questions, please feel free to contact the researcher
on: 0438 950 246
Thank you for taking the time to read this information sheet. . . .

Appendix 7—Client consent List

CLIENT CONSENT LIST

NAME OF MIDWIFE COLLECTING INFORMED CONSENT

PLEASE SIGN THE APPROPRIATE COLUMN IF THE WOMAN CONSENTS TO PARTICIPATE IN THE RESEARCH STUDY

DATE		SIGNATURE OF MIDWIFE	SIGNATURE OF RESEARCHER
	CLIENT 1		
	Initial of client		
	CLIENT 2		
	CLIENT 3		
	CLIENT 4		
	CLIENT 5		
	CLIENT 6		

THANK YOU FOR YOUR HELP WITH THIS STUDY

If you have any queries regarding the study or this form, please contact me,
Karen Heyward on: 0438 950 246.

Appendix 8—Plain Language Statement for [REDACTED]

Ethics Approval Application

Background and purpose

This study focuses on midwives who visit women and their babies at home after a hospital birth, during what is known as the postnatal period. This period is a significant time for women to bond with their babies, learn and develop confidence in their mothercraft skills and heal from pregnancy and birth. It is important that health professionals assist women and their babies in this period and, as needed, refer them to other health professionals.

Currently women and babies leave hospital earlier than they used to even 10 years previously. Thus, midwives need to make home visits to women and babies to provide postnatal care that was traditionally provided in hospital. Such midwives are termed domiciliary midwives.

Little research has been done to ensure that the in-home care women and babies receive is appropriate, timely or even helpful following early discharge from hospital. Therefore this ethnographic study will explore the role and experiences of midwives who provide in-home postnatal care.

Design

Domiciliary midwives who regularly and mainly provide in-home postnatal care, and who are interested in and eligible to support this study, will be recruited. Three ten-minute information sessions will be held during double staff time of the shift so as to reach as many suitable participants as possible. Participants will receive an information package about the study and a written consent form.

The [REDACTED] Manager at [REDACTED] within the [REDACTED] Network agrees to the recruiting of midwives, which will assist in ensuring there are enough participants in the study.

The researcher will observe six to ten domiciliary midwives in their work role that includes individual home visits and interactions with other health professionals.

The researcher will observe each participant over two or more partial or complete shifts within a three-month period. While this study is about midwives, not mothers and babies, the mothers will be required to give verbal consent for the researcher to observe each visit.

Results and sponsorship

The researcher will collect and analyse the data then produce two main documents. These are a summary for distribution to the participants and a thesis documenting detailed research findings and analysis.

The results will be submitted for a Master of Midwifery (Research) at the Australian Catholic University (ACU). The researcher has been granted a scholarship by ACU for tuition.

Appendix 9—Participant Observation and Critical Conversation Schedule

Site One:

Two introductory conversations and emails with the Health Network	Nov 11
Phone conversation and emails with health network to commence fieldwork	May/June 12
Fieldwork 1 (introducing myself and the research project)	04/06/12
Fieldwork 2 (introduction and on the road with Shae)	05/06/12
Fieldwork 3 (on the road with Charli)	06/06/12
Fieldwork 4 (on the road with Portia)	12/06/12
Fieldwork 5 (on the road with Portia)	18/06/12
Fieldwork 6 (on the road with Christie)	20/06/12
Fieldwork 7 (on the road with Shae)	21/06/12
Fieldwork 8 (on the road with Christie)	25/06/12
Fieldwork 9 (on the road with Charli)	29/06/12
Fieldwork 10 (on the road with Shae)	11/07/12
Fieldwork 11 (on the road with Portia)	11/09/12
Critical conversation and reflection 1 (Charli)	01/10/12
Critical conversation and reflection 2 (Shae)	01/10/12
Critical conversation and reflection 3 (Portia)	09/10/12
Fieldwork 12 (on the road with Christie)	10/10/12
Interview and reflection 4 (Christie)	19/10/12

Site Two:

Phone calls and emails to commence fieldwork	Oct/Nov 12
Fieldwork 13 (introduction and on the road with Giselle and Adelia)	20/11/12
Fieldwork 14 (introduction and on the road with Ingrid)	25/11/12
Fieldwork 15 (introduction and on the road with Giselle and Ingrid)	27/11/12
Critical conversation and reflection 5 (Giselle)	30/11/12
Fieldwork 16 (on the road with Adelia)	17/12/12
Critical conversation and reflection 6 (Adelia)	20/12/12
Critical conversation and reflection 7 (Ingrid)	01/02/13