Women’s views on postnatal care from a midwife (or midwives) who has/have not provided their pregnancy and birth care:

Implications for establishing effective midwifery relationships.

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A thesis submitted in fulfilment of the degree Master of Midwifery
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Submission Date: 28/02/2022
Declaration

Declaration Concerning Thesis Presented for
the Degree of Master of Midwifery

I, Sally Louise Horncastle

of New Zealand

solemnly and sincerely declare, in relation to the thesis/dissertation/exhibition entitled:

1. That work was done by me, personally

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Date: 28 February 2022
Abstract

In Aotearoa New Zealand (from hereafter New Zealand), postnatal care is typically provided in hospital and at home by a known Lead Maternity Carer (LMC) midwife who has provided continuity of care and lead maternity care throughout the childbearing episode. While this model of maternity care is accepted as optimal, increasingly and for a myriad of reasons, postnatal care is being provided by a midwife or midwives previously unknown to the woman and her family. This study aimed to explore women’s experience of postnatal care when provided in this context, in order to understand the critical components for establishing a constructive and supportive postnatal care experience.

The study design was qualitative descriptive to enable a rich and data-close explication of the women’s experiences. Semi-structured interviews with eleven first-time mothers were analysed thematically to develop three main themes that captured the essence of their experiences. The findings confirmed that postnatal midwifery care is a highly valued and vital component of postnatal adjustment as a new parent. While continuity of care was desired by most women, they articulated a range of ways that midwives can build meaningful relationships when they meet women for the first time postnatally. Themes centred around how women navigated the postnatal period which was characterised as being challenging and how the midwife provided an anchoring presence as these new mothers grew in confidence as new mothers and when caring for their babies.

Sub-themes identified why the study participants were cared for postnatally by midwives who were previously unknown to them, examined their postnatal experiences in hospital prior to going home and describes their first meetings with their postnatal midwives and the key ingredients which enabled their alliances to work constructively.
Acknowledgements

Thank you to the participants in this study who generously gave their time and candidly shared their thoughts, reflections, and experiences of what was clearly a poignant and significant time at the beginning of their lives as new mothers.

The journey for me has not been short but hugely illuminating and rewarding for me both personally and professionally. I am immensely grateful for the support I have received from Otago Polytechnic, the guidance and encouragement from my supervisors Dr George Parker, Dr Suzanne Miller and latterly Dr Lorna Davies.

Also thank you to my family for always being there for me and encouraging me to keep going. Special thanks to my husband and life partner Mike who has always held complete belief in the value of the research and to my two beautiful daughters, Alice and Emily, who have taught me so much about motherhood.

Dedication

This thesis is dedicated to my mother, Jennifer Ann Thow, who passed away during the writing of this thesis. She was a great believer in the care and support that midwives give to women during their early weeks as new mothers.
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Chapter 1: Introduction and Background

Introduction

In this qualitative descriptive investigation I set out to discover how women experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care. I acknowledge that continuity of care is the model of midwifery care in New Zealand and set out to examine the relationship between women and their postnatal midwife when they have not met before the start of the postnatal period. The research is not seeking to provide a comparison with continuity of care models of postnatal care. It is hoped that by understanding how women perceive their postnatal experience when the care is provided in this context, critical components for establishing a midwifery relationship will be revealed that will facilitate a constructive, helpful and supportive postnatal care experience. In particular the study sets out to evaluate what elements of care are effective and which segments of the relationship can be identified which create optimal outcomes for mothers and babies.

Postnatal care is an under-researched but a critical component of maternity care during which both mother and new baby are supported in their post birth transition. Due to the international growing trend towards early discharge from hospital after childbirth, effective home-based postnatal care is even more vital and can facilitate the detection and prevention of serious problems in both mother and baby (Bayoumi et al., 2016; Bowers & Cheyne, 2016; Fahey & Shanessa, 2013; Jones et al., 2021; Lefevre et al., 2019; Macdonald et al., 2021; Vance, 2013).

Midwifery in New Zealand is currently navigating through a period of unrest and

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1 The words ‘woman/women/her/she’ are used throughout this thesis, yet the author wishes to acknowledge trans/nonbinary individuals and male midwives within our communities and within the maternity space.

2 The provision of continuous lead maternity care throughout the antenatal period, the labour and the postnatal period and that this lead maternity care is provided by the LMC with whom the woman has registered. The LMC may be part of a group practice that provides reciprocal back-up and in the process of providing that back-up may from time to time, provide some of the woman’s care to enable 24/7 service provision (MOH, 2021).
change with some studies examining burnout amongst midwives and concerns around the sustainability of the Lead Maternity Carer (from hereafter LMC\(^3\)) model of midwifery care (Crowther et al., 2016; Davies et al., 2020; Dawson et al., 2019; Dixon et al., 2017; Young, 2011).

Currently there are no existing studies examining the relationship between new mother and previously unknown postnatal midwife or how women experience postnatal care when it is provided in this context. This research is therefore particularly significant given the current maternity climate within New Zealand of midwife shortages, increasing workloads and postnatal care modules now often provided separately by midwives who have not provided their pregnancy and birth care.

Purposive sampling was used to recruit 11 women as participants for the study. They participated in semi structured interviews which examined the critical components of the relationship with their postnatal midwives and used thematic analysis to scrutinise themes from the data. The study also investigated why participants had received postnatal care in this way and revealed insightful elements of the current midwifery postnatal care provision in New Zealand. The findings were analysed utilising thematic analysis with key themes emerging from the data.

The introduction provides a foundation for the main body of the thesis. It firstly presents a definition of postnatal care and examines how postnatal care is generally seen in the literature. An overview of postnatal care in New Zealand is presented acknowledging that midwifery in New Zealand is unique in comparison with other countries particularly in relation to midwives being able to practice autonomously as self-employed case-loading LMC midwives and in relation to the duration of the midwifery postnatal care provision. The LMC role,

\(^3\) A Lead Maternity Carer is a midwife or an obstetrician or a general practitioner with a diploma in Obstetrics, a diploma in Obstetrics and Medical Gynaecology (or equivalent, as determined by the New Zealand College of General Practitioners) and is either a maternity provider in their own right or a practitioner (described as above) who is an employee or contractor of a maternity provider and has been selected by the woman to provide her lead maternity care (MOH, 2021, p.17).
continuity of care, partnership and the role of the midwife in postnatal care in New Zealand are discussed. The midwife woman relationship is then examined before presenting the research aims, question and method. Lastly, the introduction includes a researcher perspective outlining how my interest in the research topic was ignited and a synopsis of my background before concluding with a brief thesis overview.

Definitions of Postnatal Care

A statement made by the UK Audit Commission in 1997 still resonates today as much in New Zealand as in the UK:

There is some uncertainty about what postnatal care is aiming to achieve – whether it is solely to prevent and treat immediate health problems in the mother and the baby or whether it is aiming to enhance the overall experience, giving mothers time to recover and get to know her baby … Perhaps because of this uncertainty there is considerable variation in the nature of postnatal care … (UK Audit Commission, 1997)

By definition, the postnatal period is the phase of life immediately after childbirth although some researchers argue that there is no one absolute definition of postnatal care (Wray, 2006, 2011). In New Zealand, postnatal care is defined as “the services provided in the period from two hours after the birth of the placenta until forty-two days following the date of birth” (MOH, 2021, p.18). The World Health Organisation (WHO, 2015) suggest that the adoption of a single unifying term ‘postnatal’ should be used “for all issues pertaining to the mother and baby after birth up to six weeks (forty-two days)” (WHO, 2015, p.1).

Although the duration of the postnatal period is culturally variable, it is generally regarded cross-culturally as the first six weeks (42 days) after childbirth (Finlayson et al., 2020). There does, however, appear to be some uncertainty regarding the agreed length of the postnatal period; it has been described as “the phase of life immediately following childbirth” (Finlayson et al., 2020, p.2) and “a time point of
eight weeks but the postnatal period does not, of course, end at eight weeks” (NICE, 2021). The usual assumed time period of postnatal recovery of six weeks has been challenged in many studies (Davies et al, 2020; Hamilton et al., 2018; Knight et al., 2021). The ending point of the postnatal period is also debated by some authors claiming that ‘postnatal care as an entity is not an end point’ (Wray, 2011, p.223) and suggesting that the postnatal period should be viewed as a ‘starting place’ rather than it being seen from the maternity services and midwifery viewpoint as an ‘endpoint’ (Wray, 2009, p.28). Generally, women receive a final postnatal check ‘around 6-8 weeks after the birth of their baby. In New Zealand this is generally carried out by the midwife providing the woman’s care and the woman is also advised to see her own GP at this point for a postnatal assessment. Concerns have been raised in recent literature around the adequacy and timing of this final postnatal check (Knight et al., 2021; Macdonald et al., 2021) and certainly in the UK, the six-to-eight-week postnatal check is now mandated in the GP contract agreement (NHS England, 2021) to acknowledge that many women experience continuing problems well after the defined end point of the postnatal period.

Positionality of Postnatal Care

Although my research is centred in New Zealand, much of the literature on postnatal care is based in the UK. However, it still holds relevance as it contributes to scene setting for this thesis and is significant when discussing how postnatal care appears and sits amidst maternity care as a whole. In addition, in the UK postnatal care provided by a previously unknown midwife or midwives would appear to be the norm, making comparisons with the UK relevant to this study. I will also present the background around postnatal care in an international context more generally,

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4 This check would normally include a review of the woman’s history to date including pregnancy, labour, birth and postnatal recovery. An assessment and review of the woman’s physical health status, emotional wellbeing and family/whanau support and discussion regarding the outcomes of this assessment with her and any health issues that are ongoing, ensuring that the woman has follow-up if required (NZCOM, 2015, p.47).
Many studies acknowledge that the postnatal period is critical in the lives of mothers and babies (Dermott et al., 2006; Knight et al., 2021; Macdonald et al., 2021; NICE, 2021; Say et al., 2014) and state that most maternal and infant deaths occur in the first month after birth (WHO, 2015). The importance, value and potential of postnatal care is also widely accepted in numerous sources (Brodribb et al., 2013; Davies, 2014; Finlayson, 2020; Knight et al., 2021; Macdonald et al., 2021; NHS England, 2016; NICE, 2021). Recent literature recognises the continuing risk to women during the first year after giving birth acknowledging that this is after the end of contact with support services (Knight et al., 2021; Macdonald et al., 2021). Considering this, it seems ironic that the postnatal period receives less attention from healthcare providers than either pregnancy and childbirth and is described in many studies as the least emphasised element in maternity services occupying the lowest priority in policy, practice, teaching and research (Albers, 2000; Bick et al., 2020; Dermott et al., 2006; WHO, 2010).

Postnatal care would seem to occupy a rather ‘lowly’ reputation in literature discussing the sphere of maternity care. In 2006, Wray coined the phrase a ‘Cinderella service’ and went on to state “postnatal care is referred to as the Cinderella of maternity care thus supporting the marginalised status within the profession” (Wray, 2006, p.8). This analogy has been echoed in more recent studies; (Garland, 2018; Macdonald et al., 2021; Macgregor et al., 2020; NICE, 2021; Schmied, 2014). Other studies describe postnatal care as “the poor cousin” of maternity care (Byrom et al, 2010, p.49) and having “increasing invisibility” (Byrom et al., 2010, p.vii). The result of this less than favourable image is further described by Yelland (2010) as, “a dearth of papers regarding women’s and midwives’ views of postnatal care” (p. 49). This has significant implications for practice and increasing concerns have been reported regarding the quality and effectiveness of postnatal care from the perspectives of both women (Bhavnani & Newburn, 2010; Bick et al., 2020; Fahey & Shanessa, 2013; Forster et al., 2008; Razurel et al., 2011; Waldenstrom et al., 2006) and care providers (Bick et al., 2011; Catrell et al., 2005; Macdonald et al., 2021).
Many studies and reviews describe the provision of postnatal care as “inadequate and scanty” (NICE, 2021) “not fit for purpose, lacking any basis in either evidence or maternal need” (Davies, 2014, p.97) and suffering from being inadequately resourced and historically insufficiently funded (Fenwick et al., 2010, Macdonald et al., 2021). There is a general agreement in the literature that research in the area of postnatal care has been neglected leading to an inadequate body of knowledge and evidence to support it (Dermott et al., 2006; MacArthur et al., 2002; Wray, 2002).

Numerous studies highlight that women are more dissatisfied with postnatal care than other areas of maternity care (Bhavani & Newburn, 2010; Brown et al., 2005; Davies, 2014; Waldenstrom et al., 2006). Women’s lower ratings of satisfaction with postnatal care compared with intrapartum and antenatal care have been reported in Australia (Brown et al., 2005; Cooke & Stacey, 2003; Forster et al., 2016) as well as the UK (Bhavnani & Newburn, 2010; Davies, 2014; Malouf et al., 2019; Redshaw & Heikkila, 2010) and in Sweden (Rudman & Waldenstrom, 2007; Waldenstrom et al., 2006). Some studies suggest that historically the crucial element of providing quality care during the postnatal period has gone unrecognised resulting in the needs of postnatal women remaining relatively invisible (Fenwick et al., 2010, p.11). I acknowledge that some of these studies are rather dated and that findings from over a decade ago may not reflect current practice. However, this reflects the reality of the current attention on this area of practice and lends weight to the need for further study into the provision of postnatal care in a contemporary New Zealand context.

Postnatal Care in New Zealand

There is no doubt that the midwifery postnatal care provision in New Zealand is unique in relation to both its life span and the aspiration of continuity of care throughout. It would therefore be of value to situate postnatal care amidst the current maternity care landscape in New Zealand before moving on to examine
the provision of postnatal care both in New Zealand and internationally. This will contextualise NZ provision of care within a global setting.

The role of the midwife postnatally will be discussed in greater depth later in this introduction to this thesis but it is acknowledged here that in New Zealand a large part of the funded maternity care is community-based encapsulating an enhanced level of autonomy within the everyday practice of midwives providing postnatal care in the community (Clemons et al., 2021). The Statuary Frameworks for midwifery in New Zealand give privileges to midwives that are rarely experienced elsewhere in the world. The Nurses Amendment Act (1990) restored registered midwives’ independence and legal autonomy as practitioners. It enabled midwives to provide all primary maternity services without medical supervision, gave them limited prescribing rights, access to specialist and hospital services and the same funding for maternity care provision as doctors (Grigg & Tracy, 2013). The Health Practitioners Competence Assurance Act (2003) required all registered health practitioners to have their own regulatory authority responsible for ensuring that all its members are competent and safe to practice their profession. Midwives in New Zealand have their own regulatory authority; Te Tatau o te Whare Kahu Midwifery Council, which is responsible for registering midwives, issuing practising certificates and essentially protecting the public against professional incompetence and misconduct by ensuring midwives are competent and fit to practice.

It is of relevance to this research to briefly clarify how the midwifery workforce in New Zealand is distributed. In the Te Tatau o te Whare Kahu Midwifery Council of New Zealand 2021 Midwifery Workforce Survey, there were 3283 midwives who held annual practising certificates (APC’s) at the time of the survey; 39.20% of midwives (1287) reported caseloading as their main work situation. The majority of these were self-employed LMC midwives (1079). LMC midwives make up 83.84% of the caseloading midwives and 32.87% of the midwifery workforce in New Zealand (NZMC, 2021). While 47.82% of midwives (1570) reported core
midwifery practice as their main work situation, 24.79% of midwives (814) reported a second job and 10.02% of midwives (328) reported a third job (NZMC, 2021); 54.86% of midwives (1801) reported a District Health Board (in various work situations) as their main employer (NZMC, 2021).

Women in New Zealand receive midwifery input in the postnatal period for the six-week period (up to 42 days) following the birth (MOH, 2021, p.53). This is the maximum period of the postnatal midwifery care as some women are discharged from midwifery postnatal care at 28 days after the birth. This postnatal midwifery input includes “one consultation at the woman’s home before the end of the day after discharge from the maternity facility” (MOH, 2021, p.54 (ii) and “at least seven postnatal consultations in total including a minimum of five consultations conducted in the woman’s home” (MOH, 2021, p.54 (iii).

Postnatal care currently floats upon a tide of more general unrest in maternity care in New Zealand. Numerous studies and media reports highlight a current and persistent shortage of midwives nationally, dissatisfaction with pay and conditions, professional burnout, increasing numbers of midwives leaving the profession and the lack of sustainability within the current models of maternity delivery (Calvert & Benn, 2015; Corlett, 2021; Cox & Smythe, 2011; Forbes, 2020; MacGregor & Smythe, 2014; McAra-Couper et al., 2014; Nugent, 2018; NZIER, 2020; Young, 2011). This climate is impacting on the delivery of postnatal care, with shorter hospital stays and fewer home visits as midwives struggle to provide care with the flexibility and time required. The impact of COVID-19 in New Zealand has also had implications for the New Zealand midwifery workforce whose principles of care are partnership, collaboration, safety, and relational continuity (Pairman & McAra-Couper, 2015). Recent studies have shown that midwives in New Zealand were key influencers and facilitators for continuity of care to continue throughout the COVID-19 response despite the personal risk to themselves and their families (Crowther et al., 2020, 2021). During the initial five-week lockdown in March 2020 which required all New Zealanders other than
essential workers (such as midwives) to stay at home, midwives continued to provide care within a system where midwifery is continually reported to be under resourced, underpaid and relatively invisible (Crowther et al., 2021). Community based postnatal care continued across all settings despite an increased workload for midwives with many new mothers facing isolation and the challenge of minimal support from families and friends due to travel restrictions and a general reluctance to go into hospital environments or stay for longer than was absolutely necessary (Crowther et al., 2021; Sweet et al., 2021).

Studies exploring the sustainability of maternity care illustrate the effect of an ‘increased complexity of health issues in the cohort of expectant mothers in New Zealand’ (NZIER, 2020, p.9). Other studies illustrate that internationally obesity levels, diabetes and cardiac disease are all on the increase in women who are becoming pregnant (Bird et al., 2016; Cantwell et al., 2011; Thorogood, 2015). Eclampsia, caesarean section, and postpartum haemorrhage rates are also rising, and physical problems can be compounded for many women by co-morbidities such as mental ill-health as well as social issues such as poor housing and isolation (Callaghan et al., 2010; Thornton et al., 2013; Schmied et al., 2013; Woolhouse et al., 2015). These complexities demand more time from midwives (NZIER, 2020) and it has been suggested that the expectations of women receiving care have changed creating more demands made on LMC midwives to meet their needs (Welfare, 2018).

Inequality and social justice issues add a further layer of complexity. Some studies claim that ‘despite a socialised health system’, maternal health inequalities still exist in New Zealand (Dawson et al., 2019, p.3) despite other studies suggesting that the midwifery led, continuity model of maternity care is a key contributor to the reduction of these (Vedam et al., 2018; McRae et al., 2018). It would seem that inequalities still exist in access to maternity services experienced by many women from refugee and migrant populations (Ou et al., 2010a; Ou et al., 2010b). There is evidence that the maternal-infant healthcare system in New
Zealand is failing Māori, who are tangata whenua, (the indigenous people of New Zealand) (Graham & Masters-Awatere, 2020; Stevenson et al., 2020). In addition, Māori wahine (women) and their babies face higher rates of morbidity and mortality than non-Māori (Stevenson, 2018; Stevenson et al, 2020; Blaiklock & Kiro, 2015) and Māori babies are more likely to be born preterm (born before 37 weeks gestation) (Mantell et al., 2004).

All of these factors make postnatal care provision in New Zealand more challenging as midwives strive to provide continuity of care amidst a weakened workforce blighted by staff shortages and workforce sustainability issues. Many women report negative experiences in hospitals prior to returning home earlier now with their babies (Fahey & Shanessa, 2013; Jones et al., 2021; Malouf et al., 2019; Rayner et al., 2010). It could be argued that these factors compound to make the relationship with the midwife postnatally even more important.

The LMC Midwife Role in New Zealand

It is relevant to present the unique role of the LMC midwife in New Zealand and to illustrate where the role currently sits within the framework of the partnership model and continuity of care as this explains why postnatal care is delivered in its current form in New Zealand. The LMC is a self-employed practitioner paid by the government under Section 88 of the NZ Public Health and Disability Act 2000 on a contract for service basis (Grigg & Tracy, 2013). The LMC can be a midwife, a general practitioner (GP) or an obstetrician and is responsible for assessing needs in early pregnancy, planning, providing and co-ordinating maternity care for the woman from early pregnancy until six weeks (42 days) after the birth (Grigg & Tracy, 2013). As already acknowledged earlier in the thesis, of the 3283 midwives in New Zealand who held annual practising certificates at the time of the 2021 Midwifery Workforce Survey, 39.20% of midwives (1287) reported caseloading as their main work situation and the majority of these were self-employed LMC midwives (1079) (NZMC, 2021). Most LMC midwives are community based and
the remainder of midwives work as core midwives⁵ on hospital maternity wards or within hospital community teams ⁶ both employed by District Health Boards. 

LMC midwives practice within a model of partnership and continuity of care (these are discussed in the next two sections) and this creates many additional facets to the relationship between mother and midwife. Literature supports the expectation that when women choose an LMC midwife to care for them throughout their pregnancy, birth and postnatal period, they are more likely to receive continuity of care from the same midwife across the whole maternity journey (Crowther et al., 2016; Lewis, 2018; McAra-Couper et al., 2014). The other key component of the LMC role is the expectation of professional autonomy which is an integral part of the professional standards, regulation, ethics, and education which are key components of midwifery practice in New Zealand (Clemons et al., 2021).

For many pregnant women the initial process of choosing an LMC to care for them is currently fraught with difficulties (Dawson et al., 2019) and it would seem that many women give up in the initial stages (Priday et al., 2021). A qualitative comparative study by Priday et al., 2021 described finding an LMC as “the first barrier to accessing early midwifery care” (Priday et al., 2021, p.29) and “circumventing the maternity care maze” (Priday et al., 2021, p.30). It may be that there is minimal understanding about how the LMC model of care works or some women may feel reticent about approaching unknown LMC midwives for care (Lewis, 2018). Certainly, for vulnerable women, the process of finding an LMC can be particularly frustrating and yet the right person to lead their maternity care can be essential for achieving optimal outcomes (Hatherall et al., 2016; Ryan et al., 2017). The challenges many women face in securing an LMC midwife at the start of their pregnancies is discussed in greater detail in the discussion chapter of this thesis.

⁵ Midwives who are employed by District Health Boards and work shifts in hospitals and maternity units.
⁶ Midwives who are employed by District Health Boards who provide care in the community setting.
Alternatives to LMC midwives are limited as “few General Practitioners are providing obstetric care in New Zealand” and the “costs of private obstetricians (this option is not available to all women) is significantly high” (Dawson et al., 2019, p.9). Many women register with hospital community midwifery teams at the start of their pregnancy simply because they are unable to find an available LMC midwife that has any availability. Women who have existing health problems or develop complexity during pregnancy may receive specialist care from a hospital based obstetric team specific to their particular needs and then receive postnatal care from a different midwife who is part of the obstetric team. The findings chapter of this thesis identifies that not all the study participants had managed to secure an LMC midwife at the start of their pregnancy and many had registered with hospital-based community midwifery teams and hospital based obstetric teams during their pregnancies. So, these women experienced fragmented care throughout their childbearing journey.

It is known that some Māori women face greater barriers in accessing information about choosing an LMC and knowing what to expect in pregnancy (Ratima & Crengle, 2013). Having to ask a health professional to care for them can be a culturally and socially challenging aspect of securing an LMC for many Māori and Pasifika women and something that many will avoid (Bartholomew et al., 2015; Corbett et al., 2013; Makowharemahihi et al., 2014). Māori and Pasifika women often express that they would like a midwife of their own culture/ethnicity and may not be able to locate one (Ratima & Crengle, 2013; Kenney, 2011). The small number of practising Māori midwives limit their choices and accessing culturally responsive and appropriate care may be challenging (Ratima & Crengle, 2013).

Many women in New Zealand are cared for postnaturally by their LMC midwife who has cared for them throughout their pregnancy and birth and this is within the continuity of care model which is a requisite of the New Zealand midwifery provision. Often though when there is increased complexity in the form of health problems that develop in pregnancy requiring specialist referral, there is
increasing fragmentation of care and an increase in the number of caregivers involved (De Jonge et al., 2014).

There is also an absence of accessible information regarding the proportion of women in New Zealand who receive postnatal care from a previously unknown midwife. As acknowledged earlier in this chapter, within the current climate of midwife shortages and increased workloads within hospital community teams, many postnatal women are placed with new and sometimes multiple midwives to care for them. In their case, continuity of care is not achieved, and it is the views of these women that this study is aiming to present.

**Continuity of Care/**

It has already been acknowledged that New Zealand has a unique model of women centred maternity care with continuity of care being supported and promoted through various frameworks, specifically the Primary Maternity Services Notice, (MOH, 2021). Continuity of care describes a package of care in which the woman chooses an LMC midwife at the start of her pregnancy who leads her maternity care throughout her childbirth experience and this model of care is also sometimes referred to as continuity of carer (Freeman, 2006; McAra-Couper et al., 2014). In New Zealand, the definition of continuity of carer means “one midwife (and her backup colleague) providing midwifery care throughout the entire childbirth experience” (Guilliland & Pairman, 1995, p.39). Continuity of midwifery carer has been integrated across all levels under the partnership model of midwifery in New Zealand (Guilliland & Dixon, 2019). Due to current midwife shortages some midwives operate within small group practices where women who register with them are seen by most or all midwives in the group. This team approach to LMC care has value within a sustainability model of care and is still considered to be continuity of care (Gilkison et al., 2015). This distinctive care context has been demonstrated to provide improved satisfaction and outcomes for women and their babies (Perriman et al., 2018: Moncrieff, 2018).
Existing studies internationally have examined the value of continuity of care in maternity care (Bagheri et al., 2017; Huber & Sandall, 2009; Perriman et al., 2018; Perriman & Davis, 2016; Rayment-Jones et al., 2020; Sandall et al., 2016). Continuity of care during low-risk pregnancy, labour and birth has been demonstrated to improve certain measurable outcomes and not increase risks for mother and baby (Devane et al., 2010; McLachlan et al., 2012; Perriman et al., 2018; Rayment-Jones et al., 2020; Sandall et al., 2016).

Certainly, in the UK, fragmentation of maternity care would seem commonplace and seeing many different midwives throughout maternity care is an accepted aspect of postnatal care (Care Quality Commission, 2019). Some studies highlight that the trusting relationships with midwives created in a continuity of care model are key to improving outcomes and women’s satisfaction with care (Lewis et al., 2017; Perriman et al., 2018; Rayment-Jones et al., 2020). In contrast, NHS England (2016) describes continuity of carer throughout maternity care as one of its key recommendations but presents it as a ‘team approach’ describing it as ‘every woman should have a midwife, who is part of a small team of 4-6 midwives, based in the community who know the woman and family and can provide continuity throughout the pregnancy, birth and postnatal period’ (NHS England, 2016, p.9).

It would certainly appear that in the UK, most continuity models are best achieved through caseloading or team midwifery approaches to maternity care (Sandall et al., 2016).

Continuity of carer in the postnatal period specifically is not examined in many studies but in those accessed was shown to be a crucial element in determining quality of care and women’s increased satisfaction of it (Aaserud et al., 2016; Barimani et al., 2014; Kurth et al., 2016; Walker et al., 2019) and in identifying maternal needs, generating trust, supporting breastfeeding and for women to feel more comfortable when discussing their birth experiences with midwives (Dahlberg et al, 2016; Schmied et al., 2010). Dahlberg et al., (2016) concluded from her Norwegian study of postnatal visiting at home by midwives, that women who
received a home visit from a midwife they had not met before found the visit to be “less significant especially with regard to the emotional aspect and the processing of the birth experience” (Dahlberg et al., 2016, p.60). Contrastingly a recent UK study carried out by McLeish et al., (2021) which concurs with my findings found that while continuity was preferred, emotional support could be present where one-off interactions were managed skilfully by the midwives and when the women felt safe, valued, and cared for. A small selection of studies I could locate relating to continuity of carer in the postnatal period are included as a critical analysis table (Appendix A) to illustrate how I have attempted to “nut out” my research question. They are also included more generally in the literature I have reviewed for this thesis and appear in the literature review chapter.

As maternity care environments become more complex it could be argued that the benefits of continuity of care are undermined (Skinner, 2008). There is some suggestion that the continuity of care/carer involved in caseloading LMC midwifery exposes the midwife to greater risk of emotional burnout and that robust policies are required for its implementation to “protect the giver of the care as well as the recipient” (Young, 2011, p.57). Conversely, a New Zealand based study involving 1073 midwives found that self-employed LMC midwives in New Zealand providing continuity of care to a caseload of women had better emotional health and less burnout than midwives working in exclusive employed capacities (Dixon et al., 2017).

Clearly, continuity of care and carer are concepts of maternity care that are highly valued by midwives and women alike. However, it could be argued that discussion around these concepts regarding their implementation are needed within an ever-changing healthcare landscape, and that effective evaluation methods of this type of care need to be set in place. It could be argued that continuity of carer is not a clear predictor of women’s satisfaction and that for many women it is the content of the care provided that is significant rather than the model (Freeman, 2006). Women would appear to conceptualise continuity of
care and carer in a variety of different ways (Jenkins et al., 2015) and going forward, there may be an increased demand for continuity in midwifery care to be enhanced through online contact, communication and support accessed via social media (McCarthy et al., 2017).

**Partnership**

The LMC model of partnership with the woman is a highly regarded and integral aspect of New Zealand’s commitment to continuity of care (Grigg & Tracy, 2013; Lewis, 2018; McAra-Couper et al, 2014). The overarching principles of New Zealand midwifery care are partnership, collaboration, safety, and relational continuity (Pairman & McAra-Couper, 2015). These principles lie at the centre of Te Tiriti o Waitangi, New Zealand’s founding document, of Te Ao Māori (the Māori world) and of New Zealand midwives’ commitment to cultural safety (Farry & Crowther, 2014). A partnership model of midwifery care is generally seen as central for midwifery practice in New Zealand as it forms the foundation on which all care is based (Guilliland & Pairman, 1995; Kennedy & Shannon, 2004).

The New Zealand College of Midwives first Standard for Practice states that ‘the midwife works in partnership with the woman’ (NZCOM, 2015, p. 18) and the Midwifery Scope of Practice confirms that

the midwife works in partnership with the woman, on her own professional responsibility to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn (MCNZ, 2021).

For many LMC midwives, the partnership model of midwifery care encompasses a reciprocal relationship which sustains them in their practice and encourages them to stay in the profession for longer (Cox & Smythe, 2011; McAra-Couper et
al., 2014; Sullivan et al., 2011; Versaevel, 2011). In other literature the partnership model is presented as being protective for both woman and midwife describing; “a relationship based on negotiation, equity and shared decision making, which if done well protects both the woman and the midwife from miscommunication and failed expectations that could impact negatively on a woman’s maternity experience” (Guilliland & Pairman, 2010, p.631).

Contrastingly, it could be argued that there is a lack of evidence to support the implementation of the partnership model into maternity care (Mander, 2011) and some suggestion that it may not be what every woman wants (Boyle et al., 2016). Certainly, for midwives, it would seem that the partnership approach has the potential to create tension and high expectations around what is realistically workable (Cox & Smythe, 2011; James, 2020; MacGregor & Smythe, 2014) and there is some suggestion that there is a lack of guidance tools available for midwives to assist their navigation through it when providing care (James, 2020; Lewis, 2018; Young, 2011).

Questions are raised over whether the partnership model of care fits well in the current contemporary maternity landscape serving more women with a host of complex social, psychological, and medical issues (Crowther et al., 2016; Dixon et al., 2017; MacGregor & Smythe, 2014; Young, 2011). Even though, women in New Zealand are able to maintain a continuous partnership with their LMC midwife, in addition to receiving obstetric input within hospital environments, they may not feel that partnership with their midwife is something that they want. This maybe particularly so for those women with complex health issues who may actively seek guidance from obstetricians (Carolan, 2005; Carolan & Hodnett, 2007).

Further potential problems with the partnership model are highlighted from a Māori perspective suggesting that it was devised and developed by “non-Māori women of European descent” (Kenney, 2011, p.127). Kenney (2011) goes on to acknowledge the small percentage of the midwifery workforce that is made up of Māori practitioners which makes a full understanding of Matauranga Māori
(indigenous/cultural knowledge) questionable amongst midwives generally. This then has further implications when providing culturally appropriate maternity care for Māori whānau.

The Role of the Midwife in Postnatal Care in New Zealand

Traditionally postnatal care has been centred on identifying ill health, problems and preventing maternal and infant mortality (Dixon and Schmied, 2015). However, societal changes and the provision and focus of postnatal care has altered this. A number of studies and guidelines have attempted to address the aims of postnatal care and also the role of the midwife in postnatal care (NICE, 2021; NZCOM, 2015; Schmied et al, 2008). There is some suggestion that the role of the postnatal midwife is under-researched and too focused on physical factors within a biomedical model rather than the provision of psychological, emotional, and social support for new mothers (Waldenstrom et al., 2006) though it is generally acknowledged in the literature that the midwife’s role in the postnatal period is to be available, supportive (both emotionally and practically), competent and knowledgeable (Hunter, 2004; McLeish et al., 2020, 2021; Persson & Dykes, 2002; Slomian et al., 2021).

The New Zealand College of Midwives (NZCOM) in its Handbook for Practice ‘incorporates the Scope of Practice and Competences required of a Registered Midwife by the Te Tatau o te Whare Kahu Midwifery Council of New Zealand’ (NZCOM, 2015, p.2). Also included are the standards of practice which ‘provide guidance for the midwife’s practice and the appropriate usage of midwifery’s body of knowledge’ (NZCOM, 2015, p. 17) and The Decision Points which provide ‘a guide for midwives to be able to identify those times when there may be an assessment required during pregnancy and childbirth’ (NZCOM, 2015, p.28). In relation to postnatal care and what is required of the midwife, there are three specific sections – the first decision point is immediately post birth (up to and including the first twenty four hours), the subsequent decision points in the
postnatal period are every twenty four to forty eight hours until the woman becomes confident in her home environment and the third decision point is at six weeks or the final postnatal visit (NZCOM, 2015, p.43, p.45, p.47). Each decision point illustrates the necessary assessments of the woman and baby, any investigations that should be undertaken, possible treatments, legal aspects and also any recommended discussions between the woman and postnatal midwife. These decision points present clear professional guidance of what is expected of the midwife providing postnatal care in New Zealand.

Overall, the midwife in New Zealand has a complex and detailed role to play in the lives of postnatal mothers and their babies. Her practice is regulated and monitored by Te Tatau o te Whare Kahu Midwifery Council of New Zealand. She is responsible for planning, accessing, and providing all care and support to the woman and baby for, and up to, the first 42 days after the birth. She provides home visits and also provides a continuously available channel of advice and support for the first six weeks of the postnatal period. This care involves prescribing and administering medication and contraception within her scope of practice, ordering, and interpreting any necessary screening tests on mother and baby, performing full examination on the normal neonate, recognising deviations from the normal and organising timely referrals to medical colleagues if deemed necessary. She liaises with other health practitioners to provide a link to the postnatal woman and is key to building a scaffold of support around the woman and her family. Other crucial elements of the role of the midwife in postnatal care include the provision of information and breastfeeding support (Bagheri et al., 2017; Schmied et al Zadoroznyl et al., 2015).

Her clinical role is essentially to ensure both mother and baby are well. This includes regular monitoring of the wellbeing of the mother and baby and generally takes the form of questioning and listening to mothers, performing any health checks she deems necessary or that the woman asks for, involving other sources of support in their care and ensuring that care is transitioned to the well
child provision at the ending of the six-week postnatal period. Intertwined within these aspects of physiologically caring for the postnatal woman are surveillance and support around her mental health, ensuring she is recovering from her birth and transitioning into motherhood. In addition, the midwife observes that the postnatal woman is relating well to her baby, that the establishment and maintenance of feeding is ongoing and that she is generally managing within her growing family.

With respect to the newborn, in addition to ensuring the baby remains well and is growing and thriving, the postnatal midwife is responsible for performing regular neonatal examinations as stipulated in the Well Child Book dictated by clinical guidelines. This is unique to the role of the postnatal midwife in New Zealand as full neonatal examinations are not a stipulated or expected requirement of the midwife role in many other countries unless the midwife has undertaken additional training to equip her to perform a full neonatal examination.

In addition to ensuring both mother and baby are well, the postnatal midwife also has a responsibility to ensure both mother and baby are safe. This involves the detection and recording of the presence of any family violence or issues that might potentially endanger mother or baby going forward and the involvement of other key services such as safeguarding teams and social workers to ensure both mother and baby are protected.

As already acknowledged earlier in this thesis, the postnatal midwifery care and support that the midwife is responsible for providing in New Zealand is enveloped within a reciprocal partnership model of care where the woman and midwife work together to achieve optimal wellbeing for both mother and baby. Within the partnership model of maternity care in New Zealand, ideally all aspects of care in the postnatal period such as frequency, timing and ending of visits, the nature of the visits and any specific needs the individual mother or baby may have would be discussed and negotiated between the individual woman and the midwife. There may be, for example, a need for increased and more intense
visiting for some women from the midwife and the plan of postnatal care should be culturally sensitive and tailored to the needs of the individual woman and baby. The midwife can request additional support for the woman and baby during the postnatal period and orchestrate a multi-agency approach to care if required.

The Midwife Woman Relationship

As the participants in this study were focusing on their relationships with previously unknown postnatal midwives it would seem relevant to explore the generalised concept of the midwife woman relationship to provide a foundation for my more specific focus. As previously acknowledged, continuity of carer is the model of midwifery care in New Zealand where women are seen by the same midwife within a partnership relationship throughout their childbirth experience. There are no known existing studies that examine how the provision of a new, previously unknown midwife at the start of the postnatal period affects this relationship (although this is normal care internationally) and my study therefore fills this void in the literature.

The experiences that women have with caregivers in the early postnatal period can be transformative and have a pivotal effect on their long-term health, wellbeing, and their transition to motherhood (Aune et al., 2012; Dahlberg et al., 2016; Kurth et al., 2016). The relationship between mother and midwife has been identified in many studies to be the key sustaining element and vital component of safe midwifery care (Crowther & Smythe, 2016; Hunter et al., 2008; Leap et al., 2011; Perriman et al., 2018). The significance of the midwife-mother relationship has been identified specifically in relation to postnatal care. Studies indicate the crucial element of the relationship and interactions with midwives as being associated with more positive experiences of postnatal care (Barimani et al, 2014; Boyle et al., 2016; Dahlberg et al., 2016; Walker et al, 2019). In addition, the ability of women and midwives to connect in the early postnatal period has been shown to markedly enhance women’s early parenting experiences (Ong et al., 2014) assist
their transition to motherhood (Walker et al., 2019) and reduce postnatal complications such as depression, anxiety, and stress (Dahlberg et al, 2016). Many women expect and attach value to personalised interactions with midwives during their transition to motherhood and any sense of disconnection between new mothers and midwives has been shown to potentially affect the health and wellbeing of new mothers (Martin et al., 2014; McKinnon et al., 2014; Walker et al., 2019).

Postnatally, it would seem that the relationship between midwife and woman can be constructed with many supportive elements. The importance of non-judgemental, reassuring guidance, positive affirmation and information sharing during the postnatal period is reflected in literature (McLeish et al., 2020; Slomian et al., 2021; Walker et al., 2019). Trust has been shown to be a central element within the midwife woman relationship and women are more likely to want midwives to guide their care if they know and trust them (Edwards, 2010; Huber & Sandall, 2009; Lewis et al., 2017; Wilkins, 2010).

There is a sense that somehow even though relationships with women are at the heart of midwifery practice, models of care supported by health policy continue to be at odds with the centrality of this element (Boyle et al., 2016; Crowther et al., 2016). It could be argued that the medical model of care is in conflict with woman centred care in which the relationship between woman and midwife is based on partnership and reciprocity (Boyle et al., 2016). Midwife shortages and increased workloads can create conflicts when trying to build relationships with women within time constraints (Bryson & Deery, 2010). In New Zealand, it could be argued that the intimacy of the midwife woman relationship can challenge the understanding of professional boundaries and contractual responsibilities (James, 2020). It would seem that setting safe professional boundaries is key to the relationship being reciprocal and equitable and there is the suggestion in some literature that difficulties arise when women being cared for by the midwives are not engaged, do not want a partnership approach to care or have different
expectations of the relationship (James, 2020; Macgregor & Smythe, 2014; McAra-Couper et al., 2014).

**Research Aims and Question**

This research sets out to answer the question: How do women experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care? By examining key concepts of the relationship between mother and previously unknown midwife or midwives it is hoped that a greater understanding will be gained of the critical components that facilitate a constructive and supportive postnatal care experience for women when the care is delivered in this context.

**Method**

The research described in the thesis gives voices to women having their first baby who receive postnatal care from a previously unknown midwife; a midwife who has not provided their pregnancy or birth care. The aim of the research is to present the postnatal experiences of women receiving postnatal care in this context and illuminating the implications for establishing effective midwifery relationships when care is provided in this way. I employed a qualitative descriptive approach as it suited the aims and objectives of the research. Qualitative descriptive research facilitates an effective method for exploring human existence as it occurs in everyday life (Sandelowski, 2000). Study participants described in everyday language their experiences of receiving postnatal care from a previously unknown midwife, how they perceived the relationship from first meeting until postnatal discharge. By gaining descriptions during semi-structured interviews from the eleven participants, I was able to identify themes and patterns which emerged from the data. The interviews were
recorded and then the data was thematically analysed as described by Braun and Clarke (2014).

**Researcher Perspective**

My research journey began with a passion for postnatal care and a curiosity in the postnatal care provision in New Zealand in comparison with other countries. I have worked as a midwife continuously since qualifying in Liverpool, United Kingdom in 1995 and have worked in a wide variety of settings ranging from stand-alone birthing units, rural community teams offering home births and busy city based obstetric units. I have also worked within community teams in the United Kingdom where postnatal care is delivered by a small group of midwives.

Since moving to New Zealand in 2014 I have been employed as a core midwife within a hospital maternity unit, worked in a small primary birthing unit and as a Lead Maternity Carer. Since December 2020 I have been employed by a District Health Board working within a community-based midwifery team. I still find the postnatal period the most interesting and often challenging element of my work. I have never tired of meeting the women, listening to their stories, and trying to really understand their postnatal experiences. The research study has given me the opportunity to immerse myself completely in the literature around what is for me the most interesting part of the maternity journey from a midwifery perspective. The postnatal period holds so much potential for midwives to really make a difference for women and their babies. It is a short time of opportunity for women to be supported to discover strengths within themselves that maybe they didn’t know were present and to achieve their full potential as mothers.

The women I see postnatally do not receive continuity of care due to excessive workloads, staff shortages and working patterns. They see different midwives from within the team in which I work. In comparison with previous postnatal work when I was an LMC, my current working experience has convinced me that
continuity of carer is much more beneficial from so many angles; it is an amazing opportunity to really get to know women and their babies and so the care is more streamlined and tailored to them as individuals.

Realising just how absent postnatal care and a supportive postnatal midwife are for many women internationally has been the sad element of this research for me. Here in New Zealand where my research has been based, the postnatal care provision is abundant and relatively easy to access. For me it was essential that the research acknowledged other areas of the world in which postnatal women receive no care at all for the first six weeks after their births and beyond in order to highlight the uniqueness of this care context for international readers of my work.

Listening to the participants speak during the interviews and when transcribing their words has given me ideas to apply to my own practice as a midwife when I am visiting postnatal women at home. The process of completing the research has made me stop and think. Over the years I have practised I have always placed my listening ability as one of my strengths as a midwife but now I listen more. I have always taken time to watch women with their babies but now I watch for longer. And I now listen to what the women tell me before I give advice and suggestions in an attempt to tailor any guidance I give to the women as individuals. The research has made me stand back and reflect on my work as a midwife particularly when visiting postnatal women and babies.

Reading the literature on postnatal care has reinforced for me just how vital the care is that we offer as midwives during the postnatal period is. It has fortified for me how valuable an enabling relationship between postnatal woman and midwife can be. Postnatal care holds the potential to open the doors to confident, independent motherhood for all women. It can help to identify vulnerable, compromised, or unwell women and babies who need additional support, time or intervention. It can help to weave an individualised support tapestry around women and babies which can lead to the additional support of multi-agency
involvement during the postnatal period and in so doing set parents⁷ on the road to successful parenthood.

I understand and acknowledge that the research may potentially be influenced by my own current employment recognising that I care for postnatal women regularly who see a variety of different midwives to those who cared for them during pregnancy and their births. I did recognise the areas which may be influenced by my positionality and I discussed these with my supervisors. One of the advantages of choosing a qualitative, descriptive methodology for my research is that the results remain ‘data near’, the data is true to the voices of the study participants and requires minimal interpretation.

**Thesis Overview**

The thesis comprises five Chapters.

Chapter 1 introduces the study and background. It then discusses how postnatal care is defined and presented in the literature and examines the current provision of postnatal care in New Zealand. The chapter then presents a range of supporting concepts including the LMC, continuity of care/r and partnership, all of which are critical components of postnatal midwifery care in New Zealand. Lastly the introduction discusses the role of the midwife in postnatal care in New Zealand and the midwife-woman relationship before continuing on to provide research aims and question, method, the researcher perspective, and a thesis overview.

Chapter 2 contains the literature review in which I present a background to the provision of postnatal care both in NZ and internationally by presenting the available literature. There is an absence of literature directly related to my research question, so this research is the first that explores how women experience

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⁷ When the term parents or parent is used it should be taken to mean anyone who has main responsibility for caring for a baby
postnatal care when it is provided in this context. Preparation for the postnatal period is then examined as is the concept of the fourth trimester. Women’s experiences of postnatal care, what they want from it and whether they look to alternatives to midwives for help, information and support in the postnatal period are examined. Finally, the importance of creating additional sources of support for postnatal women and ways of fostering self-reliance are then examined in the literature. The chapter concludes with a brief reflection on the literature.

Chapter 3 examines the methodological approach to the study, outlines the rationale for the study and discusses the research methods employed.

Chapter 4 details the findings of the research which are presented to highlight three overarching themes: Navigating the postnatal period, meeting the midwife for the first time postnatally and establishing effective midwife woman relationships postnatally. These three key themes acknowledge the experiences of all the participants finding themselves in completely unknown and unexpected territory on entering their lives as new mothers, the significance of meeting the previously unknown postnatal midwife for the first time and how the relationship was initiated, developed, and grew over those early weeks of motherhood. The sub-themes are described in more detail at the beginning of the findings chapter. The findings present the voices of the participants and directly represents their experiences. The women were given free rein to voice their perceptions of how they experienced this phase in their lives as new mothers and how their relationship with their midwife featured within this.

Chapter 5 is a discussion of the findings of this study. The study’s strengths and limitations are acknowledged plus implications of the findings for the field and recommendations for future research and practice. The chapter then concludes with a researcher reflection.
Chapter 2: Literature Review

Introduction

The purpose of this literature review was to identify and critically evaluate research conducted both in New Zealand and internationally that was pertinent to the research question: How do women experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care?

There is a dearth of studies in New Zealand generally relating to both postnatal care and how women perceive postnatal care as recipients, and this became very obvious from the beginning of the literature review. Studies from other countries, focusing on women’s views and experiences of postnatal care have employed a variety of methods including focus groups, interviews, cross sectional surveys and qualitative methods. On the whole, studies exploring postnatal care provision in this specific context are relatively rare. The table of studies illustrated in Appendix A presents the small number of literature studies that I could locate which focus on continuity of care/r with a specific focus on the postnatal period. There is an absence of research relating directly to my research question even though many postnatal women are currently receiving their midwifery care in this way in New Zealand.

Literature Review

The following databases were accessed through the Robertson Library at Otago Polytechnic to search for relevant published literature: CINAHL, ProQuest, PubMed, Cochrane Database and Google Scholar.

Keywords and phrases employed in the literature searches were; Postnatal care and period, postpartum care and period, puerperal period, What women want from postnatal care, partnership model of midwifery care in New Zealand,
midwife mother relationship, continuity of care/r, a different midwife for postnatal care, postnatal midwife, becoming a mother, experiences of postnatal care for first time mothers, midwife as professional friend, postnatal care relationships, hospital based postnatal care, postnatal care in the community, New Zealand midwifery, postnatal care at home. I used Boolean operators to combine keywords in an attempt to obtain a more focused result, for example, I searched for ‘midwives and postnatal care provision’ and ‘women and postnatal midwives.

Numerous books and journal articles from a broad range of countries and settings were retrieved for my review. I accessed and read dissertations, PhD theses, books and journal articles all focusing on postnatal care both in hospital environments and within the community. Postnatal care provision varies enormously, and women do not receive the same level and input of care worldwide. I accessed the websites of the New Zealand College of Midwives, Midwifery Council of New Zealand, Royal College of Midwives (UK). I examined their documentation relating to postnatal care provision, the role of the midwife in postnatal care, the midwife codes and scope of practice relating to postnatal care, newsletters and journals and also read consensus statements and decision points relating to postnatal care.

Postnatal Care Provision Internationally

Contemporary postnatal care in most western countries is characterised by a short length of stay in hospital (Jones et al., 2021). There is little consistency in the type, frequency, timing, location, and availability of health professional contact women receive in the postnatal period both within and between most countries (Burgess et al., 2015; Kikuchi et al., 2015; Langlois et al., 2015; Schmied, 2014; Wiegers, 2006). None the less, many recent studies acknowledge the significant value that first time mothers from a range of demographics attach to effective postnatal social support from health professionals (McLeish et al., 2021; Slomian et al., 2021;
Walker et al., 2019) though many studies report significant barriers and obstacles to midwives providing constructive and good quality postnatal care in hospitals (Beake et al., 2005; Bick et al., 2011; Fenwick et al., 2010; Forster et al., 2016; McLachlan et al., 2008, Schmied et al., 2008).

As already acknowledged earlier in this thesis, postnatal care in the community is becoming increasingly important as post-birth hospital and birthing unit stays have reduced substantially in most countries over the past 50 years (Cuncarr & Skinner, 2011; Dana, 2003; Goulet, 2007; Jones et al., 2021; Walker et al., 2019). Recent studies illustrate that access to home visiting from midwives in the postnatal period is effective in supporting women during their transition to motherhood (Aaserud et al., 2016; Dahlberg et al., 2016; Kurth, et al., 2016; McLeish et al., 2021; Walker et al., 2019) and in addition women generally prefer home visits from midwives rather than having to attend a community postnatal clinic (Bagheri et al., 2017; Boyle et al., 2016; Kurth et al., 2016; Martin et al., 2014; McKinnon et al., 2014; Walker et al., 2019). A large systematic review based in the UK, examined the effects of different home visiting schedules on maternal and newborn mortality during the early postpartum period and concluded that increasing the number of postnatal home visits from health professionals may promote infant health and exclusive breastfeeding and more individualised care may improve outcomes for women (Yonemoto et al., 2021).

The level of community support available to postnatal women once they leave a hospital or birthing unit varies considerably between countries (Burgess et al., 2015; Jones et al., 2021). The timing of the first recommended postnatal home visit from a midwife varies also. In New Zealand it is a contractual requirement for a visit to occur within the first 24 hours post discharge (MOH, 2021) and in the UK it is recommended within 36 hours of discharge (NICE, 2021). Some UK studies show a reduction in the number of postnatal contacts in the community (NHS England, 2016; Care Quality Commission, 2019; Schmied and Bick, 2014). Many women report experiencing confusion and disorganisation regarding postnatal
home visiting and speak of a lack of information over the schedules for these (McLeish et al., 2021). A further finding was that easy access to a midwife outside hospital settings for early postnatal care in some countries cannot be guaranteed for all women (Brown and Dietsch, 2013; Zadoroznyj et al., 2015).

In other western health care systems, the provision is hugely variable. In America women receive one single postnatal appointment 6 weeks after the birth (Krishnamurti et al., 2020). In Australia, women receiving their maternity care in public hospitals are offered at least one postnatal home visit by a midwife (Forster et al., 2005). Women in Australia receiving private care, however, do not always receive routine postnatal care at home after leaving hospital (Rayner et al., 2010).

In Holland professional postnatal care is provided by MCA’s (Maternity Care Assistants) who visit the postnatal woman at home for at least 3 hours a day for seven or eight consecutive days following birth and provide help in the home such as cooking and cleaning in addition to basic physical care (Wiegers, 2006 p. 1). These MCAs are supervised by midwives and midwives visit four or five times during this period (Wiegers, 2006, p.1.). In the UK most women receive an average of 3.1 midwife visits at home postnatally with 97 percent of women having at least one visit from a midwife at home (NHS England, 2016).

In New Zealand postnatal care is universally provided free of charge for all women and babies who are New Zealand citizens or permanent residents (MOH, 2011). Currently New Zealand remains an exception to the reduction in postnatal home visiting provision that is evident in many other countries (Care Quality Commission UK, 2019; Davies, 2014; James 2021; NHS England, 2016; Schmied & Bick, 2014). Women remain entitled to receive a minimum of seven home visits (between five and ten and more if indicated) from their midwife over the first four to six weeks of the postnatal period (MOH, 2021). Results from the 2014 New Zealand Maternity Consumer Survey (3,801 respondents) demonstrate that 58% of all respondents reported having received up to six visits during the four to six weeks following birth, 34% percent received between seven to twelve visits and
six percent received thirteen visits or more; 89% percent of all respondents reported being satisfied or very satisfied with care received postnatally (MOH, 2014). Yet despite this mandatory and unique provision, it would appear there is still dissatisfaction with certain elements of postnatal care as in March 2021 around 55,000 people signed a petition created by Kirsty Watt (a personal trainer with an interest in pre and postnatal pelvic floor healthcare) calling for improvements in postnatal pelvic health (Cooke, 2021). Petition signatories are campaigning for better ongoing postnatal care regarding perineal pain, continence problems and birth injuries calling for free pelvic health checks and more funding for Continence NZ. They are also signposting for improved recognition and treatment of mental health problems occurring during the postpartum recovery period. (Cooke, 2021).

**Preparation for the Postnatal Period**

Many studies identify a lack of preparedness for the postnatal period (Darvill et al., 2010; Howell et al., 2010; Leahy-Warren et al., 2011; Martin et al., 2014; McLeish et al., 2020; Rowe et al., 2013; Tobin et al., 2014) and this was certainly the case amongst all the study participants. This is discussed in further depth in the discussion chapter of this thesis. This lack of preparedness may be due to women focusing on the birth and preparation for it with less thought given to what happens after the baby is born (McLeish et al., 2020; Razurel et al., 2011, Renkert & Nutbeam, 2001). Some literature suggests that there is a need for improved antenatal access to comprehensive information regarding postnatal care generally (Manuel et al., 2012; McLeish et al., 2020; Shaw et al., 2006; Slomian et al., 2017). Certainly, there is evidence in the literature to suggest that first time mothers experience a smoother transition to parenthood when they have had access to comprehensive information about the timing, location, content, and purpose of postnatal care (McLeish et al., 2020). Women planning ahead for postnatal care by discussing it with their midwives during pregnancy has been addressed in a range
of studies (Bick et al., 2011; Yelland et al., 2009). Flexible planning of homebased postnatal care has also been shown to be beneficial as it gives new mothers the opportunity to plan their care and tailor it to their own needs (Lambermon et al., 2021).

Antenatal education classes generally provide a good foundation of information and support for many women in pregnancy but some studies have identified these as inadequate for postpartum needs and even suggest that the classes did not devote enough time to the postnatal period (Corrigan et al., 2015; Darvill et al., 2010; Dwyer, 2009; Entsieh & Hallstrom, 2016; Mcleish et al., 2021; Razurel et al., 2011). There seems to be a general lack of evidence of which method is most effective in meeting the needs of expectant parents who attend antenatal education sessions (Gagnon & Sandall, 2007).

A randomised controlled trial in Australia (Svensson et al., 2009) focused on a new antenatal education program called ‘Having a Baby’ with enhanced parenting content as compared to the regular antenatal education programme. Results showed that the perceived maternal self-efficacy and parenting knowledge of women in the intervention group was much greater compared to those in the control group (Svensson et al., 2009). Other studies show similar results (Ahlden et al., 2012) where the educational content concentrated on the specific needs of expectant and new parents, being adequately prepared for early parenting and to feel confident and secure in caring for the baby. Contrastingly, other studies show that despite being exposed to balanced amounts of childbirth and parenthood educational material, satisfaction levels of the participants involved were low as compared to those who were exposed to childbirth education with psychoprophylaxis (Bergstrom et al., 2011).

It would appear that many women are confused about which postnatal information they should trust as they seek it out from a huge variety of sources both online and from other people (Aston et al., 2018; Entsieh & Hallstrom, 2016; Henshaw et al., 2018; McLeish et al., 2020; Price et al., 2018). Once within the
postnatal period, a need has been identified for providing further support for new parents’ desire for information (Manuel et al., 2012; Shaw et al., 2006; Slomian et al., 2017) and some literature recommends that parenthood education classes are introduced early in the postnatal period (McKellar et al., 2008; Razurel et al., 2011; Tighe, 2010). Some studies make recommendations that shared, personalised postnatal care plans are given to women either during pregnancy or post birth (Dermott et al., 2006; Prevatt & Desmarais, 2018).

The fourth trimester

The recommendation that postnatal women should receive care for longer and criticism that the current accepted six-week postnatal period is too short a recovery period for many women are current and significant global issues in relation to postnatal care (Bick et al., 2020; Knight et al., 2021). The fourth trimester is discussed, acknowledged and recognition of it encouraged in many areas in recent literature (Bick et al., 2020; Hamilton et al., 2018; Knight et al., 2021, Montogomery & Laury, 2019; Stube et al., 2021; Tully et al., 2017) and is discussed in greater detail in the discussion chapter of this thesis. There are a plethora of definitions of the fourth trimester but it is generally accepted that it relates to the three-to-six-month period after the birth of a child (Matambanadzo, 2014) although this is debated in some studies (Bick et al., 2020; Knight et al., 2021; Stube et al., 2021). Postnatal midwifery care in many countries ends around six weeks after the birth and certainly in New Zealand this is described in the Decision Points for Midwifery Care as “six weeks or final postnatal; this timing provides for the completion of the midwifery relationship and feedback about the care given” (NZCOM, 2015, p.47).

Many studies identify that recovery from birth and the journey into motherhood are both highly individual and women vary in the time needed to adjust and adapt (Knight et al., 2021; Wray, 2011). The acknowledgement that many women
suffer significant physical problems and mental health challenges within the first year of birth when critical input from support services and, importantly, midwives has come to an end is being recognised in many recent UK research studies (Davies, 2014; Knight et al., 2021; Macdonald et al., 2021; NCT UK, 2017).

**Women’s experiences of Postnatal Care**

Little is known about first time mothers’ expectations of postnatal care or how these expectations relate to their experiences (Finlayson et al., 2020; McLeish, 2020, 2021). It would appear that internationally postnatal care is the aspect of maternity care that women are least satisfied with (Beake et al., 2010; Bhavnani & Newburn, 2010; Redshaw & Henderson, 2015). In contrast the New Zealand Maternity Consumer Survey 2014 (3,801 surveys completed) identified that 80% of all respondents were satisfied or very satisfied with the overall care they received in the hospital or birthing unit after they had given birth (MOH, 2014).

Numerous studies present scathing reports of hospital based postnatal care illuminating inadequacies (Malouf et al., 2019; McLeish et al., 2021; Rayner et al., 2010; Rudman & Waldenstrom, 2007), which included lack of privacy, disruptive hospital routines (Finlayson, 2020) fragmentation of and insensitive care (Dykes, 2005) and unsupportive carers (Ockleford et al., 2004). As already acknowledged, postnatal care at home delivered by midwives is generally well received by new mothers (Aaserud et al., 2016; Dahlberg et al., 2016; De Vries et al., 2021; Fenwick et al., 2010; Kurth et al., 2016; Walker, et al., 2019). Further studies suggest that new mothers find postnatal midwifery home visits supportive and reassuring (Hunter, 2004; Lock & Gibb, 2003, Walker et al. 2019). Other studies show that the key element in supporting women in a successful transition to motherhood is the ability of midwives and women to connect at a relational level and that this is best achieved by postnatal home visiting (Walker et al., 2019).
What Do Women Want from Postnatal Care?

Existing literature on postnatal care focuses predominantly on the effectiveness of specific postnatal interventions or around women’s experiences of postnatal care services. This has resulted in limited literature about what women themselves value during this period. There are few New Zealand studies examining what women want from postnatal care but common themes do emerge from international studies.

Contemporary postnatal care is sited within a place of changing provision and societal expectations. Postnatal care provision is often criticised for being inflexible, too standardised, and not tailored to the personal needs of women (Delaney et al., 2018; Lambermon et al., 2021). In a rapidly developing technological world, women seek and request postnatal digital information and welcome phone consultations in addition to home visits from midwives (Guerra-Reyes et al., 2017; Kurth et al., 2016; Letourneau et al., 2007; Sawyer et al., 2019; Slomian et al., 2021). They are keen to receive peer telephone support and use smart phone or computer apps to assist with breastfeeding (Danbjorg et al., 2014a; Forster et al., 2014, 2019; Shorey et al., 2018)

Finlayson et al., (2020) conducted a large qualitative review to examine what matters to women in the postnatal period. This review provided findings to inform the background of a new World Health Organisation (WHO) postnatal guideline. This study represented the views of more than 800 women from a wide variety of settings and contexts including Europe, Africa, North & South America, Australasia, and the Middle East. The study concluded that what mattered to women was a positive postnatal experience where they were able to adapt to their new self-identity and develop a sense of confidence and competence as a mother, adjust to changes in their intimate and family relationships including their relationship with their baby; navigate ordinary physical and emotional challenges and experience the dynamic achievement of personal growth as they adapt to the ‘new normal’
of motherhood and parenting in their own cultural context (Finlayson et al., 2020, p.1).

Many recent studies demonstrate that first time mothers from a range of demographics attach significant value to effective postnatal social support from health professionals in addition to support from family and friends (Leahy-Warren et al., 2018; McLeish et al., 2021; Slomian, et al, 2021, Walker et al., 2019). Connection with midwives in the early postnatal period has been shown to increase women’s satisfaction with postnatal care (Boyle et al., 2016; Dahlberg et al., 2016, Zadoroznyj et al., 2015). The importance of trusting relationships and the recognition of women’s personal and cultural contexts are also shown to be important to postnatal mothers (Finlayson et al., 2020).

Many studies reflect the value that women place on being treated as individuals; with kindness; being supported and given consistent information in the postnatal period, (Beake et al., 2005; Finlayson et al., 2020; Jomeen & Redshaw, 2013; McLeish et al., 2020; Redshaw & Henderson, 2012). Postnatally, women expressed a desire to be listened to by midwives and for the opportunity to be involved in decision making (NHS England, 2016; Finlayson et al., 2020; McLeish et al., 2020, 2021). Certainly, many studies affirm that it is the appraisal and supportive information from health professionals that provide the salient building bricks for new mothers to develop confidence (Aaserud et al., 2016; Leahy Warren, 2005; McLeish et al., 2021; Walker et al., 2019).

Literature which has examined the promotion of breastfeeding during the postnatal period has demonstrated the key role of midwifery advice and support (Backstrom et al., 2010; Henderson & Redshaw, 2011; Schmied, 2011; Zadoroznyj et al., 2015). While initial breastfeeding rates may be high immediately after birth, some studies demonstrate that women experience challenges after leaving hospital (McLelland et al., 2015). The importance of support in the early postnatal period from professionals though has a positive impact on breastfeeding outcomes and this is clearly shown in the systematic review of 51 international studies by
Renfrew et al., (2012). Crucially, in another more recent Cochrane review including 100 trials involving more than 83,246 mother and infant pairs, the duration and exclusivity of breastfeeding has been shown to be increased through breastfeeding support from health professionals (McFadden et al., 2017).

Do all women want postnatal care and information from midwives?

Levels of informal postnatal care and support vary widely across cultural and social settings. Within different contexts and cultural settings, social support is viewed as a pivotal component in the transition to motherhood for women (Finlayson et al., 2020; Negron et al., 2013; Raman, et al., 2014; Toomey et al., 2013). Studies focusing on midwives’ views on supporting women in their transition to motherhood illustrate the need for an inclusive family approach; involving the needs of the family and thereby promoting the health of the family overall (Bradfield et al., 2018). This is acknowledged in other studies (De Sousa Machado et al., 2020; Finlayson et al., 2020; Mbekenga et al., 2018; Ong et al., 2014; Raman et al., 2014).

Many women live within extended families and have good practical support within their own home environments. They are not as reliant on health professionals for practical or emotional support. Many new mothers rely on their own mothers, family members, and community elders for support in the postnatal period and for many it is vital to remain in their own home environments (Finlayson et al., 2020; Leahy-Warren et al., 2012; Ong et al., 2014; Raman et al., 2014; Reid & Taylor, 2015).

Other studies describe how isolated and alienated many women feel within hospital settings lacking the support of their family and friends (Beake et al., 2005; Finlayson et al., 2020; Xiao et al., 2019.). For many women, other informal valuable sources of postnatal support exist and they turn first to partners, friends, neighbours, peer counsellors and traditional birth attendents rather than
midwives (Mbekenga et al., 2011a; McLeish & Redshaw, 2015; Prevatt & Desmarais, 2018).

In contrast, other literature suggests that involvement of friends and family to support women during their postnatal transition to motherhood is not always plain sailing suggesting that cultural and family influences may interrupt a woman’s transition to motherhood in the early postnatal period (Bagheri et al., 2017). Many women feel that friends and family lack understanding about how they feel and have difficulties in talking openly to family and admitting their real feelings for fear of being judged (Dennis & Chung-Lee, 2006; Letourneau et al., 2007). Some women may feel reluctant to go to their own mothers for help and advice regarding care of their babies feeling that things have changed significantly over the years since they were born (McLeish et al., 2021).

Many postnatal women turn to friends who are already mothers for support (Negron et al., 2013) but this can itself create problems with competitiveness amongst new mothers as described in other studies (Letaourneau et al., 2007, McLeish et al., 2021). Some women report turning to other mothers as a good source of support due to being frustrated with partners and other family members (Hong Law et al., 2018). In addition, other studies show that many new parents experience confusion when being cared for by both informal care givers, family, and health care professionals postnatally as they had to choose whether to follow advice from health care professionals or their informal caregivers (Lugina et al., 2001).

It would seem that most women seek out information during the postnatal period from a variety of sources and often look to the internet for reassurance that all is well with themselves and their babies (Slomian et al, 2017(A); Slomian et al, 2017(B)). Some studies illustrate the possibility of creating follow-up support for postnatal parents discharged early from hospitals by implementing online communication, telemedicine, and an evidence-based information knowledge base (Danbjorg et al, 2014a; 2014b, Danbjorg et al., 2015). Peer support for postnatal
women with vulnerabilities and the valuable contribution of telephone peer support for breastfeeding mothers is highlighted in many studies (Forster et al., 2014; 2019; McLeish & Redshaw, 2015) and the effective use of apps during the postnatal period is mentioned in other studies (Sawyer et al., 2019).

The literature suggests that women want a variety of support interwoven in contemporary postnatal care provision. It could be said however that for many women, nothing replaces the role of the knowledgeable, experienced human caregiver shrouded in kindness and the relationship that is created alongside.

Weaving a Tapestry of Support for Postnatal Women

Within the current climate of more complex postnatal needs as discussed earlier in this thesis, it is acknowledged and recommended that many postnatal women require care incorporating a multi-team approach to create a safety net around them (Davies et al., 2020; Finlayson et al., 2020; Knight et al., 2021; Slomian et al., 2021, Walker et al., 2019). The emotional well-being of postnatal women is seen as a critical part of their care and emotional support can be facilitated by strengthening the woman’s own ability to mobilise social support, develop self-efficacy and positive coping strategies (Fahey and Shenassa, 2013). Postpartum distress of some form is experienced by many women post birth from the more common ‘blues’ to depression (Slomian et al., 2017). This distress is not specific to particular groups of women and can be experienced up to 24 months post birth ‘regardless of income, education, race, perceived social support or the sense of competence’ (Chavis, 2016, p.474.). Research suggests that many women are reluctant to acknowledge or admit feelings of depression or distress for fear of not being seen as a good or capable mother (Hong Law et al., 2018) and societal pressures may inhibit women from sharing how they really feel (Hong Law et al., 2018; Prevatt and Desmarais, 2018).
Many studies recognise that midwives hold the potential to weave webs for postnatal mothers and promote individualised social support (Barkin & Wisner, 2013; Chavis, 2016; Hong Law et al., 2018; Leahy Warren et al., 2012; 2018; McLeish et al., 2021; Ni and Lin, 2011, Walker et al., 2019; Wray, 2011). Ways of improving individualised social support for new mothers is discussed in greater depth in the discussion chapter of this thesis. These studies sit well alongside the section entitled ‘the fourth trimester’ in this literature review which acknowledges recent literature that highlights that for many women, postnatal recovery and health problems continue throughout the first year of motherhood and beyond and that the current six week postnatal “cut off” is inadequate and antiquated (Davies, 2014; Knight, 2021).

**Fostering self-efficacy and reliance in new mothers**

The concept of encouraging postnatal women to be more independent and self-reliant and how midwives can promote this is discussed in many writings (Leap, 2010; Leahy Warren, 2005; McLeish et al., 2020, 2021). It could be argued that how to weave this network of support without ‘nannying’ the postnatal woman and how to promote confidence without ‘taking over and instructing’ are challenging skills for many postnatal midwives. Postnatal midwives certainly interact with new mothers at a critical starting point on their journey to parenthood and have a chance to really make a difference thus “your goal as a midwife is to leave the woman feeling strong and independent as she embarks on her mothering role” (Miller & Wilkes, 2010, p.414).

Avoiding creating an over dependence on postnatal midwives and supporting women to develop confidence in their abilities as new mothers are discussed in more detail in the Discussion chapter of this thesis. Leap (2010) describes her philosophy around enabling new mothers to become more confident and self-reliant and suggests there should be a greater focus on listening to postnatal
women rather than performing rigorous checks, some of which are no longer advocated as routine postnatal care procedures (Leap, 2010, p.17).

In New Zealand, the partnership model of midwifery care which was discussed earlier in the introduction chapter of this thesis could be promoted as an approach to increase independence and self-belief in new mothers through a reciprocal and enabling relationship. The woman midwife partnership is described as “evolving throughout pregnancy, labour, birth and postpartum periods in a holistic manner, enabling women to feel safe, to take up their power themselves, rather than being empowered by a superior influence” (Pincombe et al., 2015, p.757).

Certainly, for postnatal support to be individualised which has been shown to be so crucially important in many studies (Hong Law et al., 2018; Leahy-Warren et al., 2018; Slomian, et al., 2017) some studies suggest that women need help to recognise their own personal support needs and have the confidence to ask for them (De Sousa Machado et al, 2020). It could also be argued that a relationship between mother and postnatal midwife built on partnership, sharing, trust and reciprocity is the key igniter for the inclusion of a personalised postnatal support network for the new mother.

**Reflection on the Literature**

My review of the literature has demonstrated that postnatal care, despite its vital potential and importance for the health and wellbeing of women and babies, holds an undervalued reputation within maternity care.

The appraisal of the literature has revealed that new mothers primarily need support and to build strong relationships with midwives. It has also shown how significant the connections made between mothers and midwives can be and what potential they hold. The support given to women postnatally should ideally be individualised, culturally appropriate and given at the right time and from the right variety of sources. Postnatal midwives have a ‘magic moment’ of
opportunity that is short but during which they can weave a web of care for women according to their needs and where they can facilitate access to appropriate support services as necessary. The literature review has confirmed that women are generally ill-prepared for the postnatal period, including how much it will challenge them and place them in unfamiliar territory. They are not aware that the challenges may continue for a considerable amount of time after the birth of their babies. The literature reviewed reveals concerns that the generally accepted six week ending of the postnatal period is potentially insufficient and inadequate for women’s needs who often struggle with psychological and physiological difficulties long after the birth of their babies. Studies evaluated also revealed that many women seek postnatal care and support from other sources ranging from family and friends to online support groups and breastfeeding apps.

A review of the literature did not identify any studies that have specifically examined how women experience postnatal care when it is provided by a midwife previously unknown to them but it is acknowledged that the international studies examined included such women. In addition, a review of the literature did not surface any studies that focus on postnatal care provided in this way within a maternity care context where continuity of care/r is the norm and is supported by evidence as the optimum model of care. Research that is focused on how women experience postnatal care delivered in this way and how best to establish effective midwife mother relationships in this context is therefore needed.
Chapter 3: Research Methodology and Study Design

Introduction

The research aims of my study were to describe and make meaning of women’s perspectives on their postnatal care provided within the context of not having a known midwife in the postnatal period, whilst acknowledging continuity of care/r as the model of midwifery care in New Zealand (Guilliland & Dixon, 2019). As discussed in the introductory chapter, this research did not set out to evaluate the effectiveness of this form of postnatal care in relation to continuity models, but rather to gain insight into how postnatal care delivered in this context may achieve good outcomes when continuity of care throughout the childbirth experience is not possible.

The intended purpose of my study was to discover how women experience the relational aspects of postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care. The research investigated the significant elements of the key alliance between the new mother and the previously unknown postnatal midwife experienced by participants. I was keen to understand and accurately present the experiences of first-time mothers who met their postnatal midwives for the first time at the start of such a significant journey in their lives. To this end, I chose a methodology that would enable me to remain close to my data in the reporting, letting the participants’ words speak for themselves rather than engaging in deep interpretation which might risk reflecting my own bias. Ontologically, perspectives about midwifery care provision rest within assumptions about midwives working in partnership relationships in continuity of care contexts. My study interrogates what happens when this is not achievable and coming to this knowledge (epistemology) required a methodology that speaks directly to the experience – thus a qualitative descriptive approach was the best ‘fit’ for my purpose.

I was interested to explore which elements of the relationship between the mother and the postnatal midwife were identified as enabling good care and practice, thus
creating positive outcomes for mothers and babies. Understanding how women perceive their postnatal care in this context where continuity of care is, for whatever reason, unachievable, has the potential to surface the critical components for establishing a midwifery relationship that facilitates a constructive, helpful, and supportive postnatal care experience.

A qualitative research design provided the appropriate method for this study given that my research question was focused on experience, meaning and perspective (Braun & Clarke, 2013) with a focus on the thoughts and feelings of postnatal women. In particular, I was interested in capturing what might be the key components of mothers’ experiences of their postnatal care when it was provided by a previously unknown midwife.

This chapter introduces and explains the methodological approach to this study which is informed by Sandelowski’s qualitative description (Sandelowski, 2000; Sandelowski, 2010). In addition, the rationale for the study design is outlined and then the research methods are discussed including participant recruitment, data collection, data analysis, ethical and cultural considerations. Later in the chapter I present my reasons for choosing thematic analysis to present the data obtained from participant interviews and how I approached researcher positioning and any positional bias.

Methodology

Why qualitative research?

Qualitative research is centred on capturing meaning and exploring human experiences in a context specific, naturalistic setting (Braun & Clarke, 2013; Hoepfl, 1997; Sandelowski, 2000; Sandelowski, 2010). This methodological approach has the potential to illuminate “rich and compelling insights” into the real worlds, experiences, and perspectives of research participants (Braun & Clarke, 2014, p.1) and it is about words and meanings people attribute to their own experience of
something (Braun & Clarke, 2006; Liamputtong, 2014). The aim of qualitative research is ‘to describe and understand the nature of reality through participants’ eyes with careful and on-going attention to context’ (Milne & Oberle, 2005, p.413). Qualitative research is well described by Neergaard et al., (2009) who suggest that it can be used “as an empirical method of investigation aiming to describe the informant’s perception and experiences of the world and its phenomena” (p.2).

Qualitative research is sometimes criticised in the literature by proponents of quantitative research for lacking scientific rigour (Burgess-Allen & Owens-Smith, 2010). It has been referred to as the “poor cousin to more developed methods of quantitative enquiry” (Milne & Oberle, 2005, p.413). However, qualitative research methods can investigate peoples’ thoughts and perspectives in a way that is not possible using quantitative research methods, and can lead to enhanced understanding of the topic in question (Burgess-Allen & Owens-Smith, 2010). Quantitative research seeks to “approximate the truth about phenomena” by complying with a range of well understood processes (Milne & Oberle, 2005, p.413). In contrast, qualitative research “seeks not to reveal ‘truth’ but to generate insights” (Milne & Oberle, 2005, p.413).

As discussed in the Literature Review chapter of this thesis, there is no known research on this topic and although continuity of carer throughout the whole childbirth journey is the model of care that underpins maternity care in New Zealand, there is currently a growing number of women who do not receive this for a variety of reasons. This will be investigated further in the discussion chapter of this thesis. A qualitative study therefore held the potential to give this group of first time postnatal women who receive their midwifery care in this context a voice that otherwise may not be heard. The purpose of qualitative research is to unravel the complex and intricate webs of contexts and people so we can appreciate what the phenomenon is really like in practice (Dougherty, 2002. p.1). A qualitative research approach provided me with the opportunity to present the
viewpoints and stories of those participating by focusing on their lived experiences.

**Qualitative Descriptive Research**

Qualitative description is a commonly used approach which has established its own legitimacy as a significant research methodology in the qualitative paradigm (Sandelowski, 2000; 2010). As Sandelowski acknowledges researchers using qualitative description “stay closer to their data and to the surface of words and events” (Sandelowski, 2000, p.336). Qualitative description “follows the tradition of qualitative research – and is an empirical method of investigation aiming to describe the informant’s perception and experience of the world and its phenomena” (Neergaard et al., 2009, p.2).

A qualitative descriptive approach was chosen specifically for this research for the following reasons. Often labelled a “descriptive interpretive approach” and described as having a “strength in its straightforwardness” (Smythe, 2012, p.6) it has allowed me to present a summary of events in everyday language - to present the “who, what and where” of an experience (Sandelowski, 2000, p.338). A further key benefit of qualitative description that makes it of value in my study, is its ability to give a “well-substantiated description of a phenomenon in its contextual setting thereby assisting readers to form a better understanding of it” (Nieuwenhuis, 2015, p.420). The aim of a qualitative descriptive study is to obtain knowledge of the experiences, events, and interactions of a phenomenon from the viewpoint of insiders (Bradshaw et al., 2017). Researchers “generally draw from a naturalistic perspective and examine a phenomenon in its natural state” (Kim et al., 2017, p.2). Qualitative description is “especially amenable to health research because it provides factual responses to questions about how people feel in a particular space” (Colorafi & Evans, 2016, p.17).
In an area where there is little documented research, a qualitative descriptive research approach offers flexibility; the researcher is not obligated to commit to a hypothesis or a firm structure but is able to adapt to the data being presented (Kim et al., 2017; Sandelowski, 2010). As I was unable to identify any published research in New Zealand regarding the topic of interest in this study, I was especially determined to stay close to the participant’s descriptions of their experiences. I aimed to provide a thoughtful overview of the data without the need for any specific theoretical underpinnings and facilitate a clear representation of the participant’s perceptions of their experiences of postnatal care provided by a midwife previously unknown to them.

**Researcher Reflexivity**

When considering the authenticity of my study, I was aware of the need to acknowledge and reflect upon my own biases and the effect of my presence and contribution to the construction of meanings during the research process (Finlay, 2006; McCabe & Holmes, 2009). Developing an awareness of the views, experiences, and beliefs of the researcher and how they may have influenced the research process and the data helps to enable an accurate representation of the data (Lambert et al., 2010; Ramani et al., 2018).

It was important to consider how my clinical background might influence the study as already acknowledged and discussed further in the Researcher Perspective in the Introduction and Background chapter of this thesis. Self-reflexivity refers to “people’s careful consideration of the ways in which their past experiences, points of view and roles impact their interactions with, and interpretations of, any particular interaction or context” (Tracy, 2020, p.24). It is a central way to achieve sincerity and asks researchers to express awareness, self-critique and vulnerability in their research (Tracy, 2020). Reflexivity in qualitative research provides the ongoing process of critical self-reflection by the researcher.
(Barrett et al., 2020; Braun & Clarke, 2013; Ramani et al., 2018) and is an essential component to incorporate into, and engage within, the research process to demonstrate trustworthiness and self-awareness on the part of the researcher (Finlay, 2006). A reflexive approach can help to reduce the likelihood of researcher bias and in so doing enhance the credibility of the study. As McGrath et al., (2019) suggest it is important to view the interviewer not as a potential contaminant of, or of bringing bias to the data but rather as a “co-creator of data together with the interviewee, where the interviewer’s previous knowledge may play an important part in understanding of the context or the experiences of the interviewee” (McGrath et al., 2019, p.3).

I aimed to utilise my clinical background but was careful to ensure that this was done in a considered way. I was keen to share with participants my own motivations for wanting to conduct the study and why I held a particular interest in it. I achieved this by explaining my background and experience to the participants at the start of each interview and my particular interest in the provision of postnatal care. When devising the interview guide (Appendix B) I used my clinical knowledge when deciding on the question content and examined ways of extracting rich descriptions around key areas of the postnatal care experience. My background knowledge also enabled me to probe further during the interviews if required and to ensure that participants were able to follow their own train of thought. I also considered the interview questions carefully and the context of the conversation during the interviews to ensure that participants were not ‘led’ by suggestive questioning. I ensured that I asked open ended questions to elicit an open response from participants.

Careful examination and descriptions of each participant’s perceptions required acknowledging “each and every one of them as experts of their own experiences and remaining open to what they believed” (Milne & Oberle, 2005, P.418). I also kept a research journal throughout the research process reflecting on my ‘double’ role of researcher and clinician in addition to ensuring that the data evolved from
those participating. I was careful to ensure that the original meaning of the participants’ data was maintained and preserved, and my repeated reading of the transcripts assisted me in this.

**Study Design**

The methodological design and the methods chosen reflect my standpoint as a midwife who views the childbirth continuum through a social lens. This is why I chose interviews as the data collection method for this study because building relationships in order to gather data is important to me.

In the second part of this chapter, I present the study design, including ethical approval and cultural considerations set in place prior to beginning the active phase of my study. In addition, the method of recruiting participants, the way data was collected and finally, the data analysis itself will be considered.

**Ethical and Cultural Considerations**

Prior to the recruitment of participants, ethical approval for the study was sought from the Otago Polytechnic Midwifery Research Ethics Committee (OPMREC). The application was approved on 22/10/19 (Appendix C).

Further approval was requested on 11/11/19 (Appendix D) and approved on 14/11/19 (Appendix D). (The reason for the extension is discussed later in the chapter).

Support for the research to proceed was granted by the Kaitohutohu Office at Otago Polytechnic (Appendix E). The role of the Kaitohutohu Office is to ensure that research is conducted safely for Māori and that the relevance of the research to Māori was considered in line with the principles of Te Tiriti o Waitangi. New Zealand is a culturally diverse nation. It is therefore essential to approach any research project with an understanding and appreciation of cultural diversity and
the values upon which Te Tiriti o Waitangi, the founding document for New Zealand is centred, namely, protection, participation, and equity. The 2019 Hauora Report recommends the following principles for the primary health care system. These principles are tino rangatiratanga, equity, active protection, options, and partnership (https://www.health.govt.nz/our-work/populations/Māori-health/te-tiriti-o-waitangi.) Working openly in partnership to ensure cultural safety is honoured and protected and is inherent in midwifery practice and this has to be mirrored within any research studies undertaken.

In addition to gaining ethical approval from the Kaitohutohu office at Otago Polytechnic I also arranged to speak to Scott Klenner, Director of Māori research at Otago Polytechnic. I was keen to discuss with him how I could gain a greater understanding of how I could incorporate a Māori world view into my research study in terms of Mataurangi Māori. I met with Scott on 12/8/21.

As the research was conducted in New Zealand, I was committed to consider my responsibilities as a researcher under Te Tiriti o Waitangi and to specifically consider the relevance and any effects of the project for Māori. I anticipated and hoped that this research would attract participants identifying as Māori as I believed that this research could be particularly beneficial to Māori as research indicates that Māori women experience inequalities in access to maternity care services. It is therefore important that research intending to encourage high quality postnatal care experiences includes the voices of Māori women and can hopefully address their specific needs in relation to postnatal care relationships (Moewaka Barnes et al, 2013).

Other Ethical Considerations

My research topic involved exploring potentially pivotal experiences for the participants and I was eager to ensure their safety when sharing their experiences
in the interviews. As pointed out by Husband (2020), “researchers cannot simply extract information without acknowledging that they may elicit deeper responses from participants” (Husband, 2020, p.7). Many studies address the challenges facing researchers when carrying out studies involving interviews around sensitive topics (Dickson-Swift et al., 2007; Mitchell, 2011; Scerri et al., 2012). I was mindful of acknowledging the potential impact of the interviewing on the participants (Husband, 2020; Richards & Swartz, 2002).

Managing the ethical dimensions within my interviewing process was something that I gave a great deal of thought to and read widely about (Clarke, 2006; Corbin & Morse, 2003; Mitchell, 2011; Richards & Schwartz, 2002). I had already planned what I would do in the event of any of the participants becoming distressed when recalling their postnatal stories but I was also aware that the distress experienced by participants might not be visible or expressed. I wanted to acknowledge the emotions of participants in the event of them becoming upset, but also to offer them a break in the interview or to terminate it completely. I decided I would offer a debrief or referral to counselling after the interview for all participants to acknowledge any potential emotional upset during the process. Key for my interviews was to listen actively⁸ to participants. There were silences during the interviews, but these were seen as periods of reflection and most participants then carried on speaking.

One participant in particular had experienced undiagnosed postnatal depression and overwhelming emotional distress during the postnatal period. She had found the relationship with her previously unknown postnatal midwife particularly significant. During the interview she became upset and tearful. I had prepared for this occurrence when considering my interviewing techniques and I asked her if she wished to terminate the interview and suggested that we could repeat it on another occasion. She elected to continue her conversation with me. After the

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⁸ Refers to preferred interviewer behaviour of concentrating, understanding, remembering, and sometimes responding to what is said (Tracy, 2020, p.206).
interview I asked again if she felt okay and offered information regarding local
counselling and postnatal support groups.

**The Participants**

Purposive sampling was used to recruit a sample of 11 women who were first-
time mothers. Purposive sampling involves identifying and selecting individuals
that are especially knowledgeable about or experienced with a phenomenon of
interest (Cresswell & Plano Clark, 2011). It has been acknowledged as being
particularly helpful in obtaining broad insights and rich information when
utilising qualitative descriptive methodology (Neergaard et al., 2009; Sandelowski,
2000).

So, for this study, I chose women who had experienced postnatal care delivered by
a midwife who was previously unknown to them as they could provide rich data
for the study. I was also aware of the ethical dimensions of taking up time from
the participants so I was careful to choose only as many as I needed in the project
and to select participants who would have thoughts and insights of the
phenomenon in question.

Eleven participants were considered an appropriate and sufficient number for this
research project as the number of participants needs to be enough to create a
variety of detailed descriptions and experiences while too many participants may
provide repetition and little new data (Hennink et al., 2011).

The inclusion criteria were:

**Article I.** To be domiciled in New Zealand

**Article II.** To have had their first baby within the past 12 months (any mode of
birth)

**Article III.** To have been cared for in the postnatal period by a midwife or
midwives who had not provided their pregnancy or birth care and was previously
unknown to them
The exclusion criteria were:

1. Any women not meeting the above criteria
2. Any women that I was caring for/had cared for or were being /had been cared for within my own practice as this could create potential bias and a distortion of data.

**Participant Recruitment**

For the purpose of this research the recruitment of participants who had experienced postnatal care from a previously unknown midwife or midwives formed the sample population. In qualitative descriptive research, the focus should remain on the quality of the data collected, not the quantity.

To recruit participants, research flyers (Appendix F) were initially distributed throughout local midwifery clinics, breastfeeding drop-in centres, GP surgeries, libraries, citizen advice bureaus and agencies involved in supporting new parents, for example, Plunket clinics and Tamariki Ora. Research flyers were also sent electronically to New Zealand College of Midwives (NZCOM) national networks and Lower North Island Māori Health Providers. At this stage of the research my targeted area was the lower half of the North Island of New Zealand and I did not plan to use social media to advertise my study. I chose to restrict my study to the Lower Half of the North Island of New Zealand to prevent excessive numbers of respondents and I was also keen to interview all my participants in person so they needed to be located within a reasonable geographical distance from where I reside.

After a slow response to my recruitment drive, I decided to revisit the strategy. I contacted the Ethics Committee again to obtain approval to increase the geographical coverage for recruitment from the lower half of the North Island of New Zealand to the whole of New Zealand. I also decided to extend the time period from six to twelve months prior to the study within which participants
would have had their first babies. Permission was also sought to begin advertising my study on social media and I placed my research flyer on some Facebook sites, namely, “The Big Latch On” which is a New Zealand wide Facebook group focusing on the celebration of breastfeeding and World Breastfeeding Week. I also advertised my study on BreastfeedingNZ another Facebook breastfeeding group. I acknowledged the advantages in advertising my study on social media, namely, I hoped to reach a larger group of potential participants quickly and easily across the whole of New Zealand. Whilst I acknowledge that not all women breastfeed their babies and so by advertising on a Facebook breastfeeding group I was potentially excluding new mothers who choose to formula feed their babies, as 77.48% of babies in New Zealand in 2020 were exclusively breastfeeding on discharge from baby friendly services (NZBA, 2020), I believed that this advertising strategy would attract more potential participants.

I received confirmation from the Ethics Committee about their agreement to this revised strategy on 14/11/19 (Appendix D) and this was also affirmed by my supervisor. I also clarified that the study participants may have been cared for postnatally by several midwives rather than one single midwife and that this still fulfilled the criteria for answering the research question providing that participant had not previously met any of the midwives who were caring for them postnatally. After advertising the study on social media, there was an increase in interest in the project and further emails were received making enquiries. Responses were sent to all interested potential participants together with a participant information sheet (Appendix G) providing background information to the research. All the women who expressed interest in the study were contacted and followed up 2-3 weeks later by email asking them if they were still keen to participate in the study. At this point I had 12 enquires and then one person decided not to participate leaving me with a cohort of 11 women. The participants
were spread all over the North Island of New Zealand with none in the South Island.

**Interviews as a method of Data Collection**

The purpose of an interview is to investigate and explore the meanings, interpretations, and perceptions that participants attribute to their experiences (Lavender et al., 2004). I chose to collect data through semi-structured, open-ended individual interviews that defined specific areas of focused interest. Because the interviews were semi-structured, allowance was made for me to ask additional questions if an interesting or new line of inquiry arose in the interview. The open-ended questions also acted as prompts facilitating exploration of other emerging points during the interviews. The semi-structured interviews “offered additional depth by inviting dialogic exchange” (Husband, 2020, p.8) and treating the interview as a reciprocal, two-way process was something that I aimed to achieve (Alvesson & Skoldberg, 2000).

The geographical distance between myself and seven of the participants made online or telephone interviews the only financially viable option. Interviewing as the data gathering technique enabled the collection of rich, descriptive data for my study but also allowed me to work within the geographical limitations. Preparing my own approach to the interviews was something I considered carefully. I had already become familiar with the data recording equipment I intended to use but I also considered again the scope and focus of my research question. I introduced myself at the beginning of each interview and explained my background and reasons for my interest in the research topic. This was in an attempt to build rapport with participants and put them at ease which is considered to be fundamental to effective interviewing (Stiles, 1993; Mears, 2017, Gray, 2018). As part of my aims to exercise self-reflexivity, I also strove to be non-judgemental (Bryman, 2016) and sensitive (Mann, 2011).
A test interview was conducted with a peer which enabled me to explore language, the clarity of my questions and aspects of active listening. As already acknowledged earlier in this chapter, an interview guide was constructed (Appendix B). McGrath et al., (2019) recommend adjusting the interview guide after the initial interview as part of “reflecting upon whether the questions are being understood the way you intended” (McGrath et al., 2019, p.1004).

It was intended that participants would be asked to explore:

- How they experienced establishing a relationship with their midwife or midwives during the postnatal period?
- What elements of their postnatal care received from their midwife or midwives they valued and what aspects would they have changed?
- How did the postnatal care they received from their midwife or midwives impact on their post-birth transition?

As a final part of my interview preparation and self-reflexivity, I considered the effect of my own preconceived ideas and how these may affect the interviewing (Banner, 2010). An attempt was made to also reflect on this during the transcribing and analysis of the data from each interview. This process would significantly increase the trustworthiness of the data obtained (Banner, 2010).

**Format of the Interviews**

Eleven semi structured individual interviews took place. Four interviews were held in person and seven were via Skype online using video. When obtaining consent for the interviews, participants were made aware that due to geographical constraints, skype interviews would involve video and recordings made on my mobile phone. All participants were comfortable with these aspects of the interviews.
The interviews were undertaken over the course of a six-week period in February-March 2020. I allocated one hour for each interview realising that some may not take this long. Participants attending face to face were given a choice regarding venue of the interviews and all participants were offered to choose a time to suit. They were informed that they were welcome to bring a support person/s and whanau present if they wished in either modality.

The remote interviews were due to the geographical location of the participants. I did not feel that the locations of the interviews (some face to face, some remote) affected the kind of data I obtained as all the participants were so eager to talk about their experiences. During and after the interviews I made discrete notes which contained features of each interview; so, body language, appearance of the participants and their disposition and tone of voice of the participant, whether babies were present or not, whether participants breastfed during the interview. I also noted down aspects like where participants were sitting, comfort, noise, distractions, reactions, and gestures. These notes served to enhance the trustworthiness of the data and it made sense to record them as literature suggests that a variety of nonhuman factors can impact human behaviour and interactions (Koro-Ljungberg et al., 2018).

Prior to commencing the interviews, participants were asked if they had any further questions about the study and the age and ethnicity of each participant and the age of their baby was reconfirmed. Written and signed informed consent (Appendix H) had been obtained from each participant before the interviews began and they were also informed that they could withdraw from the study at any time and withdraw data already given at any point up until data analysis had commenced which would be one month after the interviews. I also ensured that participants knew that they could decline to answer any questions if they wished and could ask for the recording to be stopped at any point during the interviews. Participants were informed that they could see a copy of their interview after transcription if they wished and could remove or edit their responses. Interviews
were recorded on the researcher’s password-protected cell phone and, as already acknowledged, participants agreed to the interviews being recorded as detailed on the consent form. Recording the interviews was considered important as “recording the interviews makes it easier for the researcher to focus on the interview content and the verbal prompts and thus enables the transcriber to generate ‘verbatim transcript’ of the interview (Jamshed, 2014, p.87).

After the interviews I gave each participant a supermarket gift card as a small kohā⁹ as a gift of thanks for sharing their time and their experiences. All the participants were eager to share their stories and seemed keen to talk about their experiences candidly and openly.

Confidentiality and the use of Personal Information

Participants were all aware that they would be allocated a pseudonym to maintain confidentiality. None of the participants made a request for a specific pseudonym so they were allocated by the researcher. Female first names were randomly allocated to each participant.

Original electronic data from the research was stored in a password protected computer file only accessible to me. All digital recordings were deleted after transcripts were made and further electronic records will be deleted after completion of the study. All paper documentation pertaining to the interviews and participation in the study (such as signed consent forms) remains stored in a locked filing cabinet by the researcher during the research period and will be stored in this way for seven years following the study completion. After this period, the paper files will be destroyed by secure shredding and the electronic files will be deleted. These were all requirements for ethics approval.

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⁹ A gift, present, offering, donation, contribution – especially one maintaining social relationships and has connotations of reciprocity (Te Aka Maori Dictionary).
Data Analysis

Thematic Analysis is a useful method for identifying, analysing, and reporting patterns (themes) within qualitative data (Braun & Clarke, 2006, p.79). Thematic analysis with an inductive approach was used to analyse the raw data to extract significant themes as described by Braun & Clarke (2006). Common themes emerge not just from the words of the individuals but from “clustering together common ideas from multiple individuals to re-present the data” (Willis et al., 2016, p. 1193). As discussed in my section on reflexivity, I acknowledge that I was an active participant in the process of identifying themes by drawing together the threads within the women’s conversations with me during the data gathering process.

I chose thematic analysis as it is known to be a flexible approach (Maguire & Delahunt, 2017, King, 2004) and “not tied to a particular epistemological or theoretical perspective” (Maguire & Delahunt, 2017, p.3352). Thematic analysis is also described as “a useful method for examining the perspectives of different research participants, highlighting similarities and differences and generating unanticipated insights” (Nowell et al, 2017, p.2). Braun & Clarke (2006) introduce six steps to analyse the data: “familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, producing the report” (Braun & Clarke, 2006, p.87). This provided a systematic and logical process that proved a useful structural approach for me.

The analysis of the data commenced with verbatim transcriptions of the interviews (Braun & Clarke, 2013; Willis et al., 2016). I decided to transcribe the data myself to further familiarise myself with the data. As I am a trained typist (from a past life before midwifery) this was an easy task for me and I found it productive as it helped to fully immerse myself in the data. I had made notes during and after each interview and I added these notes to the transcriptions as
reflections. Reflecting on the data throughout the whole process of analysis was enhanced by the lengthy process of transcribing the data.

I transcribed the recording within a few days of each interview as this enabled me to begin the process of identifying similarities and differences between different interviewee’s experiences and also to ensure clear recollection and accuracy. After the transcriptions were made, I felt I had developed a broader understanding of what the participants had described during the interviews. I listened repeatedly to the interviews which helped to consolidate the data, ensure its accuracy, and also often revealed new aspects of what had been said. I then re-read the interview data to become totally immersed in it and develop a familiarity to allow me to begin coding the data for words and opinions. Throughout this process I ensured that the original meaning of the participant’s data was preserved.

Whilst going through the process of re-reading, listening, and transcribing the data, common patterns and themes were emerging clearly and I was able to categorise or code the patterns (Braun & Clarke, 2013; Joffe, 2012). Braun & Clarke (2006) describe a code as “the most basic segment or element of raw data or information that can be processed in a meaningful way” (p.18). The advantages of coding are to “simplify and focus on specific characteristics of the data” (Nowell et al., 2017, p.5) and to provide a process of reflection on and interaction with the data which enables the generation of thoughts (Savage, 2000).

I found that coding gave organisation and structure to the data and I was able to examine it in a systematic way helping to increase the validity of my analysis. For me, coding provided a bridge between the data and the idea so helped me to organise the data accordingly. It was a challenge to do the coding myself without using computer software programme, but I believed I was organised and creative enough to make it work well. I also saw manually coding as a way of becoming even more familiar with the data and having better ownership of it. It also meant that I could focus on the data not the software involved in electronic coding. Disadvantages of coding can be an overload of codes and having to decide what to
include and what to omit. Coding is time consuming and doesn’t require a specific procedure to follow.

The codes and collated data were re-examined further to refine the codes, identify broader patterns of data and to reveal potential themes. During this phase, the analysis moved from codes to themes through code analysis. Themes were then analysed further in detail and a focus for each theme identified. Each theme was analysed individually and also in relationship to the other themes. An informative name for each theme was decided on and a clear identity for each theme illustrated. I coded the data using a colour coding system which meant I could group coloured codes together to assist with identifying the themes.

I wrote notes on what themes and subthemes were emerging and my analysis brought to light three overarching themes well supported with participant quotes. During this phase, a thematic map (Appendix I) was created to illustrate relationships between codes and themes and to help develop overarching themes and sub themes. According to Braun & Clarke the refining and defining of themes means identifying the ‘essence’ of what each theme is about (as well as the themes overall) and determining what aspect of the data each theme captures (Braun & Clarke, 2006, p.92).

The three overarching themes which emerged from the data were: Navigating the postnatal period, meeting the midwife for the first time postnatally and establishing effective midwife-woman relationships postnatally. All of the three overarching themes had sub themes and these will be introduced in the next Chapter.

**Chapter Summary**

This chapter discussed the qualitative descriptive methodology used in this research project.
By capturing the participant’s experiences about their postnatal care relationship with the midwife, the research question was brought into the light and the data provided constructive answers. Eleven women were interviewed (four in person and seven by skype) who were first time mothers, had given birth within the last twelve months and were cared for postnatally by midwives who had not provided their pregnancy and birth care.

The study method was designed to involve minimal interpretation of the data obtained but rather to gather and present the information gained and to provide a platform for furthermore in depth research.

A thematic analysis of the data resulted in three overarching themes which are presented and discussed in the following chapters.
Chapter 4: Findings

We must listen with our full attention to women’s stories of how it is to be a new mother and then let them tell us what care they would like from us

(Anderson & Podkolinski, 2000, p.13).

Introduction

The postnatal period can be a unique and special time for a new mother and her family as significant physical, psychological, and social changes occur including those relating to self-identity and the redefinition of relationships (Finlayson et al., 2020; Leahy Warren, 2005; McCourt & Stevens, 2009; McLeish et al., 2021; Shaw, 2006). Without exception, the participants in my study found the transition from pregnant woman to mother overwhelming and shrouded with unexpected emotional changes. The relationship with the postnatal midwife was hugely significant for every participant and it was this that I particularly wanted to explore as it formed the basis of my research question. The research question aimed to investigate how women experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care.

In this chapter I report the experiences of the women in the study who met the midwife/midwives providing their postnatal care for the first time after the birth. I will examine the implications for establishing effective relationships between the women and the postnatal midwife/midwives as I was keen to discover how the relationship unfolded in this context. The eleven women who participated in this study were all first-time mothers. The study included women who identified as Indian, European, and New Zealand/European. While some participants did have English as a second language, they did not require the assistance of an interpreter.
The three overarching themes are;

1. Navigating the postnatal period “It’s such a rollercoaster” with one subtheme; midwife as anchor “calm in a storm”.

2. Meeting the midwife for the first time postnatally with three subthemes; finding a midwife to form a relationship with, a challenging start in hospital postnatal wards and becoming acquainted with the postnatal midwife, and

3. Establishing effective midwife woman relationships postnatally with four subthemes; establishing rapport, knowledge and competence, reassurance and non-judgemental approach and that special midwife magic.

1. Navigating the postnatal period “It’s such a rollercoaster”

This first theme identified explores participants’ reflections on the significance of the postnatal period in their own personal childbirth experience and the important role of postnatal midwifery input in supporting them through the challenges of having a first baby, regardless of the context in which that care is delivered.

Postnatal midwifery care was valued by participants as a vital dimension of support for navigating the challenges they experienced. They expressed a need for practical, emotional, and psychological support from midwives and placed a particular value on visits to their own homes. They also wanted information and reassurance delivered consistently from authentic and familiar midwives. By using the term ‘authentic’ I am attempting to acknowledge the huge importance that all the women in the study attributed to being able to trust their midwife – that she was genuine, competent, and true to her profession. It was unclear whether this expectation was due to the nature of continuity of care in New Zealand or whether it was something that all participants wanted from the relationship with the postnatal midwife.

Although there is a general expectation that the transition to motherhood will be a joyous and transformative experience, most of the women in the study struggled
with the challenges of first-time parenthood amidst their changing priorities. The sub-theme in this first section discusses the role of the midwife as an ‘anchor’ and ‘navigator’ during the postnatal period as all participants had acknowledged how much they relied upon the midwife for support, guidance, and solidity during what was for most a challenging experience. As Jennifer poignantly described the adjustment to motherhood “I think it’s such a rollercoaster. You have so many hormones racing around and you don’t know which way it’s going to go. We are so vulnerable as new mothers.”

As illustrated in my literature review, it is acknowledged in many studies that family members play a key role in supporting postnatal women. For many participants in this study, family members were not on hand to support them and this emphasised the need for postnatal midwives who would support them and that they could trust. This was well described by Emily:

I am still new here and then having a baby in a different country and not having any family members here so it was just me and my husband so I really needed that person who would understand all this background and then would take care of me and my baby. (Emily)

For Jennifer, whose own mother had been unable to be present for any of the postnatal period, she attributed her success as a new mother to the care she had received: “we got by without her because of the midwifery care.”

Many participants remembered the desperation of feeling at their lowest point during the postnatal period and gave rich descriptions of how this felt for them. Several of the participants revealed that they had experienced postnatal distress of varying degrees and this was described candidly by Eleanor and Emily.

We’d had another bad night. For the first 2 weeks I didn’t get dressed, the curtains were closed and I just kind of broke down. I said, “look I can’t do this anymore, this is bullshit, I’m covered in this rash, I’m in pain, the baby’s crying and won’t sleep and I feel awful yelling at the baby but I’m
just so exhausted”. I was spiralling into a dark place. I think looking back
on it, it was just that the baby blues had hit but it hit me like a
sledgehammer. (Eleanor)

It was an anxious thing for me – not being able to get hold of your own
psyches, come out of those dark days or moments and you don’t feel
happy, you don’t feel like yourself and you don’t know how to take care of
your baby. (Emily)

Some participants did not instinctively feel an attachment with their babies from
the start of the postnatal period and found the postnatal midwife instrumental in
encouraging and facilitating the connection between them during those early days
after the birth. Joanne described “I found it hard to bond with my baby, I mean I
loved him, but I didn’t take to parenting naturally.” And Lynne remembered “the
first week was quite difficult for me as my baby and I didn’t quite connect. You
hear some people say that they immediately fall in love with their baby but that
wasn’t really me.”

Struggles to adjust to their new identities as mothers were described by all
participants with some even remembering viewing themselves in a completely
new light during this postnatal transition, almost as if in some way their identities
had been temporarily stolen from them. As Mia described: “that feeling of
vanishing into someone pushing a pram rather than being a person people look
at.”

Feeling unprepared for motherhood was a common thread between the
participant’s reflections on those early postnatal weeks. Most described feeling
that they did not know anything about caring for their babies, felt anxious and
generally lacked confidence. Charlotte remembered this feeling well:

You try to prepare yourself for it because you know you’re going to get this
baby who is so reliant on you but I don’t think you can prepare yourself for
that, it’s a 24/7 job, you can’t just get in the shower when you feel like it,
that kind of thing. I think I really didn’t appreciate that at all. (Charlotte)
As Emily reflected, “It was an anxious thing for me. I was always really anxious. People would tell me to enjoy her but then I was worried, and I couldn’t enjoy.” Mia also emphasised that sense of being unprepared and the associated feelings of being overwhelmed: “You also have that whole feeling of being in a completely new world and having no idea what’s going on.”

For some participants, feelings of isolation, loneliness and vulnerability surfaced during the early days with their new baby, often even when plenty of partner and family support was available as Sophie recalled:

You feel lonely but not quite lonely in the sense that you don’t have anybody but lonely as you’re going through such a big adjustment. You do feel lonely – you have everyone around you but then no-one at the same time. (Sophie)

1a. Midwife as anchor; “Calm in a storm”

Women in the study talked about the relationship they formed with the midwife providing their postnatal care and looked forward to their visits during the tumultuous early days. The midwives provided guidance and a kind of anchoring for them at this time. Participants valued the opportunity to be social and connect with a skilled professional who cared for them and their babies. They clearly looked forward to their postnatal visits.

I remember sitting on my couch here watching and waiting for them to come down the driveway. Yes, just knowing they were coming was like having an old friend come to visit but one with experience and a purpose to help this relationship build. (Jennifer)
The provision of midwifery guidance which affirmed participants in their care of their babies and in their role as mothers was a valued part of postnatal care. Lynne, for example, described the invaluable direction her midwife had given her when it came to establishing breastfeeding: “especially something like breastfeeding – you can’t do that or practice that without a baby and the support we got from our postnatal midwife was amazing and it meant that now our journey is brilliantly successful.”

A common theme amongst participants was that the relationship with the postnatal midwife provided a much-needed therapeutic element to the start of motherhood making them feel nurtured and cherished. As Jennifer described: “she would come in with this big kit bag and I think she was maybe early fifties and it felt like, nurturing, and I felt taken care of.”

Emily had a similar reflection remembering how cared for she felt:

I felt that she [midwife] was caring and compassionate about what was happening to me, you know, she understood that it was my first baby and I had delivered early and going through a failed induction and everything. So, she was very concerned about what was happening to me over the coming days. That was something that stayed with me for a while. (Emily)

Being seen by the midwife in their own home environment was clearly significant for all participants. Angela described the feeling of relief after the midwife’s first visit to her home after she had left the hospital the night before: “the first visit at home after 24 hours was so important. When you come home, having someone that knows babies and would come and look at things and say you’re okay, baby’s okay, just keep going.”

Many participants acknowledged the distinctive nature of postnatal midwifery visits that occurred in their home and with a focus on wellbeing compared to other health consultations that occur in medical centres or surgeries. As Mia described: “It’s so specific a focus. You know, it’s that whole different thing from
seeing the GP or a specialist. The midwife’s real focus is to make sure you’re alright and everything’s fine.”

All the study participants were keen to talk openly about their experiences. It was as if they had been drawn to the research study due to it potentially providing an opportunity to talk openly and debrief about the postnatal period and how it had been for them when meeting a previously unknown midwife to provide their care.

2. Meeting the midwife for the first time postnatally

The key focus of this study was to explore how women experience postnatal care when it is provided by a midwife who has not provided their pregnancy and birth care and who they are therefore meeting for the first time during the transition to postnatal care. In the first theme I have demonstrated how challenging the early postnatal period can be for women and the value and importance women place on postnatal care from midwives in supporting them through the early postnatal days.

In this second overarching theme ‘Meeting the midwife for the first time postnatally’, participants’ accounts of meeting the midwife for the first time postnatally are explored. I examine how it was for the women when they first met a new midwife in the early postnatal days, especially in a maternity care context where continuity of midwifery care throughout the childbirth journey is the norm. I also investigate how the midwife-woman relationship developed and grew during the postnatal period.

The first sub-theme; 2a ‘Finding a midwife to form a relationship with’ focuses on participants’ views on not being able to access continuity of midwifery care/r for their childbirth journeys in a maternity care context where this is the best practice model of care.
The second sub-theme; 2b ‘A challenging start in hospital postnatal wards’ demonstrates how postnatal hospital care did not meet participants’ expectations or needs, amplifying the importance of postnatal midwifery care once participants got home. Although it is acknowledged that this sub-theme is not the direct focus of the study, it remains a valid theme in situating why postnatal midwifery care was so important, because most of the study participants had got off to a less than optimal start during their hospital postnatal stay.

The last sub-theme 2c ‘Becoming Acquainted with the postnatal midwife’ explores how, despite not achieving the ideal of continuity of care, most participants were still able to establish trusting and effective relationships with the midwives who provided their care postnatally. Within this theme, I also reflect on the finding that most participants were completely unprepared for the arrival of an unfamiliar midwife and how this initial meeting affected their experience of the early postnatal days at home. Also included in this theme is the finding that most participants had experienced the postnatal period as a starting point rather than an ending. All wanted the postnatal period to go on longer and some found it genuinely hard to say goodbye to their midwife as if it was somehow a too abrupt an ending to what had been a transformative phase in their lives as new mothers.

2a Finding a midwife to form a relationship with “Continuity of Care is the ideal”

Continuity of midwifery care is the model of care that underpins New Zealand’s maternity services supported by evidence that it provides optimum outcomes for mothers and babies (Guilliland & Dixon, 2019). As already acknowledged earlier in this thesis, for a variety of reasons, continuity of care is not always achievable meaning that many women will, and do, receive postnatal care from a previously unknown midwife. This sub-theme explores the circumstances by which participants came to be meeting a midwife for the first time postnatally and their
perceptions about the lack of continuity of midwifery care throughout their childbirth journey.

While evidence supports continuity of care models within maternity care as optimum (Guilliland & Dixon, 2019; Perriman, 2018; Sandall et al, 2016) there can be many reasons why this is not achieved in practice. Some participants in this study had failed to secure a LMC midwife at the start of their pregnancies for a variety of reasons including lack of LMC midwife availability, difficulties in navigating through the contacting process, finding the right person, or not understanding how to find an LMC midwife. The challenges involved in securing an LMC midwife at the start of pregnancy is discussed in greater depth in the discussion chapter of this thesis.

Some women were directed to hospital-based community midwifery teams by their GPs at the start of their pregnancies. This involved care by a group of midwives employed by District Health Boards not all of whom they had met by the start of the postnatal period. There was a mixed response to this amongst participants. Angela reflected that she would have preferred a single midwife providing her postnatal care: “having the same midwife coming over, that would have been so nice. If it had been only one that would have been so much better.”

Other participants, such as Mia, felt that seeing different ‘team’ midwives postnatally had been generally positive whilst also identifying the preferability of continuity:

I was quite happy to see several different midwives but I can definitely see the value of seeing just one. Certainly, when I go to see my GP I always try to see the same one. Not only have you already built that relationship which gets you past any time-consuming bits at the beginning of each consultation but they’ll at least have a recollection of what is going on with you. A midwife would be much closer than that…much more intense so they would really know what was going on in your life. (Mia)
Some participants chose to be cared for postnatally by a different midwife due to their geographical location. Eleanor, for example, recalled:

I didn’t have my own midwife when I was pregnant. I just used the hospital team, and it was only through my local antenatal group that I met the midwife who looked after me postnatally as she was looking after some of the other women in the group. (Eleanor)

Rachel also recalled not being able to find a Lead Maternity carer: “It was difficult, yes, I would have definitely preferred to have had someone the same right through but it was just a really busy time so I couldn’t find a midwife.”

Other women in the study were cared for by private obstetric teams based in hospitals. As already discussed earlier in this thesis, these teams often utilise specific midwives for the postnatal period. Lynne, who had a particularly positive experience of postnatal midwifery care from a previously unknown midwife, was more philosophical about the lack of continuity in her care:

I think all this depends quite heavily on the person themselves, what the mother is like. For me, it didn’t matter, as I’m so used to building relationships with people that I can get on with anyone. Whereas for some women, they would really appreciate the continuity of care in terms of that one person with them throughout. (Lynne)

For some participants, the midwife who had cared for them throughout their pregnancies was unavailable to provide their postnatal care either due to leave or sickness, so a new midwife was allocated to them. This was the case for Joanne: “I ended up having an emergency caesarean early and my usual midwife was on holiday at the time. Then her mother came over from the UK so she wasn’t actually looking after me for quite a bit of it.”

For some participants, the lack of continuity of care had some negative consequences and many participants recounted a sense of regret at not securing one midwife at the beginning of their pregnancies who would care for them
throughout. Some expressed a desire to do things differently next time. Charlotte, for example, who had complex medical problems in her pregnancy and so was cared for by a hospital obstetric team reflected:

In the future I would go down the independent midwife route if I had the choice just because even before the birth, I felt like we were just a number and we had to go to the hospital to see different people and they would ask the same questions each time that the others had previously asked. If I was going to have another baby, I would definitely try to find someone I could form a relationship with. (Charlotte)

This suggests that lack of continuity of care during pregnancy within a hospital environment can create a lot of repetition and disclosure of information for women which was an element of their antenatal care that was not well received.

Eleanor had a similar reflection:

I just thought, well in England you don’t have your own midwife anyway and where we lived at the time, the hospital was right there. I think looking back, I would have probably made more of an effort to get my own midwife and if no one was available I would have pestered people until it happened because the consistency of the care in the run up to her being born just wasn’t there and the midwife I did see most of the time was a bit airy fairy. (Eleanor)

Many participants described a loss of the personal connection that comes from knowing a midwife across the childbirth journey. Angela who received postnatal care from a few different new midwives who she had never previously met, describes how she felt during postnatal home visits as the midwives scrutinised her notes to familiarise themselves with her history:

... because they did not know me or my baby they were always looking at papers, looking at the Plunket book or the hospital report all the time
instead of looking at my face. I remember that. That was something that I didn’t like. (Angela)

Rachel shared a similar experience: as she experienced confusion due to lots of different advice:

…. because I didn’t have just one midwife, it meant that I got quite a lot of mixed advice, one would tell me one thing, one was very inexperienced, you know, that type of thing so it was all just very varied. Made it quite difficult to know what to go with. (Rachel)

Mia missed the sense of sharing progress and the reaching of milestones that are facilitated by continuity of midwifery care:

Yes, I think I probably did regret not having one midwife as it’s nice to be able to see one person and say look how far we’ve come, here’s the thing that we spoke about last time that I was finding challenging that you’ve helped me with and we’re in a different place now. (Mia)

2b A challenging start in hospital postnatal wards “it was a stressful time”

Compelling evidence has already been acknowledged earlier in the thesis that highlights the limitations of inpatient hospital postnatal care and the impact of this on women and their babies in relation to postnatal outcomes (Forster et al, 2008; Yelland et al, 2009). Acknowledging that inpatient postnatal care is not the focus of this study (and was not something that was included specifically in the Literature Review) this sub theme supports existing research by identifying the shortcomings of inpatient hospital care for the participants in this study. Of particular importance to this research is that the postnatal care provided in hospital did not secure a good foundation for the start of participants’ postnatal journey. This meant that on their arrival home, the emphasis placed on postnatal midwifery care by participants was heightened adding additional challenges to the establishment of a relationship with a previously unknown midwife.
Most study participants experienced difficulties during their hospital postnatal stay. The busy hospital postnatal ward did not live up to the expectations of many participants who described struggling to begin motherhood within this environment. There was little or no opportunity for the women to really connect with hospital postnatal midwives due to the ever-changing staff on shifts, shortages of midwives, time pressures due to high numbers of inpatients, poor staffing, and task driven care. For many, the memories of those early days of motherhood within the hospital were associated with feelings of discontent and stress. Eleanor recollected: “My partner couldn’t stay with me, I’d had a C section, high blood pressure and then I had a crying baby and I didn’t know what to do with him. So it was a stressful time.”

Most participants found the constantly changing staff members, often several during one day, challenging. Joanne remembered: “all these different midwives and nurses that I had to retell my entire story to.” For Rachel, the many different faces of the staff were an obstacle at the start of her motherhood journey: “the worst thing was probably actually being in the hospital because not having one midwife I could call on or a constant – yes, they were all so different.”

Seeing different midwives on shift changes generated mixed feelings from participants who found listening to various different views about how to feed their babies frustrating:

I feel like there were lots of different opinions about what I should be doing. He was very small at birth and didn’t feed very well so I had one midwife saying give him formula, another one saying persist with the breastfeeding and it was just like I couldn’t win. (Joanne)

For Eleanor, the ward was busy and she had a sense of different views amongst differing nurses and midwives caring for her but also acknowledged that this was a facet of hospital based postnatal care.
They’re busy and there’s not enough of them and it’s September so peak season and you know that they’ll use anyone they can on a shift, and somebody might have different views and different ways of doing stuff. You know, you can’t expect to stay in hospital and have it all. (Eleanor)

2c Becoming acquainted with the postnatal midwife “I think we just clicked”

In this final sub-theme for theme 2, participants describe their return home, and the experience of meeting the midwife who would provide their postnatal care for the first time. Participants’ first encounter with this midwife is identified as a critical moment for the establishment of a successful relationship with a previously unknown midwife postnatally. The women in the study had a sense of whether they liked the midwife or not. One of the significant findings of this study was how unprepared many participants were for meeting a new midwife postnatally. For Angela although she had seen a variety of midwives throughout her pregnancy, having a new midwife postnatally was still significant:

I have to say I was kind of already used to having different midwives and then this other midwife came to my house, it was weird but after having seen lots of different midwives it was just like, here’s another one. (Angela)

Emily remembered the first time she met her postnatal midwife as a largely positive experience despite the challenging circumstances of her birth.

When I first met her, it was in the hospital as I delivered five weeks early. She came to see me and I was dozing after my caesarean so it was a kind of blurry meeting but I knew that she was my postnatal midwife and I had a face to her name. She was wearing a uniform, it was white and blue, I remember those two colours. She came to see me again the next day and I found her pleasant. I felt comfortable talking to her. (Emily)
Anna also recalled meeting her postnatal midwife in positive terms: “she was very upbeat and cheerful despite the fact that it was pouring with rain. She said that she had sat in her car as she was a little early for the appointment and studied my notes.” The preparedness and consideration of the midwife was valued by Anna.

The initial meeting with the postnatal midwife made a positive lasting impression on most participants with memories of “I felt like I just connected with her.” (Sophie) and “I think we just clicked.” (Anna).

A number of participants recalled an instant connection with their postnatal midwife on first meeting and remembered liking certain qualities about them. Eleanor recalled: “she came round to the house the day after we got home from hospital and she was just really friendly and nice and we got on well. She was useful and helpful even though I barely knew her.”

Participants described their sense of the immediate kindness shown to them by their postnatal midwife and valued the focused, caring aspect of that first connection. As Anna describes:

   I said you should have come in when you arrived but she said no I don’t want to take up too much of your time, I know how much sleep you need so all these things she spoke about, understanding and not taking up too much of my time. That is what made me like her. (Anna)

Mia also described a positive first impression: “It was very much focused on me and my baby and how things were going and it wasn’t about ticking boxes. It did feel very personalised for someone who was meeting us for the first time.”

For Jennifer who lived in a particularly remote area within New Zealand, meeting the midwife who would provide her postnatal care was particularly poignant and the midwife was always coupled with a student. It was important to Jennifer that the postnatal midwife was friendly and easy to get to know; “their personalities
made it really easy to establish a relationship. I would imagine if it wasn’t a positive relationship, because it’s such a sensitive time, you almost wouldn’t want them in your home.”

While most participants described their first meeting with the postnatal midwife in largely positive terms it was also described as anxiety inducing and overwhelming for some. This was particularly the case for participants who had endured traumatic pregnancies in which they had suffered with debilitating pregnancy-related medical problems. Other participants had experienced premature or traumatic births and emergency surgery in addition to all the usual challenges of the early postnatal days. For these participants, having to contend with developing a new relationship with their postnatal midwife was seen as adding an unwelcome additional challenge. It was evident that most participants were unprepared for a new midwife in the postnatal period and hadn’t even considered who would care for them, how the provision of postnatal care worked and for how long. This was the case even for participants who hadn’t received continuity of care throughout their pregnancies and births.

For Lynne, the organisation of her postnatal care midwife had been rather haphazard:

There was a bit of confusion actually as to who we were going to be sent. The obstetricians work with a bunch of different midwives and I actually had the name of a different midwife in my file to who I actually got. And because it was the holiday period and not a huge amount of people were working, they had written down and assigned me one postnatal midwife and then last minute changed to the one I got. (Lynne)

Some participants’ anxiety about meeting a new midwife in the early postnatal days was compounded by a sense of unpredictability and that there had been no information or guidance about how their postnatal care would proceed.

Charlotte captured this well:
The new midwife that we started seeing after the birth came to see us the following day. Prior to that we hadn’t been introduced to her, not even over the phone or anything. It wasn’t really explained to us what she was going to be doing or how the hand over would happen. It was a little bit odd because we didn’t know each other, I didn’t know what she would look like, how friendly she was going to be and it was all a bit overwhelming. (Charlotte)

For those participants who had experienced continuity of carer throughout their pregnancies and then received postnatal care from a midwife they didn’t know, they described feelings of vulnerability after having had that close relationship with their original midwife.

The new midwife took over on day thirteen or something and then I saw two other midwives on two different days in a row. It was weird because you’re so vulnerable at that stage and you’re inviting them into your house. It made me feel quite insecure having two strangers in my house when you’re in that state and you’ve got a new baby. (Sophie)

For Emily, it was not just meeting a new midwife that was anxiety inducing but also an unfamiliarity with the midwifery model of care having not had access to any midwifery care during her pregnancy:

I was really anxious when I knew I was having a postnatal midwife because I didn’t see any midwives during my pregnancy. I only saw one nurse so I did not have any ideas how midwives think and what they do or how they do it. (Emily)

The end of the postnatal period and the imminent arrival of the chosen well child provider ¹⁰ around six weeks after the birth signified the finality of what had been a distinctive phase for all participants. Reflecting on their experiences, the transition

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¹⁰ A Well Child Provider is a child and family support agency (usually Whānau Āwhina Plunket or Tamariki Ora) for all New Zealand children from birth until the age of five years. These providers take over care around five/six weeks after the birth as the midwifery care ends.
out of midwifery care and onto a well child Provider programme was another aspect of their parenting journey that required some adjusting to. The start of motherhood had clearly been challenging for all but also life enhancing. The postnatal midwife had been a navigator throughout this phase and most participants were unready to see her go. I was struck by the participants’ poignant descriptions of the ending of the relationship between mother and postnatal midwife. There was a sense of difficulty for most participants in saying goodbye to their midwives and a feeling that they weren’t ready or prepared for the finality of it. Most seemed unready, even reluctant, to continue on their motherhood journey without the midwifery support.

Many participants expressed a desire for the postnatal midwife to continue to visit and saw the ending of the relationship as a turning point in their experience of the early postnatal weeks. This was well described by Emily:

> By the end of six weeks, I still felt I needed that support and when we transitioned to Plunket I felt it was a bit rushed. I could have spent more time with her and if she could have carried on for a few more weeks, I felt the goodbye was a bit rushed. (Emily)

Some participants suggested a longer postnatal visiting schedule as suggested by Lynne: “to be honest, if I could have had a preference I probably would have said 8 weeks with the midwife would have been better.”

And other study participants acknowledged how important the relationship with the postnatal midwife had been as recalled by Mia:

> We suddenly stopped getting the midwife visits and I felt quite sort of abandoned. That feeling that we were really on our own now reflects that I really relied on those midwife visits in those early weeks and they were something to count on. (Mia)

Some participants found saying goodbye to their postnatal midwives emotional and viewed the midwife’s departure as losing a trusted friend. For Sophie, in
particular, she had been acutely aware of the absence of her own mother during her pregnancy and birth and had built an almost maternal bond with her midwife:

It was quite hard because I had talked to my midwife about the struggles that I had with my mum and my life, growing up and I had to say goodbye to the person I felt I could go and talk to. (Sophie)

3. Establishing effective midwife-woman relationships postnatally “the ingredients for effective care”

The relationship that builds between the woman and the midwife is at the very heart of human caring and provides the foundation on which the professional body of midwifery knowledge is built. The value of this relationship is enshrined in the model of midwifery continuity of care/r which recognises that optimal outcomes are achieved when the midwife and woman form a known and trusted relationship.

In this final theme, the ability of midwives and women to form effective and therapeutic relationships, despite the challenges of meeting for the first time postnatally, are explored. The findings illustrate the key elements that support the establishment of a successful therapeutic relationship between the postnatal midwife and woman when they are meeting for the first time postnatally. These key elements which form the sub themes are establishing rapport, midwifery knowledge and competence, a reassuring and non-judgemental attitude from the midwife and finally, that special midwife magic. These elements of successful midwifery care delivered in the postnatal period are explored below.
3a Establishing rapport “A listening lady”

Many studies illustrate and acknowledge the importance of strong rapport in effective healthcare relationships (Bakic-Miric & Bakic, 2008; Norfolk et al., 2007). Rapport can be defined as the ability to develop and sustain a working partnership and is considered essential to establishing trust (Godsell et al, 2013). It could be argued that because, in this study, the postnatal midwife and new mother are establishing a new relationship at a challenging time during the childbirth journey, the establishment of rapport plays an even more significant part within the dynamic of the alliance.

It was evident throughout the interviews with participants that the relationships between the postnatal midwife and new mothers characterised by trust and rapport, not only contributed to better care experiences, but also alleviated anxiety and enhanced the involvement of participants in decisions about their motherhood journeys. All participants described this ability to build rapport with their postnatal midwife as the key to forming a positive relationship with them. Participants recounted vivid descriptions of how the connection with their postnatal midwife made them feel and the level of understanding that had built between them. Eleanor recounted: “she was just really friendly and we got on really well. Even though I barely knew this person, she very quickly became someone I trusted and a really good friend which was nice.”

The women in the study built rapport with their postnatal midwives through the shared interest and investment in their postnatal journeys, mutual understanding, respect and empathy. In the creation of this shared ground, walking together in their postnatal pathways, rapport was essential to the therapeutic development of the relationship between the women and their postnatal midwives. Many participants struggled to ‘label’ and articulate why they had emotionall

\footnote{The development of a therapeutic relationship based on mutual understanding, respect, empathy and trust (O’Toole, 2008).}
connected with the midwife during the postnatal period as if it was something rather intuitive or instinctive. Again, the immeasurable qualities of the ‘rapport’ between them can be hard to express but certainly this rapport enabled the relationship to be established and sustained throughout the postnatal period. Anna commented: “I think communication with a lot of empathy is very important in the relationship. The minute they (the midwives) say they understand everything that you’re going through, everything is alright”.

For many, rapport was generated through the ease of the reciprocal interaction with the postnatal midwife. Most participants described key likeable elements of the postnatal midwife’s personality that put them at ease. Emily remembered: “When you see someone, and you feel relaxed. She had a humanistic humane part of her personality that would make you feel comfortable.”

Other participants also described the ways in which their midwife’s personality and style of engagement put them at ease and made them feel calm. Eleanor remembered: “having the midwife that I had…she helped sort of keep me calm.” and Jennifer recalled “the relationship is critical, and I think you open up to people you feel comfortable around.”

The rapport established between participants and their postnatal midwife/midwives was significant in building trust between them. This then generated confidence in participants to rely on their postnatal midwives and the advice that they gave. A tangible example of how this helped to facilitate postnatal care was the ways in which it left participants feeling able to ask questions freely. As Anna described:

Every complaint of mine, everything I tried to explain, they (the midwives) didn’t just say: “Oh you know, it’s okay, we’ve seen it a hundred times’. They responded to me like they totally understood and always suggested why don’t you try this? They might have said that to a hundred people but they didn’t say that which made me feel better. Because that’s what you
want. You might keep repeating things but you’re being treated as a completely different individual. (Anna)

For Emily, who had experienced years of unexplained infertility, IVF pregnancy and a traumatic premature birth, the postnatal midwife listening to her was particularly valuable. She describes how important the ‘listening’ element of the relationship was to her during the postnatal period:

She was a listening lady. She would listen to what I said you know so she understood what I was going through. She was not in a rush and she would listen to what I was saying and then feedback or advise. (Emily)

3b. Knowledge and Competence “I trusted her”

Trust in the midwives’ clinical knowledge and competence was identified by participants as a key element for establishing an effective relationship with their postnatal midwife. Participants described their postnatal midwife’s professional competence and specialisation in her field which facilitated their feelings of trust in the information and advice given. Lynne described her postnatal midwife as “incredibly knowledgeable and having a good area of expertise.” Similarly, Anna described her midwife as “doing her job diligently.” For some participants, the existing level and longevity of experience the midwife possessed was appreciated. As Emily described:

She was very experienced. I mean her resume said she had 35 years of experience of teaching younger midwives and then having been a head of a department so she comes with experience. She was referred to me by a friend who had her previously so I had confidence and trust in her. (Emily)

Midwives’ knowledge and competence was described by participants as facilitating feelings of trust and safety. As Lynne described:
Every question I had, she was able to confidently answer. I don’t think there was ever a time when she said she had to get back to me. And you know, you can usually tell with people if they’re not sure and they’re making up answers because they don’t quite know. There was none of that. (Lynne)

Participants particularly appreciated how midwives were open and approachable with their knowledge and expertise, facilitating an interactive exchange where participants could be involved in two-way conversation and collaborative decision making about their postnatal care. The integrity of the postnatal midwife’s advice and information was particularly valued by those participants who were navigating the conflicting advice of social media and family members. As Jennifer described:

Everyone has ideas to share but it’s nice having that trained expert handy. Both of us found it helpful having them share their wisdom. You can google everything but there’s nothing like having a midwife there to actually answer questions, dig deeper and give you confidence and reassurance. It’s just that one-way relationship – reading is not the same. (Jennifer)

The knowledge and competence of the postnatal midwife in relation to their baby’s wellbeing and infant feeding was of particular value to the participants in this study, who valued the practical nature of the advice given and the thorough nature of their midwives’ assessments.

Emily, for example, described: “My baby couldn’t latch properly because she was premature so the midwife was very helpful in that regard. She would come and see me and guide me, show me different positions and different ways of doing it.”

Eleanor also valued her midwife’s advice about baby care: “… just ways of holding her, sleeping habits, what to look out for when she’s tired, tips on napping.” Angela also appreciated the practical support offered by the postnatal
midwife: “she gave my partner a few tips on how to change the nappy and how to bath him.” as did Rachel: “she definitely put a big emphasis on teaching me about safe sleep because that’s important.” Anna particularly appreciated the sense of her midwife’s thoroughness in checking the baby:

They would do their job. They checked my baby’s eyes and everything – even if I said they had been checked already, they would say yes that’s okay I’ll just check it again and write it in the notes. I noticed this with everything, probably because I’m a doctor, but I thought that was impressive. (Anna)

For some who had encountered clinical problems during the postnatal period they had no hesitation in turning to their postnatal midwife for advice with complete confidence in her abilities and judgement. As Lynne described:

When I thought I was getting mastitis, I contacted her and said these are my symptoms and this is what’s happening. She just walked me through using a heat pack and expressing and I kept doing that. And it worked and she also gave me an antibiotic script to have on hand if I needed it. So again, her support has just been really thorough and really good. (Lynne)

3c Reassurance and non-judgemental approach “Just very non-judgy”
All study participants described feeling reassured by the presence of their postnatal midwife as they adjusted to life with their new baby. Participants described the key role of their postnatal midwife in providing reassurance that they were ‘doing it right’ in the care of their babies, helping participants build confidence and lower their anxiety. Most participants expressed a need for interactions with the postnatal midwife that were affirming.

As Lynne described:
She definitely helped me to be calmer and more confident. She helped to reassure me in what I was doing with my baby which was really good. And definitely with the confidence. She helped with how we interacted with the baby and eased my mind with how I was doing, (Lynne)

This positive reassurance helped the women settle into motherhood and develop confidence in their own abilities. As Jennifer reflected:

To have reassurance that I was doing the right thing. It was confidence boosting I would say because you can quite easily talk yourself into feeling like you’re not doing it good enough or right, particularly when you’re tired. They gave me the reassurance that I was doing things correctly and in the best interests of my baby and gave me that confidence to keep going. (Jennifer)

This significance of this reassurance that ‘everything is okay’ was echoed by many participants. As Eleanor describes: “We didn’t know what we were doing, we were like, ‘why is the baby crying?’ We fed her, we changed her, baby’s just crying. I think having the midwife that I had…she helped sort of keep me calm.”

And for Emily, she relied heavily on her midwife’s guidance; “she was a reassuring lady, you know, when you talked to her you would feel that things are fine and if she says everything is fine, then everything is fine.” Other participants described how just knowing that the midwife was there for them provided a safety net of reassurance and the feeling that they had a skilled professional they could turn to for advice. As Eleanor reflected: “She said anytime you know, I’ll be round, even if it’s in the middle of the night and you can’t sleep or whatever …”

The way the reassurance was delivered was also hugely significant for participants. Participants described the importance of the postnatal midwife’s non-judgemental attitude which supported them to navigate their own routes along the journey. Anna remembered “the first thing she said was that she didn’t judge me. She could relate. And I liked that.” Participants particularly valued the
provision of information from the postnatal midwife in a relatable way in which participants felt guided but also didn’t feel judged or under surveillance. The voices of the participants in this theme well illustrate this feeling of wanting to be supported and helped but not for the relationship to be a restraining one. As Eleanor described: “She was just very non-judgy. She couldn’t have been that much older than me, but she was just very ‘it’s okay to feel like this’. Having a midwife that didn’t push a certain agenda or way of doing things.” (Eleanor)

The impact of a reassuring and non-judgemental attitude from the postnatal midwife was described as empowering by participants. Emily, for example, appreciated how her midwife’s approach supported her to use her own instincts:

When I asked her what she would have done if she hadn’t had any breast milk, she said she would have trusted her own intuitions and done what I was doing. That was a bit of a relief for me. Having someone saying, “trust your own intuitions, you’re a mum now”. It was nice. (Emily)

As new mothers, many participants valued and listened to the midwifery advice but also eventually wanted the independence to find their own way and discover what worked for them as a new family unit. This presented an interesting paradox as participants wanted the guidance but also needed to use flexibility to make their own choices particularly regarding the care of their babies. They wanted to connect with their postnatal midwife’s knowledge and be able to utilise it but it was also necessary for them then to have the freedom to apply it as they wished. This was well illustrated by Rachel, who valued the support to decide her own path; “They didn’t push any of their personal opinions or I didn’t feel like I was being pushed in any one direction. They were supportive.”

3d. That special midwife magic

It has been acknowledged within the previous themes, that all participants valued the skilled, non-judgemental, compassionate, and reassuring elements of the
relationship with their postnatal midwives. Even though the midwife was someone participants had to forge a completely new relationship with, most participants described forming an emotional connection with the midwife/s providing their postnatal care and reflected positively on the care they received. Many participants described a calming, nurturing and comforting quality when trying to define what was valuable to them about the postnatal midwife. This made me consider whether there was in fact a therapeutic quality to the presence of the midwife. And whether this potentially strengthened and enhanced the establishment of effective postnatal relationships between the participants and their previously unknown postnatal midwives.

This last theme, within the exploration of establishing effective postnatal midwife-woman relationships, examines ‘the way that midwives are’ as perceived by the study participants. In examining this theme ‘that special midwife magic’ I hope to illuminate this indescribable ‘nurturing’ and ‘empowering’ quality that effective midwife-woman relationships encapsulate.

All participants described feeling ‘cared for’ by their postnatal midwives – this ‘caring’ element could be likened to a comfort blanket which enveloped the new mother in those early weeks of postnatal care as she settles into motherhood. Certainly, for some participants it was just the way their postnatal midwife was that made the relationship so special.

Emily described this perfectly when asked what it was about her postnatal midwife that had generated such a good relationship. She identified a personable quality in her midwife and contrasted this description with other midwives she had met in her pregnancy in the hospital who were, in her opinion, quite task focused

I have met other midwives who are very experienced and expert in what they do but then they are very robotic and mechanical in their procedures.
She had this humanistic, humane part of her personality that would make you comfortable. (Emily)

This caring presence was certainly a highly appreciated element of the relationship between many participants and their postnatal midwives. As Joanne described, “I didn’t take to parenting naturally and just having a midwife coming in almost like a mother figure and say you’re doing a good job. That’s what I appreciated the most.” For other participants, only the presence of the midwife would suffice in those difficult times as recounted by Emily:

And I didn’t feel happy, I didn’t feel myself. I knew there was a helpline I could ring and a text message service but then I wasn’t interested in that kind of stuff. I needed a person who could help me figure it out. A person listening to me when I could see them. (Emily)

For many participants, they attributed the connection they had established with their postnatal midwife as guiding them through the more challenging times during the postnatal period. Eleanor remembered, “When I had those dark times as I call them, she was really helpful.”

**Conclusion**

The findings have established that postnatal care mattered significantly to the women participating in the study. A positive relationship formed with the postnatal midwife or midwives at the start and throughout the postnatal period was anchoring for all the participants. It helped to build confidence in themselves as mothers, created self-reliance and self-esteem and provided guidance along a previously untrodden path.

This study acknowledges that continuity of care and the partnership approach to care provision is the most fitting model for women receiving care in New Zealand but the women participating in this study did not receive this continuity
postnatally and this was the trigger for my research. Most participants acknowledged that they would have preferred postnatal care from a familiar midwife, someone they had received care from prior to the commencement of the postnatal period, but this did not seem to prevent them from having a positive experience and receiving good support. The findings demonstrated that what seemed to be of greater importance to participants was that the midwife delivering their postnatal care was clinically competent and knowledgeable, listened to their concerns, respected their views, and guided them down their chosen path of motherhood without judgement.

These findings reveal that even though participants had to forge a completely new relationship with the midwife/midwives who provided their postnatal care, it was still an alliance in which the new mothers and babies could flourish and the postnatal transition be supported successfully. Experiencing authentic postnatal care not only seemed to promote participants’ postnatal recovery from the birth but also opened the door of confident motherhood and eased their transitions through.
Chapter 5: Discussion

This chapter begins with my interpretation of my findings in relation to the aims and objectives outlined in the introduction to this thesis. I follow this with a brief summary of the main findings before expanding each of these by contextualising the emergent themes using the extant literature and discussing what they mean for midwifery practice and the contribution they make to our knowledge base in this area of practice. Finally, I will outline the strengths and limitations of my study, identify opportunities for further research and consider the implications for midwifery practice.

This research aimed to discover how first-time mothers experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care. The relationship with the postnatal midwife was pivotal to all of the study participants as they embarked on their new lives as mothers. It was this relationship that I particularly wanted to examine as it formed the foundation for my research question.

My review of the literature (Chapter 2) highlighted how neglected care within the postnatal period is within research and thus my study makes a small contribution to understanding a specific aspect of postnatal care – that of women’s experiences when their care is provided by someone previously unknown to them. My hope was that by examining postnatal care in this context, critical components could be identified to inform future practice and bring to the forefront the voices of women who experienced this type of postnatal care. I also aimed to highlight the importance and significance of postnatal care and to discuss the unique provision of postnatal care in New Zealand in comparison with other countries throughout the world.
Overview of the study findings

Before going on to discuss and analyse the study findings in more detail I will briefly summarise them. The findings concur with much of which is already acknowledged in the literature; that the postnatal period is a critical time in the lives of new mothers and their babies; how valuable and empowering postnatal care can be and how surprising it is that there is little research attention focused on it. In particular the study participants expressed their appreciation of midwifery input based in their home environments and these findings reflect those of other studies presented in the Literature Review. The study findings also demonstrate how challenging participants found the hospital postnatal environment before returning home. An unpreparedness for the postnatal period was experienced by all participants; how unexpected the arrival of an unknown postnatal midwife was for many of the participants and how difficult the ending of the postnatal midwifery input proved to be for many of them.

There is a wealth of research evidence which illustrates that the quality of relationships with caregivers is fundamental to a woman’s experience of childbirth (James, 2020; Kirkham, 2010; Lundgren & Berg, 2007; Sandall et al., 2016). Most participants expressed a preference for continuity of care from a known midwife in the postnatal period and this has been shown in other studies (Aaserud et al., 2016; Dahlberg et al., 2016; Kurth et al., 2016). The varied reasons why the study participants received postnatal care from previously unknown midwives are presented in the findings. Importantly, however, most of the women in the study achieved meaningful and productive relationships with their postnatal midwives, despite having to develop new relationships with them at the beginning of what was for them a critical time as they set foot on the road to parenthood. The women in the study all identified key elements from their relationship with the postnatal midwife which they perceived had enhanced their experience as new mothers.
The therapeutic and cathartic quality of qualitative interviewing is acknowledged in many studies (Corbin & Morse, 2003; Hutchinson et al, 1994, Ortiz, 2001). Some of the participants had experienced an unhappy start to their new lives as mothers and were keen to debrief about how this had been for them and how the relationship with a new midwife had anchored them or in some cases challenged them. This opportunity to debrief had clearly not been a feature of the postnatal care they had received from their previously unknown postnatal midwife.

**Motherhood in the 21st century; Expectations and Realities**

Most women in New Zealand receive continuity of care throughout their pregnancies, births and postnatally where they are able to build and maintain a positive and reciprocal relationship with the same midwife based upon sharing information and planning agreed care. Yet, it would appear from the literature accessed for review and the findings from my study, that many new mothers say that they feel knowledge deficient when caring for themselves and their babies in the postnatal period. This seems hard to conceive when the current generation of pregnant women and new mothers have a wealth of information available to them online at the click of a button and by using social media which is a fundamental part of their everyday lives. Social networking sites and the internet are central sources of information and support for new parents (Archer & Kao, 2018). Online communities can offer social connections for many new mothers who describe feeling isolated. They can tap into a community of likeminded mothers who are experiencing the same problems of early parenthood and can share their views. Breastfeeding mothers burning the midnight oil can talk to other mothers also breastfeeding in the early hours on Facebook. They learn from other mothers online and according to Alianmoghaddam et al., 2019 they can gain ideas for improving self-management in early motherhood. In contrast, looking online at other mothers who present their lives as perfect can exacerbate feelings of inadequacy and anxiety in some new mothers (Archer & Kao, 2018).
Pressure on parents to provide for their baby’s every need is ever present during pregnancy and early parenthood due to the internet (Davies, 2011). Promises from baby product companies and advertisements that various gadgets will provide complete safety for their baby, educational and developmental progression and easy parenthood are ever present online (Falconer, 1993). All this constant directed information targeting new parents must be overwhelming and confusing.

It feels as though many mothers in the 21st century are expected to be masters of all things; money earners, career achievers, self-confident, outgoing, flexible, and adaptable, managing their family’s physical and emotional wellbeing, facilitating and balancing their children’s hobbies and activities, maintaining an optimal work life balance in addition to managing household finances. That is all in addition to being pregnant, giving birth and becoming a mother. Wilson and Yochim (2015) describe this as ‘becoming mamaprenuerial’ and it has been suggested that “financialisation reframes motherhood as an entrepreneurial activity” (Daellenbach & Daellenbach, 2020, p.270).

Gill and Orgad (2017) describe the rise of the ‘confidence culture’ which encourages women to be confident as mothers, to love themselves and that this confidence will be the vehicle that leads to maternal satisfaction. They go on to state that this places enormous pressure on new mothers and suggests that any signs of unhappiness, discontent or low confidence is seen as a personal failing rather than being caused by something systemic. Ideologies about making women responsible for their own success suggests a sink or swim attitude which may contribute to new parents feeling bewildered and unsure.

Many women become mothers for the first time at an older age (OECD, 2019) which might suppose a societal expectation for women to be financially secure prior to entering pregnancy. Many pregnancies are planned to fit in with career aspirations and with those plans come aspirations of healthy and fulfilling experiences of parenthood. For some women, their labours and births are traumatic or complicated and they feel bitterly disappointed that their experiences
did not resonate with their expectations. My study has shown that many mothers have postnatal experiences that demonstrate a contrast of joy and bewilderment and feelings of fatigue and ill-health which can override wellbeing. This paradox means that many new mothers are happy to be mothers and have their babies but unhappy at the losses that they feel becoming a mother has enforced. Many new mothers feel they simply cannot admit to feeling unhappy or appearing that they cannot cope. Presenting oneself as a competent mother to those perceived to be experts would seem to be important to many women in the postnatal period (Miller, 2002). Furthermore, some women feel unable to discuss openly how they really feel in the postnatal period for fear of being judged by others (Prevatt & Desmarais, 2018; Slomian et al., 2017).

Contrastingly, some literature proposes that giving birth can result in a two-sided transformation for women (Kurz et al., 2021). On the one hand, women are transformed negatively (sometimes due to birth trauma which can result in significant and long-term threats to a woman’s wellbeing) but also there is the potential for positive transformation (Kurz et al., 2021). The positive transformation brings a sense of achievement, self-efficacy, and empowerment (Browne, 2008; Howarth, 2018; Meyer, 2013). It seems that becoming a mother is double-edged, it is a time of both new opportunity and threat for women. Certainly, a huge idealisation of motherhood exists, and the literature indicates that many new mothers feel they cannot live up to it. A trusting relationship with a midwife during the postnatal period is key to optimising the chances to candidly explore how the transition to parenting is going for the new mother and has the potential to enhance the woman’s experience of becoming a mother.

**Finding a midwife**

As discussed in the introductory chapter of this thesis, many women in New Zealand register with an LMC midwife or group at the start of their pregnancies
and can expect to be cared for by the same midwife (or her partner) throughout the entirety of her pregnancy, labour, and postnatal period. As acknowledged in the findings chapter of this thesis, this wasn’t the case for all of the study participants for a variety of reasons.

Currently in New Zealand most women search the internet for an available LMC midwife by accessing a website called ‘Find Your Midwife’ (findyourmidwife.co.nz). Midwives are located on the website by choosing the relevant region of New Zealand in which the woman resides and then entering the month her baby is due to check availability of LMC midwives who practice in the area she has selected. The search for a midwife can be narrowed by additional filters such as where the woman plans to have the baby, language requirements and whether the woman prefers a Māori or Pasifika midwife. Each midwife’s calendar details her availability. Women can then click on each midwife’s profile to read more about her and decide whether the midwife feels like a good match.

It could be argued that this online system is set up for technically competent people who are then expected to choose from an online profile of someone they know nothing about. This creates uncertainty for the woman as the LMC midwife she chooses is still completely unknown to her and who can say whether the woman will like the midwife or feel an affinity with her when they first meet. Currently due to midwife shortages, the system becomes similar to a lottery operating on a first come first served basis and luck regarding whether LMC midwives happen to have availability at the right time. The current process of finding a midwife in New Zealand would seem difficult and frustrating as women are faced with numerous unsuccessful attempts to secure one. The process of telephoning numerous midwifery practices only to be rejected (or get no response at all) can be disempowering for women during what for many will be an anxious time at the start of their pregnancies. For the women who are not able to secure a registration with an LMC at the start of their pregnancy, the alternative is to book with a hospital community midwifery team or an obstetrician as discussed earlier.
in this thesis. Generally speaking, this will mean that the woman will not receive continuity of care involving one/two or a small group of midwives but will receive care from a larger team of midwives and other care givers throughout her pregnancy, birth, and postnatal period.

Broadly speaking until the latter half of the 20th century, women knew who their midwives were as they generally worked within their own community and the role held status and was usually highly valued. Communities are now fragmented, ironically when being connected has never been easier and midwives as local community identities are no longer quite so visible, particularly in modern urban environments. Anecdotally at least, word of mouth would seem to remain a time-tested successful mechanism for connecting women and midwives. This would again suggest that building community links for mothers and families is vital in maternity care so that recommendations for midwives can be shared between mothers and newly pregnant women. Within the current climate of midwife shortages and increased workloads, it is difficult to imagine how the challenges involved in accessing and securing a midwife early in pregnancy can be overcome.

Preparing women antenatally for a different midwife in the postnatal period

Most of the women in the study were unprepared for the introduction of new midwives in the postnatal period and also for their experiences of the postnatal period as a whole. It was clear from their discussion that the participants were not aware or had even considered that they may receive postnatal care from a midwife they had not met before. Whether they just had not thought about it due to being focused on their pregnancies and births or whether they hadn’t been informed during pregnancy, was not clear in the findings. What was clear however was that most of the participants did not know that a new midwife at the start of the postnatal period would be part of the care they were receiving.
Some of the study participants had been cared for antenatally within hospital based obstetric teams where it is customary to allocate postnatal care to specific midwives as a separate module. This was an aspect of care that many participants hadn’t considered during pregnancy, and they had assumed that the postnatal midwife would be someone they had already met and knew. None of the participants had met these midwives before the start of the postnatal period and it is not clear whether this is an expectation when women are cared for antenatally by obstetric practices. An introduction to the postnatal midwife or midwives towards the end of the woman’s pregnancy could be a good way of bridging this transition and is included in recommendations for practice section towards the end of this thesis.

Some of the study participants felt that predictability is something that enabled them to feel less stressed so to know which midwife would be calling and when was important to them. This predictability regarding the postnatal midwife and her visiting schedule is something that is shown to be important to women in other studies (Aaserud et al., 2016; McLeish et al., 2020). Crucially, the scheduling and predictability of ongoing community support given to breastfeeding women has been shown to increase the duration and exclusivity of breastfeeding (McFadden et al., 2017). This Cochrane review included 100 trials involving more than 83,246 mother and infant pairs (McFadden et al., 2017) and concluded that women needed to be able to predict when support is available and that the support was individualised to suit their needs.

It would seem that official information during pregnancy from an authoritative source regarding what postnatal care women can expect to receive, from whom, when and for how long is something that many women desire (McLeish et al., 2020). Disorganisation around community midwifery visiting was described by some of the study participants who had no idea when they would be visited or who it would be and this was found to be the case amongst women in the UK (McLeish et al., 2021). In New Zealand, information about ‘expected care’ in the
The postnatal period is available on the Ministry of Health website (https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-weeks/health-checks-first-6-weeks) but it is not easy to access. The introduction of a list of standard postnatal appointments with their likely timing, location and schedule might be helpful for new mothers and this is a recommendation for future practice in this study. As has already been acknowledged, many women leave hospital early not really considering who will visit and provide care from there on. Some literature even suggests that women should receive a personalised postnatal care plan during their pregnancy (Dermott et al., 2006).

It would be reasonable to assume that discussions around the provision of postnatal care would take place at some point between the woman and her midwife during pregnancy. Certainly, recommendations for these discussions regarding parenting education, the postnatal period and care of the newborn are clearly signposted to occur at set points throughout the pregnancy as detailed in the Decision Points located in the Midwives Handbook for Practice (NZCOM, 2015).

Lack of Preparedness for early parenthood

For all of the study participants, who were all first-time mothers, it seemed the postnatal period was the least prepared-for phase of their maternity experience. They all described lacking confidence in their abilities to care for their babies and were also surprised at how much their lives had changed as a result of becoming a parent. Many women feel a strong sense of loss, isolation, and overwhelming fatigue in the early weeks of motherhood and find the demands of infant care relentless (McQueen & Mander, 2003; McVeigh, 2000; Nystrom & Ohrling, 2004). As acknowledged in the Literature Review, this lack of preparedness for the postnatal period and parenting is echoed widely in recent literature (Benza & Liamputtong, 2014; McLeish et al., 2020; Razurel et al., 2011; Slomian et al., 2017;
Tobin et al., 2014; Walker et al., 2019). It would seem that feelings of being ill prepared for motherhood can be experienced by any woman from any demographic profile even those who are well resourced, in stable relationships and well educated (all factors associated with a positive transition to motherhood (Mercer, 1981, 1985) as demonstrated in a study by Barnes et al., 2008.

Nine of the participants described feeling particularly inadequate and lacking in confidence when caring for their babies and this is reflected in studies which identify a huge gap between what parents imagine early parenting will be like and the realities of the postnatal period (Grimes et al., 2014; Kurth et al., 2016; Razurel, 2011). In many western style family environments, people do not generally grow up watching family members feed and raise their babies. Other cultures with deeply embedded “collective” identities and extended family living arrangements can create a lifetime of opportunities for observing the intricacies of early parenting. Growing up around family members who are pregnant, have babies and become mothers is an accepted and familiar aspect of family life for those who experience it within their own kin and cultures. For those who never see this, expectations regarding motherhood tend to be based on socially constructed myths meaning that new mothers are unprepared for the everyday realities of parenting (Staneva & Wittkowski, 2013).

Antenatally, many women concentrate on their impending births and possibly are less likely to show an interest in, absorb and retain information given about the postnatal period. This would suggest that the needs of postnatal women are somehow overshadowed by their needs during pregnancy and that this could account for their feelings of being knowledge deficient during the early weeks postnatally. This notion is reflected in the literature (McKellar et al., 2008). It could be argued that during pregnancy the woman is at the centre and things revolve around her and postnatally the focus becomes her baby. This may for some women be part of their difficulty in adapting to motherhood (Slomian et al., 2017).
Nine of the participants in my study had attended antenatal birth education classes that included postnatal preparation and care of the newborn baby and yet they still felt unprepared for parenthood. Antenatal preparation classes are popular worldwide and are intended to equip expectant and new parents with information on pregnancy, childbirth, and the transition to parenthood (Entsieh & Hallstrom, 2016; Renkert & Nutbeam, 2001). Despite the variety of ways that antenatal education is delivered and facilitated, evidence is still lacking about the best method to meet the needs of expectant parents (Gagnon & Sandall, 2007). In congruence with what the study participants found, some literature, already acknowledged in the Literature Review, suggests that antenatal education focuses too heavily on the processes of labour and childbirth (Corrigan et al., 2015; Dwyer, 2009; Entsieh & Hallstrom, 2016; Razurel et al., 2011) and are of little value during the postpartum period (Razurel et al., 2011) leaving first time mothers feeling inadequate during early parenthood (Nelson, 2003). It could be argued that the emotional health of the expectant parents, the couple’s relationship and elements of self confidence in parenthood are left untouched during antenatal classes (Entsieh & Hallstrom, 2016).

Within the context of New Zealand, other than within a dated study by Dwyer (2009) who found that the education content of antenatal classes at that time lacked information on parenting, not much literature exists on the effectiveness of antenatal education programmes. Identified in Dwyer’s work was that parent and childbirth education is not easy to access for some groups in our community including Māori, Pasifika and young women and there is no indication that things have changed in recent years. I do acknowledge that the participants in my study who did attend antenatal education classes represented a privileged group of expectant mothers who did have easy access to sessions. There is currently a shortage of Childbirth Educators in New Zealand and the fact that there was a five-year hiatus in the provision of education for childbirth education training has compounded this (Davies personal correspondence, 2022). Currently though,
there is a plethora of advertised antenatal and parenting classes available within New Zealand both within District Health Boards and external providers such as Parent Centre Aotearoa and Tu Ora Compass Health. Breastfeeding classes are also offered antenatally plus postnatally there are many community-based and remote breastfeeding support resources available to women.

Many studies stress the importance of preparing physically and psychologically for motherhood during pregnancy, in the hope that women will find the adjustment postnatally easier (Staneva & Wittkowski, 2013). Birth education classes could include more sessions and discussions around expectations of motherhood and different styles of mothering which would generate more realistic images of motherhood, the baby, the future roles and identities and relationships with others involved. As recommended later in this thesis, future research could be carried out to investigate the psychological effects that existing beliefs and expectations may have on postnatal behaviours such as care of the baby, breastfeeding, and evolving identities.

Interestingly, as already acknowledged in the Literature Review, there are some studies that reflect a need for new parents to have access to parenthood classes in the early weeks of the postnatal period (Barnes et al., 2008; Entsieh & Hallstrom, 2016; Shorey et al., 2015) although the benefits of these programmes remain unclear (Bryanton et al., 2013). An example of this would be the innovative and popular ‘Baby and You’ classes provided in the community by Parent Centre Aotearoa. This would provide some community links and support networks as new parents meet other parents and their families. It would also serve to provide clear information for new parents on what they are actually experiencing at the time which may result in a more immediate absorption of information.

It would appear that for a variety of reasons, information regarding early parenthood and the postnatal period in general is not always reaching expectant parents. Possibly traditional and content-based approaches of delivering the information are not effective. Narrative pedagogy is suggested by Andrews et al.,
2001 who suggests that in the context of learning to be a mother, an approach that acknowledges the woman’s background, life history and experiences and facilitates sharing and developing knowledge may work better rather than one that is content driven prescriptive and information overloaded. As already acknowledged, if women traditionally learned about mothering from other women, a narrative pedagogical approach may prove effective in providing such opportunities. Experienced mothers are invited to classes as ‘peer learners’ and classes are centred on the learning needs and experiences of the participants.

These findings mirror studies calling for more postnatal preparation during the antenatal period enabling realistic expectations of the postnatal period to be formed and identifies a lack of comprehensive postnatal information provided to women antenatally (Corrigan et al., 2015; Darvill et al., 2010; McLeish et al., 2020).

**What were the positive elements of the relationship with the postnatal midwife?**

The findings of my study illustrate that there were certain threads within the relationship with their postnatal midwives that all participants remember as being vital and essential to a positive experience. The women searched for certain attributes in the postnatal midwife; being listened to; affirmation that they were doing things right; clinical expertise; breadth of knowledge; feeling safe and cared for and not feeling judged by the midwife. These findings concur with other recent studies which illustrate similar attributes which help to support women to develop as new mothers (Bradfield et al., 2019; Finlayson et al., 2020; Howarth et al., 2011; McLeish et al., 2020, Slomian et al., 2021; Walker et al., 2019).

Most of the women in the study were very aware of their lack of experience with babies and worries about being judged by the midwife and were linked to their apprehension about being new to parenting. Even though all the participants were first time mothers, they all had their own ideas of the type of mothers they
wanted to be and particularly appreciated that the midwife did not judge them. The importance of postnatal women receiving affirmation from midwives that they are doing things well but at the same time being able to make their own independent choices without feeling judged is echoed in many recent studies (McLeish et al., 2020, 2021; Walker et al., 2019). The women in the study wanted to be supported postnatally but to feel able to choose their own motherhood path.

**Helping to Generate Confidence and Self Belief in New Mothers**

All of the participants in my study expressed a need for readily available access to midwifery advice and support. Most voiced remembering their postnatal midwife’s advice that they could contact them ‘at any time day or night’ and this is a contractual feature of the LMC midwife role in New Zealand (MOH, 2021, DA6 (2) pg. 35). A desire for easy and continual access to midwifery advice during the postnatal period has been shown in other studies (Danbjorg et al., 2014b; Kurth et al., 2016; Wilkins, 2006). It could be argued that this expectation of wanting continual seamless access to postnatal midwifery services is reflective of an over dependency on care services in postnatal women and their families. Although, midwives in the postnatal period are perfectly placed and equipped with transferable knowledge to build up the confidence of the new mothers in their care, Leap (2010) encourages midwives to be mindful of not creating mutually dependent relationships with women and to assist in linking into community support to create a stronger support network for women going through childbirth and becoming mothers. Leap (2010) considers the philosophy ‘the less we do, the more we give’ and encourages the reader to think of it in terms of a metaphor. Pregnancy, birth, and the postnatal period is viewed as a journey, but the woman is always the driver. The midwife provides a map for the woman if required, identifies difficult bends in the road ahead or uncharted landscapes for which there is no warning. The midwife offers support for particularly difficult parts of the journey as she is familiar with them but when she is absent, she ensures the woman is in touch with others with the expertise to be able to assist
during complicated sections of the route. At the end of the journey the midwife will enjoy celebrating with the woman who has found her independence, a sense of achievement and completed her journey safely (Leap, 2010). The women in the study wanted individualised care tailored to them as people and once they felt able to be independent as mothers, they wanted to be in the driving seat (Leap, 2010).

Empowerment is a commonly used word in literature on maternity care but enabling postnatal women to become confident in their abilities to mother really is an integral facet of the relationship between midwife and new mother. In addition to midwives sharing expertise and knowledge with new mothers, confidence building can be generated through mothers spending time with other mothers, learning from each other, and sharing experiences. Midwives are well placed to create community networks, motherhood cafes, ‘baby and you’ groups and other innovative ways of forming links for postnatal women to other women with young babies. It is acknowledged that due to social inequity, these community hubs, gatherings and access to them may be easier to access for certain groups than for others.

All of the study participants vocalised their need for guidance and advice from their postnatal midwife as their perception was that she was a trained and experienced expert. If midwives are seen by new mothers as trained experts who hold the ‘expert’ knowledge, they can enable new mothers to develop self-efficacy by sharing their expertise to promote independence and responsibility. Leap (2010) describes this as a way of generating confidence in new mothers and encourages midwives in the postnatal period to question women about how they are and actively listen to their answers rather than the emphasis being focused on performing rigorous physical checks. It could be argued that postnatal care remains too regimented with an emphasis on repetitive checks, tick boxes and routines. Due to current workloads for community-based midwives, the time to listen to new mothers to really discover how they are is diminished. The NICE
(2021) guidelines also emphasise the listening aspect of care in the postnatal period; “when caring for a woman who has recently given birth, listen to her and be responsive to her needs and preferences” (NICE, 2021, 1.1.1.). It is only by listening to women that midwives really discover what matters to them, what is working for them as new mothers, and what could be put in place to support them. This active listening also fosters individualised care for new parents which is promoted as a way of encouraging them to utilise their own self efficacy.

It would seem in the western world there is a lack of societal motherhood role models for women to aspire to and societal framing of the ‘perfect mother’ can make new mothers lack self-esteem and confidence in their own abilities. Midwives are in a prime position to give powerful messages to new mothers about how they can utilise their own abilities to be the mothers they want to be. The findings of my study concur with existing studies acknowledged in the literature review illustrating the significance of interactions and positive relationships with midwives as being linked with improved experiences of postnatal care as a whole (Aune et al., 2012; Finlayson et al., 2020; Huber & Sandall, 2009; McLeish et al., 2020; MacArthur et al., 2002; Sandall et al., 2016).

**Building bridges for Postnatal Women**

Arguably if women and their families are over reliant on maternity support services in the postnatal period it could be a reflection on life in a western healthcare context where communities and families may be more fragmented and living geographically distanced from each other, with many people living in isolation and therefore less able to support each other. In the current climate of Covid 19, many women experience isolation due to absent family members and friends which could be amplified when the postnatal midwifery input stops. New parenthood can be such an immersive and consuming activity that many new mothers drop out of view within their community for a time. The midwife can be
the linking thread to the outside world and is heavily relied upon as a conduit to that world. When women are encouraged to attend antenatal education classes, the friendships and support networks formed there are usually significant and can last throughout the infancy to adulthood period of their children. The creation of relationships and community networks are essential facets of the bionomics of sustainable human living and are effective resources on which women can draw upon during their transitions to parenthood. Friendships created at antenatal education sessions can continue throughout the postnatal period and beyond with meet ups with parents, new babies, and children.

Some of the study participants had complex backgrounds and had experienced additional issues such as premature birth, postnatal depression, and exacerbation of existing health problems. The importance of a culturally appropriate, multi-agency approach to care during the postnatal period is illustrated and recommended in many studies (Davies & Crowther, 2020; De Sousa Machado, et al., 2020; Finlayson, et al., 2020; Slomian, et al., 2021) and my study acknowledges the importance of midwives fostering links to local support agencies for postnatal women to weave a tapestry of care to prevent isolation and over dependence on one care provider. The key role of the postnatal midwife as ‘Social Connector’ is acknowledged in literature on sustainability in midwifery practice (Davies & Crowther, 2020, p.83; Gladwell, 2006) and that by making sense of complexity they are ‘enabled to resolve fears and concerns in a way that assists them in developing autonomy and a sense of personal empowerment’ (Davis & Crowther, 2020, p.85). Midwives can provide the link to social support systems to help counteract the isolation and anxiety experienced by many new mothers. As seen earlier in this thesis, midwifery continuity of care is the perfect facilitation mechanism for involving agencies and family members and friends to build scaffolds of support for the new mother and her baby. Midwives who work in partnership with women by engaging in trusting relationships empower and enable them in their roles as new mothers. Community development brings people together and can
be the process of increasing social capital. Social capital is concerned with ‘the network and trust between people, which can be highly significant in building strong communities, combating social exclusion and providing a basis for long term economic development’ (Health Development Agency, 2004). In other literature it is suggested that ‘social capacity’ is a more relevant term for social capital and describe it as “recognising the value of connectivity of community and how this engenders reciprocity, powerful social norms that nurture trust and cooperation” (Davies & Crowther, 2020, p. 86). When midwives build relationships with postnatal mothers, share information, and assist them to liberate internal assets they are subscribing to the increase of social capital. The key is to encourage and assist new mothers to establish their own networks of support and friends.

In the current climate in New Zealand of midwifery shortages and increased workloads, it seems unthinkable that midwives could take on extra responsibilities in building bridges for postnatal women to community links and projects. When midwives are already working within the community there could be scope for facilitating postnatal clinics, breastfeeding cafes, drop-in classes, or groups. This process would make midwives more visible in communities, enhance consistent information and provide opportunities to offer support by engagement with women and their families.

**Care at Home/Promoting Wellness**

As already acknowledged in the literature review chapter of this thesis, the provision of community based postnatal care for six weeks in New Zealand is completely unique in an international context. For postnatal women in many other countries this unique provision of home-based midwifery visiting for up to six weeks after the birth is not something they receive but it is certainly something that many women would very much like, as demonstrated in many studies.
The women in the study had all begun their lives as new mothers in hospitals and most experienced difficulties adapting to the surroundings and adjusting to their new role within the hospital environment. The challenges for many women when receiving postnatal care in hospital settings are widely illustrated in literature already acknowledged in this study (Beake, et al., 2005; Fenwick, et al., 2010; Forster, et al., 2016; Zadoroznyj, et al., 2015; Malouf, et al., 2019). All of these studies resonate with the findings in my study where participants described inconsistent advice regarding feeding their babies, insufficient time for input from midwives, ever-changing midwives providing their care and stressful, noisy environments on hospital wards.

For most of the study participants, getting home signified a new door opening, a new phase in their lives as they set about creating their family life in the comfort of their own personal surroundings. Once at home, the midwife or midwives provided much needed support and guidance. The fact that the midwife was visiting the women at home was an element of the care that all the study participants reflected on, describing feeling that they were involved in decision making regarding their care and the valued support gained from this input. This finding from my study is reflected in the literature (Aaserud, et al., 2016; Bagheri, et al., 2017; Dahlberg, et al., 2016; Danbjorg, et al., 2014b; McKinnon, et al., 2014).

Home based postnatal care sits within the woman’s own cultural norms and family values (Ong, et al., 2014; Probandari, et al., 2017; Russo, et al., 2015) and many women feel more secure and comfortable in their own home environments (Askeldottir et al., 2013). Being at home moves care from an illness-orientated focus towards a more flexible, family centred environment and within the partnership model of midwifery care, the midwife and family unit are ‘nested’ within a social and community context. Supporting women at home in their transition to motherhood enables seamless health promotion from midwives and
easy ways for the midwife to promote wellbeing and include family in the support of the postnatal mother (Bradfield et al., 2018). A study by Heinonen (2021) suggests that a more conscious salutogenic approach in midwifery care can encourage effective postnatal support for the new parents in their new roles by considering the family as a unit. By concentrating on the positive aspects of maintaining the wellbeing of mother and baby in their own home environment, a salutogenic midwifery approach can strengthen a woman’s external resources by encouraging her to build connections to family, community links and specialist care if necessary (Mathias et al., 2021). There is also a suggestion that this approach to postnatal care can enhance and support a woman’s own internal resilience and maintain the woman’s personal autonomy (Mathias et al., 2021).

Debriefing in the Postnatal Period

All the study participants were keen to talk openly about their experiences of new midwives in the postnatal period and how their relationship with them had developed. It was as if they had been drawn to the study due to it potentially providing an opportunity to talk openly about the early weeks of motherhood. During the interviews, most participants talked openly about their births in addition to discussing their postnatal midwives. The therapeutic and cathartic quality of qualitative interviewing has been acknowledged in many studies (Corbin & Morse, 2003; Ortiz, 2001). Postnatal debriefing has been the subject of many studies (Baxter, 2019; Dahlberg et al, 2016; Gamble et al, 2002; Razurel et al, 2011) but was not a component of the postnatal care received by the study participants. The reasons for this were not clear in the findings.

If midwives have been present at the birth of the baby, the postnatal debriefing can be so much more than just a debriefing process as the midwife and woman

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12 An approach to human health that examines the factors contributing to the promotion and maintenance of physical and mental wellbeing rather than disease with particular emphasis on the coping mechanisms of individuals which help preserve health despite stressful conditions (Merriam-Webster Dictionary, 2021).
have been present in the experience together. In New Zealand, within the LMC model of care for women, there is so much more scope for postnatal debriefing as so many more women are cared for throughout the whole childbirth journey by the same midwife or her partner. For the women in my study this has not been possible for them during the postnatal period but certainly participating in the research gave them the opportunity to debrief and it appeared that it was a process that they all enjoyed.

Navigating the closure of the Midwifery/Woman Partnership

The ending of the postnatal period signified a turning point for most participants who were reluctant to let go of the input from the postnatal midwife. They had all become accustomed to the midwife visits, relied on, and valued the guidance and navigation through early parenthood that the midwife provided and were also reluctant for the relationship with the midwife to end. Even though in my study, the postnatal midwives were previously unknown to participants, all expressed a desire for the support and the relationship to continue longer than six weeks suggesting an extended visiting schedule and for the Well Child Provider to assume ongoing care at a later point in time. These findings reflect some of the studies already acknowledged in the Literature Review regarding the fourth trimester within maternity care and the value of providing extended community support for women and babies.

In New Zealand, there is professional guidance on the closure of the midwife woman partnership as documented in the NZCOM final decision point which illustrates the finality of the completion of the postnatal care input for women stating, ‘this timing provides for the completion of the midwifery relationship and feedback about the care given’ (NZCOM, 2015, p.47). Standard Nine of the standards for practice states that ‘the midwife negotiates the completion of the
midwifery partnership with the woman’ (NZCOM, 2015, p.26). Pairman et al, 2015 describe,

‘The midwife signals the closure of this relationship in advance. The focus is on holistic completion of the midwife-woman partnership through thorough assessments of mother and baby, clear communication and debriefing on care and smooth transfer of care to well woman and well child providers as appropriate’ (Pairman, 2015, p.843).

I have recommended an enhanced ‘handover’ process to well child providers in my summary at the end of this thesis to ensure that vital information about the woman and baby is transferred in an efficient and timely manner. This recommendation ties in well with the challenge most participants found during the ending of the postnatal midwifery relationship. For all the study participants, the ending of the midwifery input around six weeks after the birth was a pivotal time signifying their emergence into completely independent parenthood and responsibility (with the input from well child services).

**Comparisons with other studies**

The findings of my study echo those of other studies acknowledged throughout this thesis illustrating the vital contribution of competent, trusted, and consistent postnatal midwifery care to the lives and wellbeing of new mothers and babies. The significance of the relationship between the new mother and postnatal midwife is pivotal to the woman growing in confidence and independence as a new mother and the midwife has a crucial role to play in weaving a blanket of multi-agency support around the new mother to give her every chance to grow as a mother.

What is evident is that despite the fact that the women in the study didn’t know their midwives prior to the start of the postnatal period, they still managed to benefit and be supported by them and establish effective relationships with them.
Most participants experienced varying challenges, felt overwhelmed in the early postnatal period and some expressed anxiety at the prospect of a new, unknown midwife calling at their houses. Despite not knowing their postnatal midwife, study participants built constructive relationships where their midwife’s clinical knowledge and expertise made a positive difference to their postnatal experience; their relationship built on mutual trust and reciprocity.

As already acknowledged in the literature review, many studies illustrate that internationally there is minimal consistency in the type, frequency, timing, location, and availability of health professional contacts women receive postnatally both within and between countries. New Zealand’s postnatal care provision is unique particularly in the life span of the care from midwives and so it is challenging when attempting to provide comparisons to other studies. In most other countries such as the UK receiving care from previously unknown midwives in the postnatal period is commonplace and more recently the number of postnatal home contacts provided to women by midwives has been reduced as Health Visitors take over care at postnatal day 14-20. Some studies have recently promoted a small team approach to postnatal care provision so a previously unknown midwife providing postnatal care would not be seen as unusual (NHS England, 2016).

The findings of my study are salient as they serve to create a small body of knowledge which fills a void within current research. The study gave the participants a platform from which to speak of their experiences of postnatal care when it is delivered in this context. It is intended that these findings will contribute towards informing future studies of how women experience postnatal care and the postnatal period as a whole.
Limitations and strengths of the study

The findings of my study only pertain to the context in which data were collected so are not representative of a large number of women. As a self-selecting recruitment strategy was used, the views of people who did not elect to participate cannot be known and these may differ from the collective experiences of the participants as presented in this thesis. The study endeavoured to engage with new mothers identifying as Māori and study information was mailed and emailed to many Māori health care providers across the North Island of New Zealand. Even though my recruitment strategy attempted to make the research accessible to Māori, no one who identified as Māori responded to the study invitations. I feel disappointed that the study did not include participants identifying as Māori but it could be argued that as a pākehā (non-Māori) researcher their story is not for me to tell. Qualitative exploration by a Māori researcher about the postnatal experiences of Māori women is recommended as an area for future research so that we can more fully appreciate how best to improve equity and meet the needs of Māori families.

Within the participant group there were no new parents who did not identify as female. Views from new parents who identify as gender diverse, trans or non-binary were not obtained and this is a further recommendation for future research.

I was unable to provide comparisons with other studies examining how women experience postnatal care when it is provided by a midwife or midwives who did not provide their pregnancy and birth care within a prevailing continuity of care context as there are no known existing studies investigating this area. Although data capture mechanisms do identify when there is a change in the LMC registration during an episode of maternity care, they do not reliably identify every person who has a new midwife providing care in the postnatal period. There is thought to be a growing population of new mothers in New Zealand receiving postnatal care in this context, but due to this constraint I was unable to provide up to date numbers of these or cite current data pertaining to this.
The findings of the study were expressed as authentic views of the women participating in the study and as such the study findings can be used as evidence to inform other studies and future research. This research is the first of its kind in New Zealand so provides new and current information into how women experience postnatal care in this way. The study also contributes to raising the profile and status of postnatal care within the maternity spectrum and is an addition to the existing body of knowledge.

**Implications of Findings for the Field/ recommendations for future research and practice**

The study participants were all first-time mothers who did not receive continuity of care in the postnatal period. The reasons were varied as discussed in the findings chapter. Within the current tide of LMC midwife shortages, increased workloads amongst hospital-based community midwifery teams and an increasing number of women with antenatal health challenges, it would seem that this scenario may actually become more common in the future. A question about postnatal care provision by a previously unknown provider could be added to existing data capture mechanisms. This would enable reliable assessment about the frequency of care provision in this context and facilitate future research opportunities to further explore this phenomenon both qualitatively and quantitatively.

The findings of this study certainly suggest that there is a crucial need for more antenatal preparation for the postnatal period and value in preparing women antenatally for the postnatal care provision and how the midwife caring for them may change during this period. A recommendation of this study is that a list of standardised postnatal appointments, likely timing, locations, and schedules could be given to women as they leave the hospital just to reaffirm who will be coming to see them at home and when.
For hospital based obstetric practice groups, this study recommends the provision of information antenatally in written form and within verbal discussion to prepare women for a change of midwife postnatally. Some participants described confusion and disorganisation regarding the postnatal visiting generally - which midwife would be coming and when. This contributed to their general anxiety as they navigated through what was already a challenging time as new mothers. A further recommendation of this study is for the woman to be given the opportunity to meet with the midwife or midwives towards the end of pregnancy who will provide the woman with her postnatal care. This would familiarise the woman with the midwife in advance of the start of her life as a new mother and could be done in a friendly, informal way to enable introductions to be made at an earlier stage. Alternatively, a flyer given to the woman towards the end of her pregnancy, containing information about the midwife and a proposed postnatal visiting schedule would meet this need and not create additional work for the midwife.

Making this process easier to navigate and an enhanced understanding of the LMC model of care would be a good recommendation for the future. The findings of the study suggest that possibly too much emphasis is placed on birth preparation during the antenatal period when in fact the postnatal period is longer and potentially more life changing and critical for many women. A further recommendation of this study is the provision of parent education programmes at the start of the postnatal period for new parents which would provide community-based information and also foster links to other new parents. Future research focused on the psychological effects that existing beliefs and expectations of motherhood may have on postnatal behaviours such as care of the baby, breastfeeding and self-esteem might help to inform and prepare women for the experience of early parenting. A postnatal debriefing is recommended as part of routine postnatal care.
An electronic shared healthcare record for each woman accessed by herself plus all people involved in her maternity care is a recommendation of this study. This would provide a central platform recording all communications, planning and provision of care for each individual woman and would create an easily accessible illustration of the existing support network in place. This maternity record would also go some way towards an easy transition between providers of care and ensure that vital information is transferred with the woman herself.

A more robust transfer of care from postnatal midwife to well child provider might ease transition for the woman from one caregiver to another. The means of transfer of information other than paperwork, forms and emails might enhance this process enabling complex needs of postnatal mothers and babies to be transferred more effectively and in a timely manner. The shared maternity record previously mentioned would assist in the timely transfer of accurate, up to date information for each woman and baby.

Ways of raising the profile of postnatal care through future research and improved quality and provision of postnatal education for practising midwives is a suggested area for future growth and development. There appears to be little ongoing training and updating opportunities concentrating on postnatal care for midwives at present. Investigations into what practising midwives would like in terms of postnatal education in an arena where continuity of care can be challenging would be a good initiative.

For midwives and other caregivers involved with women and their families during the postnatal period, there is a need for an increased awareness of the potential for prolonged health problems, mental health challenges and social issues amongst women and their families during the postnatal period and within the first year after birth. As demonstrated in the literature review, many health providers and medical fields are now recognising the vulnerability of women and babies during the first twelve months after birth and an increased understanding of this critical time is something that could be promoted through enhanced
training and study focused on postnatal care. The role of the postnatal midwife has been shown to be pivotal in guiding the woman onto the path of independent motherhood and creating scaffolds of support within those early weeks. Further research is recommended on how women perceive the postnatal care they receive from midwives and flexible, individualised ways of delivering postnatal support investigated. Despite not having met the postnatal midwife before, the study participants were able to build trusting and reciprocal relationships with their midwives and had positive experiences. All valued the postnatal input for their midwives and most voiced a desire for the care to go on longer. The enhanced use of social media, telephones and online exchanges could (and potentially will) be utilised in the future to streamline, organise, and inform postnatal care.

Amidst the current shortages of LMC midwives in New Zealand and the excessive workloads of hospital-based community midwifery teams, it would seem possible that postnatal care from previously unknown midwives may become more common, certainly for the foreseeable future. The body of knowledge from this study provides new insights into how women experience postnatal care when it is delivered in this context but future research on a larger scale is recommended.

**Researcher Reflection**

Carrying out this research study has been a transformative experience for me as a new researcher. Not only has it allowed me to examine postnatal care in great detail, but it has also given me the privileged position of allowing me access into the experiences of eleven new mothers and an insight into how their postnatal lives began and developed.

It has reaffirmed my absolute belief in midwifery postnatal care, its potential to empower and strengthen the experiences of early motherhood for women and reminded me of how fortunate we are as midwives to be able to share the early days of parenting with women, their babies, and families. It has also made me
reflect on the powerful bonds between women and midwives and the capacity within the relationships forged to create new beginnings, turn corners, and dispel difficulties.

The importance of concentrating on wellness, helping to build individualised support systems for postnatal women and the recognition that the accepted ending of the postnatal period at six weeks after the birth does not always “fit” every woman are key messages I will take away from the study.

I hope that the research material will contribute to a foundation of information for future researchers to utilise in further studies focusing on postnatal care and inform on how we can improve our relationships with and postnatal care of women and babies in the future.
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<tr>
<td>Dahlberg et al., 2016. Women's experiences of home visits by midwives in the early postnatal period.</td>
<td>Norway. Six focus groups. Twenty-four participants. Qualitative approach for data collection. The transcribed interviews were analysed through systematic text condensation.</td>
<td>To gain a deeper understanding of women's experiences of midwifery care in connection with home visits during the early postnatal period.</td>
<td>&quot;It is important to promote relational continuity models of midwifery care to address the emotional aspects of the postnatal period.&quot;</td>
<td>Women want to discuss their birth experience preferably with the midwife present at birth. All participants stressed the importance of being visited by a midwife they already knew. When the woman already had a personal relationship with the midwife who visited her she felt the visit was safe and predictable. If the woman already knew the midwife who was visiting her postnatally she had less need for information. Discussions about challenges were easier, and the woman felt an inner calm and confidence.</td>
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<td>McLeish et al., 2021. A qualitative study of first time mothers' experiences of postnatal social support from health professionals in England.</td>
<td>UK (England). Qualitative descriptive study, theoretically informed by phenomenological social psychology. Based on semi-structured in-depth interviews with 32 mothers from diverse backgrounds.</td>
<td>To explore how first-time mothers in England experienced social support from health professionals involved in their postnatal care.</td>
<td>Health professionals working in postnatal care can play an important role in helping first time mothers cope with the stress of becoming a parent and to thrive by taking every opportunity to give appropriate and personalised appraisal, and informational and emotional social support alongside clinical or functional care.</td>
<td>In this study only a few participants received continuity of care during the postnatal period. Mothers in this study described how emotional support could occur in the context of an ongoing relationship in the few cases where that existed, but it could also occur when one-off interactions were managed skillfully by a health professional.</td>
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<td>Aase and et al, 2016. Home visits by midwives in the early postnatal period.</td>
<td>Norway. Nine participants Qualitative study with semi-structured interviews. Data analysed using a qualitative content analysis, inspired by hermeneutic interpretation and a systematic condensation of text.</td>
<td>To shed light on women's experiences with home visits by a local midwife in the postnatal period.</td>
<td>The continuity in the relationship is claimed to help bolster the woman's trust in the midwife's expertise, advice and guidance, and in addition the midwife can reinforce the woman's trust in their own resources.</td>
<td>• The woman felt more confident when talking to a midwife they knew from their pregnancy. • The Midwife can use their skills and precious relationship with the mother to accommodate her individual needs. • The midwife's professional skills may help the woman perceive consistency and continuity in her understanding of the process.</td>
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<td>Walker et al., 2019. Women's successful transition to motherhood during the early postnatal period: A qualitative systematic review of postnatal and midwifery home care literature.</td>
<td>Australia. A total of 19 articles met the quality criteria and were included in the data evaluation process. Research teams from Asia-Pacific, Europe, the Middle East, and North America generated the 19 qualitative journal articles.</td>
<td>To determine what women need to successfully transition to motherhood during the early postnatal period and whether postnatal home care delivered by midwives supports this process.</td>
<td>Four themes were identified from the qualitative systematic review including women and midwives connecting, identification and meeting of women's individual needs, family and cultural influences, and education and support.</td>
<td>The ability for women to connect with midwives during the early postnatal period assisted them in overcoming barriers and successfully transitioning to motherhood. Overwhelmingly the findings showed that postnatal midwifery home care is important. The study found that women preferred home visits from midwives they knew rather than being required to attend a midwifery clinic for postnatal follow-up care. Technology may provide a way for midwives and women to connect and has the potential to offer the desired personalised interventions.</td>
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<td>Schmied et al., 2010. Women’s perceptions and experiences of breastfeeding support. A metasynthesis.</td>
<td>Australia. Thirty-one studies included. The metasynthesis included studies of both formal and ‘created’ peer and professional support for breastfeeding women but excluded studies of family or informal support.</td>
<td>To examine women’s perceptions and experiences of breastfeeding support, either professional or peer, to illuminate the components of support that they deemed “supportive”.</td>
<td>The findings emphasise the importance of person-centred communication skills and of relationships in supporting a woman to breastfeed.</td>
<td>Organisational systems and services that facilitate continuity of caregiver, e.g. continuity of midwifery care or peer support models, are more likely to facilitate an authentic presence, involving supportive care and a trusting relationship with professional caregivers.</td>
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<td>Barinami et al., 2014 Support and Continuity during the first two weeks postpartum.</td>
<td>Sweden. Cross-sectional survey, mixed-method design.</td>
<td>To investigate mothers’ perceived satisfaction with support from antenatal care, postpartum care, and child health care respectively during the first two weeks after childbirth.</td>
<td>Continuity needs to be improved to raise the quality of care for mothers.</td>
<td>Continuity of care in this study is described as a “chain of care”. Most comments about relational continuity were about relationships made with the midwives during the antenatal period. Mothers were disappointed that these previous contacts were broken so completely after pregnancy. This study suggests that midwives who care for women in the antenatal period have the best overall understanding of mothers needs and could act as coordinators of care during the first week after childbirth.</td>
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<td>Kurth et al., 2016. Safe start at home: what parents of newborns need after early discharge from hospital – a focus group study.</td>
<td>Switzerland. Six focus group discussions with new parents (24 participants)</td>
<td>Aimed to investigate the experiences of new parents and examine their views on care following early hospital discharge.</td>
<td>After hospital discharge, new parents need practical support, monitoring and care.</td>
<td>Continuity was shown to be a major factor in determining quality of care. A health professional who knows the family and the health history, who establishes a bond of trust, offering care oriented to the family’s specific needs.</td>
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Appendix B: Interview Guide

**SEMI-STRUCTURED INTERVIEW GUIDE**

Question 1: In terms of your overall maternity care, how important is the care that you receive postnatally?

Question 2: Why was it that you received postnatal care from a midwife or midwives you were meeting for the first time?

Question 3: Tell me about your experiences of postnatal care/the first 4-6 weeks after the birth of your baby?

Question 4: How was it meeting your postnatal midwife/midwives? Where did you first meet her i.e., Hospital, home?

Question 5: Were there any aspects of the postnatal care from your midwife/midwives that you thought were particularly helpful or constructive?

Question 6: Can you name one aspect of the postnatal care you received from your midwife/midwives that you particularly valued? Can you describe why that was so important?

Question 7: Were there any particular aspects of the postnatal care you received from your midwife/midwives that you wish had been different? If yes, what were they and why?

Question 8: How did the postnatal care received from your midwife/midwives impact on your post-birth transition?

Question 9: What are the key ingredients for a positive postnatal care experience?
Category B Ethics Approval Letter

Date: 22nd October 2019

Address:

Dear Sally

Re: Application for Ethics Consent

Reference Number: 005

Title of Application: Women’s Views on postnatal care from a midwife who has not provided their pregnancy and birth care: implications for establishing effective midwifery relationships.

Thank you for your application for ethics approval for this project.

The review panel has considered your revised application including response to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm category B ethical approval for your project.

Many thanks for your careful responses to our recommendations.

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings and/or conclusions to the Midwifery Research and Ethics Committee.

All correspondence regarding this application should include the reference number assigned.

Best wishes with your research

Chair Ethics Committee

School of Midwifery
Appendix D: Email requesting further ethics approval due to changes regarding recruitment strategy and email confirming approval

RE: Revised Ethics Application

Jean Patterson <Jean.Patterson@op.ac.nz>
Thu, 11/14/2019 10:16 AM
To: Sally Horncastle <Sally.Horncastle@student.op.ac.nz>; George Parker <George.Parker@op.ac.nz>
Cc: Jean Patterson <Jean.Patterson@op.ac.nz>; Sally Beddick <Sally.Beddick@op.ac.nz>; Karen Wakelin <Karen.Wakelin@op.ac.nz>; Rachel Byars <Rachel_Byars@op.ac.nz>

Kia ora Sally

I have consulted with the ethics research panel who originally reviewed your ethics application regarding your request to extend your recruitment options by placing your advertising flyer on the named social media sites.

All are happy for you to do this.

That is - using the social media platforms to widen your options for recruitment only.

For the interviews you must adhere to your research plan as detailed in your original ethics application.

We wish you every success in your recruitment drive and for the interviews.

Warmest regards.

Ngā mihi nui
Jean

Jean Patterson RM, PhD.
Assoc. Professor & Postgraduate Lecturer

School of Midwifery Te Kura atawhai ka Kaiakepono te Hauaitanga
Otago Polytechnic | Te Kura Mataoranga i Otago
Forth Street, Private Bag 1016, Dunedin 9054, New Zealand
+64 0800 762 788 | www.op.ac.nz

From: Sally Horncastle <Sally.Horncastle@student.op.ac.nz>
Sent: Monday, 11 November 2019 6:24 PM
To: Jean Patterson <Jean.Patterson@op.ac.nz>
Cc: George Parker <George.Parker@op.ac.nz>

Subject: Revised Ethics Application

Dear Jean,

Please find attached my Ethics application revised slightly to reflect the fact that I am intending to include a small amount of advertising of my research project on a few Facebook groups.

I have made a couple of alterations; the first on page 4 under Research Design.

The second on page 6; the last paragraph before the heading "Participant interviews".

I have had no participants yet and I have circulated my flyers as I stipulated in the ethics application.

Hopefully I will get some soon.

Kind Regards

Sally Horncastle
Appendix E: Support from Kaitohutohu office for research to proceed

| WHAIA TO PAE TAWHITI KIA TATA, WHAIA TO PAE TATA KIA MAUA |
| PUSHERE THE DISTANT PATHWAYS OF YOUR DREAMS SO THEY MAY BECOME YOUR REALITY |

Office of the Kaitohutohu Research Consultation Feedback  
Date: 11 July 2019  
Researcher name: Sally Homcastle  
Department: Otago Polytechnic, Midwifery  
Project title: Women’s views on postnatal care from a midwife who has not provided their pregnancy and birth care: Implications for establishing effective midwifery relationships.

| INDIGENOUS INNOVATION: Contributing to Māori Economic Growth |
| TAIHIA: Achieving Environmental Sustainability through Iwi & Hapū Relationships with the Whenua & Moana |
| MUTAUROKA MĀORI: Exploring Indigenous Knowledge |
| HAUORA / ORANGA: Improving Health & Social Wellbeing |

**INDIGENOUS INNOVATION:**  Contributing to Māori Economic Growth

**TAIIIAO:** Achieving Environmental Sustainability through Iwi & Hapū Relationships with the Whenua & Moana

**MĀTAURAKA MĀORI:** Exploring Indigenous Knowledge

**HAUORA / ORANGA:** Improving Health & Social Wellbeing

*Te whenua te wai-u mo ngā uri whakatipu. The ability of the land to sustain human life is likened to the milk from a woman’s breast for infants. This study aims to explore a new area of research that could make a real difference in postnatal care of and for Māori mothers and their pepi. It is pleasing to see that the applicant has considered how to reach Māori mothers through Māori organisations. The research includes consideration of Te Tiriti, exploration of relevant Māori literature, and Māori ethical guidelines. It would be important to record participants ethnicity, so that the voice of Māori mothers is visible. This is especially important given that Māori women make up 22% of infants in Aotearoa, have children younger than the average age, and have high birth rates and fertility is increasing. As well as the disparity in SUDI, there is also a current topical issue of the high percentage of Māori infants uplifted at or just after birth, which makes this research even more pressing. The applicant identifies research that describes components that contribute towards effective midwife / mother relationships, but the cultural component is not clear. Possible questions could be posed around the value of tikanga, mātārangi Māori and hāngāwhana Māori values. Midwives know the value of whakawhanaungatanga, building relationships, and an insight into how midwives could build postnatal relationships with Māori mothers based on trust, confidence and safety is very valuable. Therefore it would be useful for the researcher to ask: a) ethnicity data, b) to seek participants cultural experiences of postnatal care. As the data will be gathered via semi structured interviews, it may be important to some Māori mothers to have their whānau present to tautoko them at the time of the interview. You may also like to consider an experienced Māori midwife / doctor to discuss and analyse the anonymised data. We wish you all the best for your research.*

| TO LIVE AS MĀORI: Kauiaki to Ensure Māori Culture and Language Flourish |

**TO LIVE AS MĀORI:** Kauiaki to Ensure Māori Culture and Language Flourish

**UNLOCKING THE INNOVATION POTENTIAL OF MĀORI KNOWLEDGE, RESOURCES & PEOPLE**

Name: Kelli Te Malihōra  
Position: Turuwhenui: Rakahau Māori | Director of Māori Research, Otago Polytechnic
Appendix F: Research Flyer

**RESEARCH PARTICIPANTS NEEDED**

- Have you had your first baby in the last six months?
- Did you have a postnatal care midwife who you hadn’t known before the birth?

**If you’ve answered YES to the above questions, would you consider being part of my research?**

The title of my research is:
Women’s views on postnatal care from a midwife who has not provided their pregnancy and birth care: implications for establishing effective midwifery relationships.

What is my study about?
I am researching how women experience postnatal care from midwives when this care is provided by a midwife who has not provided their pregnancy and birth care. I am keen to explore the critical components in establishing a postnatal care midwifery experience that can best support a new mother and her baby.

What will your participation involve?
A single interview with me lasting approximately one hour at a location that suits you. You will need to be based in the lower half of the North Island, have had your first baby within the past six months, and received postnatal care from a midwife who did not provide your pregnancy or birth care.

You will receive a $30 petrol/supermarket voucher to thank you for your time (koha).

If you’d like to participate, please contact me (Sally Horncastle) for further information at horns1@student.op.ac.nz

This research is part of a Master of Midwifery Postgraduate Degree at Otago Polytechnic. It has been approved by the Otago Polytechnic Ethics Committee on 22 October 2019, Reference Number 005.
Appendix G: Participant Information Sheet

**PARTICIPANT INFORMATION SHEET**

**PROJECT TITLE**

Women’s views on postnatal care from a midwife (or midwives) who has/have not provided their pregnancy and birth care: Implications for establishing effective midwifery relationships.

**INTRODUCTION**

Kia ora, my name is Sally Horncastle. I am a midwife and Master of Midwifery researcher at Otago Polytechnic.

I am researching how women experience postnatal care when it is provided by a midwife or midwives who has/have not provided their pregnancy and birth care. I am interested in how midwives and women form relationships in this context and the critical components in establishing a postnatal care midwifery experience that can best support a mother and her new baby.

The aim of my project is to improve our understanding of effective postnatal care when it is provided as a separate module to pregnancy and birth care, whilst acknowledging continuity of care as the model of midwifery care in Aotearoa New Zealand.

I am particularly interested to discover how women established the relationship with the midwife or midwives providing their postnatal care, how the relationship developed and grew and the significance of this relationship in their journey with their new baby.

**WHAT ARE THE POTENTIAL BENEFITS OF THE PROJECT?**

It is hoped that by understanding how women experience their postnatal care in this context, the critical components for establishing a postnatal midwifery relationship that facilitates a constructive, helpful, and supportive postnatal care experience will be identified.

**WHO IS ELIGIBLE TO PARTICIPATE IN MY STUDY?**

To be eligible for the study, you need to

A. have had your first baby within approximately the last twelve months,
B. have received your postnatal midwifery care from a midwife or midwives who did not provide your pregnancy and birth care, and
C. live in New Zealand.

I cannot include you in the study if you received your midwifery care from me or my practice partners.

**WHAT WILL MY PARTICIPATION INVOLVE?**
Should you agree to take part in this project, you will be interviewed for approximately one hour at either your home address, another location of your choice or remotely via Skype or Adobe Connect. A convenient time will be arranged and your family/whānau, baby and/or children are welcome to attend if you would like them to. Your participation is entirely voluntary.

**WHAT DATA OR INFORMATION WILL BE COLLECTED ABOUT ME AND HOW WILL IT BE USED?**

I will ask you to tell me about your postnatal journey and the part that your midwife/midwives played in this story. With your consent, your interview will be recorded, and I may make notes throughout the interview. Following the interview, the recording will be transcribed verbatim. You will be offered the opportunity to review your transcript and make any changes prior to analysis commencing. Your words may be used in my Master of Midwifery thesis, or in a midwifery journal publication or conference presentation. You will not be identified in any way.

**HOW WILL CONFIDENTIALITY AND ANONYMITY BE PROTECTED?**

All data collected will be completely confidential and protected. You will be assigned a pseudonym by the researcher, or you may choose to use your own or your first name only. All data (transcripts) and consent forms will be stored in a secure place for seven years after the research takes place. It will then be destroyed. Recordings and transcribed word files will be kept on a password protected computer so that they cannot be accessed by casual users.

**WHAT HAPPENS IF I DECIDE NOT TO GO AHEAD WITH PARTICIPATION IN THE PROJECT?**

You can withdraw from the research study at any time without giving a reason. You can decline to answer any interview questions and/or ask for the recording to be stopped at any time. You can also withdraw any information that has already been supplied until data analysis has commenced, which will be one month after your interview.

**WHAT HAPPENS NOW?**

If you would like to participate, please contact me (details below) and I will get in touch to arrange a suitable interview time. If you have any questions about the project, either now or in the future, please feel free to contact me, or my research supervisors.

Sally Horncastle (Researcher) horns11@student.op.ac.nz

George Parker (Supervisor) George.parker@op.ac.nz

This research project has been approved by the School of Midwifery Research Ethics Committee on 22 October 2019 (Reference Number 005) and endorsed by the Otago Polytechnic Kaitohutohu Māori Research Office.
Appendix H: Consent Form

Women’s views on postnatal care from a midwife who has not provided their pregnancy and birth care: implications for establishing effective midwifery relationships.

CONSENT FORM

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:
• My participation in the project is entirely voluntary and I am free to decline to answer any particular question
• I am free to stop participating at any time
• I can choose to withdraw information provided without giving reasons and without any disadvantage
• I cannot withdraw any information I have supplied after analysis of the data has commenced.
• Any raw data on which the results of the project depend will be retained in secure storage for seven years after which it will be destroyed. If it is to be kept longer than seven years, my permission will be sought.
• I will receive koha (supermarket or petrol voucher) from the researcher as a token of appreciation of my time given to this project.
• The results of the project may be published and/or used at a presentation in an academic conference, but my anonymity/confidentiality will be preserved.
• I can ask to receive a copy of the research findings

Additional information given or conditions agreed to

I agree to take part in this project under the conditions set out in the Information Sheet.

................................................. (signature of participant)
................................................. (full name of participant – please PRINT)
................................................. (signature of researcher)
................................................. (full name of researcher – please PRINT)
................................................. (date)

This project has been reviewed and approved by Otago Polytechnic School of Midwifery Research Ethics Committee on 22 October 2019 Ref. No. 005.
Appendix I: Thematic Map

Navigating the Postnatal Period

Midwife as anchor - "Calm in a storm"

Meeting the midwife for the first time postnatally

Finding a midwife to form a relationship with - "Continuity of care is the ideal"

A challenging start in hospital postnatal wards - "It was a stressful time"

Becoming acquainted with the postnatal midwife - "I think we just clicked"

Establishing effective midwife woman relationships postnatally

Establishing rapport - "A listening lady"

Knowledge and competence - "I trusted her"

Reassuring and non-judgemental - "Just very non-judgy"

That special midwife magic