Bouncing back?
An ethnographic study exploring the context of care and recovery after birth through the experiences and voices of mothers

Julie WRAY

Ph.D. Thesis 2011
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Julie WRAY

Salford Centre for Nursing & Midwifery Research
School of Nursing & Midwifery
University of Salford, Salford, UK.

Submitted in Partial Fulfilment of the Requirements of the Degree of Doctor of Philosophy (PhD), February 2011
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Abbreviations
I have used the terms postnatal and postpartum interchangeably as for the most part they mean the same thing. Birth recovery however takes on a unique differential perspective for which this thesis provides evidence.
Abstract

Bouncing back? An ethnographic study exploring the context of care and recovery after birth through the experiences and voices of mothers.

Background.
There is an increasing evidence base concerning the need for effective and timely postnatal care to prevent physical and physiological maternal and infant morbidity, but there is little evidence of women’s experiences of postnatal care or their views of their recovery after birth. The ethnographic study presented in this thesis sought to increase our understanding of the role of postnatal care and birth recovery over time through the experiences and voices of mothers.

Method.
The study was located in the neighbourhoods of Salford and Trafford in the North West of England. A period of participant observation in two maternity units using a continuum-based approach was undertaken to explore the influence of the context and environment of postnatal care on women’s immediate recovery from birth. This was followed by in-depth conversational interviews with 17 women (three interviews were conducted with each woman) during the first seven months following birth.

Findings.
Analysis of observational and interview data revealed that initially the impact of power of place of birth impinged upon the celebration of birth as the atmosphere of the postnatal wards with their established rules and care ethos sought to confine women in an unhelpful way. The ward experience revealed contested views between the women and the staff in terms of needs and wants. Thus the promotion of choice and individualised care relied more on chance rather than a formal process of care available for all women.

During the provision of formal care giving, constructs of ‘normal’ were attached to women as midwives searched to manage the occupants of the wards (mothers and babies) and engaged in body regulation processes as a means to judge adaptation to motherhood and recovery.

Over time notions of ‘self care’ prevailed in that women learnt how to manage and cope with their own recovery from birth and adaptation to motherhood. The health and wellbeing outcomes that mattered to the women were centred upon the ways in which they interpreted motherhood and claimed back the self.

Conclusions.
This study reveals that the current planning and content of routine provision of postnatal care in hospital requires urgent revision. Women’s expectations of their health and wellbeing and their needs in the early weeks and months after giving birth, differ from those understood by professionals who continue to adhere to a traditional and ritualistic provision of care. Midwifery needs to re-examine its role in postnatal care, take account of what women say and consider new ways of addressing care after birth.
Acknowledgments
I consider myself to be a lucky person as I have been surrounded by so many people who have supported me. ‘Thank you’ feels like such a small word but it is the perfect one and so a massive Thank You to all.

Most importantly I owe a debt of gratitude to the women who agreed to be in this study, they gave up their time generously to talk to me and share their experiences. Also I am grateful to the many staff at the NHS Trusts who made me welcome and showed interest in the study. I also offer an enormous thanks to my supervisor Martin Johnson (Professor in Nursing) with his patience, kindness and tolerance has been a wonderful teacher. Debra Bick (Professor in Evidence Based Midwifery) has been an excellent advisor and motivator. I feel privileged to have learnt from both of you.

It feels like a cliché to list people but I have to mention Majid and our sons Ebbie and Sameed, for keeping out of the way! But when my sudden illness arrived during 2006 they were an amazing team and encouraged the completion of this thesis. All of this support gave me the confidence to apply to the Iolanthe Midwifery Trust. In 2008/9 I was awarded the Iolanthe Research Fellowship. I am grateful to the Iolanthe Charity and Trustees for choosing me and for providing this wonderful opportunity, for me it was the icing on the cake.

Declaration
In preparing this thesis I have published papers related to the topic of ‘postnatal care’. My paper in 2006¹ referred to aspects of data collected for this thesis. I have provided a list of outputs which have taken place during my doctoral studies (see appendix 1. Mostly these have been presentations. In addition, I registered the study with an NHS database INVOLVE which is focused on research that involves service users. The research is all my own.

1. Introduction

My thesis explores postnatal care and the time-boundness of birth recovery through the experiences and voices of mothers. In seeking to capture meaning and understanding about the ethos of postnatal care I chose an ethnographic approach for its capacity to:

‘Seek out ordinary people with ordinary knowledge and build on their common experience’ (Spradley, 1979: 25).

In doing ethnography I have brought together a number of theoretical strands. Notably I have drawn upon sociological, psychological, feminist and midwifery (bio-medical) literature. An important dimension to this work has been a desire to communicate the knowledge and understandings held by women in a style that best represents their voices.

This introduction presents a brief outline of the thesis.

In the background and literature chapters I provide details of the rationale that underpinned this ethnography. Very briefly, I have taken the view that health can be seen as a socially constructed phenomenon and as such has different meanings for different people. The background, presents how I located myself in relation to postnatal care and some reflective comments. I then present an overview of commonly used terms, a brief historical perspective and insights into relevant policy. I do this before presenting the literature chapter as in my view practice and policies have very much shaped the ways in which postnatal care is experienced.

The structure of the literature chapter reflects what is known and where the gaps or limitations in knowledge exist. There is no doubt that the continued dominance of the bio-medical lens regarding postnatal care features in the research community on this topic. I highlight two important issues, one being the invisibility of the woman’s voice whereby research tends to be ‘added on’ or an afterthought. Second, is the discovery that postnatal care remains low
in status within the childbirth continuum and within midwifery as a whole, despite policy and research covering aspects of the topic.

The methods chapter is in two parts. Part one is focused on the research design and part two focuses on the ‘doing’ of ethnography. There then follow three detailed chapters on the findings from having observed on two postnatal wards and in talking to 17 individual and unique women. The final chapter presents a lively discussion in pulling it all together. I have avoided a list of recommendations instead offering a commentary on the implications of my study in connection to policy, practice and future research.

**Aim and Objectives**

The overarching aim of the study was critically to explore the nature of postnatal care and recovery from the mother’s perspective by increasing our understanding of care from a health and wellbeing viewpoint. Birth recovery was to be explored from the mother’s perspective during the first 7 months following birth to understand their perspectives of their experiences postnatal care; birth recovery and wellbeing outcomes that matter to them.

Project objectives were:

1. To conduct a detailed exploration of women cared for by two neighbouring NHS Trusts with particular emphasis upon the provision, nature and context of postnatal care/birth recovery

2. Critically to explore experiences of these mothers regarding their health and well being after birth in hospital and at home up to seven months after the birth

3. To identify what birth recovery outcomes matter to the women studied during their ‘journey’ of recovery in the first seven months following birth
Overview of the study
In seeking to understand and challenge the ‘official framing’ of postnatal care and women’s recovery as depicted by the bio-medical model, this study of two local NHS Trusts sought to focus upon individual women’s experiences, their interpretations and understandings of health and wellbeing. Central to this focus was to reveal the meanings that women gave to their own recovery in terms of time, their realities of recovery and the outcomes that mattered to them in the process. Thus the following key research questions were subsequently synthesised:

- How do women experience the nature of being postnatal?
- What constitutes the care context within postnatal wards to enable birth recovery in the first few days and months after birth?
- What outcomes do women consider to be important to their own recovery process?
- How can we help women to articulate what they want and then match our practice to that need so as to ensure optimum health and well being after birth?
2. Background: Giving meaning to postnatal care

Introduction
In this chapter I provide insights into the meanings attached to postnatal care. Firstly a personal location contextualises my perspective and predispositions before providing details on how postnatal care is understood and the ‘rules’ of the game. I then proceed to give some definitions of postnatal care, followed by a comprehensive discussion of the historical perspective and key policy influences that have shaped provision of services. It is important to note here that I have contextualised policy and key influences with respect of ‘time and place’. In other words, I have drawn upon policies and materials that were current and available at the time of constructing this study in 2003. From 2006-2008 I had to take an unexpected ‘interruption of study’. With support of the 2008 Iolanthe award I was able to return to my project, however, newer policies had been published with recommendations for the maternity services in England. Therefore, bearing in mind the policy landscape following my study, I take account of these within the discussion chapter (p200).

A personal location
This thesis on women’s recovery after birth owes some debt to a plethora of insights that I have encountered during my professional life and personal experiences of being a mother and a woman. I feel privileged that together these roles have enabled contacts with hundreds of mothers and the sharing of their experiences concerned with all aspects of childbirth and mothering. I mention this here as how I understand birth recovery has been shaped by these influences. For example it is worth noting that I started my midwifery training in 1981, which followed the publication of the Peel Report in which the UK government had recommended hospitalisation for all births (DHSS, 1970). Consequently, during my training and for over a decade beyond, the dominant practice was to not only to birth in hospital but to be confined or stay in hospital afterwards for a definite period of time (the evidence base for optimum length of stay is covered in the literature chapter) (p24). Thus hospitals throughout the UK either created postnatal wards or expanded
existing ones (Ball, 1987). This meant that almost all postnatal care provision moved from the privacy of the home to the public domain of a hospital ward (Bick et al 2009). As a consequence this shift towards hospitalisation as the ‘norm’ has paved the way for institutional dominance over birth recovery, celebration of birth and postnatal care provision.

I declare from the outset that having worked in clinical practice for many years, and in particular as a midwife for 19 years, I have found maternity care to be a messy and complex business. Despite this, there are many fascinations in that the work requires sensitivity and ways of being that demonstrate the essence of a midwife in being ‘with woman’ (NMC, 2004). Poignantly my notions that practitioners embrace the miracle of childbirth and the subsequent joys of motherhood were somewhat far removed from the reality. For example I often met colleagues who expressed a preference not to work with the babies, in other words on the postnatal wards. On the one hand the organisation of maternity care at the time, influenced by ‘custom and practice’ enabled midwives to choose where they preferred to practice. Therefore, I was familiar with midwives who, for example, had worked solely on the labour ward or in the antenatal clinic for their entire careers. On the other hand, this practice was unsustainable in the long term and during the 80’s NHS reforms, workforce planning and to a lesser degree emerging research resulted in this ‘custom and practice’ being challenged (DH, 1993; Benoit et al, 2005).

I have vivid memories of being a ward sister on two different postnatal wards in the same hospital. The parochial distinctions between the two were that one was for the ‘normal’ (uncomplicated births) and the other for the ‘abnormal’ (complicated births and for mothers whose babies were ill or had died). There were known criteria that applied to selecting which women were admitted onto the wards. From my perspective the nature of this work was enjoyable and diverse, I liked babies and found working with mothers interesting and challenging. I recognised that postnatal care had marginal status for many midwives and I naively considered this to be unproblematic at the time. It was the institutional and professional ‘norm’ and it was public
knowledge. Indeed postnatal care was referred to as the ‘Cinderella\(^2\)' of maternity care thus supporting the marginalised status within the profession. This symbolic metaphor of ‘Cinderella' has been accepted within midwifery discourse (DHSS, 1970; HMSO, 1985; Ball, 1987; Dykes, 2005; NCT, 2010).

I recall being curious as to why this metaphor was so embedded and why postnatal care had minimal appeal within the profession more broadly. It was much later in my career that I reflected back upon these observations and started critically to question these negative connotations in regard to postnatal care provision.

On a personal level I have experienced childbirth, having had two sons in hospital and spent time on postnatal wards as a service user. Whilst I recognise that becoming a mother has been a major life event, I feel that my own experiences of postnatal care in particular were rather uneventful. However, it is true to say that I have experienced adjustment and the impact of a child upon my life. As such I can identify with Barclay and Lloyd (1996), who in examining transition to motherhood theory, commented that transition can be enormous and is marked by psychological and social changes, many of which are experienced as 'losses'. They go on further to suggest that:

> The losses inherent to parenting are often ignored or unrecognised, both by women and health professionals (1996; 137)

Expectations of motherhood can be high. Too often assumptions are made within society and the professions that mothers can simply deal with their new role and just adapt (Barclay et al, 1997; Smith, 1999; Mercer, 2004; McCourt, 2006; Bhavnani and Newburn, 2010). In support I have found that women, tend to gravitate towards me upon learning that I am a midwife and mother, to disclose and share their childbirth stories, including care after birth and their experiences of new motherhood.

\(^2\) Noun - a poor, neglected, or unsuccessful person or thing (Wikipedia 2009).
One thing that has struck me over the years is the vividness and precision with which women of all ages divulge their experiences of childbirth. Much has been voluntarily and generously shared over the years. Of note was one occasion when a woman asked that I illuminate her negative experience of postnatal care, within the context of a publication that would enable midwives to learn and understand more about the patient perspective (Wray 2003). This publication in the form of an editorial comment in a practice based journal (see appendix 1) attempted to stimulate debate regarding the priority and essence of postnatal care. In it I put forward a euphemism suggesting that postnatal care is often regarded as an 'afterthought'. With this context in mind I was arguing that the time after birth continues to be a neglected phase of the procreation journey. The adjustment and transition to parenthood can be a hybrid of emotions from pleasure to despair, often overwhelming mothers and fathers immediately after birth and beyond (Barclay and Lloyd, 1996; Smith, 1999; Nelson, 2003; Mercer, 2004; Leahy Warren, 2005). This can be compounded by the lack of opportunity for recuperation and rest during the early stages of the postnatal period (Barclay et al, 1997; Wray, 2003; Buckley, 2006; McCourt, 2006; Beake et al, 2010). As an editorial my intention had been to stimulate some kind of debate, unfortunately this did not occur although importantly the mother who had shared her story expressed satisfaction with the outcome.

Coincidently around this time I had begun to explore postnatal care and women’s experiences of care provision within my academic work. I had been involved in two substantive projects on postnatal care. Firstly, a project commissioned by the National Institute for Clinical Excellence (NICE) to produce national guidance to support practice in postnatal care (RCM, 2000a). In this instance I was co-author and distinctly recall a sense of surprise at the lack of evidence to uphold many aspects of care after birth. Research studies were mostly concerned with the biophysical aspects of postnatal care and offered minimal insights into women’s experiences. Secondly, I was appointed project lead for a funded study exploring local mother’s views about postnatal care and this involved working with service user groups (Wray, 2002). A survey method was chosen by the service users
to capture women’s views, however limitations with this method unfolded such as a low response rate, nature of the questions in that they were structured around service provision and policy. In other words this study merely resulted in a satisfaction survey.

Collectively these projects highlighted that there exists a lack of knowledge and evidence to underpin much of postnatal care. Furthermore, that seeking service users’ experiences, in this context women, is repeatedly mishandled and not always believed (Oakley, 1979; Brown et al, 1994; Smith, 1999; Turris, 2005). The decision to focus upon post-birth women was influenced by a degree of naivety in the first instance as I constructed simplistic arguments that as individuals’ women were overlooked or neglected in some way following birth. I therefore wanted to pursue an in-depth study that had the capacity to combine the need for an evidence base with a methodological approach that was sensitive and appropriate to exploring service user’s experience. Subsequently, I realised that this viewpoint had some resonance with Foucault’s argument in terms of power and sexuality (Foucault, 1963). The important concept described by Foucault as the ‘gaze’ (clinical) opened up the possibilities to re-examine the debates and theories in relation to the arguments that women are viewed narrowly through the bio-medical lens. As will be seen in the following chapter it is the ‘broken body’ of sickness (p69) and ‘birth dirt’ that play a key part in understanding the construction of postnatal care and how women experience recovery from birth (Shildrick, 1997; Kirkham, 2007).

**Understanding what postnatal care is**

Before moving on to explore key concepts it is worth contextualising the impact of the Peel Report (DHSS, 1970) upon current trends regarding place of birth. In 2008 the NHS hospital episode statistics showed that in 2006/7 of 629,207 births in England and Wales the majority took place in hospital and birth in hospital rose by 3% compared to the previous year (NHS, 2008). Overall, these figures have been relatively consistent since such data collection began and the implementation of the Peel Report. Therefore, few women escape a hospital ward stay after birth. Accepting that variations in
length of stay on a hospital ward exist I would suggest that this volume of inpatient activity represents considerable use of NHS resources (Wray, 2006).

**Definitions**

In searching for a definition by which to give meaning to ‘postnatal period’, I discovered that interestingly according to the World Health Organisation (WHO) neither ‘postpartum period’ nor ‘puerperium’ are formally defined. In acknowledgment of this the WHO comments that:

‘Although not officially sanctioned, traditionally the postpartum period is supposed to end 6 weeks after birth. The period of 6 weeks fits very well into cultural traditions in many countries, where often the first 40 days after birth are considered a time of convalescence for the mother and her newborn infant. In many countries at that time a routine postnatal visit and examination are planned. Six weeks after delivery the body of the woman has largely returned to the non-pregnant state’. (WHO, 1998: 8)

Within the UK midwifery and medical literature it is widely accepted that the postpartum or postnatal period refers to the first six weeks after the birth, although the duration of care with respect to midwifery contact is defined as a period of time that it is not less than 10 days and not more than 28 days following birth (UKCC, 1998; Marchant, 2003). In 2004 the Nursing and Midwifery Council (NMC) which replaced the United Kingdom Central Council for Nursing, Midwifery & Health Visiting (UKCC), made a slight amendment regarding the rigidity of an endpoint of the postpartum period stating ‘being not less than 10 days and for such longer period as the midwife considers necessary’ (NMC, 2004: 6). The National Services Framework (NSF) for Children, Young People and Maternity Services, suggested 3 4- months as the end of postnatal period (DH, 2004). This said, the most recent national guidance published by NICE on routine postnatal care, provides no definition (Demott et al, 2006) instead a broad statement that:
‘This guideline aims to identify the essential core (routine) care that every woman and her baby should receive in the first 6-8 weeks after birth’ (NICE, 2006: 4).

The tradition within British maternity care since the publication of the first Midwives Rules in 1905 has been to accept the notion that recovery from birth is located within time parameters and is temporally understood (Bick et al, 2009; Beake et al, 2005). A connected term ‘the puerperium’ provides further insight into the temporality of recovery. Specifically it is the time between the birth of the placenta and membranes to six weeks postpartum; whereby a woman’s body will have recovered from the effects of pregnancy and returned to the normal non-pregnant state (Beischer and Mackay, 1986; Marchant, 2003).

Interestingly, these parameters which remain embedded within maternity care discourse can be found on the popular Dr Foster website where it states that:

‘The postnatal period begins immediately after birth and extends for about six weeks. It is a time when the mother’s body, including hormone levels and uterus size, returns to how it was before pregnancy. The newborn infant also starts to adapt to life outside the womb and its health during this time will be monitored. Another focus of postnatal care is to make sure that the new mother is healthy and capable of taking care of the baby and knows how to breastfeed correctly and adjust to a new life with her baby’ (Dr Foster, 2009)

Without doubt there is an agreed consensus that recovery from birth is temporal (Dykes, 2005; McCourt, 2006; 2009); there is a start and an endpoint as explained by the terms; postnatal, postpartum and the puerperium. Dykes’ ethnography of the nature of interactions between midwives and breast feeding women within postnatal wards noted that ‘for service users, the postnatal ward represented the last stop in a medicalised journey’. (2005:249). Crucially, this defined period of time from birth until
discharge from maternity care is synonymous with the physiological process of birth recovery, as described earlier. This restricted temporal view of six weeks has been challenged by researchers including MacArthur et al (1991), Marchant and Garcia (1995), and Bick et al (2009) who undertook observational studies of health following birth, and suggested that women’s recovery often takes longer than 6 weeks. For a small minority of women their health may never fully recover. In the case of an absolute definition of the postnatal period, the reality is that one does not exist – what we have is an ‘artificial’ definition which has met the needs of acute service provision, resource planning and reimbursement claims for GP provision of maternity services.

**Statutory Rules**

It is also necessary to consider further the rules which have determined the content and provision of midwifery postnatal care. An integral part of postnatal care in the UK is the statutory duty of a midwife to provide care, support and monitor the health and well being of both mother and baby. The midwife’s role and responsibilities are embedded in statute and regulation (UKCC, 1998; NMC, 2004), with a universal requirement for the rules to be adhered to. The Midwives Act of 1902 sought to ensure midwifery became a profession, supervised and regulated by explicitly outlining precise rules for the profession and content of midwifery practice. In relation to postnatal care regulation focused upon the content and timing of care in response to the then high maternal mortality rate from haemorrhage and puerperal sepsis, the focus of care intended to identify and prevent life threatening morbidity (Garcia and Marchant 1996). Over the past century there have been several amendments to the midwives’ rules, with debates and challenges to the regulatory framework which have been termed ‘the rules of the game’ (Kirkham, 2004: 272). For the purpose of this thesis it is the nature of the rules which define the content and duration of midwifery postnatal care that are of relevance.

The emergence of rules for postnatal care, I would argue, created a set of routines that have been powerful in shaping the organisation and provision of
postnatal care for the profession. For example it was the Central Midwives Board that created the first postnatal rules. According to Leap and Hunter (1993) these were colloquially known as *nursings* and were designed to pre-empt puerperal infection. *Nursings* included routine observation, later known colloquially as the routine ‘check’ (Baston, 2004) requiring midwives to perform observations of the woman’s temperature and pulse, assess the lochia and measure uterine involution. In addition to these rules on content of care, rules on the pattern of visits were stipulated. Midwives were to visit (check) the woman twice a day for first three days and then daily for 10 days, accordingly mothers were expected to ‘lie in’ during the first 10 days (Leap and Hunter, 1993). It was to be in the early 60’s that a successive Midwives Act extended postnatal care to 28 days (RCM, 2000a) with a further rule amendment in 1986 that recommended introduction of ‘selective visiting’ (checks) as opposed to the prescribed daily visits or checks (UKCC, 1986). These postnatal care rules were for many years entirely prescriptive and one dimensional in their ethos and instruction in that they were focused upon the profession rather than the woman. I would argue that the construction of this background has been dominated exclusively by the profession, regulatory framework and their collective values. Ways of considering the woman’s perspective has ultimately relied upon the bureaucratic obligation to conduct patient satisfaction surveys or in response to formal complaints by individuals or feedback from patient groups such as National Childbirth Trust (NCT). As will be seen in the literature chapter (p25) research activity has predominantly focused upon the bio-physical elements and clinical perspective. According to Marchant (2003) the origin of how these rules and routines in postpartum observation came about is unclear.

The rules for postnatal care have received minimal modification and evaluation despite the dramatic decline in maternal mortality from 1937 onwards (Loudon 1987) and considerable improvements in the health and wellbeing of women and their infants (RCM, 2000a: Marchant, 2003; Bick et al, 2009). In 2010 the NMC announced a consultation period in response to proposed changes to the midwifery rules including the sphere of postnatal care (RCM 2010a). Whilst this process is incomplete I will include some
discussion of the proposed changes in the final chapter of this thesis (page 200). An important dimension on a wider scale to the meaning and purpose of these rules is the institutional imperative to organise services whilst at the same time address the growing policy demands to individualise care (DH, 1993; DH 2004; NICE, 2006).

An integral component to achieving these demands is the requirement for a degree of predictability that allows for some planning of services, which can be beneficial to both the institution and profession (Kirkham, 2004). Thus postnatal care compares favourably in this sense to other aspects of childbirth (Dykes, 2006). With its defined time period, set of rules and minimal risk of emergencies predictability can unfold as a means to take control over professional work. According to Kirkham the desire to standardise maternity care, control the options available to women and have ‘routinisation’ within practice collectively reinforces the institutional ideals and retains the power of medicine above that of the individual woman (Kirkham, 2004: 280).

The reality of postnatal care practice is such that huge variations within the NHS exist in relation to how it is organised for example in the content and patterns of care. Baston (2004:40) notes that any capacity to offer care up to and beyond 28 days is dependent upon sufficient staffing levels and what she refers to as ‘supportive evidence-based guidelines’. The relationship between the statutory rules and how the institution responds to them is in my view connected to the social, cultural and professional rhetoric of motherhood. On the one hand there is a widely held belief that motherhood naturally happens (Ruchla and Halstead, 1994). For example motherhood is considered to be ‘natural’ and a biological destiny for women thus inferring that women are capable of perfect mothering (Nelson, 2003; Ward and Mitchell, 2004). However, it is recognised that becoming a mother involves a transition, a changing role and huge learning experience for most women in order for them to gain confidence in their ability to mother and adapt to their motherhood role (Barclay et al, 1997; Bondas-Salonen, 1998; Lock and Gibb, 2003; Leahy Warren, 2005; McCourt, 2009). Therefore in opposition to notions of motherhood being innate, the rules suggest that women need to
learn, be instructed, acquire skills and require professional guidance and observation. At the same time UK policy emphasises the pivotal role of postnatal care in easing the process of motherhood, of enabling a sense of capability and confidence in mothers (NMC, 2004; NICE, 2006; Demott et al, 2006). The threads running through these rules are contradictory in that mothering is seen by professionals as being both natural and fraught, it involves physical, and to a lesser extent, social characteristics and the current language parallels to Rothman’s (2000:7) claim that mothering is seen ‘as an activity, as service, as work and children as the product of the labour of mothering’. Therefore, I would argue postpartum rules not only place an emphasis upon prescriptive surveillance of early motherhood by professionals but also a reliance on their official and experiential knowledge.

According to Miller (2005; 2007) mothering is a diverse and not universal experience and yet often the experiences of mothering are not voiced or valued within western societies. The adjustment and transition to parenthood can be a hybrid of emotions from pleasure to despair, often overwhelming mothers and father’s immediately after birth and beyond (Alexander and Higgins, 1993; Barclay and Lloyd, 1996; Barclay et al 1997; McCourt, 2006; Ellberg et al, 2010; Bhavnani and Newburn, 2010). The rhetoric is that postnatal care should be unique, special and delivered to mothers in a sensitive and caring way so that they feel able to recover, adjust and even enjoy themselves (RCM 2000a, 2000b; NICE, 2006) and yet it remains that postnatal care is referred to as the ‘Cinderella’ of maternity care (NCT, 2010). More importantly if this is the professional context then questions unfold as to the impact upon women and their families. For example it is known that women make more negative comments about postnatal care than any other aspect of their maternity care and in particular women cite that their hospital stay was their least satisfying experience (Audit Commission, 1997; RCM, 2000b; Singh and Newburn, 2000; Dykes, 2005; Healthcare Commission, 2007; Bhavnani and Newburn, 2010). Importantly the nature of postnatal work and seemingly low or even ‘invisible’ status within maternity care (Bondas-Salonen, 1998; Bick et al, 2008) profoundly contradicts the central concern of understanding maternal transition. As McCourt (2009) reiterates
the prime concern of modern maternity care is to focus on birth rather than postnatal transition. An interesting point that I noted in attending the Royal College of Midwives annual conference in 2009, was that just one out of the 60 accepted papers focused on postnatal care. This backdrop I postulate mirrors the social, cultural and professional rhetoric of motherhood.

**Low status of postnatal care**

Nevertheless, it needs to be recognised that during the postnatal period as the majority of women are deemed to be ‘healthy’, obstetricians and other medical doctors have had minimal input into care provision. As a consequence midwives have experienced less role conflict than in other areas of maternity care, are the primary care givers and experience considerable scope for decision-making (RCM, 2000b). The reality is that as a domain of practice, postnatal care can be burdensome to midwives (Rudman and Waldenström, 2007). I would argue this reflects the notion of a ‘hierarchy’ within the spectrum of childbirth and the professional work of midwives. Figure 1 depicts the notion of a ‘hierarchy of childbirth’ (p17) in parallel with the hierarchy of evidence within the evidence based practice literature (Muir Gray, 2001), whereby evidence is weighted according its ‘robustness’ and status. Taking forward this analogy in relation to the practice of, and research into, childbirth a distinct hierarchy would unfold. As shown in figure 1 birth would be positioned at the top followed closely by antenatal care, with postnatal care being situated at the lowest level within the hierarchy. Over a decade ago Bondas-Salonen (1998) observed that a professional bias exists towards pregnancy and childbirth and that professional attention switches from the mother to the baby following birth, thus suggesting the low status of postpartum care. As Bondas-Salonen summarises:

> ‘Postpartum care is seldom either technological or dramatic and has been shown to be given low priority in maternity care and research’ (1998: 166)
This lowly positioning within the techno-medical hierarchy was noted by Dykes (2005). Dykes in acknowledging this lowly position of postnatal care aligns it in part to ‘impoverished resourcing and staffing and women’s dissatisfaction with postnatal care’ (2005:242). Without seeking to oversimplify this analogy, I would argue that the important point here is the creation of a structure and order that has downgraded ‘postnatal care’ towards the lowest position within childbirth (to use the term childbirth continuum does not apply in this context) and maternity care generally. More strikingly this outlook has been sustained over time (McCourt, 2009; NCT, 2010).

![Hierarchy of Childbirth](image)

**Figure 1: Hierarchy of Childbirth**

Viewing birth, antenatal and postnatal as three distinct entities supports a separatist view of childbirth which connects with the biomedical interpretations of childbirth. Oakley, for example, has written widely about the desire of medicine to control childbirth, treat it as an illness and seek to intervene (Oakley, 1980). The dominance of the bio-medical and pathological perspective Smith (1999) argues is reflected in research on transition to motherhood. Within this medical framework the female body is constructed as ‘fragile, a passive vessel and requiring medical assessments and interventions’ (Nettleton, 1995: 7). Women actually interpret and experience their body differently from this. As Oakley points out, women’s own
experiences are often dismissed by doctors as subjective and irrelevant (Oakley, 1980; 1992). I expand upon these ideas in the literature chapter (p24) and explore the bio-medical perspective in some detail. My point here is to highlight the tension between a separatist view and the notion that childbirth is a continuum which together creates ambiguity about the values that underlie childbirth from the professional perspective.

On a more macroscopic scale childbirth (in terms of illness and disease) and women’s reproductive health more generally has often been portrayed as having a low position within the hierarchy of health and illness. Moreover, this low status of women’s health and childbirth has been powerfully criticised and debated by many (Oakley, 1992; Nettleton, 1995; Barclay et al, 1997; Barry and Yuill, 2002; Walsh, 2004; Kirkham, 2007) for its potential to devalue and reduce the importance of women’s health and wellbeing. In opposition to the dominant biomedical view sociologists argue that disease and illness are *socially constructed*. Nettleton recognises that:

‘...disease categories are not accurate descriptions of anatomical malfunctionings, but are socially created; that is, they are created as a result of reasonings which are socially imbued. Medical belief systems, like any others, are contingent upon the society which produces them’ (1995: 7)

Nettleton goes on to highlight an example, drawn from the nineteenth century, whereby medical evidence supported the belief that women were unsuited to education. In relation to childbirth, Hellman et al (1962: 221) highlighted that ‘parturition was considered an abnormal and bruising process with women remaining in bed prostate and in binders, in order to reconstitute their abused internal organs’. This medical belief about resting in bed (referred elsewhere as the *lying in period*) transformed into fact, in that it was widely practiced for many years becoming socially and medically accepted.

**Historical perspective**
Historically some aspects of postnatal care have changed, although it remains grounded in rules and routines connected to notions of temporality (Dykes, 2005; 2009). In seeking to understand different perspectives on the cultural meaning and purpose of postnatal care I came across information on a now forgotten ritual known as ‘the churching of women’, an Anglican ceremony of thanksgiving after childbirth (Newell, 2007). Its roots were firmly embedded in biblical narratives and notions of purification. From my perspective this was a new discovery. According to Newell (2007) this rite of passage symbolised thanksgiving for birth through blessing and Christian prayer. It was rooted within a religious framework that permitted the celebration of a woman’s achievement of procreation. Newell (2007) outlined the deeper meanings entwined within the ritual, and the perceived unclean elements of birth created by blood loss known as lochia;

‘During the time of her lochia alba, the woman may not enter the sanctuary of the tabernacle. That the postnatal woman underwent a ‘ritual cleansing’ or ‘blessing’ in temple or church that symbolically brought her back into the ‘community of faith’, does not mean that she was not mobilised by degree before the time of the ritual. Despite the maternal body’s implied and considered impurity, nowhere in Hebraic Old Testament is the process of childbirth considered symbolically unclean’ (Newell, 2007: 48)

Within this context it was considered that lochia was dirty and unclean. Interestingly this view only affected how the woman was perceived and did not include the baby. There was a strong association with laws on purification which connected to a passage of time where thereafter women were regarded as clean and purified. What Newell drew my attention to were the subtle and powerful ways in which notions of dirt and pollution related to risk and danger (above and beyond mortality and morbidity) which influenced how women after birth were viewed and treated within society and communities.
Newell (2007) further believed that this purification ritual established power over women and their bodies. The church regarded the leakage of vaginal blood as suspicious. Consequently following birth women needed to be separated, controlled and monitored. She further explains that;

… the organic processes of childbirth and the puerperium is disguised by investing the process with the dignity of a social occasion and celebration (Newell, 2007: 50)

In summary my understanding is that churching goes some way to explain the pragmatism of segregating women during the puerperium by creating a social meaning (later medical) that is highly sequential. From this a distinct accepted mechanism or even ritual (albeit modern) has emerged that seeks to control women in their recovery following birth (UKCC, 1998; NMC, 2004). The purification ritual has stood the test of time and has been embedded within UK childbirth care perhaps under different guises but nevertheless the origins I feel contribute insights into the creation of the ‘lying in’ period (Hellman et al, 1967) and subsequent postnatal practices. In addition policy thinking parallels the rules located within a statutory framework (NMC, 2004), which reflects the established clinical context and beliefs about place of care which, for the majority of women in the UK, is in hospital (Audit Commission, 1997). The formal view of temporality has consistently been legitimised within policy which maintains a bio-physical approach to motherhood and birth recovery.

Policy perspective
As already indicated there is a universal requirement to address the rules pertaining to postnatal care. However, traditionally UK policy has tended to be inconsistent in how it deals with postpartum care. On occasions it is portrayed as a separate entity (HMSO, 1985; RCM, 2000; NICE, 2006; Bhavnani and Newburn, 2010) and on others attended to as an integral feature of maternity care (DH, 1993; DH, 2004). As far back as 1985 when the first Maternity Services Advisory Committee was commissioned to look closely at maternity care and offer guidance for good practice with a plan for
action, postnatal care was not defined. The guidance produced by a government advisory committee was called ‘Maternity care in action’ and interestingly a separate report dedicated to Postnatal and Neonatal Care was published entitled ‘Care of the mother and baby (HMSO, 1985). I actually recall the impact of this publication as at the time it felt like it was ground breaking and influential, as postnatal care had previously had minimal exposure. Indeed I still have my own copy of this postnatal report, as all midwives were urged to use the information to underpin their practice. The press coverage (professional and user groups) at the time was considerable and my observation was that as a dissemination process to practitioners huge efforts were deployed. Although interestingly in evaluating the document for the purpose of this thesis there are no references or citations, the evidence appears to have been generated from the 24 members of the advisory committee, in other words it is based upon their experiential knowledge. In the foreword the Chairman, Alison Munro, thanks the members for their ‘goodwill and constructive efforts’ also stating that they had arguments and disagreements but that in the end each member recognised the need for a consensus and she concluded that:

‘..a small sacrifice of an individual viewpoint is more than compensated for by the strength of the united view expressed and the promise which the reports of this Committee should provide of a high level of maternity and neonatal services throughout England and Wales’ (Munro, 1985 pviii in HMSO)

Such transparency about how the group worked has little resonance within contemporary national publications to inform health practice and the evidence based practice movement (DH, 1997; Muir Gray, 2001; NICE, 2006). That said, what this 1985 publication undoubtedly reflected was a methodology that was respected and valued at the time. Since 1985 the creation of national guidance has been superseded by a radically different methodology, one that places a high value upon knowledge derived from scientifically controlled sources e.g. systematic reviews and randomised controlled trials and reflects the evidence based practice notions of a
hierarchy of evidence (Muir Gray, 2001). Therefore the place for experiential knowledge is regarded non-scientific, less reliable and untrustworthy. Within this paradigm what counts as evidence corresponds to the National Institute for Health and Clinical Excellence (NICE) framework (2006) and connects to the bio-medical thinking on illness, disease and health as depicted in the hierarchy of evidence (Muir Gray, 2001). Some 20 years on from Maternity Care in Action, NICE singled out postnatal care as a topic requiring national clinical guidance to underpin what they referred to as ‘routine’ postnatal care (Demott et al, 2006; NICE, 2006). Predominantly this current guidance focuses on clinical issues related to physical recovery and mental health and wellbeing. Much of the discourse relating to clinical practice maps to that which values evidence based practice and wherever possible local protocols and documented care planning is suggested. Set against this context, is the strong requirement for individualised care and notions of working in partnership with women. There is a new emphasis on women being involved in informed decision making and informed choices. Communication skills and information giving about recovery are crucial. I would suggest that a kind of self-efficacy principle is implicitly outlined, whereby professionals under the guise of communication and information giving to enable individualised care are to inform women about the ‘normality’ of recovery and what actions to take if women are concerned about thresholds of normality.

The principles of individualised care (although not explicitly described) are regarded to be the most efficient and effective service for women (NICE, 2006: 8). This guidance offers a different model of postnatal care, one that embraces self-efficacy, with reduced physical visits (the check) and midwife contacts based on need. I would argue that this policy has failed to grasp why women are dissatisfied with postnatal care and feel abandoned on the hospital wards. Moreover, it misses why midwives find postnatal work burdensome and do it half heartedly despite the profession wishing to retain the work. Within the institutional ethos and workforce this guidance infers contradictory remedies for dealing with birth recovery. For example there is a tension between more reliance on self-efficacy, family centred and individualised care and documented protocols, ways of being efficient,
effective and ensuring professional surveillance and assessments are performed (Alexander and Higgins, 1993; Rogan et al, 1997; Troy and Dalgas-Pelish, 2003; Kirkham, 2004; Dykes, 2005;). On one level Ellberg et al (2008) claim that reduced hospital stays have led to parents’ responsibilities increasing within postnatal care. Whilst this shift towards reducing postnatal stays, visits and contacts appears simplistic the actual impact upon women is rather more complex. With regard to this policy context it seems that the outcomes that matter to women remain poorly understood. This said, recovery from birth has been assumed to be a natural progression to a good state of health for most women in the UK. Additionally, it is suggested that women in the UK normally make a full recovery from the physical, emotional and psychological impact of childbirth by at least six weeks (UKCC, 1998; NMC, 2004; McCourt, 2006). However, the NICE (2006) guidance makes clear that this fixed period is not always the case and that some women need longer.

Over the years policy has emphasised the need to individualise care and work in partnership with women (DH, 1993; RCM, 2000a; NICE, 2006) alongside rule changes e.g. selective visiting and care beyond 28 days which together aim to improve care and postnatal outcomes. However, as the Audit Commission, the Healthcare Commission (now the Care Quality Commission) and research studies have shown this has had minimal impact upon women’s experiences, expectations and satisfaction with postnatal care provision (Audit Commission, 1997; Lock and Gibb, 2003; Lugina et al, 2004; Beake et al, 2005; Maher and Souter, 2006; Healthcare Commission, 2007; Bhavnani and Newburn, 2010). I would argue that contemporary policy glosses over the meaning and purpose of postnatal care and does not consider the ways in which the requirement for individualised care can be realistically delivered. For example are we pushing midwives beyond what they can deliver? Is it simply a fantasy to believe that all women can be cared for as individuals? Why has policy been so professionally grounded? In what ways does the hospital stay and care provision affect women? Do we really know what women need?
To summarise I would argue that policy and to some extent the profession of midwifery has failed to grasp why women are dissatisfied with postnatal care in hospital and why midwives find postnatal work unpopular and burdensome. There seems to be a contradiction between the profession wishing to retain the work but yet appearing to do it half-heartedly with women reporting that they feel abandoned at a crucial point in their adaptation to motherhood (Audit Commission, 1997; Garcia et al, 1998; Healthcare Commission, 2007;). In the following chapter I will explore research landscape and related literature that seeks to shed light on these tensions and insights into our understandings of postnatal care issues.
3. Literature: What the papers say

Introduction
This review of the literature of postnatal care includes studies undertaken within midwifery, nursing, psychology, medical and social science. It was considered necessary to undertake a broad perspective of the review to capture different understandings and experiences of postnatal issues with a strong focus on the perspective of women’s experiences of, and their views about postnatal care and recovery. It is important at this point to note, as highlighted in the background chapter 2 (p4-24), that much of postnatal care in the UK is policy driven and in the Western world largely dominated by a bio-medical perspective alongside embedded traditions and rituals. Therefore, a broad perspective has been adopted in seeking to locate relevant research studies. This decision was influenced by the primary aim of the study. To reiterate: this study is primarily concerned with birth recovery from the mother’s perspective during the first year following birth, thus the literature presented here embraces this objective. In so doing a liberal approach was taken to the interpretation of women’s views that aimed to look beyond the clinical and professional literature.

Search strategy
The literature review was based on searches of relevant electronic databases such as the Cochrane Library, Pubmed, OVID, PyscINFO, Applied Social Sciences Index and Abstracts (CSA) and CINAHL from 1960 to 2006 (revisited in 2009), including searches of MIDIRS, RCM, BMJ and NICE. In addition, citation tracking and hand searching of key maternity and perinatal health journals such as Birth, Journal of Reproductive and Infant Psychology, Sociology of Health and Illness and Midwifery were undertaken. To supplement both the quality and range of literature within the search, appropriate non-published literature, published policy documents and knowledge from experts in the field was further incorporated and evaluated guided by Long et al (2002). In terms of the inclusion and exclusion criteria I made a decision to exclude postnatal depression, infant feeding and issues that related to parenting, for example bonding. As stated I did seek to include
studies and any literature that focused on women’s health after birth, women’s views of postnatal care, the voice of women/mothers and in particular longitudinal studies that focused on women’s experiences of birth recovery. Additionally, prior work concerned with postnatal recovery and adjustment to motherhood from a psychological and social science perspective was included. The subject headings and key words reflect this reasoning. An example of the subject headings used for each database to guide the search strategy can be found in appendix 2.

In assessing the initial findings from the searches there were many studies located that related, albeit tenuously, to postnatal care. To assist in dealing with this initial volume I designed a screening tool (appendix 3) as a means of selecting literature that specifically connected with the primary aim of the search. Interestingly, the use of this screening tool not only resulted in a precise and managed appraisal process of relevant literature but additionally provided an excellent source of papers for use throughout this thesis.

The findings of the review are organised very broadly into three main sections; the first section concerns insights into the context of care (includes power of place, optimum length of stay and biomedical dimension), the second section explores mother’s experiences with a final section providing insights into women’s health and wellbeing after birth (from a clinical to an holistic perspective). However, as will be seen, this separation is an artificial one as each dimension is interconnected. There will then follow a discussion of the differing methodologies used and the gaps in the literature before presenting some final summary comments. Before moving on to discuss the literature in more detail I will firstly provide a background section as a prelude to discussing the literature in detail.
Background - Setting the scene
The literature review began in 2001 with an examination of historical references and a point well made in the National Audit report ‘First Class Delivery’ (Audit Commission, 1997) that;

"Women’s views of maternity care show that many are dissatisfied with aspects of postnatal care, that they consistently express negative comments about postnatal care and view this aspect of their care as the least rewarding of the childbirth experience" (1997: 50)

This large scale audit undertaken across England and Wales had a remarkable impact within, and on, maternity care. At the time I was working in a clinical audit unit under the auspices of the Royal College of Obstetricians and Gynaecologists and was actively involved in conducting national audits in maternity care. I distinctly recall the report being debated in professional journals (notably British Journal of Midwives, The Practising Midwife), at conferences (Royal College of Midwives) and anecdotally in practice. It had a substantial impact partly in response to its timing in that it shadowed the implementation of Changing Childbirth (DH, 1993), a national policy for maternity care that explicitly put the woman at the heart of care, under the ethos of ‘women-centred care’. This audit was a detailed assessment of progress towards meeting Changing Childbirth objectives and considered to be extremely useful as it provided an insight into how practice connected up with policy. As a strategy for taking forward the findings the report had an intended audience, which the authors explicitly stated was commissioners, purchasers and managers of maternity services. Given that there is wide agreement that evaluations, including research, frequently fall short of being implemented in practice (Johnson, 1992) I would argue that this forethought towards its impact factor and dissemination suggested a commitment to supporting the implementation of the findings. A further dimension adding to its value and reach was the reporting mechanism which was two-fold. Firstly, each participating NHS Trust received complete feedback on its own performance. Secondly a national report was published
setting out the summarised findings and lessons for maternity services throughout England and Wales.

Specifically for the purpose of this review a separate report was published by Garcia et al (1998) that concentrated on the women’s views captured within the survey and the qualitative elements of the data. Undertaken by a survey method, 2,406 women completed a lengthy (45 page) questionnaire asking them about their experiences of care in pregnancy, before, during and after birth. Whilst recognising that postnatal care was not the main focus of the survey, these women revealed overwhelmingly more negative aspects than positive ones about their hospital postnatal care. Most notably within the additional comments section of the questionnaire, where they asked ‘is there anything else you would like to tell us…’ a total of 1,559 comments were received and of these, twice as many were judged to be negative as positive about care generally. The overall themes that emerged were in relation to staff attributes e.g. kindness and respect, support, information and communication, good care, choice, staffing levels and continuity of care. The level of detail specific to care after birth is minimal, length of stays, number of visits at home and broad questions about their health were addressed. It is difficult to ascertain what precise elements of care after birth concerned these women, in part due to the survey being about the entire childbirth experience and bias towards the organisation of care. However, the Audit Commission did question the value of postnatal care and highlighted a lack of evidence of its effectiveness. Whilst it is known that surveys have flaws and limitations (Turris, 2005) in this example data collection did provide a ‘snapshot’ of the views and experiences of a large group of women. Explicitly the authors state that limitations to the questionnaire existed in that it was retrospective, not focused on effectiveness of care and response rates were low from young and disabled women. However, I would argue that this distinctive report sent out a strong message at the time that women’s views count or least should be considered in evaluations (Drife, 1997; Garcia et al, 1998). Indeed as a separate report dedicated to women’s voices it symbolised an important shift from a passive to a more active position of
valuing service users in the context of service evaluations as Garcia et al stated:

‘Allowing more space to be given to women’s views and experiences is important’ (1998: 4).

In recognition of the methodological challenges to obtaining service user’s experiences and the desire to avoid being tokenistic, critically I would argue that this audit sought to be authentic in reflecting service user’s experiences.

According to Haigh (2008) a problem can exist in trying to associate user involvement with improved services and outcomes. In Haigh’s review of the evidence base to support patient involvement and managing health care she cautions that involvement does not necessarily equate to improved clinical outcomes. Being involved as a service user may be considered in this sense reduced to feeling right or a good ideology. Although evidenced from a comprehensive review, what is missing in Haigh’s review is the acknowledgment that the ethos of involving service users has been a dynamic process and should be assessed in a way that reflects this continuum over time. For example in looking back to 1994 the Clinical Outcomes Group (COG) set up by the chief medical officer made absolutely clear the need to involve patients and thus set up a patient subgroup to reflect patient ideas and experiences (Kelson, 1998). More recently (Renfrew et al (2008)) as part of a study to strengthen evidence base recommendations in public health (breast feeding), found that involvement of service users in this study resulted in them having a strong voice and an active role in the whole research process. Service users were considered to be experts and valued as sources of in-depth knowledge. As such their role was integral to the production of evidence based recommendations. These two examples are drawn upon to illustrate that progress has been made particularly in relation to maternal health. Of note I registered my study with INVOLVE (set up to promote public involvement in NHS research, now part of National Institute for Health Research) and more recently have become aware of patient involvement within the James Lind Alliance
Reverting back to the Audit Commission reports (1997; Garcia et al, 1998) I would suggest these are seminal works with their focus on the relationship between practice and policy and connectedness with service user experiences. Since the quoted findings on postnatal care (Audit Commission, 1997: 50) were first published it has had much coverage within UK maternity services. Despite this, seven years on current policy suggests that little has changed. Interestingly, the same finding is highlighted again in the National Service Framework for Children, Young People and Maternity Services (DH, 2004):

“All surveys repeatedly show more negative comments from service users in relation to hospital post-natal services than about any other aspect of maternity care” (2004:31)

In 2006 national guidance produced by NICE to inform practitioners and guide their practice in routine postnatal care made explicit in the introduction that:

‘There has been limited research into provision and content of postnatal care, and the number and range of postnatal contacts women have with their midwife, health visitor and GP are not well documented’ (Demott et al, 2006: 9).

A key component of the NICE guidance (2006) is the notion of empowering women. I would argue that the guiding principle here is information giving so that women are informed of the evidence base (contributing to the evidence base would be the ideal) and are able to participate in informed decision making about their own care and outcomes. National policy and guidance documents have consistently emphasised the need for ‘empowerment’ in childbirth (DH, 1993) so NICE (2006) are not stating anything new. However, perhaps what they are reiterating is the on-going need to achieve this goal. In addition, at the heart of this national guidance is a desire to raise the profile
of postnatal care by providing an evidence base to support practice (NICE, 2006; Demott et al, 2006).

Bearing in mind this background I will now return to discussing the review in detail. All the studies included in the review are summarised in table 1. To reiterate this study is primarily concerned with birth recovery from the mother’s perspective during the first year following birth. Therefore, I have included in the assessment of each study the different ways in which authors categorise women’s views, within table 1 a brief comment is given (using a code ‘WV’) as a way to provide some insights. This is a value judgment and I argue reflects the dynamic nature of the ‘service user’ continuum within health research.
<table>
<thead>
<tr>
<th><strong>Short reference</strong></th>
<th><strong>Method</strong></th>
<th><strong>Sample size and characteristics</strong></th>
<th><strong>Main Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barclay et al (1997) Becoming a mother - an analysis of women’s experiences of early motherhood. <em>Journal of Advanced Nursing</em></td>
<td>Qualitative Focus groups (9) Grounded theory method</td>
<td>55 1st time mothers (drawn from support groups for new mothers). Age babies ranged 2 - 26wks. Australia</td>
<td>Six categories emerged centred upon a core category ‘becoming a mother”; these categories were: realising, unready, drained, aloneness, loss and working it out (displayed in figure 1, p721). The study concluded that these mothers underwent a period of profound reconstruction of the self and that this process is not bounded by a particular timeframe. No comments on postnatal care and context of care giving in postnatal period. <strong>WV</strong> Women were research participants (met once for the focus groups) but no direct/active involvement.</td>
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<tr>
<td>Bondas- Salonen (1998) New mothers’ experiences of postnatal care – a phenomenological follow-up study. <em>Journal of Clinical Nursing</em></td>
<td>Qualitative Interviews</td>
<td>9 mothers (data collected end of pregnancy, 3wks, 3 months and 2 ½ yrs after birth) Finland</td>
<td>This paper and its findings are part a larger longitudinal study studying health, suffering, care and the organisational culture in Finnish maternity care. Re; this paper on postpartum care several themes emerged related to women’s understanding of caring, involvement of the family and other mothers. Caring experience is on a continuum, it is slow and intense. <strong>WV</strong> Women were research participants who stayed with the study for 2 ½ years.</td>
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<tr>
<td>Brown and Lumley (1997) Reasons to stay, reasons to go: results of an Australian population based study. <em>Birth</em></td>
<td>Postal Survey Questionnaires (retrospective)</td>
<td>1336 women from state of Victoria, (surveyed 6-7 months after birth) data collected 1993 Australia</td>
<td>The original study looked at the whole of maternity care – postnatal care was an element. This paper reports on women’s views and experiences of length of stay following birth – insights into impact of early discharge. No findings to support concerns about possible adverse outcomes resulting from shorter postnatal stays. <strong>WV</strong> Women were research participants but no direct/active involvement</td>
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<tr>
<td>Morrell et al (2000) Costs and benefits of community postnatal support workers: a randomised controlled trial. <em>Health Technol Assess</em></td>
<td>Randomised controlled trial (RCT)</td>
<td>623 randomised women Followed up at 6 wks and 6 months postnatally England</td>
<td>RCT comparing health status in a group of women offered postnatal support from community midwifery support worker (SW) with a control group of women not offered this support. No evidence of significant differences between two groups and at follow ups. Authors argue that postnatal home visiting lacks any coloration to clinical effectiveness and that care content does not always meet the women’s needs. <strong>WV</strong> No direct involvement or studies included reflecting active involvement</td>
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<tr>
<td>Reference</td>
<td>Methodology</td>
<td>Sample</td>
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<tr>
<td>Singh D &amp; Newburn M (2000)</td>
<td>Survey (retrospective)</td>
<td>960 women throughout UK (first few days, 4-10 days and 11-30 days)</td>
<td>Conducted by the NCT, looked extent of postnatal care meeting needs of women at three distinct points in time. Found overall that physical needs were more likely to be met than emotional needs, support and information needs. Found transition from hospital to home disruptive. Similar trends emerged at the different points in time. Sample was drawn from NCT member’s journal (New Generation) and Baby world internet site.</td>
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<tr>
<td>Bhavnani and Newburn Survey (retrospective)</td>
<td>Baby World internet site and NCT journal</td>
<td>UK</td>
<td>* as aspects of this study revisited in 2010 by Bhavnani and Newburn</td>
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<tr>
<td>Martell (2001)</td>
<td>Qualitative: using grounded theory</td>
<td>32 1st time mothers (x2 interviews during 1st wk and then 1-2wks later)</td>
<td>The major theme that emerged was ‘Heading toward the new normal’, a process through which the participants began to reorient their lives as mothers. The supporting categories were appreciating the body, settling in, and establishing a new family. This study was re-evaluated looking at hospital ward experience and published in JOGNN 2003</td>
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<tr>
<td>Martell (2001)</td>
<td>Qualitative: using grounded theory</td>
<td>USA</td>
<td>Women involved as research participants</td>
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<tr>
<td>Martell (2003)</td>
<td>* Martell (2003) further paper based upon this study</td>
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<tr>
<td>Dowswell et al (2001)</td>
<td>Literature review</td>
<td>40 Papers included (used comparisons)</td>
<td>Studies were descriptive and quality impinged upon scope to be generalised. However, the papers included in the review on postnatal care were of a relatively small number and were of both a poor design and quality. Found that with the impact of shorter hospital stays and earlier discharge there was some evidence that women were more likely to be satisfied with care at home. Authors concluded that more high quality information based upon the needs and preferences of local service users is required.</td>
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<tr>
<td>Dowswell et al (2001)</td>
<td>Literature review</td>
<td>USA</td>
<td>* No direct involvement or studies included reflecting active involvement – did include a MORI poll of women’s views</td>
</tr>
<tr>
<td>Persson and Dykes (2002)</td>
<td>Qualitative: open interviews (grounded theory)</td>
<td>12 parents (6 mothers/ 6 fathers)</td>
<td>Found that parent’s sense of security was enabled by midwife’s empowering behaviour and affinity of the family. Participants had to be married or living with father and mothers/fathers had to be ‘healthy’.</td>
</tr>
<tr>
<td>Persson and Dykes (2002)</td>
<td>Qualitative: open interviews (grounded theory)</td>
<td>Sweden</td>
<td>Women and partners involved as research participants and data collected at one point in time (2/3wks).</td>
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<tr>
<td>Reference</td>
<td>Study Title and Details</td>
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<tr>
<td>Health Technology Assessment</td>
<td>A cluster RCT 36 general practice Clusters = intervention (n=17) or control (n=19) Included 1087 intervention group, 977 women in control. Postal questionnaire at 4 months- primary outcomes. Women’s views at 2 months postpartum West Midlands health region of UK Re-designed midwifery led care (intervention group) = was over a longer period of time, used a symptom checklist and guidelines to manage postpartum health all were used. Overall women’s mental health measures were improved in intervention group (designed midwife led care) at 4 months and 1 year. The physical symptoms – no difference between groups. WV No direct involvement, women involved as research participants</td>
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<tr>
<td>Martell (2003)</td>
<td>Postpartum women’s perceptions of the hospital environment</td>
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<tr>
<td>JOGNN</td>
<td>Interviews: content analysis 31 first time mothers (same study as Martell 2001 – secondary analysis of data on environment) Found data within transcripts concerning impact of environment through content analysis. The categories that emerged regarding hospital ward environment were; context, physical conditions, socio-cultural conditions, contingencies and consequences. WV No direct involvement, women involved as research participants</td>
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<tr>
<td>Journal of Advanced Nursing</td>
<td>Quantitative and qualitative evaluation via MGI: Questionnaire and structured interviews 103 women surveyed at 6-8 weeks and 8 months post-birth Scotland A pilot study of the MGI – found a wide variety of quality of life aspects were reported, including emotional, social and financial concerns. Tiredness was prevalent in all groups, but other physical problems were rare at 8 months. Mothers with low quality of life (Primary Index) scores at 6–8 weeks and 8 months commonly reported having less personal time. Low scoring areas, which health professionals might consider in greatest need of attention, were often not the ones mothers deemed most important. Findings linked to perinatal mental health. WV No direct involvement, women involved as research participants</td>
<td></td>
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<tr>
<td>Lock and Gibb (2003)</td>
<td>The power of place</td>
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<tr>
<td>Midwifery</td>
<td>Phenomenology 5 women (conversational interviews one before birth, one just after and final one 6 weeks post-birth) Australia 4 major constructs of experience were revealed and include spatiality, corporeality, temporality and relationality. This paper focuses upon components of spatiality as expressed through the power place. The impact of place as a foreign space on these women is real and infringes their sense of security and support. WV No direct involvement, women involved as research participants but study designed to be woman centered and based on feminist framework</td>
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<tr>
<td>Levitt et al (2004)</td>
<td>Systematic Review of the Literature on Postpartum Care: Methodology and Literature Search Results Review</td>
<td>Systematic Review</td>
<td>138 papers included and sorted by topics Canada</td>
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<tr>
<td>Wiggins et al (2004)</td>
<td>The Social Support and Family Health Study: a randomised controlled trial and economic evaluation of two alternative forms of postnatal support for mothers living in disadvantaged inner-city areas</td>
<td>RCT</td>
<td>731 women offered either of the support interventions (control) compared with standard services only (control).</td>
</tr>
<tr>
<td>Lugina et al (2004)</td>
<td>Assessing mothers’ concerns in the postpartum period: methodological issues</td>
<td>Quantitative: semi-structured interview schedule and card sort methods</td>
<td>Cohort of 1st time mothers was followed-up 110 at 1 &amp; 83 at 6 weeks after childbirth in Sweden</td>
</tr>
<tr>
<td>Boulvain et al (2004)</td>
<td>Home-based versus hospital-based postnatal care: a randomised trial</td>
<td>RCT</td>
<td>460 women randomized to 2 groups 1. home based (n=228) 2. hospital based (n=231) postnatal care Switzerland</td>
</tr>
<tr>
<td>Source</td>
<td>Methodology</td>
<td>Sample</td>
<td>Findings</td>
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| Hunter (2004) The views of women and their partners on the support provided by community midwives during postnatal care

*Evidence Based Midwifery* |
| Qualitative semi-structured interviews | 5 couples (mothers and fathers) interviewed 6 wks after birth England | Seven themes emerged which all linked to meeting their needs by providing more midwifery support and practical help. These couples wished for care hand over to the health visitors to be delayed. |

*British Journal of Midwifery* |
| Semi-structured interviews (used a schedule) | 39 mothers in 2 ethnic groups (Indian and White) data collected 13 weeks after birth East Midlands region of the UK. | The Study was prompted by a local maternity services liaison committee. The findings fell into 2 distinct time periods, in hospital and at home. Experiences of hospital ward were affected by nature of the ward e.g. staffing levels, busyness and women’s expectations. Authors claim there was a mismatch between expectations and the actual service. No differences between ethnic, religious and experiences of mothering with these women. Found anxiety about going home for some women and that community and family provided valuable support and information. |

*The Cochrane Library* |
| Systematic review | 8 trials | Highlighted that there is ongoing controversy concerning whether or not staying less time in hospital is beneficial or harmful. Regardless of this assertion from a ‘gold standard’ high quality systematic review, it is still the case that throughout the UK firmly held beliefs exist that this well established reduced hospital stay with early transfer home is highly advantageous to women’s health and recovery processes. |

*Evidence Based Midwifery* |
| Semi-structured interviews | 22 women England | Focused on all aspects of maternity care, Findings emerged that were specific to postnatal care, in essence the main themes were; support, how women feel and the environment. Exact details as to how these themes emerged is limited. Data collected in 1990’s published 2005, due to lack of research in postnatal care. |

**WV** Small scale study, women involved as research participants and data collected at one point in time (6wks). |
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Findings</th>
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<tr>
<td>Dykes (2005)</td>
<td>A critical ethnographic study using participant observation and interviews</td>
<td>61 postnatal women and 39 midwives Two maternity units England</td>
<td>Focused on breast-feeding and interactions between midwives and women found postnatal wards influenced encounters with women and contributed to the global theme ‘taking time and touching base’. The nature of the wards impacted upon midwives’ experiences of temporal pressure and inability to establish relationality with women due to their working patterns. The global theme was underpinned by five organising themes: ‘communicating temporal pressure’; ‘routines and procedures’; ‘disconnected encounters’; ‘managing breast feeding’; and ‘rationing information’. The culture of postnatal wards impacted upon midwives and their relationships with women. Questions were asked about the purpose of postnatal wards in their current state.</td>
</tr>
<tr>
<td>Watt et al (2005)</td>
<td>Quantitative Questionnaires</td>
<td>1250 Mothers across 5 hospital sites Canada</td>
<td>Women were offered a 60-hour postpartum in-hospital stay following an uncomplicated vaginal delivery. Uptake of longer stays varied across the 5 sites, all 24hrs stays reduced; women seemed to like the offer of a longer stay. Irrespective of length of stay outcomes for mother and infant were unchanged at 4 weeks.</td>
</tr>
<tr>
<td>Shaw et al (2006)</td>
<td>Systematic Review</td>
<td>22 studies met inclusion criteria (RCT’s only) Canada</td>
<td>Studies on postnatal support (had a definition for purpose of search – a tested intervention – measurable outcomes), overall found no rct that endorsed universal provision of postpartum support to improve parenting, maternal mental health, maternal quality of life, or maternal physical health. They found that there is some evidence that high-risk populations may benefit from postpartum support.</td>
</tr>
<tr>
<td>Wray (2006)</td>
<td>Questionnaire</td>
<td>452 newly delivered mothers England</td>
<td>Postnatal care at home was highly regarded by mothers in this study. Concerns continued to be raised about hospital care, as the postnatal ward proved to be challenging for some women and their partners. Fundamental components of service delivery regarding cleanliness and hygiene, noise, rest and support for infant feeding and baby care were key findings.</td>
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<tr>
<td>Source</td>
<td>Methodology</td>
<td>Participants</td>
<td>Summary</td>
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<td><strong>Maher &amp; Souter (2006)</strong>&lt;br&gt;It's much easier to get help for the baby*: Women, postpartum health and maternal and child health care groups.</td>
<td>Focus groups</td>
<td>32 women (involved in maternal and child health care groups)&lt;br&gt;1st time mother only&lt;br&gt;Australia</td>
<td>The aim was to identify key health issues in women postpartum and their use of health care services in response to health needs. Women identified (minor) health issues but were not addressed as they adjusted to motherhood. These women were accessing a postnatal group – so had contact with professionals and other women on regular basis, provided a useful forum.</td>
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<tr>
<td><strong>Lof et al (2006)</strong>&lt;br&gt;Factors that influence first-time mothers’ choice and experience of early discharge</td>
<td>Interviews</td>
<td>9 1st time mothers&lt;br&gt;Sweden</td>
<td>Factors that influenced first-time mother’s choice and experience of early discharge were their sense of confidence and security, that they had support from their partner and that they could trust the follow-up organisation. Displayed data using process of text categorization (Burnard 1991)</td>
</tr>
<tr>
<td><strong>Zadoroznyj M (2006)</strong>&lt;br&gt;Postnatal care in the community: report of an evaluation of birthing women’s assessments of a postnatal home-care programme</td>
<td>Semi-structured interviews and telephone interviews&lt;br&gt;Survey</td>
<td>4 strands to the evaluation 93 interviews with postnatal women plus 163 postnatal women in satisfaction survey&lt;br&gt;Australia</td>
<td>Described as an evaluation of a new ‘Mothercarer service’ into the South Australian healthcare system where a new worker - postnatal home-care worker – was introduced. Marketing of the worker had to take place to encourage take up, confusion existed as to who could use this service but of the mothers who used the service liked it. Satisfaction rates were good. Only difference was seen in increased breast feeding at 3months.</td>
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<tr>
<td><strong>Miller (2007)</strong>&lt;br&gt;“Is this what Motherhood is all about?” Weaving Experiences and Discourse through Transition to First-Time Motherhood</td>
<td>Qualitative longitudinal - semi-structured interviews - plus an end of study follow up questionnaire</td>
<td>17 1st mothers (sampling = snow-balling)&lt;br&gt;3 interviews (prenatal, 6-8 wks and 8-9months post birth)&lt;br&gt;UK</td>
<td>Using a feminist framework and discourse analysis. Prenatal dimension, overall these data reveal the different ways women anticipate and gradually make sense of becoming mothers. Found a disjuncture between expectations and experiences, these new mothers found different ways to position themselves through transition to motherhood. Detailed on the impact of personal experience and gendered discourses.</td>
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</table>

*WV* No direct involvement, women involved as research participants.
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Setting</th>
<th>Findings</th>
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<tr>
<td>Rudman &amp; Waldenström* (2007) Critical views on postpartum care expressed by new mothers</td>
<td>Longitudinal population-based survey</td>
<td>3445 women from 593 clinics; questionnaires given in pregnancy, 2 months and 1 year after birth Sweden</td>
<td>The questionnaire was pre-designed to focus on four different aspects of postnatal care in hospital. A number of characteristics impinged upon women’s satisfaction with care, such as being young, migrants, first time mothers, complex births and short length of stay. Flagged up issues previously found re: organisation and content of hospital care.</td>
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<tr>
<td>Schmeid et al (2008) Time to listen: strategies to improve hospital-based postnatal care</td>
<td>Action research</td>
<td>Phase 1: identification of the problem Phase 2: Planning - range of data sources &amp; methods from staff Australia</td>
<td>An action research working group was set-up to facilitate the study and enable phase 2, the implementation of change. All data retrieved from midwives, staff and their managers – but on behalf of women and used background literature on women’s views. Strategies to improve hospital-based postnatal care included, ‘one-to-one time’ training and support for midwives.</td>
</tr>
<tr>
<td>Forster et al (2008) The early postnatal period: Exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia</td>
<td>Focus groups and interviews</td>
<td>52 women (8 pregnant, 44 postnatal) 8 focus groups and 4 interviews Australia</td>
<td>Themes that emerged were: anxiety and/or fear; and the transition to motherhood and parenting. Needs of 1st mothers were different to the needs of women who had already experienced motherhood. The women were generally concerned about the safety of their new baby, and lacked confidence as new mothers regarding their ability to care for their baby. A consistent view that the physical presence and availability of professional support helped alleviate these concerns, and this was especially the case for women having a first baby.</td>
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<tr>
<td>Bashour et al (2008) Effect of Postnatal Home Visits on Maternal/Infant Outcomes in Syria: A Randomized Controlled Trial</td>
<td>RCT</td>
<td>3 groups of new mothers (n=876) were randomly allocated to receive either 4 postnatal home visits (A), one visit (B), or no visit (C). Damascus, Syria</td>
<td>In Syria early postnatal home visiting is not the norm. This study sought to assess whether an early home visiting intervention resulted in improved (specified) outcomes. There was no difference in the overall outcomes between groups. The one difference was found in breastfeeding rates a significantly higher proportion of mothers in Groups A and B reported exclusively breastfeeding their infants (28.5% and 30%, respectively) compared with Group C (20%), who received no visits.</td>
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| **Bhavnani and Newburn**  
<table>
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<th>(2010)</th>
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| *NCT Report*  
| *(NCT (2010): a supplementary summary report)* |
| **Survey** | **1260 1st time mothers**  
| *(NCT readership/members)* | **UK** |

This study replicated aspects of the NCT survey conducted in 1999/2000 (Singh and Newburn 2000). Focused on mostly closed questions (related to standards in postnatal care (NICE, 2006) found limited improvements in postnatal care. Of note is the finding that in the first 3 days care and support was considered poor – issues that need addressing are kindness, listening and help in adjusting to the new demands of motherhood.

**WV** – National user group devised study, women involved as research participants

**WV**: Women’s Views – how women were involved or included in the studies.

**Note**: this is a value judgment and reflects the dynamic nature of the ‘service user’ continuum.
Insights into the context of care

Regulatory definitions
As previously described in the background chapter, traditionally the postnatal period with respect to midwifery care began immediately following the birth of the baby and ended on the 28th day after delivery. To reiterate the United Kingdom Central Council for Nursing, Midwifery & Health Visiting (UKCC) defined the postnatal period from a midwifery perspective as being of not less than 10 and not more than 28 days after the end of labour, during which the continued attendance of a midwife on the mother and baby is requisite (UKCC, 1998). However, in 2004 the Nursing and Midwifery Council (NMC) redefined the “postnatal period” stating that it: ‘means the period after the end of labour during which the attendance of a midwife upon a woman and baby is required, being not less than ten days and for such longer period as the midwife considers necessary’ (NMC, 2004: 6). In parallel to this shift in definition the reality is that postnatal length of hospital stay has reduced (McCourt, 2006; NCT, 2010) and transferring women home early is a well established practice (Bick et al, 2009). Thus I will show from the literature that the context of place, be it in hospital or at home, is often interpreted as some kind of competition between the different environments.

The power of place
Creating knowledge and understandings about ‘place’ of care has been the focus of much health research and maternity care policy during recent years (DH, 1993; Brown et al, 1994; RCM, 2000a; Ockleford et al, 2004; Walsh, 2004; Brown et al, 2005, Beake et al, 2005; Wray, 2006; Schmeid et al, 2008, Dykes, 2009; Beake et al, 2010). Such endeavours have included large scale comparative studies between care in hospital and at home. Simultaneously concerns about ascertaining the optimum time to discharge women and their baby home have increased. Additionally, over the past decade health research in the UK has moved towards integrating economic dimensions into many large scale research studies and evaluations. As noted by Zadoroznyj (2006) cost savings and the institutional benefits associated with childbirth such as reductions in the length of hospital stays after birth has international
appeal. Clearly the healthcare landscape has changed as fiscal restraint under the guise of efficiency and effectiveness has become a critical element of service provision and health discourse. For example a comparative study conducted in the early 90’s, led by a health economist designed and assessed an ‘economically efficient’ postnatal care model in Scotland focussed on individual needs, outcomes of which were compared with current care (Twaddle et al, 1993). This was a leading study at the time in the quest to demonstrate that reduced staffing costs were possible if postnatal home visiting was more coordinated, flexible and individualised with no potential detrimental effects upon women.

I would argue that the construction of fiscal constraints in particular has impacted upon all practitioners involved in health care delivery and moreover service users. Despite the fact it is well documented that the time after childbirth is profound and overwhelming (Bick and MacArthur, 1995; RCM, 2000a; Bick et al, 2001; Wray, 2003; Dykes, 2006; McCourt, 2006; Bhavnani and Newburn 2010) seeking to reduce hospital stays after birth irrespective of the type of birth (normal or assisted) is a widespread objective and considered to be cost-effective (Hellman et al, 1962; Twaddle et al 1993; Dowswell et al, 2001; Boulvain et al, 2004). However, it could be argued that opportunities to assess what worked well in regard to longer hospital stays (confinement as it was termed) have been lost, as since the late 80’s there has been widespread implementation of reduced hospital stays afterbirth. Before discussing the literature on length of stay in relation to the care context, it is worth explaining that I have chosen the label ‘power of place’ from Lock and Gibb (2003) as a means of encapsulating the impact of place regarding care after birth. What is interesting here in terms of place is the fact that their study was located in Sydney, Australia, where a ministerial intervention in 1989 decreed a move towards early discharge (leaving hospital between 24 - 48hrs) of women, which reflects the UK trends to reduce hospital stays.
Impact of place

This small scale study by Lock and Gibb (2003) which is informed by phenomenology and placed within a feminist framework sought to explore the experiential viewpoint of women who had selected early discharge from hospital. They claim to be woman-centered in terms of design and conduct, in that Lock and Gibb explicitly reject the positivist tradition of ‘adding on’ women’s experiences to a known phenomenon’ (2003: 133). Lock and Gibb recruited a convenience sample of five women (from an initial group of 13) from ante-natal clinics and collected data by undertaking three conversational interviews with each woman, one before birth, one just after and a final one six weeks post-birth. The process of data analysis influenced by van Maanen’s (1988) interactive model of data analysis was described as ‘thematic’. What they revealed through analysis were four major constructs of experience which were; spatiality, corporeality, temporality and relationality. Overall data unveiled the power of ‘place’ and to some extent how ‘space’ affected the experience of these mothers, in particular their expression of comfort, self-agency and security. Movement from one environment to another, home to hospital, then hospital to home, not surprisingly created a powerful split between different values and ways of being. For example women were affected by the act of ‘being given a bed’ on the ward which for them symbolised ‘illness’ and resulted in a loss of privacy and control. As stated by Lock and Gibb:

‘The apparent absence of being able to nominate with whom this bedded environment would be shared points to the authority the place of the hospital assumed over the social milieu of the women. It also indicates how the public authority of the institution impinges onto directing the space of the bed, usually an essentially private matter’ (2003: 135)

Lock and Gibb included the component of women’s anticipatory feelings by undertaking data collection (conversation interview) during pregnancy. As such it is difficult to assess how this aspect of the data contributes to the four main constructs described. It would appear that impressions of the hospital
were formed during pregnancy but details are scant to be certain of this. For example there is no indication as to whether any of these women were admitted to hospital or a ward during pregnancy or what their experiences consisted of. This said, it is clear that the power of place, anticipated or experienced, or what I would refer to as the ‘representation and reality’ can be profound. The authors discuss the limitations of this detailed and reflective study. One consideration is the size of the study although they align this to phenomenological tradition and claim to have delved adequately into the nature of early discharge home. However, Lock and Gibb conclude that there is merit in aligning midwifery models of care with feminism, claiming that in so doing a philosophy of treating women as individuals could unfold. Therefore, Lock and Gibb advocate the use of the ‘Midwifery Partnership model’ designed by Guilliland and Pairman in 1995 in New Zealand which has a philosophical underpinning of woman-centredness. How this model deals with hospitalisation and power of place is not explored and I would argue this is a substantial recommendation to make based upon such a small scale study.

In 2001 Dowswell et al conducted a comprehensive literature review on women’s views related to care in the community and found women were generally more satisfied with postnatal care at home. Importantly though, the aim of this review was UK literature relating women’s views on community based maternity care, so it was not exclusively concerned with postnatal care. However, I draw upon Dowswell et al (2001) here as they support the finding above that care at home can be more satisfying for women, in other words positive benefits of this ‘place’ exist.

**Early transfer home**

A qualitative study from Sweden by Persson and Dykes (2002) explored factors influencing the experience of mothers and fathers when they had chosen early transfer home. Respondents found being at home created ‘a sense of security’. Data were collected in 1997/8 following a re-organisation of postnatal care whereby early discharge with midwifery care at home was introduced in 1992 in this region of Sweden. Interviews with 12 parents were
conducted in the first week at home and mothers and fathers were interviewed separately. What this study found was that if mothers chose to go home early, had the father of the baby participating and being supportive and had prior parenting experience then a sense of security emerged. This ‘sense of security’ impacted upon feelings of control and autonomy, physical wellbeing, affinity with the family and the relationship with the midwife, which is described as ‘empowering behaviour’. Critically it is evident that in this study the participation of the father was a defining factor. That data were only obtained at one point in time in the first week at home is a disappointingly narrow perspective, resulting in a linear view of well supported mothers.

As with many articles on midwifery ‘support’, in its broadest form, has tended to be highlighted as an essential component in the practice and experience of the postpartum period (McCourt, 2006; Shaw et al, 2006). By reducing the findings from Lock and Gibbs to simply being associated with choosing early transfer home and the nature of place is misleading. Lof et al (2006) in their qualitative study explored factors that influenced first-time mothers’ experiences during the first postnatal week after early discharge without a domiciliary visit by the midwife. They also found a sense of security and confidence as distinct features of being at home. Again located in Sweden and with all women feeling supported by their partner and staff, they nevertheless found that being in the ‘place’ home beneficial to their own recovery. Lof et al conclude that:

‘A sense of confidence and security was a factor that influenced first-time mothers’ choice and experience of early discharge. The mothers in this study were all well prepared before birth but did not intend to go home early. When they felt ‘back to normal’ it became an option. Thanks to their partners’ and the staff’s supportive attitude and the fact that they could trust the follow-up organization, the decision to go home early from the hospital developed in a natural way, as the obvious choice’ (2006: 329).
Puerperal change theory

In contrast Martell (2003) found that the hospital ward environment hugely influenced a sample of first time mothers in a negative way. Based upon a secondary analysis of data from a larger study published in 2001 on first time mothers’ experiences during the first two to three weeks following vaginal birth (Martell, 2001) the impact of the hospital ward emerged as a key feature of the data. By origin Martell undertook a qualitative study (2001) that sought to develop a theoretical description about contemporary first time mothers’ experiences following vaginal birth. Thirty one mothers recruited in pregnancy and anticipating a normal birth were interviewed twice after birth. The first interview within the first week at home focused on mothers’ early postpartum experiences and the second interview one to two weeks later were designed to saturate emerging themes and verify the findings from the first interviews. A grounded theory methodology was adopted seeking to generate descriptive theory. Martell makes reference to Rubin’s *Puerperal Change* part of the emotional adjustment theory developed in the late 1960’s where it was found that after birth, ‘new mothers exhibit taking in and taking hold behaviours’ (2001: 497) during their hospitalisation. Martell claims to show that this theory was no longer valid. Rubin’s *Puerperal Change* is temporal in that the two explicit behaviours taking in and taking hold are said to be manifested by mothers during the first 10 days postpartum. Table 2 summarises Rubin’s puerperal change theory as cited by Martell (2001).
Table 2: Summary of Rubin’s Puerperal Change Theory

<table>
<thead>
<tr>
<th>Taking in (birth to 3rd day postpartum)</th>
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<td>After giving birth, mothers are fatigued, will sleep if left alone. They:</td>
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<td>- Want to talk about the labour to anyone who will listen, focus on the past</td>
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<td>- Are self-focused</td>
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<tr>
<td>- Need direction and are dependent, want others to meet their needs</td>
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<tr>
<td>- Are hungry, concerned about newborn’s intake</td>
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<td>- Are euphoric</td>
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<th>Taking hold (3rd to 10th day postpartum)</th>
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<tr>
<td>On the 3rd postpartum day, mothers become active even though they may be sleep deprived. They:</td>
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<td>- Focus on the present, especially learning mothering tasks</td>
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<td>- Regain bodily functions</td>
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<td>- Become focused on themselves in relation to others, especially with their newborns</td>
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<td>- Tend to be anxious and impatient with themselves, especially if they are not perfect mothers</td>
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<td>- Have mood swings, which become less frequent and less intense overtime</td>
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Ref: Adapted from Martell (2001)

Developed over 40 years ago from the doctoral work of Reva Rubin, one of the first specialists in maternity nursing in North America, this theory was a component of her grander theory ‘Maternal Identity’ and later ‘Maternal Role. In her doctorate she collected data by observing women during pregnancy, labour, birth and during the early postpartum period. She integrated those observations into a theory about the development of maternal identity, based on the childbirth continuum in its entirety. Overwhelmingly her work revolved around motherhood, identity and attachment and was highly influential in North America. Her contribution and esteem within maternal health was paid tribute by the journalist Michael Elliott in her obituary in the New York Times:

‘In scores of case studies she observed and documented as a nurse, midwife and teacher, she examined how mothers use a variety of
senses -- sight, smell and touch -- to become familiar with their newborns. To encourage the bonding that she observed, she was an early proponent of keeping the mother and the newborn together as much as possible during the first days after birth. By the 1980’s, the concept that there is a special time right after birth during which mothers become emotionally attached to their babies began to receive criticism from some researchers, although the changes in hospital practice that the research wrought were never questioned’ (Elliott, 1995).

Despite being a respected and notable thinker on maternity care in North America, Rubin’s *puerperal change* theory is relatively unknown in the UK. It has not been operationalised within maternity care or cited within the UK midwifery literature. Primarily I would suggest this is due to differences between the UK and North America such as the ethos of maternity care, ‘rooming in’ practices and community follow up care. Moreover, historically the UK with the existence of midwifery as a profession, the Midwives Act and the NMC rules has meant a framework to support postnatal care has long existed. However, like Rubin’s theory the UK has adopted a temporal and medically constructed principle towards postpartum care. That arguably has built within it a sequential recovery process that women move through whilst at the same time facing a complex array of institutional rituals and rules within the ‘place’ of care (Garcia at al, 1998; Wray, 2006; Forster et al, 2008).

In the UK much research and other literature reveal similar concepts and evidence to those of Rubin concerning adjustments to motherhood and mothering (Ball, 1994; Barclay et al, 1997; RCM, 2000a; Cronnin, 2003,). For the purpose of this review it is the existence of institutional analysis of the ‘place’ where women experience their postpartum care that is of relevance. However, from my perspective I was curious about the apparent lack of knowledge of Rubin’s theories and contacted leading researchers in the field of postpartum care, they confirmed minimal insight (p/c Bick and Yelland 2009). Paradoxically it would seem that such theories have not been used within midwifery practice and enacted upon in maternity policy in the UK.

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However, what has emerged over the years is the question about the efficacy of postnatal hospital care. Ockleford et al (2004) along with others such as Beake et al (2005), myself (2006) and Rudman and Waldenström (2007) have raised the question based on research findings sourced from women about their negative and dissatisfied experiences of the ‘place’ namely the hospital ward after birth.

For example Ockleford et al (2004) in a qualitative study using semi-structured interviews with 39 women, reaffirmed the ‘power’ of the hospital ward both in terms of the culture of the environment and the experiences encountered by the women. These women perceived staffing shortages on the wards, which in turn resulted in limited help being available to them. Compounded by the fact that many did not always know how to obtain information and be pro-active in seeking help. The findings highlighted that on leaving hospital and going home, these women felt unprepared, apprehensive and found transition to motherhood difficult. This said, women were resilient and used their family members and community midwives to meet their needs.

Returning to Martell (2003) whilst the original data collection (open-ended interviews) did not specifically ask about the ward environment Martell claims that a major theme focused specifically on the environment unfolded as a distinct feature within the dataset. In response secondary analysis was undertaken of the original interviews after which a further four distinct categories emerged pertaining to the ward; the physical conditions, sociocultural conditions, contingencies and consequences. Together these categories impacted upon postpartum recovery and overall these mothers felt that their hospital ward experiences had not met their expectations. Critically an apparent mismatch between expectations and service provision unfolded in what I have earlier referred to as the ‘representation and reality’ of care after birth. Others more recently such as Miller (2007:337) recognise this as a ‘disjuncture between expectations and experiences of mothers’. As did Rudman and Waldenström (2007) it is worth pointing out that both sets of findings (Martell, 2001; 2003) were taken from a homogenous sample of first
time mothers who had had a vaginal birth in North America. Furthermore, that this retrospective study sought theoretical description rather than explanatory theory limits insights into the complexity of the ward experience. I would argue that despite such limitations these women’s interpretations of their experiences of the hospital ward, go some way to convey the message that ‘place’ matters and that the ‘power of place’ should not be underestimated for its potentiality to impact (according to many in a negative manner) upon women. As later discovered by Rudman and Waldenström (2007) in a large prospective longitudinal survey of 2,783 women, a representative sample of women gave negative comments about postpartum care. Findings spanned six categories, of relevance of which those related to the hospital ward ‘organisation and environment, staff attitudes and behaviour and information’, together served to frustrate and disappoint women. They also experienced a sense of dehumanisation and lack of sensitivity towards having their needs and concerns met by staff.

Clearly, the hospital postnatal ward with its social order has consistently had a profound effect upon women after birth. Midwifery and health care literature has recognised for many years that the environment plays a pivotal role in women’s experience of postnatal care (Helman et al, 1962; Ball 1994; Audit Commission, 1997; Brown and Lumley, 1997; Singh and Newburn, 2000; Dowswell et al, 2001; Rudman and Waldenström, 2007) and yet little has changed, other than reductions in the length of stay. Having discussed the power of place, within the context of care, I shall now examine some of the literature surrounding the quest for the optimal length of stay on the postnatal ward.

**Optimal length of stay**

Patterns of care during the postnatal period have changed dramatically over recent decades. To illustrate, table 3 outlines the trends in postnatal hospital stays for the past 18 years in England as cited by the Hospital Episodes Statistics (HES, 2009). The trend between 1990-2008 has been towards shorter postnatal hospital stays. For example in the early 90’s 60% of hospital postnatal stays were between 0-3 days, compared with 2008
whereby 92% of stays were between 0-3 days. At the other end of the spectrum hospital postnatal stays between 4 - 7+ were 30% in the early 90’s falling consistently over the years to below 10% in 2008.

**Table 3: Duration of postnatal hospital stay in England 1990 - 2008**

<table>
<thead>
<tr>
<th>Year</th>
<th>0-3 days</th>
<th>4-6 days</th>
<th>7+ days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>92%</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>1992</td>
<td>90%</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>1994</td>
<td>88%</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>1996</td>
<td>86%</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>1998</td>
<td>84%</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>2000</td>
<td>82%</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>2002</td>
<td>80%</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td>2004</td>
<td>78%</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>2006</td>
<td>76%</td>
<td>20%</td>
<td>4%</td>
</tr>
<tr>
<td>2008</td>
<td>74%</td>
<td>22%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Distinctions were (and still are) made between length of stay for multiparous women and primigravida women (first time mothers) (Thomson, 1996). Based fundamentally on assumptions that experience of mothering and childbirth equates to different needs and requirements during the hospital stay (and beyond). Ruchala and Halstead (1994) feared that shorter hospitals stays of 12 - 48 hours would impinge significantly on the time available for assessing the mother-infant relationships and related teaching plans for all new mothers. Regardless of such fears reduced length of stay has become the norm although novice mothers are expected to stay longer in hospital and this widely held belief has translated into practice and is reflected in research studies. For example Maher and Souter (2006) selected first time mothers for their ‘newness and potential to disclose more’, whereas Miller (2007) provides no clear rationale other than by selecting first time mothers as this

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3 Source: Hospital Episode Statistics data on maternity care for 2007-08
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1040
accessed on 4.8.09 at 12.51hrs
appears to meet her study objective around the anticipation of motherhood. Others such as Martell (2001), Cronin (2003), Lugina et al (2004) and Lof et al (2006) provide minimal explanation.

Ambulation or going home?
Many Western countries have significantly reduced lengths of stay on a hospital ward after birth (Zadoroznj, 2006). Despite these reductions the optimum length of stay remains uncertain and confusing. Historically it was the practice of early puerperal rising or early ambulation that concerned the disciplines of obstetrics and midwifery for many years. Hellman et al (1962) noted that early rising implied early discharge and that the interpretation of early rising in practice resulted in increased early discharge. Hellman et al argue that the merger of the two practices created some confusion within maternity care. Clearly the two practices are and remain very different issues. In fact reaching a consensus on the definition of early discharge and what constitutes ‘early’ has escaped clarification. Furthermore, as Zadoroznj (2006) points out a further reason for a lack of consistency and clarity relates to the heterogeneity of home support systems across sites and countries. It is well recognized that in the UK a high level of service provision exists and that other countries experience minimal to no community post-birth provision (Brown et al, 2005). Where home support exists across the world it can range from actual visits from midwives or nurses to telephone support calls, trained support workers and lay support programmes (Morell et al, 2000; Wiggins et al, 2004; Zadoroznj, 2006) to nothing.

Reducing lengths of stay
Within the UK agreed lengths of stay were promoted within the acute hospital setting and accepted by the midwifery profession (Dowswell et al, 2001; Beake et al 2005). Some variations existed but up until the late 1980’s a stay of up to three days post-birth was considered the standard length of stay (Brown et al, 2005). The pursuit of evidence in this area has tended to focus on comparative schedules (Brown et al, 2001; Boulvain et al, 2004; Watt et al, 2005) and measurement of adverse outcomes (Brown and Lumley, 1997; Levitt et al, 2004). In 2005 Brown et al published a Cochrane systematic
review (included 8 trials) of early postnatal discharge from hospital for healthy mothers and term infants and found no evidence of adverse outcomes associated with policies of early postnatal discharge. Regardless of this evidence based finding from a high quality systematic review (often referred to as the ‘gold standard’), it is still the case that throughout the UK firmly held beliefs exist that reduced hospital stay with early transfer home is highly advantageous to women’s health and recovery processes (RCM, 2000a/b; Cattrall et al 2005; McCourt, 2006; Bhavnani and Newburn, 2010).

In support of the earlier assertion concerning optimal length of stay, a relevant finding was the substantial variation in the definition of ‘early discharge’ within the included studies. In addition, Brown et al (2005) draw the conclusion that widespread uncertainty as to the benefits and risks of early discharge home (transfer is a commonly used term), is due to the poor quality of studies assessed. However, as a source of evidence Cochrane reviews adopt an explicit perspective as to what counts as evidence, thus only randomised clinical trials conducted across the world are included and evaluated. According to feminist theory the female body within this paradigm is portrayed and understood in terms of pathology and thus connects with the biomedical model that largely dominates healthcare. Shildrick (1997) argues traditional health care views the body as a ‘biomedical body’ and argues that;

‘The so-called medical model, which has dominated the traditional biosciences, speaks to a powerful split between mind and body whereby the knowing subject is disembodied, detached from corporeal raw material’ (1997:13)

The broken body
Shildrick goes onto concur that the ‘broken’ body of sickness has important consequences for how we view who we are, this is played out in the representation of the bodies of women, one that is ‘morally deficient and existentially disabled’ (Shildrick, 1997:14). The important point here is that Shildrick is not referring to ‘real bodies but what she calls ‘the contradictory cultural construction of them’. Therefore, critically the construction of the
body within many studies such as those contained in Brown et al’s review (2005) also Boulvain et al (2004) and Watt et al (2005) supports the notion of the bio-medical body, one that is required to heal and repair. In contrast Lof et al (2006) and to some extent Brown and Lumley (1997) in their retrospective studies take a different view seeing women as sources of knowledge about their own experiences of length of stay, rather than seeking to quantify through statistical analysis.

In a further systematic review looking at the evidence surrounding effectiveness of clinical interventions within postpartum care Levitt et al (2004) took the view that knowledge creation rested upon one source:

‘The review included only studies with a randomised controlled trials design because of the widely accepted strengths of this methodologically rigorous approach’. (2004: 200)

The outcome of this review was inconclusive in determining an optimum length of stay and the authors recommended more clinical (controlled) research. Irrespective of the type of research evidence the move to shorten the length of stay has in the UK, as noted earlier, been influenced and firmly aligned to a pragmatic fiscal decision (Boulvain et al, 2004) and historically the actual length of a stay has mostly been informed by custom and practice (Ball, 1994; Beake et al, 2005; Wray, 2006).

In studies that have explored the reasons why women choose to leave hospital early a complex picture emerges (Persson and Dykes, 2002; Brown et al, 2001; Wray, 2002; Lof et al, 2006) that hinges on the actual ‘place’ in terms of the nature of the environment and how women respond and interpret the place. In many ways length of stay is without question associated with the complexity of the ‘power of place’, I would argue that efforts to separate out length of stay from where care is taking place contribute to notions of a dualism. In support of such complexity, Watt et al (2005) in a large scale survey that offered women the option of an ‘extended’ length of stay (up to 60 hours) across 5 different hospitals (with 1250 women,
who had uncomplicated births) in Ontario found overall length of stay reduced marginally. They discovered influencing factors of staying longer revolved around; if the baby had medical problems, if it was the first child, if the mother identified two or more unmet learning needs in hospital or if the mother was unsure about her readiness to go home. Institutional factors also came into play that served to impinge or enable a longer stay, such as attitudes of providers, fears about bed occupancy and dealing with policy changes. Regardless of the length of stay Watt et al found no differences in health outcomes for mother or infants and yet they recognise that:

‘The ability to exercise some degree of control over one’s own care continues to be an important issue in patient satisfaction and probably a factor in a women’s decision about how long to stay in hospital’ (2005: 8)

In the UK in common with other western countries it appears that the quest to establish the optimum length of stay is highly medicalised. This is in the sense that the ‘right’ protocol is measured against defined outcomes such as readmission rates, breast feeding rates, maternal and infant health and perinatal mental health (postnatal depression). Thus the involvement of the woman in making a decision regarding her preference as Watt et al (2005) suggest requires consideration. Arguably this lack of inclusion of the woman’s personal preference and disregard for her to be in control and make choices reinforces the concept that patriarchal medical thinking continues to dominate in this area (Turiss, 2005; Miller, 2007).

Biomedical body: is the body a machine?
I have already alluded to the assertion that there is a tendency in childbirth towards the ‘medicalisation’ of the female body (Oakley, 1979; 1992; Shildrick, 1997), which as highlighted in the literature produces a check list approach to handling postnatal care. In doing so I draw upon Foucault’s (1978) analysis of modern western culture and cultural perceptions of women’s bodies and the notion of the ‘body as machine’ metaphor. Thus in terms of the way postnatal care is delivered the female body could be viewed
simply as a ‘baby making machine’ one that has completed its ultimate function following birth. In juxtaposition to this notion is the dominant discourse attached to motherhood and caring, in that they are both seen as ‘natural’ and ‘instinctive’ female traits (Oakley, 1979; Miller, 2007).

Miller goes on to argue that such assumptions have neglected the ‘circumstances, power relations and interests that have made women primarily responsible for mothering’ (2006:338). Examining the way postnatal care has been medicalised and pathologised goes some way to understanding the current care context and the ways in which service provision remains predominantly clinically managed.

**Surveillance**

Almost as soon as the postpartum period commences there is a notable shift at this juncture from in-depth medical scrutiny and surveillance of the mother to the heightened surveillance of the infant where different assessments are employed to ensure progress is normal (in other words disease and illness free). This shift in priorities ties in with the subtle hand-over of care to the domain of midwives and non-medical maternity care staff (Morell et al, 2000; RCM, 2000a; Wiggins et al, 2004) yet I would suggest that the biomedical body prevails, even in the absence of bio-technology and clinical interventions, throughout the postpartum period. Indeed, many commentators argue that it is the medicalisation of childbirth that is responsible for creating the notion that childbirth, postpartum in this instance, is dealt with as a pathology that requires treatment and interventions (Oakley, 1992; Shildrick, 1997; Rothman, 2000; Miller, 2007). Such a belief has been discussed in part within the review.

**Birth dirt**

In seeking to understand the relationship between childbirth and health I have highlighted in the previous chapter the notion of a ‘hierarchy of childbirth’ and the low status of postnatal care within this hierarchy. I would suggest that a reason for the low status of postnatal care relates to the notion of ‘birth dirt’. It is in Kirkham’s (2007) book on dirt, dirty work and birth dirt
and the exploration of the differing discourses, interpretations and meanings placed upon women’s health that additional insights are revealed. For example the notion of ‘birth dirt’ resonates with the notion that during the postnatal period women have a profoundly ‘leaking body’, one that is less contained than at other time during the childbirth continuum. Perhaps it is the case that during this time the woman’s body, alongside that of her baby, with the various leaking fluids is regarded as being hugely dirty and contaminated, thus the least clean part of childbirth. According to Kirkham:

‘Birth dirt exists, but its nature will vary depending on the time, the place and the culture. Who and what is clean or dirty similarly varies and will depend on the similarly create the discourses surrounding birth in the particular time, place and culture’ (2008: 9)

I would suggest in their large scale cluster trial MacArthur et al (2002) manage to encapsulate the dissonances between notions of ‘birth dirt’ with surveillance and clinical examination against handling postnatal care within the ethos of normality. On the one hand this study challenges the temporal boundaries related to postnatal care and in the intervention arm of the trial extended midwifery postnatal community care to three months post-birth. Conversely, the ethos of identifying and managing physical and psychological recovery through use of symptom checklists and clinical and evidenced-based protocols and associated schedules for visiting women at home aligns towards a bio-physical paradigm. I would argue this equates to seeing the ‘broken’ body of sickness as in need of medical treatment. Whilst I make this critical observation it is also worth noting that MacArthur et al (2002) and Bick et al (2009) made a huge contribution in the UK to raising the profile and credibility of postnatal care and maternal morbidity after birth. However, tensions between seeking to support women to attain good health (broadest sense) after birth and the powerful medical discourses related to care after birth remain. The bio-medical paradigm is one way of understanding birth recovery. An alternative view is that many of the health disparities experienced by some women in the early postpartum weeks are rooted in social determinants of health (Wiggins et al, 2004; Landy et al,
Furthermore, health beliefs and culture can play a pivotal role in providing symbolic meaning to recovery or ‘convalescence’ after birth for many women (Pillsbury, 1984; Geckil et al, 2009) and within traditional maternity care can be overlooked or not taken into account (Kirkham, 2007).

In many cultures there are differing beliefs, taboos and behaviours relating to mothers and infants in the postpartum period. For example the prevailing western view that according to Ruchala and Halstead (1994:83) ‘once birth is over, women recover and adapt to mothering’ prevails extensively. This compares with China where traditional custom stipulates that a woman should be confined to the home for a month of convalescence after birth (Pillsbury, 1984). Therefore, as Miller (2007) has pointed out neglecting to take account of these other factors such as power relations, control and cultural issues in turn mitigates against what I consider to be progress in service provision and how women experience postnatal care. Brown et al (1994) draw attention to poor levels of understanding of the mind and body synergy within reproductive health research (within the medical paradigm) as they note ‘many flawed studies are directed by myths and culturally biased attitudes towards women’ (Brown et al, 1994:6). They further highlight that much research on reproduction attempts to find the cause or causes of a positive or negative childbearing experience within the woman herself, with the emphasis shifting to what Brown et al refer to as the ‘within person’ variables. In other words research that takes no account of the role of, and relationship with, professionals as well as the institutional factors, policies and social contexts is limiting (Brown et al, 1994). Whilst a particular version can emerge I would suggest it omits to take account of the critical knowledge that women posses about themselves and their lives.

To summarise in this section of the review on context of care I have highlighted a number of tensions and issues in relation to the power of place, length of hospital stay and the biomedical perspective as they relate to postnatal care. Whilst admitting that separation into these themes was in part artificial, the evidence identified suggests researchers tend to divide and separate out elements of postnatal care. An overarching finding has been the
way in which the female body is viewed, mostly as in need of repair and in the absence of cultural practices which go someway to understanding notions of the ‘broken’ body of sickness (Shldrick, 1997) and ‘birth dirt’ (Kirkham, 2007). A bio-medical model and positivist paradigm remains dominant alongside fiscal restraints, which together continue to shape care provision. There appears to be a focus towards concentrating more on the infant and making sense of motherhood, rather than the woman as an individual. For too long many studies and other sources of information have been unclear as to the aims (Brown et al, 1994; Garcia et al 1998) and the efficacy (Ockleford et al, 2004; Beake et al, 2005; Rudman and Waldenström, 2007) of postnatal care. Furthermore, satisfaction with postnatal care from the woman’s perspective remains a concern alongside valuing and believing what women have experienced. I will now turn to discuss this dimension in more detail.

Mother’s experiences: is the voice of the woman an ‘add on’?
Establishing insights into service user’s experiences, in this instance of postnatal care, is of immense interest to midwifery and healthcare since taking account of women’s experiences aligns in principle to the spirit of ‘woman-centred care’ (DH, 1993; Singh and Newburn, 2000; Hunter, 2004; Ockleford at al, 2004; Beake et al, 2005). As mentioned there has been a trajectory of UK policy over the years following the arrival of the ‘consumer movement’ within healthcare (DH, 1999) towards involving service users (Kelson, 1998; Singh and Newburn, 2000; Bhavnani and Newburn, 2010) in a plethora of feedback processes including evaluations and research (Haigh, 2008). Reflecting patient experiences, listening to them, consulting them and involving them are established features of NHS policy. Indeed involving service users and reflecting their perspective is complex as their concerns and priorities may well differ from those held by health care providers (Wray, 2003; 2006; Anderson and Podkolsinski, 2000; Turiss, 2005; van Teijlingen et al, 2003). In addition, Turiss (2005: 294) comments that: ‘Its utility [patient satisfaction] is based on the notion that, if patients are satisfied, they have in fact received good care’.
Believing women

Having established that capturing the patient experience is worthwhile, the thorny question emerges ‘can we believe women?’ Brown et al (1994) explicitly address this by drawing upon John Stuart Mill, the 19th century British philosopher, who unusually for his time believed that women possessed crucial knowledge about themselves. Brown et al assert that:

‘such a view is still far from being unequivocally endorsed by those carrying out research and deciding what should be published in the journals concerned with professional practice, especially where childbearing women are concerned’ (1994:1).

The social scientist Ann Oakley has over many years illuminated the subordinate way in which women and their experiences are treated, in particular in their endeavours to secure meaningful rapport with doctors and maternity care staff (Oakley, 1979; 1992). Oakley’s enlightening work has been widely disseminated and supported Brown et al’s (1994) claim that within a scientific and clinical perspective women are often seen as unreliable informants who cannot be believed in the absence of evidence from a superior source. In the research that forms the basis of this thesis I started from a different standpoint in that I like, Smith (1999) and Miller (2005; 2007), rejected the positivist position and traditionally patriarchal biomedical perspective of searching for facts and viewing women as passive, unreflective and uninformed. Whilst both Smith and Miller’s research studies centred upon first time mothers, it is their analysis and theoretical positions for challenging the dominant medical models and discourses related to the shaping of motherhood and reproduction that I am drawn towards. At the heart of such an approach is the rejection of the prevailing notion that women are at the ‘mercy of their hormones’ or are intrinsically pathological. What women report about their experiences should according to Smith (1999: 282) be taken as their interpretation of reality. Miller (2007) similarly contests such historical frameworks and supports new ways of capturing mother’s experiences. In support of these ideas women are reflective, informed, reliable informants and can be ‘believed’.
Listening to women

In 2002 I attempted albeit in small way, to highlight some of the practical steps and lessons learnt from engaging with local user groups in drawing up a purposeful action plan from a survey of women’s views on postnatal care in seeking to reflect an authentic perspective (Wray, 2002; 2006). For example a survey method was employed to collect information from newly delivered mothers about their experiences on all aspects of postnatal care provision. The main findings once again mirrored those from the Audit Commission (1997) in that women expressed more concerns with their postnatal hospital care than care at home. As a means of collecting insightful and meaningful data I would argue that in part this study was methodologically weak and lacked depth in regard to data obtained. Primarily the study was seeking to examine satisfaction with care provided. I recognise that exploring whether service users are satisfied with the care that they receive is fraught with problems and agree with Oppenheim (1997) that a survey approach has disadvantages such as the likelihood of biased responses resulting in an unrepresentative sample (in Wray, 2002 the response rate was 42%).

Nonetheless, in 2000, Anderson and Podkolinski claimed that studies continue to use women in a passive role, doing research ‘on them’ rather ‘with’ them. They stated that:

‘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’ (2000: 13).

More recently and in support Turiss (2005) in her paper entitled ‘Unpacking the concept of patient satisfaction: a feminist analysis’ suggests that:

‘…there is wide agreement that patient satisfaction is an under-theorized concept. Using current conceptualizations of patient satisfaction, we end up all too often producing a checklist approach to ‘achieving’ patient satisfaction, rather than developing an
understanding of the larger issues underlying individual experiences of health care’ (2005: 293).

It is the experience of the individual that informed my decision to code the included studies in table 1 for possible insights into women’s views concerning their postnatal care needs. Studies have been few and according to Beake et al;

‘There is a dearth of information on what women want from their postnatal care, both in hospital and at home’ ((2005: 80)

In their study using in-depth semi-structured interviews of 22 women in an NHS Trust with 2 maternity units in the 1990’s (published in 2005) Beake et al sought to understand more fully the views and experiences of women on their care. The context of care for the purpose of this study embraced all aspects of childbirth in other words pregnancy, birth and postnatal care. During the interviews women were asked to provide a narrative story eight to twelve months post birth on all aspects of their care and to ‘raise points that could be helpful, or could be changed’. Findings emerged that were specific to postnatal care. In essence the main themes were; support, how women feel and the environment. Exact details as to how these themes emerged are limited. In addition Beake et al openly admit data were old in that they were collected in the 1990’s and clearly regard these issues as limitations of the study. However at the same time they feel convinced that the situation has not improved or changed. Their method of engaging with women as research participants was a passive one; women were recruited to the survey and played no other part in the research process other than being interviewed. When data were collected is not clear and given the trajectory of increasing service user involvement over time reflects the context of that time.

In further evidence from qualitative studies seeking user’s views it emerges that often midwives and women do not concur on issues of importance within the postnatal period (Ockleford et al, 2004; Hunter, 2004; Maher and Souter, 2006). An action research study by Schmeid et al (2008) with the words ‘time
to listen...’ in the title initially provided some optimism concerning the possibility of a different perspective. This study, conducted in Australia, sought to design and implement strategies to improve hospital-based postnatal care in one hospital in Sydney. The origins of the study according to the authors rested upon previous insights and knowledge from published literature that consistently reported women are dissatisfied with hospital based postnatal care. The prime aim was to focus upon midwives and engage them in the action research process to implement change and improve hospital based postnatal care. As outlined in table 1, the study had a phased approach and whilst the new strategies designed and implemented were not particularly different or unique Schmeid et al comment:

‘Nonetheless, the findings from phase one and two of this study highlight the need for midwives to reflect on what is often ‘taken for granted’ in postnatal care and to recognise and act on the tensions between institutional priorities to complete tasks and women’s need to have a midwife take the time to listen to and address their individual concerns’ (2008: 104).

Disappointingly, Schmeid et al’s sample was restricted to midwives and staff (the only source of data throughout the study). The authors claim that past research on women’s views was the main impetus for choosing and conducting this action research study. It could be argued that as researchers they were responsive to the women’s voices and sought to utilise their experiences by selecting a prospective methodology to ensure change and improvement would ensue.

There is a predisposition towards seeking the views of women at one place in time (Singh and Newburn, 2000; Hunter, 2004; Ockelford et al, 2004; Beake et al, 2005; Lof et al, 2006; Maher and Souter, 2006; Wray, 2006; Ellberg et al, 2008) and to convey findings that are already known or to reflect a collective view, the inference being that it applies to all women (Brown et al, 2005; Forster et al, 2008). This observation on the collective view has been noted by Sheila Hunt (2004) who conducted a feminist ethnography with
individual women living on or below the breadline. She sought to challenge midwives to look beyond the stereotypes so that women could be seen as individuals. She advocated listening to women but at the same time recognizes that it takes time to uncover and understand the individual needs ‘amidst the common needs’ (Hunt, 2004: 3). Whilst it should be recognised that Hunt was exploring poverty, pregnancy and health care professions nevertheless the illustrative point here is that women’s views and experiences are unique and yet there exists a tension between capturing the collective view and that of the individual woman.

Seeking a balanced view

It is at this juncture that I draw upon Oakley’s (1992) debate on the rigidity and trap of being caught between two paradigms, where by she cites ‘the habit of thinking in dichotomies’ from the work of the US Philosopher Susan Sherwin. Oakley argues that to think in terms of either/or thinking puts what she refers to as an ‘embargo on the possibilities of both or sometimes- the one, sometimes-the other possibilities’ (1992: xi). To create dichotomy pairs such as individual or group, health or disease, normality or abnormality runs the risk of simplifying ideas and disciplines, whilst at the same time it supports elements of patriarchy. Accordingly the creation and use of dichotomies within a patriarchal structure involves power relations and relies on multiple forms of polarity (Oakley, 1992).

Therefore, a balanced view is required rather than to think in absolute dichotomies. Here though, in the example of the individual need and the common need assumptions that women are a homogenous group can emerge and be upheld. For example, in relation to postnatal care it is critical that assumptions are avoided that claim ‘needs of all childbearing women’ are the same. It is Hunt (2004) who singles out Changing Childbirth (DH, 1993) for contributing to this very issue and being responsible for creating a problem. She goes on to say ‘that there is a single, unified, childbearing voice, which demands choice, control and continuity of care in the childbearing experience. For many women this is only the beginning and, for some, the least relevant part of their care’ (Hunt, 2004:3). However, ironically
much of the evidence presented in this review suggests that even the collective view about postnatal care has not been fully appreciated, results have been communicated and published but little has changed for women. As Johnson (1992) points out investigators need to be clear about their motives for undertaking research and infers that published results are likely to improve patient care. He goes on to say ‘frequently studies remain unpublished and undisseminated to a wider public for criticism, replication and utilisation’ (1992: 215). Given that many of the studies on postnatal care and in particular those seeking women’s views have followed these processes on-going research continues to reveal a systemic problem with the efficacy and purpose of postnatal care (Audit Commission, 1997; Ockleford et al, 2004; Beake et al, 2005; Forster et al, 2008; Shaw et al, 2006,).  

**Influence of user groups**

In 2000, the National Childbirth Trust (NCT), one of the largest childbirth user groups in UK conducted a large scale survey of postnatal care. The survey was made available to all NCT members alongside a web version via BabyWorld. It asked women to reflect back on three points in time during the postpartum period (first three days, 4-10 days and 11-30 days). The respondents spanned all types of births with 69% having a vaginal birth, regarding place of birth the majority had hospital births (91%) but no baseline demographic information was collected. Overall the findings showed that women’s physical care took precedence over their need for information and support. Interestingly what these women said emulated and consequently endorsed findings from the Audit Commission’s 1997 study. Moreover Singh and Newburn’s (2000) research suggested that:

‘A much higher priority should be given to treating women with kindness, spending time with them, listening to their feelings and concerns and helping them to adjust to motherhood’ (2000: 21).

By the nature of the sample the findings are unable to be generalised and some would argue are biased in that they reflect only those women who are NCT members’, thus committed and motivated towards NCT campaigns and
ethos. However, as a voluntary organisation the findings provide an evidence base by which to validate the NCT’s work to lobby policy makers and professionals for more sensitive and accessible postnatal care provision and support. In 2010, the NCT replicated aspects of the earlier study by conducting a survey of 1,260 self selected first time mothers (Bhavnani and Newburn, 2010). Although the sample profile ‘was not typical of all childbearing women in the UK’ (2010:18) their overall conclusions based on women’s responses was that there appeared to have been an overall decline in the extent to which woman-centred quality standards were being met.

Reverting back to the question about believing women and the issue of a collective view, it is important to recognise that some women can slip off the research ‘radar’ for example women who are defined as socioeconomically disadvantaged (Landy et al, 2009) or living in disadvantaged areas (Wiggins et al, 2004) are often under-represented or less visible within health research studies (Garcia et al, 1998). Social scientists have led the way in identifying these issues (such as Oakley, 1980; Ribbens and Edwards, 1998; Miller, 2005). Health inequalities in the context of family health and childbirth have been persistent features of British society and are known to impact upon health status (Morrell et al, 2000; Wiggins et al 2004). Most of the studies in this review have involved a degree of homogeneity, certainly most women who engage with maternity care, speak English and consent to being involved in a particular type of research.

_Uncovering differences_

A further dimension to consider is the existence of ‘structure and order’ within the childbirth continuum (Kirkham, 2007), in other words clinical and medical ways of working alongside human social behaviours and cultural dimensions. Frameworks are thus designed that seek to inform and guide the ways in which consultation and engagement occurs (Kelson, 1998; Renfrew et al, 2008), often, I would argue, result in a tokenistic way of being with service users. As already highlighted meaningful consultation and exploration sometimes uncovers differences between the experiences and views of
mothers and those of professionals and this can lead to conflict and difficulties regarding how best to address issues (Anderson and Podkolsinski, 2000; van Teijlingen et al, 2003). So I would agree with Turiss (2005) that through various guises women’s views and experiences are frequently reduced to their satisfaction with service provision in other words they judge and interpret ‘what they get as good care’.

**Support**

An alternative, and some might argue more sophisticated, way of gaining insights into women’s experiences about their recovery process appears to fall under the pretext of ‘support’ (Morrell et al, 2000; Shaw et al, 2006). In a large randomised controlled trial comparing two alternative forms of postnatal support Wiggins et al (2004) found women residing in disadvantaged inner-city areas liked one-to-one support, engaged with it and yet the measured benefits were marginal. Within the context of this trial support meant ‘social support’ based on epidemiological evidence in which people’s naturally occurring social support results in health promotion. As Oakley (1992) has shown prior social support provides a strong platform for improving patterns of health and disease and has the capacity to make a real difference to motherhood. In Wiggins et al’s (2004) study support interventions were quite precise and structured. One support intervention was health visitors trained in supportive care and listening, the other was a local community support organisation. Both were available to mothers for one year after birth. Interestingly, whilst satisfaction with the health visiting support intervention was high and these mothers worried less about their child’s health and development the economic evaluation found no overall benefit of either intervention.

In a smaller qualitative study Hunter (2004) conducted in-depth interviews of first time postnatal couples (n=5) on the support provided by community midwives during home visits. Hunter found key components of reassurance, help and affirmation were at the root of support needs. Notably, Hunter selected ‘couples’ so that fathers were included as a source of data. The duality of parenting was embraced by Forster et al (2008) in which they
conducted focus groups with a diverse sample of 52 people (small number of fathers) across rural and urban states of Victoria and found a consistent view that the presence and availability of professional support helped alleviate concerns about motherhood and parenting. Anxieties and fears surrounding parenting and women’s changing role postnatally were common features in the findings. Notably, for some women being ‘cared for’ in hospital was highly valued. However, this was only found in women who had viewed postnatal care positively. What this study also discovered was a clear distinction between the needs of first time mothers and those who had experienced motherhood. This finding resonates with past postnatal protocols and beliefs, whereby institutional rituals and the social order of postnatal care meant that first time mothers received different care packages and scrutiny.

Regardless of a woman’s experience, her postnatal recovery ought to be seen in context of her life and circumstances (Bondas-Salonen, 1998). Support is defined and interpreted in a multitude of ways, not only within the literature and the different disciplines but fundamentally, I would argue, in how women view and experience it. In other words, there is seemingly a dissonance in how professionals offer support against social and cultural constructions and subsequent outcomes. This is demonstrated by Shaw et al (2006) in their systematic review of 22 trials which found only some evidence that high-risk women may benefit from postpartum support. However, the resulting position within current UK maternity care appears to be an attempt to satisfy both the policy camp (fiscally driven) and the practice of meeting the consumer agenda. The benefit of ‘other’ care that a midwife may provide during postnatal care, for example offering advice or reassurance, is unknown and what outcomes matter to women are not routinely collected or known.

In summary, attempts to balance the competing tensions of listening, believing and responding to women whilst at the same time offering an effective care package that meets the institutional requirements and expectations of the public, women in this case, is complex and challenging (Brown et al, 1994; Garcia et al, 1998; Kelson, 1998; Turiss, 2005; Renfrew
et al, 2006). For example I have discussed avoidance of being tokenistic and falling into the trap of reducing women’s experiences to purely satisfaction surveys. In addition, I have discussed the subtle ways in which women’s individual needs can be circumvented at the expense of the ‘common need’. However, from the evidence discussed in this section of the review, re-occurring themes sourced from women have been elicited and yet remain unresolved. There exists a lack of clarity regarding definitions of what support is, what is meant by postnatal care and the reality of what is experienced versus actual provision of care amongst women and professionals. Running alongside these issues is the low status of postnatal care within maternity care (Bondas-Salonen, 1998; Dykes, 2005) and the tendency to approach the service user experience in what Lock and Gibb (2003) refer to as an ‘add on’, an activity I would suggest that predominantly seems to be undertaken in a passive manner.

**Repairing or healing the ‘broken body’? Insights into women’s health and wellbeing after birth**

I have already introduced the notion of the ‘broken’ body of sickness as described by Shildrick (1997), one that is explicitly connected with the biomedical model and the construction of a temporal process of body repair after birth that follows a neat sequence of events. In particular, the dominant discourses that prevail within healthcare and midwifery literature mostly view postpartum care as pathology. I now turn to examine the literature that concentrates on health and wellbeing after birth, as seen from both a medical and an holistic context.

I am aware from my personal and professional experiences that scientific knowledge has much to offer. Yet it is the reliance upon one theoretical perspective, namely medicine that incorporates the notion of disease and illness as biological and scientific explanations only (Barclay et al, 1997; Barry and Yuill, 2002; Miller, 2007) that I consider limits our understandings of women’s recovery after birth. As Nettleton (1995) states biomedicine is ‘reductionist’ in that there is a tendency to reduce all explanations to the physical workings of the body. As mentioned fragmentation of the body from
the social, psychological and cultural factors that influence health and wellbeing is unhelpful in connection to women's health after birth (Pillsbury, 1984; Geckil et al, 2009; Parratt and Fahy, 2010). The notion that medical interventions can treat and cure underplays many other factors for example environment and lifestyle. I draw again upon Shaw et al (2006) where by they state:

‘No randomized controlled trial evidence was found to endorse universal provision of postpartum support to improve parenting, maternal mental health, maternal quality of life or maternal physical health’ (2006: 210).

Seeking to measure health and wellbeing

Each of the 22 trials evaluated used a range of measures by which to assess effectiveness of an intervention for support against a clinical outcome. Within these parameters most of the 22 trials used, or were expected to have used, validated measures or inventories to determine women's physical health, postpartum depression and quality of life. Interestingly, what Shaw et al also comment upon is the utilisation of non-universal interventions and measures thus confounding the ability to synthesise results and draw comparative conclusions about effectiveness of support interventions. In a published letter (MacArthur et al, 2007) are highly critical of this decision, as they stated that they used a universal symptom checklist in their trial. My purpose for discussing Shaw et al (2006) and MacArthur et al (2007) is twofold, firstly the epistemological decision about how they view health as a scientific measurable entity unconnected from the individual’s experiences. Further that it is unclear in the trials included in Shaw et al’s review as to how the selected outcomes were derived In other words ones that women cared about and had prioritised for themselves.

The dilemma about assessing and deriving the items by which to measure postnatal morbidity is the basis of Symon et al’s (2003) study, in which they pilot the ‘Mother- Generated Index’, which is the culmination of prior validated tools. During administration of the questionnaires postpartum mothers were
instructed to follow a complex scoring system across three structured steps. Symons et al claim these steps were designed to be a subjective inventory for measuring quality of life during the postnatal period. On the one hand moving away from medicalised questions towards a more subjective set of items is to be commended. However, I would argue that using predetermined items for capturing mother’s health problems is constraining and limited in seeking to derive what matters to women. This reflects Hunt’s (2004) perspective of seeking the ‘collective view’ rather than that of the individual woman. However, the prevalence of seeking to measure health outcomes within postpartum care is high and is embedded in research studies that are framed within the biomedical paradigm. Watt et al (2005) in their large scale population based survey used various inventories to assess the health status (4 weeks after birth) of both the mother and her infant against increased length of stay. Whilst they found that women reported their own health as ‘excellent, very good or good’, other factors impacted hugely on how women experienced length of stay and their use of services following discharge. Notably, how each hospital (five were involved) implemented the policy of extended length of stay varied considerably. Moreover Watt et al add that:

‘The attitudes of the providers, namely physicians and nurses, and the perception of administrators about the adequacy of their facilities to accommodate what they believed would be a significant uptake to the offer of an extended stay played a role in determining whether or not the practice was implemented in each of the sites’ (2005: 7)

Although Watt et al draw attention to the interplay and impact of staff attitudes, as did Brown et al (2004), and to some extent the institutional ethos that resulted in huge variations in the implementation of extended length of stay policy. Nevertheless attempting to quantify its effect upon women’s health is further evidence of the reductionist theory at play, whereby explanations and interpretations of health and wellbeing concern the mere physical process (Nettleton, 1995). It is worth noting that in opposition to capturing such data for research purposes the reality of actual practice reveals that for some women they feel that their physical health and recovery
after birth is neglected and that there is a lack of engagement with women about their health (Rudman et al, 2007).

There have been a number of studies scrutinising the physiological psychological dimensions of postnatal care (Marchant and Garcia, 1995; Cluett et al, 1997; Marchant et al, 1999) and together these have significantly contributed to a more evidence based clinical approach. In addition, MacArthur et al (1991), Bick and MacArthur (1995) in their research highlight that many women struggle on in silence for years with chronic health problems that originated from their childbirth experience, yet never seek help and health professionals do not routinely ask about them. This adds weight to various authors’ (Brown and Lumley, 1997; Bondas-Salonen, 1998; Lof et al, 2006) assertions that within official healthcare the focus of care after birth turns from the woman to the baby. Once the baby is born women become invisible. Despite receiving postnatal care, including home visits, women’s health needs may not be a priority or even explored with them (Bick et al 2009; Rudman et al, 2007). We have the example of MacArthur et al (2002) in their postnatal care trial (IMPacT) of a new model of care with extended home visiting found no improvement in the women’s physical morbidity but did find a significant difference in psychological health outcomes at 4 and 12 months after birth. What this study did reveal was that asking questions about maternal health can be beneficial. Levitt et al’s (2004) systematic review on postpartum care found that key topics searched from 1999, centered without exception on clinical topics and clinical interventions. For example, perineal pain management, nutrition supplements, postpartum medical disorders, smoking cessation, contraception to highlight just a few. These perhaps illustrate the dominance of the biomedical research endeavours dedicated to postpartum health and wellbeing.

In contrast feminists Ribbens and Edward’s (1998) concept of ‘public knowledge’ and ‘private lives’ offers useful insights that could inform postpartum care in this regard. Public knowledge here would mean a conscious effort to discuss the ‘private’ aspect of birth recovery with women. I would suggest that in some way checklists can serve to prompt such
dialogue with women about their health, their wellbeing, their feelings and experiences, although being confined to asking only about physical health and issues derived from clinical inventories could be limiting. Moreover, it is the notion of being meaningful and purposeful with women as individuals that is crucial, in other words it is I would suggest how the checklist or questions is approached, the nature of the rapport and genuineness of the interaction. Indeed application of the principle highlighted earlier by Anderson and Podkolinski (2000) engaging with women rather ‘on them’ or ‘for them’.

**Holistic insights**

In the study conducted by Lugina et al (2004) they sought to move beyond the constraints of clinical interventions in a methodological paper seeking to evaluate the sensitivity of two methods (quantitative and qualitative) of assessing mother’s postpartum concerns. They go so far as to state that an influencing factor in designing the sensitive data collection methods was ‘to give voice to the research participants’ (2004: 280). A cohort of 110 primiparous mothers with uncomplicated births participated, in either card sort instrument (flash cards) or semi-structured interviews. In common with other instruments, both these methods rested upon predetermined topics, in this case covering worries and interests (concerns) regarding the baby as well as the mother’s own health. However, it is discouraging that without exception the topics were concerned with physical and clinical issues. In part, this study resonates again with Rubin’s puerperal change theory (1967) and yet acknowledges that first time mothers have considerable worries and concerns about their own health and their infants, up to six weeks after birth.

To be clear at this juncture I am not denying that the process of birth with its physiological and emotional impacts requires a period of healing or that medical science has nothing to offer. Rather, what I am seeking to highlight is the notion that recovery is more complex, the body is not broken per se requiring interpretation through a medical lens exclusively. In 1997, findings from Barclay et al’s qualitative study located in Australia concluded that first time mothers undergo a profound reconstruction of self and that this process is not bounded by a particular time frame. Their study involved nine focus
groups with 55 first time mothers, recruited from support groups for new mothers in Sydney, and centred upon an exploration of their experiences of motherhood. The impetus for undertaking this study was rooted in challenging the assumptions, and dominant views, concerning motherhood reflected in the health and medical literature at the time. I would argue a rather unique and refreshing perspective was being adopted here. Additionally, the study sought to provide understandings about what constitutes ‘normal’ adaptation to motherhood from the perspective of new mothers. Whilst this study collected data from first time mothers only and at one point in time (their babies ages ranged 2-26 weeks), the findings generated critical insights into the magnitude of change encountered by these mothers far beyond the dominant bio-medical interpretations. Overall a degree of suffering was encountered as mothers sought to renegotiate their relationships and adjust their new sense of self as a mother over time. In revealing how adaptation to motherhood caused mothers ‘to feel isolated, alone and depleted rather than nurtured and supported’ (1997:727) Barclay et al provide an alternative and complimentary analysis. In my view this analysis of realistic insights into ‘normal adaptation and adjustment’ moves beyond the medical parameters of women’s health and wellbeing following birth.

As I have shown a medically dominated research agenda has resulted in women being ignored and mis-understood during the postnatal period and their health overlooked (Rudman et al, 2007; MacArthur et al, 2007; Bick et al, 2009). I am suggesting that other theories, with differing epistemological and ontological perspectives have something to offer in particular those that embrace a more holistic view of health and wellbeing, that look beyond what Shildrick (1997) refers to as the ‘broken’ body of sickness and Kirkham’s (2007) notion of ‘birth dirt’.

Without exception each paper examined within this review presents a backdrop of neglect in relation to postnatal care from a research and practice perspective (Audit Commission, 1997; Singh and Newburn, 2000; DH, 2004; Beake et al, 2005; Demott et al, 2006; Rudman et al, 2007). This context
transcends internationally as stated most recently by Bashour et al in which research in Syria ‘shows that the postpartum phase is a much ignored phase of childbirth’ (2008: 116). In Sweden Rudman et al state that: ‘Postnatal care is often given lower priority in research and practice than intrapartum care’ (2008: 426) and in Australia the work of, Stephanie Brown, Della Forster and Jane Yelland in particular reinforces the need to undertake more research on postnatal care. Here in the UK Christine MacArthur and Debra Bick for example who have consistently studied postnatal care since the early 90’s, in recognition of the low status of postnatal care remain champions of postnatal care by seeking to apply their expertise through evidence based guidelines (Bick et al, 2009). Clearly, there is widespread agreement that postnatal care has been ignored and neglected as a topic for exploration and development. As discussed in the background chapter this observation contributes in some way towards the notion of the hierarchy of childbirth outlined in figure 1 (page 16). Moreover, I agree with Lock and Gibb (2003) that postnatal care has been interpreted as an ‘add on’ and with Dykes (2006) reference that being postnatal represents ‘the final destination of the medial journey’ for women. In other words ‘postnatal care’ is something which is bolted on at the end to the childbirth continuum and predominantly scrutinized as a clinical issue. Furthermore, I suggest that the professional construction of care after birth is heavily reliant and dependent upon institutional input and yet as evidenced in this review women report consistently negative experiences (for example Audit Commission, 1997; 1998; DH, 2004; Dykes, 2005; McCourt 2006; NICE, 2006, Wray, 2006; Ellberg et al, 2008; NCT 2010).

Healing body

In seeking to consider a more holistic and alternative approach to facilitating the ‘healing body’ (a mind, body and spirit synergy) Caroline Flint, a high profile midwife and founder of an independent birth centre in London, controversially advocated for a return to the practice of the ‘lying in period’ in other words 10 days of bed rest after birth. The Daily Telegraph featured this timely story in December 2008 making an analogy with the birth of Christ and Mary’s recovery. This journalistic piece was headlined by a picture of Mary, in a stable holding baby Jesus with an opening paragraph saying:
‘Pity poor Mary. No sooner had she given birth in a stable than any chance of quiet recuperation was thwarted by having to entertain some shepherds and those wise men from the east. Not to mention the flight into Egypt soon afterwards. It makes the pressure on the modern mother – these days you’re considered a bit of a slacker if you’re not firing off emails on your BlackBerry from the labour ward – seem rather mild in comparison’ (Wood, 2008).

In defence of my decision to cite this journalistic account and without seeking to trivialise the impact of birth, there is a serious point here concerning recovery and recuperation in that it is a major life event. Flint is further quoted by the journalist Judith Wood as saying;

“As a society, we’re desperately cruel to women with new babies; they are expected to be up and about immediately, as though nothing major has happened. A baby needs to be cuddled and fed constantly and what better way to get to know your child than by lying in bed together?” (Wood, 2008).

Paradoxically, what Flint seems to be promoting is the notion that a symbolic ritual be attached to birth recovery, a right of passage that remains framed within a set time period, in this case 10 days. This is not a new concept. As previously discussed historically a ‘lying in period’ or ‘confinement’ existed, as far back as the Victorian era. In the references I have made to Rubin’s theory of ‘puerperal change’ there is a strong clinical element and resemblance to Flint’s suggestion. However, I would argue that there is an inference that within Rubin’s theory there exists the notion of a ‘new beginning’ or ‘change’ for a woman. Conversely with the huge shifts in the management and organization of postnatal care such as place of care, length of stay and content of care alongside the shift away from routines and medical check-ups (Bick et al, 2009) it is worth considering whether the pendulum has swung too far in the opposite direction. In other words embracing notions of woman centredness and enabling women to have
control over their own care has to some degree translated to mean ‘handing over care to the woman’ (Rudman and Waldenström, 2007) a form of self efficacy. At the same time the prevailing ethos that once birth is over women simply recover and motherhood naturally happens (Ruchala and Halstead, 1994; Miller, 2007) remains prevalent.

Intriguingly, whether or not the female body is broken and sick (Shildrick, 1997) and in need of repair, or indeed women need to be ‘cared for’ (Bondas-Salonen, 1998) dissonance remains within maternity care literature, research evidence and to some extent policy, with how postnatal care is operationalised and experienced by women. By implication maternity care has developed yet another trajectory within postpartum care of a ‘hands off’ approach by ‘doing less for women’. A number of authors (Mac Arthur et al, 2002; Lock and Gibb, 2003; Dykes, 2005; McCourt, 2006; Ellberg et al, 2008; Rudman et al, 2008) reaffirm the existence of a low level interest in postnatal care. Rudman et al go on to say that it is ‘striking’ (2008: 426). Furthermore I would suggest that the ways in which maternity care staff view and experience postnatal care as the least exciting part of their role and remit given the insights into the on-going tensions (perhaps based on a lack of interest) between the medical and holistic approaches to postpartum care are profound. As Rudman et al (2008) remind us:

‘The explanations given include the possibility that midwives experience postnatal care as disruptive, difficult to provide and as a less exciting component of maternity care, and consequently, also as less valued and prioritized’ (2008: 426).

Considering the plethora of evidence that women are more critical of postnatal care than any other part of childbirth (Audit Commission, 1997; DH, 2004; Dykes, 2005; Demott et al, 2006; Rudman et al, 2007; Ellberg et al, 2008; Bhavnani and Newburn, 2010) raises questions and uncertainties in connection to the purpose, costs and more importantly its longevity. This critical point will be re-examined and returned to again in the thesis. I will now
move onto to discuss some of methodological issues that have unfolded from conducting this review.

**Methodological discussion**

In undertaking this review of key studies outlined in table 1 (pages 32-40) and examining other literature I have taken into account all forms of knowledge for example that which is derived from a clinical perspective and experimental to that which attempted to capture the service user, in other words the woman’s experience using qualitative enquiry. At the outset I explained that a broad perspective on the location of relevant studies would be adopted focused on postnatal care. From a methodological perspective there has been a tendency towards systematic reviews, randomised controlled trials and surveys, underpinned by predetermined health outcomes and relevant measures derived from medical notions of health. Within the collection of studies on postpartum care similarities between UK and the international perspective exist, for example in Australia, North America and Sweden. Most notably in this global context is the consistent reporting of women’s negative experiences of their postnatal care. Even in this global context it is the reality that a dearth of healthcare research exists demonstrating that postnatal care is low in status and priority (for example Bondas-Salonen, 1998; Beake et al, 2005; Rudman et al, 2008). Clearly however, I have found that research interest in the postpartum period extends beyond the health discipline and includes contributions from sociology, psychology and feminism.

Having evaluated this collection of diverse studies it has struck me that the epistemological basis used within specific maternity/midwifery studies to advance knowledge tends to be one primarily rooted in the bio-medical model. That said studies by Dykes (2005), Barclay et al (1997), Smith (1999), Choi et al, 2005 and Zadoroznyj (2006)) have embraced opposing theoretical understandings around transition and life cycles as have Miller (2007) and Newell (2007). What I have found is a dissonance between the literature that exists and that which gets applied in practice as postnatal services are framed more from a bio-medical perspective. Furthermore, I discovered a
clear divide between qualitative and quantitative research methods and minimal (if any) follow-up or longitudinal studies. With the exception of Brown et al (1994), Morell et al (2000) and Wiggins et al (2004) most studies have taken a linear retrospective view of postnatal care. In terms of Brown et al (1997), Martell (2001, 2003) and Beake et al (2005) interestingly they have sought to maximise the opportunities to publish numerous papers from their data over a period of time in a range of journals (professional). On the one hand this could be interpreted as fulfilling the academic publication output agenda. However, their rationale for undertaking secondary analysis of data is substantiated by their examinations of the literature that suggests a lack of insights and dearth of evidence on postnatal care exists. In addition, others such as Rudman et al (2008) and Forster et al (2008) have gone so far as to replicate prior studies to examine trends.

According to Johnson (1992) replication in particular adds merit and credibility to the production of research thus enables improvements in patient care. In seeking to add credence to Johnson’s argument the NCT (Bhavnani and Newburn, 2010) did replicate aspects of a prior study (Singh and Newburn, 2000) and yet found minimal difference or improvements in postnatal care had occurred in a decade. Thus I am concluding that the potentiality for improving practice for the benefit of women appears to be a low priority. I have found that few if any studies examined in this review had any commentary on dissemination or implementation strategies. A rare exception is Schmeid et al (2008) who in undertaking an action research study aiming to influence and change practice, albeit with staff, claimed to have utilised prior studies to inform their design and objectives.

In considering methodological issues three themes dominated within the maternity care literature, firstly, the homogeneity of sample populations, secondly a tendency towards surveys and thirdly ways of capturing women’s experiences. I would argue that the balance of these in favour of the former has contributed to the preservation of the biomedical perspective in connection to postpartum care and perhaps to some extent the status quo in how women experience care provision.
The homogeneity of sample populations

The majority of the studies in this review opted to select sample populations that were primarily first time mothers, who had an uncomplicated birth, were supported by the father or partner of the infant and spoke the native language of the researcher (English prevailed). There was one exception of Ockleford et al (2004) who used their questionnaire in an interview context with translation for non-English speaking women. Notions of the ‘newness’ of motherhood have been offered in defence of recruiting primiparous women and the interests in motherhood have featured as a line of enquiry rather than seeking to understand how women handle their own recovery as individuals. Fundamentally the pursuit of the collective view has tended to be investigated and thus displayed in the findings. However, sampling has not tended to reflect the heterogeneity of women who experience childbirth and especially not postpartum care.

Tendency towards surveys

There has been a tendency towards surveys as the optimum method of data collection in respect of postnatal care. Indeed this finding resonates with Baker et al’s (2005a) and Miller’s (2007) observations of the childbirth literature where they comment on the tendency towards surveys for gathering women’s experiences of satisfaction regarding childbirth. In my examination of the literature pertaining specifically to postnatal issues I have discovered a widespread use of surveys, with a range of questionnaires and instruments seeking to obtain a retrospective perspective. In terms of size of samples, practice has varied considerably with a blend of large scale population based surveys to smaller more discreet surveys. Predominantly, rigid outcome measures from the biomedical and clinical perspectives have guided questionnaires. Response rates have varied across studies and many reflect a non-inclusive sample of women. For example Garcia et al (1998) noted a limitation as they obtained low responses from young and disabled people. This was despite providing ample free text in their questionnaires for women to comment beyond the structured questions. By nature of their publication they sought to give space and credit to women’s views and experiences.
However, this practice of providing ‘space’ within surveys has not transcended other surveys that have been evaluated in this review.

Capturing women’s experiences
This theme demonstrates a dissonance between what is researched and knowing what matters to women. Examples of ‘woman-centred’ research having an impact within the context of postnatal policy and practice were few. Arguably this enables the preservation of the biomedical paradigm one that considers postpartum as the endpoint point rather than a beginning stage in a woman’s life and low in status (Bondas-Salonen, 1998; Smith, 1999; Dykes, 2005). There was considerable evidence of research grounded within the positivist tradition of ‘adding on’ women’s experiences (Anderson and Podkolinski, 2000; Lock and Gibb, 2003). Despite this a trajectory of seeking to capture women’s views is apparent following the establishment of the NHS principle in the 90’s (DH, 1993; Kelson 1998) alongside national lobby groups notably the National Childbirth Trust (NCT). It should be noted that often women’s views and experiences can be circumvented by opting for satisfaction surveys (Baker et al, 2005a) and yet evidence suggests that patient satisfaction is an under-theorized concept (Turiss, 2005; Parratt and Fahy 2010). Interestingly for Klima (2001) an American feminist this backdrop reflects the medical philosophy embedded within midwifery, one that reflects the oppressive models associated with women’s health care. From my perspective this assertion resonates with the tokenistic strategies at play in seeking to be woman centered and to individualise care. It goes some way to explain the invisibility of women as active participants in postnatal care and the lack of women having a voice about their experiences (Oakley, 1979, Brown et al, 1994; Ribbens, 1998). Finally, many of the studies in this review support Brown et al’s (1994) premise that in seeking to find the cause or causes of the positive or negative experiences research tends to place more emphasis on ‘within person’ as a variable. In other words within the woman herself, thus implying that women’s experiences occur in a vacuum (Oakley, 1980; Smith, 1999; Miller, 2007). Women in my view can be constructed as fragile, a passive vessel devoid of any other variable such as the contribution of midwives and doctors, as well as social and cultural issues. Relationships
between women and maternity care staff are known to be powerful and influential (Walsh, 2004; Dykes, 2005; 2006). As Willcocks et al (1987) have shown people’s relationship with place or care settings is not straightforward. They argue strongly that an appreciation for the complex relationships and actions, between and with people, is associated with how people sense make and give meaning to their experiences. Thus the nature of interpersonal relationship is critical to how women experience caring within maternity services (Baker et al 2005). To trivialise this dimension or to underestimate its potential impact upon women by passing over the existence of, and meanings, attached to interpersonal relationships between women and caregivers within maternity care provision is in my view unwise.

These methodological observations support my analogy of a ‘hierarchy of childbirth’ where by postnatal care is located at the lowest position within the childbirth continuum and thus receives the least attention in terms of research and status amongst practitioners (Ockleford et al, 2004; Dykes, 2005; Lof et al, 2006; Rudman et al, 2008; McCourt, 2009). I would argue that based on this earlier literature there is a need for more sophisticated ways of looking at women’s experiences and needs in relation to postnatal care.

Concluding comments
This review of the literature focused primarily on research conducted on birth recovery from the mother’s perspective. Increasingly researchers from health and social science disciplines have attempted to explore the postpartum phase of the childbirth continuum meant that I had to be cognisant of the fact that progress over time in reflecting and including women in research occurred in the form of a trajectory. A large proportion of the studies represents more ‘academic’ literature created by feminists (Oakley, 1980, 1992; Shildrick, 1997; Dykes, 2005, 2006; Miller, 2005, 2007) professionals (Brown et al, 1994; 2002; Martell, 2001, 2003; Beake et al, 2005; Kirkham 2007), doctors (MacArthur et al, 2003; Boulvain et al, 2004; Shaw et al, 2006) and to a lesser extent practitioners (Hunter, 2004; Ockelford et al, 2004). In the minority was that from childbirth user groups (Wray, 2002, 2006; Singh
and Newburn, 2000; Bhanvani and Newburn, 2010). Having taken a broad approach I would suggest this has resulted in a more fruitful exploration of postnatal care.

Within the literature I have attempted to take account of the policy context and the history of UK postnatal care as outlined in the previous chapter (p6-23). On both counts postnatal care is found to be low in status with practitioners and service providers (Audit Commission, 1997; Bondas-Salonen, 1998), researchers (Beake et al, 2005; Ockleford et al, 2004; Lof et al, 2006; Rudman et al, 2008). Given the insights regarding notions of ‘birth dirt’ (Kirkham, 2007) and the re-occurring negative experiences that women report (Audit Commission, 1997; Martell, 2001,2003; Beake et al, 2005; Dykes, 2005) these factors indicate much to be gained by further exploration about the benefits and disadvantages of postnatal care for women.

A focus of the literature has been the ways in which the context and the construction of routine postnatal care interplays with notions of the biomedical paradigm, the dominant discourses attached to motherhood as being natural and instinctive (Oakley, 1979; Barclay et al, 1997; Smith; 1999; Miller, 2007) alongside Shildrick’s (1997) ‘body’ broken of sickness with the need for surveillance and clinical examinations. Studies have revealed a lack of clarity as to the purpose and efficacy of postnatal care despite the modern day aspiration to reduce institutional stays, associated rituals and maternity care traditions.

Overall a disjuncture between women’s experiences and expectations has existed for several decades and continues to be a core feature of research concerning postnatal care and motherhood (Garcia et al, 1998; Beake et al, 2005; McCourt, 2006; Miller, 2005, 2007; Rudman and Waldenstrom, 2007). I conclude this review with the eloquent quote from Anderson and Podkolinski:

‘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’ (2000: 13).
There is clearly a gap in the research literature focusing on women’s accounts of their experience of their own birth recovery overtime. Therefore it seems to me that there is much we can learn from more sophisticated ways of exploration regarding women’s experiences of postnatal care.
4. Methods

Introduction
This chapter is divided into two parts, the research design and undertaking ethnography. Part 1, the research design outlines relevant literature and theoretical influences in constructing the research framework that best fits the research questions and intention. Part 2, undertaking ethnography, presents how I sought to apply the research design. In both parts I reflect upon key issues that I grappled with in preparing and conducting the study.

Part 1  Research Design

From the very outset of constructing this ethnographic study I have been fascinated by what Brown et al (1994) have termed ‘researching up’ rather than ‘researching down’ in their research practice with childbearing women. To illustrate they state that:

‘Our research did not set out with the preconception that the problem resides within the woman and her psyche or endocrine system, nor that these factors will ultimately yield the answer to the problem…’ (1994: 7).

It seems to me that what Brown et al are keen to articulate is the need to recognise the roles and practices of care providers in shaping and influencing the ways in which women experience and construct their childbirth experiences. From my perspective I have translated this notion into giving women the opportunity to ‘tell their stories’, from an emic point of view as ‘insiders’ to their reality and version of birth recovery. Insight into the culture of care and indeed the care setting or what I have earlier termed ‘power of place’ is an integral dimension of ‘researching up’.

Initial thoughts on the research design
Before moving on to the specifics of the research design I feel it is worth mentioning some initial thoughts that I grappled with. For example in the
background chapter I explained how I situate myself within the context of care after birth, in doing so I am conscious of falling into what Thorne and Darbyshire refer to as the ‘romanticism genre’ (2005: 1110). In other words, I sought to avoid portraying myself as some kind of saviour or heroine for having developed an interest in exploring care after birth.

In their paper under the auspice of *Pearls, Pith and Provocation* Thorne and Darbyshire present a humorous and thought provoking debate regarding the lost art of critiquing qualitative research, at the same time they raise some salient points concerning assumptions and pitfalls in the practice of qualitative research. For example the various patterns and habits that have emerged in presenting qualitative research such as claiming ‘nothing is known’ in regard to the phenomenon being studied and the ways in which reporting the ‘my research journey’ can become a cliché. I confess that I arrived at this research from a position of ‘knowing’; like Pellatt (2003: 29) I already possess some ‘esoteric knowledge’. Therefore it could be argued that I came to this study as a practitioner researcher. However, it is worth stating at this juncture that from the outset of embarking on this doctoral study I considered myself to be rather novice in relation to qualitative research and its related discourse, which sought to overwhelm me in the early days. I had already developed a level of uncertainty regarding unfamiliar research methods following the completion of a quantitative study in the topic area (Wray, 2002). At this phase in the research process I felt convinced that I needed to be methodologically pure and adhere precisely to a research framework. As Johnson et al (2001) have argued the quest for British pluralism and hygienic research conduct is uncommon in qualitative research methods.

Furthermore Johnson et al state that:

> ‘Whilst rigid adherence to published procedures might be possible, we argue that in many cases this is neither necessary nor more likely to increase the validity of the research outcomes’ (2001: 243)
I had for sometime felt that much research on women omitted fully to listen to and see the world from their perspective as valid sources of knowledge. Mostly quantitative approaches were applied with a focus on causal relationships by using observation statements, verification and predication. Too often research on postnatal care has tended to use survey methods or retrospective data or adopts a linear view of postnatal care. By reading Thorne and Darbyshire (2005) it became clear that the interplay between my roles and experiences has influenced my ways of knowing about the social world and health practice which is a distinct feature of ethnography. At the same time I came across feminist literature, devoted to issues of personal experience, ways of making public the private lives of mothers and the use of reflexivity in representing the voice of both ‘self and others’ (Ribbens and Edwards, 1998; Miller, 2007). Already these feminist ideas resonated with the aims of this study as a means of placing in the public domain the knowledge held by women on their own lives and recovery. Brown et al’s (1994) notion of ‘researching up’ seemed possible and appropriate. Furthermore, it became clearer that the notion of ‘bracketing off’ or putting aside one’s background knowledge and experience in the context of research practice is not plausible (Pellatt, 2003). Indeed efforts to comply with these inherent notions of research precision and certainty implies a restricted view of the human world in this context.

The parallel here relates to the reductionist view of the physical body (Nettleton, 1995; Barry and Yuill, 2002), the bio-medical construction of temporality of the repairing body after birth (Shildrick, 1997) and patriarchal ways of knowing (Rothman, 2000; Stewart, 2004), which together have created a belief that women automatically recover from birth in an orderly and sequential way. This approach determines health outcomes derived predominantly from the bio-medical world view, one that seeks out knowledge that is objective and represents the truth prevails regarding childbirth issues (Oakley, 1992; Stewart, 2004). The creation of knowledge concerning birth recovery has been at best piece-meal (DH, 2004; NICE, 2006) but we know that women’s recovery from birth is far more complex and
receives less attention within the research context (Garcia et al, 1998; Beake et al, 2005; NICE, 2006).

It is the case that much nursing and midwifery literature is dedicated to polarised and competitive views as to the capacity and strength of one research paradigm over another. I would argue that such a presentation is not always useful, as it alludes to and supports notions of power and hierarchy. Again this resonates with Oakley’s (1992) debate on the notion of dichotomous thinking, discussed in the literature chapter, in which I suggest a requirement for a balanced view rather than to think in absolute dichotomies. In support, Letherby (2003) draws attention to avoiding what the sociologist Ann Oakley has called the ‘gendered paradigm divide’, where by qualitative is connected to feminine values and quantitative work relates to masculinity. This view of ‘gendered paradigms’ further invigorates separatism in research practice, decreases respect for particular discovery techniques and devalues particular forms of research (Hubbard, 1990; Ribbens and Edwards, 1998). Interestingly in what could be interpreted as a representation of the ‘subjective masculine paradigm’ David Sackett, a pioneer of the evidence based medicine movement, claims to have been misunderstood in regard to supporting a bias towards valuing only evidence derived from experimental studies. As far back as 1997 Sackett and Wennberg stated in an editorial that:

‘...the [research] question being asked determines the appropriate research architecture, strategy, and tactics to be used - not tradition, authority, experts, paradigms, or schools of thought. Health and health care would be better served if investigators redirected the energy they currently expend bashing the research approaches they don't use into increasing the validity, power, and productivity of ones they do’ (1997: 1636)

Similarly, Darlington and Scott whilst acknowledging the debate surrounding the split between qualitative and quantitative inquiry choose to steer away from dichotomising as they believe that in seeking to handle questions that
arise in the human services ‘requires a broad repertoire of research approaches’ (2002: 6). I would argue that there is a parallel here with both Oakley and Letherby’s words of caution for feminists (in my view all schools of thought) who can be in danger of ‘excluding themselves from certain types of knowledge and ways of knowing’ (Letherby, 2003: 87). However, for the purpose of this thesis I have taken the view that explicit disclosure of the theoretical influences and research decisions adds value and authority to what Sackett and Wennberg call the research architecture. According to Mason feminism has challenged a range of issues which are seen as being central to qualitative research (1996: 3). As an ethnographic interpretation of understanding cultural knowledge, meaning of events (Hammersley and Atkinson, 1983) and the stories that women have about their recovery after birth I have drawn upon feminist theory.

Influence of Feminism

A critical dimension in designing this study was the theoretical underpinning that corresponded with an epistemological commitment to understanding the social world from the perspective of individuals (Hubbard, 1990; Ribbens and Edwards, 1998; Stewart, 2004), in this instance ‘women as mothers’, as the experts on their own experience. As such the influence of feminism with its ethos of embracing the woman as a credible source of knowledge had appeal as Wickham (2004: 161) notes:

‘Feminists are more likely to embrace the subjectivity of each person’s individual experience than to see value in seeking the elusive ‘objective facts’.

As already discussed in the literature chapter it is apparent there already exists a partial insight into women’s recovery after birth, one dominated by the bio-medical view of the world. I have been able to uncover literature and prior research that represents a particular version of postnatal care, for women their voice, accounts and experiences of recovery from birth are not fully understood or visible. Moreover, it could be argued that this backdrop resonates with Brown et al’s (1994) notion of ‘researching down’. In fact I
would go so far as to suggest that women are inclined to be overlooked, thus their individual perspective is often missing and as such the outcomes that matter to women are imposed and assumed. Again I am arguing that insights into the nature and context of postnatal care as experienced by individuals is deficient as Crotty (2003) suggests there is value in all constructions, the ways in which women construct meaning is a concern of this research.

Returning to the influence of feminist theory my interest for the purpose of this study centres broadly upon two matters. The first of these is the social construction of motherhood, in particular, the deep rooted ways in which motherhood is shaped and experienced in Western cultures as described by Rothman (1989: 13); the ideology of patriarchy, the ideology of technology, and the ideology of capitalism. For Rothman these ideologies are interwoven rather than separate ways of thinking, they merge and are interconnected. It is the dominance of such ideologies on how life can be shaped and experienced alongside the beliefs and values that people are willing to accept that interests me. For example, the medical ideology that prevails in our society in relation to childbirth is one that rests on a power base of dominant values, attitudes and beliefs that supports childbirth as an illness, a masculine perspective. For Rothman and others (Hubbard, 1990; Ribbens and Edwards, 1998; Letherby, 2003; Hunt, 2004) women’s reality, their view of the world and how they experience it is not the dominant view here and inequalities exist. Having drawn upon Foucault (1978) earlier it is clear that within the dominant discourse Foucault’s assertion that disease is what is important not the person, resonates with how motherhood has been socially and medically constructed. In addition, he further believes that the body is the ‘object and target of power’. In the context of childbirth feminists broaden this perspective claiming that the female body is fundamentally considered to be ‘a baby making machine’ (Foucault, 1978; Rothman, 1989; Hubbard, 1990) or ‘a broken body of sickness’ (Shildrick, 1997) within the taken for granted dominant medical discourses.

The second matter relates to the value and explicit recognition of the self within research, in others words the researcher’s self (Pellatt, 2003). To
ignore the personal involvement in research is something that I have found curious and often questioned. According to Letherby (2003) feminist research accounts should be grounded in the personal and be accountable to the reader as the ‘personal is also theoretical’. Feminist research is clear that theory can be derived from experience, that reflexive and self-reflexive accounts count as data and that the nature of knowledge and its relationship to women is socially constructed (Ribbens and Edwards, 1998; Stewart, 2004). It is the interplay between theory, methodology and practice of research that has informed my thinking during the conduct of this study and the writing of the thesis; in other words the writing of ethnography. I have sought guidance within feminist theory to explore this interplay between theory and the practical dilemmas of doing ethnography. This interplay and retention of the ‘voices’ in the production of research is something I will return to in the findings chapters.

On the one hand I am arguing that irrespective of the underlying belief systems postnatal care (or alternatively birth recovery) is an intellectual puzzle, requiring explanation, moreover social explanations. Conversely, I recognise that by origin knowledge surrounding birth recovery and postnatal care has for too long been gendered. As Hubbard claims:

‘The scientific way to know has been labelled ‘objective’ and identified as masculine; artistic, intuitive and empathic ways of knowing are considered ‘subjective’ and feminine. Thus knowledge has become gendered. And because the Western world-views values objectivity over subjectivity and men’s knowledge over women’s, ‘feminine’ ways to know are by their nature inferior’ (1990: 8).

I have already shown that within midwifery there exists an opinion and indeed evidence that birth recovery is given ‘low worth’ (Bondas-Salonen, 1998; Lof et al, 2006). Parallels can be drawn to Hubbard’s assertion of giving value to objectivity derived from the masculine way of knowing. Therefore ways of capturing the individual’s voice and the woman’s reality of postnatal care has translated into an ‘add on’ (Lock and Gibb, 2003) with a ‘yawning gap
between the intention and provision of care after birth’ (Marchant, 2003: 80). How this landscape has come to be is not the prime focus of this study however, broadly speaking feminism offers a different and challenging perspective in the quest for knowledge production.

To summarise briefly at this point I have stated earlier in this thesis that I support the notion of a balanced view of research paradigms rather than absolute divisions. I have also been influenced by feminist arguments in relation to knowledge generation for its capacity to represent women’s lives and research with women. In addition, I support the notion of ‘researching up’ in the sense that it offers an alternative to patriarchal constructions of health and wellbeing alongside scope to confront the ‘baby making machine’ assumptions. The contribution of feminism and feminist theory in being able to challenge scientific discourses, power relations and a range of issues is in my view fundamental to research conduct.

**Qualitative research**

As the research questions revolved around the nature of knowledge created by women and its relationship to women it became clear that qualitative research with an emphasis upon individuals, the researcher and the researched had the capacity to address the research focus. In exploring the literature for the most suitable frame of reference by which to inform the study I was struck by Mason’s (2002) comment regarding definitions of qualitative research where she states that:

‘qualitative research – whatever it might be – certainly does not represent a unified set of techniques or philosophies, and indeed has grown out of a wide range of intellectual and disciplinary traditions’ (2002: 3).

Mason’s statement aligns explicitly with Thorne and Darbyshire’s (2005) paper on the pitfalls of portraying clichés and assumptions in the practice of qualitative research. In addition, Mason supports the notion of flexibility as opposed to adherence to a *unified set of techniques* which corroborates with
Johnson et al’s (2001) argument that the quest to achieve hygienic, neat and tidy research is misplaced.

Qualitative or naturalistic research originates within the social sciences and draws upon a wide spectrum of thought and ideas from sociological traditions, anthropology, psychology, education, feminism and post-modernists, all of these disciplines have interests in, and different interpretations of qualitative research methods (Hubbard, 1990; Mason, 1996; Crotty, 2003). Hence these collective and separate influences have been problematic within the literature concerning qualitative research. Scope and potential of qualitative research to generate knowledge, either by discovery or doubt, often gets missed in debates on methodology. Critiques of qualitative research are often reductive, arguing that it is anecdotal, simply opinion and unsystematic. As Mason further points out:

‘The idea that qualitative research necessarily has these inherent weaknesses is based on a mis-understanding of the logic of qualitative enquiry. It fails to see the strategic significance of the context, and of the particular, in the development of our understandings and explanations of the social world’ (2002: 1)

I would support Darlington and Scott’s view (2002) that qualitative research has an important role to play in understanding the social world and in complementing other forms of knowledge. Moreover, in seeking to gather women’s accounts of their birth recovery experiences necessitates research methods that can enable the woman’s voice to be distinct and discernable (Ribbens and Edwards, 1998). The underpinning epistemology of the qualitative perspective is a world of multiple realities, one that draws upon subjective reality and does not seek detachment but builds relationships with research participants (Hammersley and Atkinson, 1983) and embraces the researcher self as an integral component of the entire research process (Letherby, 2003). Overwhelmingly the different strands of the qualitative approach embrace methods of data generation and analysis which are flexible and sensitive to the social context (Mason, 1996: 4). The utility of
ethnography for its methodological capacity to elicit meaning on the nature and context of birth recovery was applied to the current study.

**Ethnography**

Overwhelmingly the priority in this study was to place an emphasis upon women as people and as the knowledge holders. In addition, a prime concern was to be able capture meaning and have insights into the culture of care as it pertains to birth recovery. Having already established that there exists an absence of theory to underpin postnatal care as a consequence reliance upon the regulatory framework and health policy to guide practice ethnography had much appeal.

There are different perspectives amongst ethnographers about the underpinning epistemology within an ethnographic account. Savage (2000) highlights a lack of consensus about the theory of knowledge amongst ethnographers. Additionally, diversity in ideas as to what constitutes legitimate knowledge and whose voice has authority have formed the basis of much debate within the social sciences. Fundamentally ethnography is committed to *learning from people* rather than *studying people* (Spradley, 1979) through the process of fieldwork, a crucial task within ethnography. I have been very much guided by Spradley and can support his preferred definition of culture in the context of ethnography when he states that culture is: ‘the acquired knowledge that people use to interpret experience and generate social behaviour’ (1979: 5). Accordingly Spradley claims that this definition reflects the goal in ethnography ‘to grasp the native’s point of view’. Notably the corner stone of ethnography is gaining an emic perspective, as such ethnographers strive to gain the insider’s view, either that of groups or communities, and give attention to context and meaning through application of different methods (Savage, 2006). The notion of ‘being there’ extends to include the relationship/s between the researcher and the researched in others words the researcher ‘acts as the primary tool for data collection’ (Savage, 2006: 385).
Importantly this study rests upon capturing meaning and understanding by learning with women regarding their ordinary knowledge by building on ‘their common experience’. As Spradley (1979: 25) states:

‘An ethnographer seeks out ordinary people with ordinary knowledge and builds on their common experience. Everyone, in the course of their daily activities, has acquired knowledge that appears specialised to others… knowledge about everyday life is common property of the human species’.

Ethnography is a broad methodology whilst at the same time it is a flexible approach. According to Hammersley and Atkinson (1983) ethnography is in many respects the most basic form of social research and ‘bears a close resemblance to the routine ways in which people make sense of the world in everyday life’ (1983: 2). With its roots and long history in anthropology ethnography can be perceived as, confusingly, both a process and a product. The term can apply to either a method, methodology and to the written account of a particular ethnographic study. Savage (2000:1400) reminds us that:

‘ethnography is not, as is often implied, a pseudonym for qualitative research in general or a way of describing studies premised solely on semi-structured interviews’.

A defining feature of ethnography is the use of participant observation involving prolonged fieldwork. There are considerably different ways in which fieldworkers represent themselves or achieve status (or not) amongst the researched and social world under study (Van Maanen, 1988). How the researcher represents themselves or becomes situated in the field is important, which I will return to, but moreover field work in Van Maanen’s words ‘is a means to an end’. By this he means that a rich and truthful account of the social world being studied is possible if the researcher is able to share firsthand the following: ‘the environment, problems, background, language, rituals and social relations of a more-or-less bounded and specified group of people’ (Van Maanen, 1988: 3). Consequently this struck a
chord with me in that I had already been introduced to the notion that ‘everything is data’ during a supervision session (mentioned again in the ethics section) and realised that the prior knowledge and experiences that I held prior to entering the field (hospital wards and the proposed sample of women) were integral to this ethnography.

Part 2

Undertaking Ethnography: application of the research design

In this second part I discuss the more practical and applied side of undertaking ethnography and in particular I have chosen to insert examples of my own learning as I prepared to enter the field. From the very outset I made a decision that data were to be collected over time, the basis for this decision was twofold. Firstly, as I have already outlined published studies predominantly opted to capture a linear view of women after birth, thus providing a ‘snapshot view of women’s health and wellbeing within the temporal boundaries central to the postnatal period. Secondly, as the research aims required insights that could give meaning to birth recovery from the unique position of women (‘researching up’) again beyond the defined postnatal period in other words what Kirkham (2004: 272) calls the ‘rules of the game’.

Field work
Fieldwork is at the heart of ethnography or in the words of Van Maanen ‘ethnography ties together fieldwork and culture’ (1998: 1). Conventionally, fieldwork requires absolute immersion and full-time involvement over period of time with those being studied (Hammersley and Atkinson, 1983). For that reason the natural environment is observed and the researcher becomes a primary tool in ethnographic data collection (Barton, 2008). Ways of capturing what is seen, heard and to some extent interpreted during the course of the study through the praxis of doing ethnography (Barton, 2008) with the application of the designated methods alongside the researcher’s reflections is crucial to fieldwork. There is a widely held belief that the experience of fieldwork is a personal journey of self discovery (Pellatt, 2003: Thorne and
Darbyshire, 2005) and I have alluded to this dimension previously, however as a major focus was the gathering of personal experiences of women the inclusiveness of flexible documentation (narratives), rather than adherence to prescriptive rules, became of paramount importance. In drawing upon just two feminist researchers at this juncture namely Finch (1993) and Miller (1998) their accounts of immersion in the lives of women (in the field) affirms the legitimacy of giving space to ‘experiential learning’ and the process of doing ethnography. To accomplish my goals I aimed to make extensive field notes throughout the study and as such give voice to a range of feelings, thoughts and happenings in a consistent manner.

Field work took place on two different hospital postnatal wards and in the homes of the women (more detail to follow in the access section). Additionally, I made notes and jottings upon leaving the field and took literally the advice of my supervisor that ‘everything is data’. In the section on field notes I discuss how I contextualised this notion.

Methods
Given that I wanted to capture insights into the provision, nature and context of postnatal care, observation was clearly an appropriate method. In addition, unstructured interviews whereby ‘naturally occurring talk’ (Finch, 1993) could occur were selected to capture the experiential dimension of women’s recovery. Furthermore, in building upon this emic perspective the nature of ethnography necessitates the integration of reflexivity thus field notes with an emphasis upon the researcher’s ‘self’ formed a valuable and complimentary data source. Therefore three data collection methods were selected for their capacity to provide rich sequential data. These were as follows:

- A period of observation of the postnatal ward environment, covering the 24 hour cycle of care within two different NHS Trusts.
- Interviews with a purposive sample of women, an initial interview, a follow up interview at three months and a final interview at six to seven months (three interviews in total).
Extensive field notes were recorded on all aspects of the research praxis.

**Participant observation**

Having decided on a period of observation as a method, I then faced a dilemma as to whether to adopt the role of non-participant or participant observer. This formed the basis for interesting discussion within my supervision meetings, we both agreed that I was not a novice in that I was familiar with the setting. In seeking guidance I turned to Hammersley and Atkinson (1983) who discusses the different roles that can be adopted in doing observation, in regard to the level of involvement or detachment. They cite Junker from 1960 who distinguishes between the ‘complete participant’, ‘participant-as-observer’, ‘observer-as participant and ‘complete observer’. On the one hand, like others who have observed in maternity care wards (Kirkham, 1992; Burden, 1998; Ridges, 2002; Dykes, 2005) absolute detachment was not feasible. Therefore, for my research proposal and ethics submissions I stated that I would be a participant observer and used the following statement to support my decision:

‘I am a registered and practising midwife but in this context I will act as a ‘volunteer’ offering to help with simple activities in busy times’.

The role I was seeking was immersion in the ward setting but with an element of detachment from participating in the giving of care and being with staff at the expense of simply being in the care setting and ‘hanging out’. Like Burden (1998), Ridges (2002), Dykes (2005) and earlier Kirkham (1992) I wished to locate myself so that I could ‘examine activities that take place within the postnatal ward’ although I differed from them in that my purpose was gather insight into the nature and context of care provision from the woman’s perspective. As Hammersley and Atkinson (1983) note limitations do exist in that one cannot observe internal processes of cognition and emotion:
‘observation alone cannot tell us why people do the things they do or what the particular activity means to them – even astute observation of non-verbal behaviour cannot provide access to a person own understanding of why they are smiling, frowning or crying’ (1983: 75).

From my perspective the ‘here and now’ would form the basis for observing women at the very beginning of their postnatal care journey. In other words I was seeking women’s insights as they experienced it upon transfer to the ward to go going home, I hoped to be able throw some light onto the care context as seen through their eyes. For the purpose of ethics and in my role as a registrant with the Nursing and Midwifery Council (NMC) my participation was in the sense that I would intervene if (through my practitioner experience) I felt it was appropriate e.g. if I thought there was a risk such as a baby placed on a bed I would intervene if thought a risk existed for baby to roll off the bed. Interestingly as the fieldwork unfolded and I spent time on the wards women were pro-active in seeking help from me. In the main I would consult with staff even if I knew the answer or response to the woman’s query. In summary staff’s reactions towards my presentation of queries and help seeking from women were either; they (staff) would I give the information and ask that I relayed it to the woman, or that I was to tell the woman they would be along in due course to help her.

I commenced observations in July 2004 and undertook a total of 60 hours observation over a 3 month period, on two postnatal wards across two different NHS Trusts (Smith ward and Thompson ward) as follows:

- Smith ward x 4 shifts = 34 hours (included a pilot observation)
- Thompson ward x 3 shifts = 26 hours

The first observation I undertook was a pilot in the sense that it was exploratory both in terms of gathering data and in being as a participant observer. I had in the past worked for this NHS Trust and although some years had passed I was known to some staff. It was through the experience of this pilot observation that the notion of what Pearsall (1965) calls the
‘continuum-based approach’ became insightful, whereby the researcher becomes an active participant at the start of the observation period, moving to a state of non-active observer towards the end. Moving along a continuum had appeal in that it would allow me to develop relationships on each ward, which was an essential part of the fieldwork, at the same time enabling a sense of detachment and minimal involvement. On the one hand observing as a role would provide data in itself at the same time the dynamic nature of being in the field would provide valuable insights.

Although each observation varied considerably, examples of help seeking from women are covered within the findings. At this point the following provides a brief insight:

A newly delivered mother who had been recently transferred to the postnatal ward from the labour ward, asked me if she could take a bath, she did not want to ring the call bell and wondered if I could find out from the staff. There were no staff around and I said that I would find someone for her. I found some staff talking in the ward corridor and I shared with them the woman’s request and asked them if they could help, they said she could bathe and that I was okay to tell her but moreover if she needed help then I could help or her relatives could. Field note

In addition, as I will outline in due course in ‘study location’ I observed in two different NHS Trusts, each postnatal ward varied in how it was organised, working practices, the layout, the ethos of care and in how the visiting hours and meals were handled. These variations were minor and only cause for interest from my perspective. However, the differential atmosphere of wards unfolded within the findings and is discussed within the chapter entitled: Power of Place (p121).
In-depth interviews: talking to women

The in-depth interviews followed the observations on the wards. From the very outset I had felt more comfortable with the choice of interviews as a method. This said I had opted to conduct in depth unstructured interviews having been influenced in particular by Oakley (1980), Finch (1993) and Ribbens and Edwards (1998) I was seeking naturally occurring talk with women or to engage in what Sapsford and Jupp (1996) refer to as ‘informal talk’. I was conscious of Finch’s discussion on woman-to-woman interviews where by she places importance on less structured methods as a means of preventing a hierarchical relationship between researcher and participants. Finch goes on to highlight her ease in talking to women and the establishment of good rapport through the application of an unstructured style of interviewing. I realised that this was the most suitable approach in seeking to elicit how women felt about birth recovery and what outcomes mattered to them in terms of their health and wellbeing. I chose to undertake a series of 3 interviews with each woman; one in the first few weeks, a second at 3 months post birth and a final one at 6/7 months post birth. The interviews were tape-recorded with the woman's permission and transcribed verbatim. I made field notes following each interview to supplement the interview conversations. Each time I met the women, I provided a brief verbal summary of the things we had spoken about.

Field notes

As discussed during the conduct of doing ethnography I considered field notes to be of paramount importance. This said, it became apparent that the act of making the actual records as I ‘hung out’ on the hospital wards had the potential to be highly problematic and to some degree burdensome. For example during an observation a manager asked:

‘What are you doing writing in that book? What are you saying about us? Can I look at it? Will you give it me I want to read it?’

Having already conducted four observations and acquired the practice of writing in a note book, albeit in an ‘ad hoc’ and discreet manner whilst on the
wards, I was rather taken aback. This staff challenge was a first. In handling the situation I reassured the manager that my notes were abstract in that there was nothing personal and that I simply did not want to forget things. I followed this up by offering her the notebook. Indeed she took the notebook and flipped through it, saying it looks a mess, she could not understand how I could make sense of any of it; she said to me that ‘it was okay’ and she did not object. In carrying out the observations I had generally been ignored by staff, therefore this encounter felt significant as up to this point I had not considered the impact or reactions of staff regarding my ‘on-the-job’ note keeping. Whilst I sought to be discreet writing in the field, with more details recorded retrospectively upon leaving the ward, the task of making notes of staff behaviour reminded me of what Pellatt (2003) refers to as ‘telling it like it is’. Moreover, I share a similar view to that of Kirkham (1992) who discusses the notion that people could be on their ‘best behaviour’ because they are being observed. Kirkham asserts that the people she observed [staff] ‘had more important pressures placed upon them than that of being observed’ (1992: 8). The way staff behaved ‘best’ or otherwise, whilst not of relevance to my study, in my view adds value to the study overall.

My field notes or jottings took on a whole different meaning during the course of the observation phase mainly as I realised they were formal and would count as real data (Johnson, 1995). I was particularly impressed by Costello’s (2000) thesis in which he provides an example of field notes/jottings to highlight his progress from the early stages and to the latter stage of his fieldwork. Informed by Costello I too include an example of field notes to highlight the trajectory of my own self development with regard to field note recordings (appendix 4).

Study location
The study was geographically located in two neighbouring localities, the city of Salford and the town of Trafford in the North West region of England. At the commencement of the study they both shared funding arrangements, service level agreements and a user group known as the Maternity Services Liaison Committee (MSLC). This contractual arrangement changed during
the course of the study due to the formation of Primary Care Trusts (PCT) with the disbandment of the MSCL and cessation of joint working. A description of the neighbourhoods with corresponding demographic statistics follows. As already indicated observations took place across two neighbouring NHS Trusts and their postnatal wards (2) with the three interviews taking place in women’s homes which were their choice of venue.

Population and health service provision within Salford and Trafford

The city of Salford and urban town of Trafford are situated in the North West of England in close proximity to the city of Manchester. Prior to the formation of NHS Primary Care Trusts (PCT) in 2001, Salford and Trafford managed their health contracts together within the same health authority. Consequently their current functions as two separate PCT’s are a relatively new feature. Whilst they are both within a health region of England which faces many socio-economic and public health challenges they a have a history of working towards similar goals and aspirations for their populations. For example, it was in 1999, as part of the government initiatives to address health inequalities that Salford and Trafford formed a joint Health Action Zone (HAZ). HAZ’s were established where poverty indicators such as unemployment, low wages and poor housing, environmental pollution and crime and disorder were highest. Whilst both communities share some similar demographic figures that enabled the formation of a HAZ variations do exist. However, they continue to share similar health care issues and demography most notably population size and birth rates. Table 4 outlines the latest neighbourhood statistics in relation to maternal health. For the purpose of this study a precise topic related context is provided as backdrop for the study locations.
Table 4: Overview of Salford and Trafford neighbourhood statistics taken from the Census 2001 and Birth ChoiceUK.

<table>
<thead>
<tr>
<th></th>
<th>Salford</th>
<th>Trafford</th>
<th>North West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>216,103</td>
<td>210,145</td>
<td>6,729,764</td>
</tr>
<tr>
<td>Female residents (%)</td>
<td>51%</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>Total fertility rate (TFR)</td>
<td>1.73</td>
<td>1.71</td>
<td>1.64</td>
</tr>
<tr>
<td>Live births to women 15-44</td>
<td>13016</td>
<td>12325</td>
<td>385,130</td>
</tr>
<tr>
<td>Home births (%)</td>
<td>1.1%</td>
<td>2.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>All caesarean births (%)</td>
<td>22.1%</td>
<td>21.5%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>671</td>
<td>417</td>
<td>17,744</td>
</tr>
<tr>
<td>Live births to mothers who live alone</td>
<td>3139</td>
<td>1668</td>
<td>75,746</td>
</tr>
</tbody>
</table>

1 National average for UK

2 Figure for England only, UK is 2.7% - taken from Birth ChoiceUK. (2007)

3 Figure for England, note: the caesarean rate is up 0.3% at 24.6%, this is due to a rise in the numbers of both elective caesareans and emergency caesareans. This continues the trend of increasing caesarean rates.

Latest data on perinatal mortality rates (PMR) relate to 2007 and show the rates were for; England and Wales a total of 5,347 (7.7 per 1,000 total births) for the North West a total of 683 (7.9 per 1,000 total births), for Salford a total of 25 (7.9 per 1,000 total births) and finally Trafford with a total of 22 (7.8 per 1,000 total births). These latest figures were obtained in 2009 from the National Centre for Health Outcomes Development (NCHOD) (website: http://www.nchod.nhs.uk/). Of note is the improvement in Salford’s rate over the past few years, as at the time of data collection for this thesis Salford had a PMR of 30 (11.3 per 1,000 total births) and Trafford had a total of 19 (7.5 per 1,000 total births). These rates highlight that since data collection Salford has experienced a marginal improvement in their PMR.

In terms of public health inequality, both Salford and Trafford have identified neighbourhoods for the government’s policy reforms for tackling inequalities. For example the implementation of Sure Start programmes and the teenage pregnancy strategy is fully underway. Sure Start is a UK government’s initiative to tackle inequalities by seeking to eradicate child poverty working with parents-to-be, parents and children. Sure Start works through
community consultation and partnerships, the programmes include general health advice, ante-natal support, smoking cessation, home visits, and early learning experiences for young children, childcare, more accessible baby clinics and advice, parenting groups and training for work (SSU, 2000). There were five designated sure start areas in Salford compared with one in Trafford. Decisive factors and specific demographic statistics had to be evident for funding by the government and for a community to be designated a Sure Start area and PMR was among such statistics.

As regards the government’s policy framework on teenage pregnancy, Salford and Trafford have employed a teenage pregnancy coordinator with a remit to implement policy and reduce the incidence of teenage pregnancy and teenage parenthood (DfSE, 1999; SEU, 1999; 2004; DH, 2002). In relation to Salford an additional government support programme specific to teenage pregnancy is in place called Sure Start Plus. Whilst it is another feature of the government’s health and social inequalities agenda, Sure Start Plus is specifically focused on the needs of teenagers who are parents–to-be and parents. Sure Start Plus pilots were identified by the government where social disadvantage and teenage pregnancy rates were highest and Salford became a pilot site in 2001 for this reason. Therefore, I have chosen to highlight and draw attention to these initiatives as examples of the local policy context that are present in Salford and Trafford pertaining to motherhood.

These two government initiatives in particular are committed more broadly to addressing social inequalities through the social exclusion unit (SEU) (www.socialexclusion.gov.uk). Social exclusion as been defined as:

Social exclusion is about more than income poverty. It happens when people or places suffer from a series of problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, ill health and family breakdown. When such problems combine they can create a vicious cycle. Social exclusion can happen as a result of problems that face one person in their life. But it can also
start from birth. Being born into poverty or to parents with low skills still has a major influence on future life chances.

(SEU, 2004: 7)

However, at a more microscopic level the Sure Start and Sure Start Plus initiatives propose to impact upon parenting and motherhood from a long term perspective. Within this context the potential population (women) for this research study could be residing in these designated neighbourhoods therefore have experiences of the social exclusion programmes.

In seeking to illustrate further the reality of the local nature of this policy context and notions of social exclusion, it is worth considering some socio-economic factors.

According to the English Indices of Deprivation (Office of the Deputy Prime Minister, 2004) Salford is the one of the most deprived local authority areas both in the North West and UK. This status continues to be reflected in figures for 2006 in which Salford was ranked 12th most deprived district in England (http://www.partnersinsalford.org/sabre-2007.pdf accessed 4.6.09 12.15hrs). In some wards the standard mortality rate (SMR) is twice the national average, for example 2003 for the city of Salford as a whole the SMR was 125 compared with a UK average of 100. An area with a mortality rate below 100 indicates a lower death rate than the national average. In contrast the SMR in Trafford was 99 in 2003. According to these figures overall the North West is the second most deprived region in England.

I have sought to draw attention to characteristics that provide insights into tangible data routinely used in health to describe contemporary neighbourhoods. Therefore, this overview of the two communities seeks to portray some of the differences and commonalities that are shared between Salford and Trafford in relation to the foci of this research study. However, I have some problems with such data in that there is an argument for saying that the use of and interpretation of statistics can serve to simply sanitise their meaning. As a consequence such data is thus endured as the ‘norm’
and accepted as one form of representation. In reality questions emerge around who decides what is collected and what the limits are; in other words what is included and excluded. Foucault (1963) says that this grouping of people into homogeneous categories demonstrates a form of power and control. He further seems to be arguing that to understand ‘things’ (phenomena) we need to use a range of disciplines and see people for what they are rather than be obsessed with artificial constructions by forcing people into bands and categories. These selected data, as with other official forms, could be depicting Salford as a troubled community and in one sense this position has been upheld and accepted within policy discourse for sometime (SEU, 1999; DH, 2004). However, there are other forms of data that display and illuminate a different sense of the community, such as that collected by local community groups, individuals and local media. Alternative forms of data could reveal a different version or account of the community and its population essentially by engaging with people in more meaningful ways, e.g. community development. However, in this context there exists a dominant view by policy architects that Salford and Trafford are somewhat unhealthy or aligns to the notions of social disadvantage and health inequalities.

Context of local postnatal care provision
At the time of the study (and data collection) the maternity care policy context adopted by Salford and Trafford stemmed from the Changing Childbirth report which was implemented throughout England from 1993 onwards (DH, 1993). Fundamentally this policy outlined a woman-centered approach to maternity care provision based upon the principles of choice, continuity and control for all women. Whilst women have the right to choose the place of birth overwhelmingly women opt for a hospital birth in both Salford and Trafford. As outlined in table 4 the home birth rates for Salford and Trafford clearly illustrate how they compare with one another and the rates for England and UK (see p104). Although the home birth rate for women in Trafford is slightly higher (1.2%) than that for Salford it corresponds similar to the home birth rate for Greater Manchester which is 1.5%. In relation to home
birth women remain in their home after birth and therefore have no hospital postnatal care experience.

In line with UK norms and trends in maternity care provision variations exist in the hospital care arrangements in that women can chose a ‘low-tech’ birth or non-interventional birth by choosing midwifery led care. In Salford this type of care is provided by booking into the midwifery led unit and in Trafford through the domino scheme. In both instances midwives function as the lead care giver in the community setting. Following the birth mothers can choose an early transfer home (minimum is 6 hours) and this could involve transfer to a postnatal ward for the 6 hours. Other care options include various hybrid models of care by midwives and/or obstetricians with a planned hospital birth on the labour ward and postnatal care on a postnatal ward. In the event of normal vaginal birth the optimal stay on the postnatal ward was typically 2/3 days and a few days longer for assisted births in other words forceps, ventouse, or caesarean births or where complications occurred (Wray, 2002). In all cases postnatal care subsequently then takes place in the home with the midwife taking control of, and having responsibility for, postnatal care.

**Sample**

In proposing to deal with the aims of the study the sample population as such required post-birth women who had experienced hospital postnatal care at either of the two maternity units in the chosen geographical area. A purposive sample of women (Mason, 2002) was required who fulfilled the following inclusion criteria:

*Women over 16 years of age, had had any type of hospital birth, with either a live baby or not and who had experienced hospital postnatal care.*

The only exclusion was women under 16 years of age. Arguably this was a somewhat pragmatic decision however in support it was based upon knowledge that young people were being invited to participate in a number of local research studies and community based initiatives. In respect of this local context I felt it was appropriate to exclude this group of young women.
Overall, the aspiration was to be as inclusive as possible by recruiting a diverse range of women to participate in the study. In seeking to attain this goal a sampling frame was designed (see appendix 5) to ensure diversity and breadth in the characteristics of the sample (table 6, p120). As Mason (2002: 140) suggests the use of a sampling frame can enable the selection of appropriate numbers and type of specific categories and thus avoid a homogeneous sample. The principal intention was to obtain women that reflected difference in terms of their experiences of birth recovery in other words, variations in age, parity and birth outcomes. Whilst these were the main categories other characteristics about the women such as whether a woman was supported, either by her partner or not, ethnicity and language issues in case an interpreter was required, all of this information was recorded within the sampling frame. However, given that the overarching purpose was to avoid a homogenous sample of women, general information was collected. For example in the age category an age band was used to display age differences. The names of women or any personal information were not recorded. Without exception the women who participated in the study expressed no anxiety about privacy in this context or declared a need for anonymity. Interestingly, during the course of the study women often asked if they could meet up with the other women involved in the study to share their stories and experiences. It had always been my intention to offer a group session at the end of the study to show my appreciation, to discuss the findings and as a way of leaving the field. I secured a small amount of money to fund a ‘party’ type event so that all the women could come together but due to my long-term sickness the opportunity was lost.

Ethics

Ethical approval was required and applied for in line with UK policy (DH 2001) and guidance produced by the Central Office for Research Ethics Committees (COREC). Due to the NHS configuration of maternity care services and study location spanning two neighbouring care settings, in other words hospital and community, this resulted in coverage of four NHS Trusts, two Hospitals and two primary care NHS Trusts. As such this was considered a single site application by COREC. The named local research ethics
committee (LREC) in the North West region of England was accessed and approval granted on first application.

In addition, research ethics approval was sought from and given in 2004 by the University of Salford Research Governance and Ethics Committee (see appendix 6). An issue I was asked to address in more detail by the University committee was the strategy for dealing with women if they became emotionally upset or disclosed sensitive information during the interviews. My responses are outlined in box 1.

**Box 1: The ethical issue addressing steps to be taken if women become emotionally ‘upset’ or disclose sensitive information.**

<table>
<thead>
<tr>
<th>Additional responses are in bold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women will be invited to talk about their own experiences of birth recovery, which may invoke emotions that could be sensitive and upsetting for them. The context of the interviews will be one to one and at any stage they can be terminated and discarded at the women's request. Referral to appropriate professionals (such as health visitor or general practitioner), self-help/support groups (National Childbirth Trust or local groups) and or counsellors. <strong>If women do get upset about issues that come up in the interviews I will assist them in getting help from professionals about such issues should this occur. I have discussed this with the NHS Trust managers and they have supplied me with details of support services locally.</strong></td>
</tr>
<tr>
<td>The nature of the data is such that participants could disclose sensitive issues and these will be treated with respect, confidentiality and used only within the context for which data were collected. I will inform participants that my duty as a professional is such that it could be the case that information requires sharing and this will be made clear should this arise. <strong>This would only occur with consent and I will inform the participants before the interviews start, and in detail, exactly what kinds of information I would need to divulge.</strong></td>
</tr>
</tbody>
</table>
Whilst it could be assumed the research ethics process was uneventful the applications did coincide with heightened anxiety as a result of the publication and implementation of national NHS Research Governance policy (DH, 2001) which could explain the request for extra information. An alternative view of safeguarding against women becoming ‘emotional or upset’ (whatever that meant) connects explicitly with the bio-medical perspective and for me to Brown et al’s (1994) analogy that the ‘problem resides within the woman and her psyche or endocrine system’. I intend to provide further details of this dimension and what I later call the ‘insurance’ discourse that I needed to provide for ethics in the findings chapter entitled ‘Bouncing Back’ (p168).

Access
Access was obtained from the senior midwifery managers within the two corresponding NHS Trusts to observe and recruit the women. Through the NHS research governance processes midwives and relevant staff were informed of the study and provided with information sheets. These information sheets were also disseminated to lead health visitors in the community. I further met with lead health visitors to explain the study, to raise awareness of its existence and my occasional presence in the community.

In seeking direct access to the postnatal wards my research practice was to negotiate three shifts for each ward for the observational phase. The intention was to undertake six observations in total, covering the 24 hours care cycle. However, in practice this resulted in eight observations being undertaken, as I chose the initial observation as a pilot and the further observation was to increase recruitment of the women.

In undertaking the interviews all the women who agreed to participate chose their own homes as the venue for data collection. I arranged all the interviews at times convenient to the women and used a risk assessment guide for ensuring my own safety and risk reduction.
Consent
Permission and consent to observe the postnatal wards, whilst secured from the managers at the outset at each of the two NHS Trusts, was verified with staff (usually midwife in charge of the shift) each time I entered the ward. In other words I negotiated and re-negotiated my presence each time I visited the wards (Naples, 2003).

In recruiting the women as participants for the interviews a written patient information sheet (see appendix 7), written letter of invitation (see appendix 8) and I provided a verbal outline of the study. This protocol was in line with LREC requirements. The written information had been constructed to enable informed choice and consent to participate in the study (see appendix 9). In practice women were less keen to read the patient information sheet and preferred verbal information about the study. They either agreed to participate there and then whilst on the ward or opted to consider the information and make contact with me once they had made a their decision or in some cases women gave their home contact details and asked me to contact them in a few days. I took all steps to enable informed consent, however during the observation phase women were pro-active in that they approached me and were curious as to the purpose of my research. Many women expressed interest to be involved on the one hand this demonstrated an ‘opt in’ scenario with women seeking me out. However a tension arose in that many of the women simply wanted verbal information, declined paperwork and liberally offered personal contact details to me.

Data Analysis
The analysis of ethnographic data is on-going throughout the course of the study; in other words during the specific stages of undertaking the fieldwork, analysis and writing up (Hammersley and Atkinson, 1983). Analysis is highly dependent on immersion and familiarity with the data, as it is a continuous process. For the purpose of this study data originated from three distinct sources, to recap these were; the observations, the interviews and the field notes. I was not seeking to draw distinctions between the different data sources rather I sought to be able to provide a sequential view of women’s
experiences and their understandings of the nature and context of care provision. Additionally, I contemplated Mason’s question concerning how far to ‘read’ your data literally, interpretively or reflexively? (1996: 109) and concluded that to ensure representation of voice I would examine the data on all three levels. Having rejected structured devices (e.g. questionnaires, interview schedules) to assist data collection thus favouring a more unstructured format I took the viewpoint informed by Sapsford and Jupp (1996) that data collection and analysis are both a creative and interactive process. Although analysis within ethnography is not a distinct phase, influences on data analysis exist, for example grounded theory and discourse analysis (Hammersley and Atkinson, 1983). Furthermore according to Hammersley and Atkinson:

‘Much ethnographic research suffers from a lack of reflexivity in the relationship between analysis, data collection and research design’ (1983: 174).

I therefore selected an analytical framework with the capacity to not only address this gap, but like Hunt (2004) I wanted to theorise data without fragmenting women’s voices and to be able to shed light on the objectives. This resulted in the decision to adopt a general framework of thematic analysis inspired by Hammersley and Atkinson’s (1983) process of analysis and Sapsford and Jupp’s (1996) analysis of unstructured data. Most approaches to qualitative data analysis are considered to be ‘thematic’ in some sense (Mason,1996), the imperative within this process was the scope to enable creativity and interaction, to give meaning to the culture (Spradley, 1979) and context of birth recovery as such the steps harnessed to theme data are outlined in table 5. These steps were followed for each case during the study. This is to say for each single observation and for every woman interviewed. Data were pooled and sorted for analysis of the whole dataset to illuminate similarities and differences in order to explain key features.
Table 5: Steps applied to thematic analysis

| 1. Close reading of field notes and listening to the stories - noting early features/patterns/significant aspects or cases |
| 2. Categories - arising spontaneously from women (termed in-vivo by Glaser and Strauss, 1967) and those identified by self |
| 3. Immersion in data – becoming familiar with the data/stories adding some structure – common themes building on ideas and concepts from steps 1/2 |
| 4. Generation of additional categories – searching for connections and links between participants e.g. changes over time, as well as difference and unique features |
| 5. Themes formulated and established links between all data sources |

Throughout analysis I continued to uphold a reflexive outlook and awareness of my relationship with participants


Data preparation

In support, there was an essential requirement to make diligent notes, jottings and records at every stage of doing this ethnography (Hammersley and Atkinson, 1983; Barton, 2008). On the one hand as the study progressed the quantity of notes and files became huge, as I accumulated paper copies from notebooks and printed sheets. Conversely, this practical and physical form of handling the data sought to enable immersion and familiarity with the data. During this phase I consistently read and re-read my notes/jottings and following the interviews listened frequently to the voices of the women as they told their story whilst at the same time I made further notes regarding my interpretations. Listening for categories that people use in informal talk (Sapsford and Jupp, 1996) facilitated clarification of any issues with women during subsequent interviews and sought to contextualise data extracts.

I commenced transcription of the interviews which was very time consuming and took a decision to fund this task. This decision accelerated the production of the written transcripts and in so doing I was able to then
supplement the voice recordings with the written words during the course of undertaking the interviews. A further advantage unfolded in that it became easier to revisit and clarify issues with women due to access to both data forms. Additionally, the transcriber and I would often talk about what women were saying and the emerging themes, therefore I asked her to summarise her impressions of the interview data. From my perspective seeking clarification from women, alongside the discussions with the transcriber and her summary added clarity and verified emerging themes.

As an on-going process of the data collection, fieldwork and performing the analysis I considered using Nvivo2 software package. I attended training sessions however I found mastering it detracted from analysis of the data. I actually needed to handle the data in its physical form, as this seemed to represent more accurately individual women, their stories and I felt more able to connect intuitively with this physical format.

To summarise this ethnography is rooted in giving women voice to their understandings and experiences of postnatal care and recovery after birth. This decision was based on the notion of ‘researching up’ and the desire to capture insights into the sequential nature of recovery. Therefore, I sought to follow a group of women from birth to seven months and focused entirely on their journeys and stories. It was important not to take a restricted view of women’s recovery and to engage in naturally occurring talk during the data collection process (Finch, 1993; Ribbens and Edwards, 1998). In the following chapters I present the findings that unfolded from observing on the wards and in talking to women. Where appropriate I weave in some reflective thoughts to support the findings and shed some light on my role as ethnographer. In summary three main themes emerged and are outlined in figure 2 below.
Figure 2: Summary of data collection methods and three main themes

Data collection methods

- Participant Observation
- Interviews (three with each of 17 women at two wks and three & seven months)
- Field notes and jottings

Thematic analysis

- Theme 1: Power of Place
- Theme 2: Reclaiming the Self
- Theme 3: Bouncing Back
5. Introduction to Findings

The findings are set out in three chapters. Having provided an outline of the three main themes within figure 2 this chapter introduces the findings and the women who participated. It is in the first chapter entitled Power of Place (chapter six) that it can be seen how powerful place was to the women in this ethnography. The impact of place had lasting effects for some women in that the ‘atmosphere’ and ambiance were instrumental to how the ward environments were experienced. By comparison I draw upon Walsh’s (2004) ethnography of a free standing birth centre whereby the postnatal stay was experienced as ‘being like a home’ or, more like a ‘second home’ and, even more profoundly ‘an oasis of calm’ (2004:169). I am aware that my data compares less favourably to these descriptions providing a different perspective on how ward atmospheres can impact upon celebration of birth. There then follows chapter seven Reclaiming the self wherein the findings reveal insights into how women reclaimed the self and grappled with their quest for getting back to normal. The final chapter (eight) details the term bouncing back a label that symbolised how these women unpacked their own recovery and took responsibility for the self. Together these findings offer further insights into the complexities of time-boundness (Barclay et al, 1997; McCourt 2009) and the different meanings attached to concepts of time in relation to birth recovery.

At this juncture it is worth mentioning that for these women the reality of being postnatal was in part sequential.

Being postnatal
The women experienced a trajectory of recovery; however the time span was much longer than that cited within professional literature and policy documents. On the one hand the notion of full recovery and return to the pre-pregnant state by six weeks was considered to be a fantasy and was disconnected from how these women experienced recovery. Conversely these women did not rely on formal care giving as a means to achieve a sense of wellbeing nor did they consider that their care had been
individualised by working in partnership with midwives (DH 1993, NICE, 2006). The landmark, six week check at which women are formally assessed to ensure their body has reverted back to the pre-pregnant state, was viewed as a disappointing encounter in that few women received a physical ‘check’ or felt they had been assessed in a way that confirmed (or not) their body had altered and reverted to a state of normality. Interestingly as one woman said:

‘God what’s normal? I don’t know what you want to term as normal, I mean everyday is different for me, I don’t think my body has [returned to normal] it’s going to take me a lot longer to recover but I put it down to the actual birth as well [caesarean birth]…. its going to take about 12 months easy, yeah definitely’

Tina final interview (7months)

I will return again to this landmark outcome of ‘reverting back to normal’ in chapter seven. My purpose for mentioning it here is to reiterate that a recovery trajectory does exist but according to the women involved in this study was nothing like the official definitions and midwives rules (WHO, 1998; UKCC, 1998; NMC, 2004). For these women recovery was not experienced within the context of some absolute time bound period, it differed considerably for each although by seven months, without exception, these women felt that they had ‘bounced back’ or were well on the way to moving forward (see: chapter eight).

Before moving on to the specific details of the findings the following section introduces the women who chose to participate in this study.

Characteristics of the sample – the women who participated

A total of 20 women expressed a keen interest to participate in the study and agreed to a series of three interviews. However, three women who had arranged an interview date and venue were unavailable on the actual day. It unfolded that two of these women, who had sick babies nursed on the special care baby unit (SCBU), felt unable to offer their time and energy to the study
and they decided not to participate. As indicated in the ethics application reminders were not sent out, so I made no contact with the third woman although she contacted me at a later date simply to say 'she was too busy'. Table 6 illustrates the characteristics in accordance with the sampling frame attributes of the 17 women (pseudonyms used) who did participate. As indicated in table 6 some diversity amongst the women occurred and avoidance of a homogenous sample was achieved. Seven women were aged under 25yrs, six women were under 35yrs and four under 45yrs. In total seven women were primigravida (first time mothers), nine were multigravida (previous mothers) and one woman was a grand multigravida in that this was her fifth child. In terms of birth type nine women had vaginal births (including ventouse delivery) and eight had caesarean sections (c/s). Two women (Toni and Trish) gave birth to twins, and they both had longer stays in hospital. Toni's babies were born prematurely, and unfortunately as both babies were seriously ill they had to be transferred to another hospital to receive appropriate care.

Overwhelmingly, for these women their actual length of stay exceeded their anticipated/expected length of stay, with the exception of Teri and Trish, although for Sally, Sue, Steph and Shirley they were fairly uncertain as to what to expect. In terms of the attribute 'support' all of the women considered that they were 'supported' even if they defined themselves as single. The aspect of support emerged as a distinct feature within the data and will therefore be discussed and debated further (p186). Despite my best efforts to be inclusive in terms of ethnicity all of the women were white European and thus a lack of ethnic diversity is apparent, although in comparison to surrounding towns the catchment for these units has a relatively low fraction of residents of African or Asian heritage. However, some of the women were from Irish and Scottish decent with one woman originating from another country in Europe. Interestingly two women representing an ethnic minority population (Asian) expressed a genuine desire to participate whilst on the ward but once transferred home they contacted me to say they had decided not to participate. I am unable to draw any conclusions as to their reasons for opting out due to a lack of evidence. Without exception I met all of these women during the observational phase on one of the postnatal wards (Smith or Thompson wards).
Table 6: Characteristics of the sample (n=17)

<table>
<thead>
<tr>
<th>Name/Code</th>
<th>Age range</th>
<th>Parity</th>
<th>Birth type</th>
<th>Support</th>
<th>Pregnancy complication</th>
<th>Anticipated length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally SA4</td>
<td>16-25</td>
<td>First</td>
<td>Planned C/S (breech, 35wks)</td>
<td>Lives with mum and husband</td>
<td>Small for Dates (SFD)</td>
<td>She was not sure Stayed 7 days (plus 3 days a/n)</td>
</tr>
<tr>
<td>Sue SA1</td>
<td>16-25</td>
<td>First</td>
<td>Ventouse</td>
<td>Lives with partner and mum</td>
<td>No</td>
<td>She had no idea Stayed 5 days</td>
</tr>
<tr>
<td>Sam SA3</td>
<td>16-25</td>
<td>First</td>
<td>Emg C/S (breech)</td>
<td>Lives with partner</td>
<td>No</td>
<td>She thought 6 hours Stayed 5 days</td>
</tr>
<tr>
<td>Sandra SA5</td>
<td>16-25</td>
<td>First</td>
<td>Emg C/S (breech)</td>
<td>Lives with partner</td>
<td>No</td>
<td>She expected 5/6 days Stayed 3 days</td>
</tr>
<tr>
<td>Steph SA8</td>
<td>26-35</td>
<td>First</td>
<td>Normal</td>
<td>Lives with husband</td>
<td>Severe nausea and vomiting</td>
<td>She had no idea was flexible Stayed 2 days</td>
</tr>
<tr>
<td>Stacey SA7</td>
<td>26-35</td>
<td>2nd</td>
<td>Normal</td>
<td>Lives with husband</td>
<td>Diabetic (Type 1)</td>
<td>Expected to stay few days Stayed 1 day</td>
</tr>
<tr>
<td>Shirley SA10</td>
<td>36-45</td>
<td>4th</td>
<td>Normal</td>
<td>Lives with partner</td>
<td>No</td>
<td>She had no plans Stayed 2 days</td>
</tr>
<tr>
<td>Sarah SA9</td>
<td>26-35</td>
<td>2nd</td>
<td>Ventouse</td>
<td>Single, felt supported</td>
<td>No</td>
<td>She expected to stay 6 hours but stayed 24hrs</td>
</tr>
<tr>
<td>Sheila SA2</td>
<td>26-35</td>
<td>2nd</td>
<td>Normal</td>
<td>Lives with husband</td>
<td>Vaginal bleeding &amp; ?SFD (baby at birth 3.4kg)</td>
<td>She thought 6 hours, Stayed 4 days</td>
</tr>
<tr>
<td>Toni TR6</td>
<td>16-25</td>
<td>First: Twins</td>
<td>Emg C/S 35 wks</td>
<td>Single lives with parents</td>
<td>No</td>
<td>Babies nursed on NNU</td>
</tr>
<tr>
<td>Tam TR2</td>
<td>26-35</td>
<td>First</td>
<td>Emg C/S</td>
<td>Lives with husband</td>
<td>No</td>
<td>She expected a short stay. Stayed 5 days</td>
</tr>
<tr>
<td>Trish TR3</td>
<td>26-35</td>
<td>2nd: Twins</td>
<td>Planned C/S</td>
<td>Lives with husband</td>
<td>Carefully monitored due to history (first child died)</td>
<td>She expected a longish stay. Stayed 7 days</td>
</tr>
<tr>
<td>Tanya TR8</td>
<td>36-45</td>
<td>2nd</td>
<td>Normal</td>
<td>Lives with husband</td>
<td>Breathlessness</td>
<td>She expected 1-2 days. Stayed 5 days</td>
</tr>
<tr>
<td>Teri TR5</td>
<td>36-45</td>
<td>4th</td>
<td>Normal</td>
<td>Lives with husband</td>
<td>Chrön’s Disease</td>
<td>She thought 24hrs and stayed 24 hrs</td>
</tr>
<tr>
<td>Tracey TR9</td>
<td>16-25</td>
<td>2nd</td>
<td>Normal</td>
<td>Lives with partner</td>
<td>No</td>
<td>She expected 6 hours Stayed 24 hours</td>
</tr>
<tr>
<td>Tina TR1</td>
<td>36-45</td>
<td>5th</td>
<td>Emg C/S (first one)</td>
<td>Lives with partner</td>
<td>No</td>
<td>She expected overnight only Stayed 6 days</td>
</tr>
<tr>
<td>Trixy TR7</td>
<td>16-25</td>
<td>2nd</td>
<td>Planned C/S</td>
<td>Lives with partner</td>
<td>No</td>
<td>She was happy to stay 3-5 days Stayed 4 days</td>
</tr>
</tbody>
</table>

Pseudonyms are given and those starting with ‘S’ denotes Salford (Smith ward) and ‘T’ Trafford (Thompson ward).
6. Theme (1)

Power of Place: The impact of place upon the celebration of birth

Introduction
In this first chapter on the findings I present insights into the impact of place on women and the connectedness with their celebration of birth. In exploring the literature pertaining to context of care I discovered that power of place arose as a distinct feature of postnatal care provision. My analysis here confirms that place matters, moreover, I find a distinct fusion between place and celebration of birth. In other words for these women celebration of birth is not only a fundamental desire, but decidedly connected to the rationale for the hospital stay and being cared for by experts. In part this desire echoes Marchant’s (2003) sentiment that there exists a ‘yawning gap between the intentions and provision of postnatal care’. Of particular note are questions and concerns regarding the purpose of staying in hospital on a ward which were posed by the women I met. Furthermore, it unfolded from the findings that there exists a dissonance between women’s views of birth recovery and those held by maternity care staff, in other words evidence of organisational rhetoric unfolded which appears to be disconnected from women’s realities and experiences of formal care. Thus the impact of being postnatal and receiving formal care in the early period after birth will be initially explored within the themes embedded in the ‘impact of place upon celebration of birth’.

Atmosphere of the wards
By atmosphere of the wards I mean such things as the physical layouts, organisational features, the process of women’s transfer to the ward, the locked door, curtain usage and noise levels. Having spent time observing on the wards I became familiar with and immersed in the atmosphere, in the sense that I could feel the tensions or the calmness and how busy things were. What I mean here is the ‘feel of the place’ as outlined by a mother on transfer to the ward when she said to me:
‘I could tell as soon as I came round that it was busy and that the staff had no time, it was all over their faces, I just felt it, it felt tense and I knew not to ask for things at first’.

Field note

Similar to the findings of Walsh (2004) and Dykes (2005) described earlier it became apparent that certain features impacted upon this sense of atmosphere. Whether imagined or real it was detected by the women I met.

Physical layout

In conveying something of the atmosphere of the wards it is worth considering the differences and similarities of the two postnatal wards under study. Bed occupancy differed marginally. Smith ward had 30 beds for postnatal women and their babies. Thompson ward had 25 beds and was a purpose built maternity unit which was equipped to deal with pregnant and postnatal women. Both wards had four bedded rooms and a number of single rooms with Thompson ward having a few two bedded rooms. Women could pre-book a single room (referred to as amenity rooms) during their pregnancy at a cost of £35 per night (costs at the time of data collection 2004/5). However, pre-booking of an amenity room was dependent upon availability as ill women or women with particular needs had occupancy priority. On Thompson ward en-suite bathrooms existed within single rooms whereas on Smith ward all bathrooms, toilets and showers were communal. All bed areas had access to TV and telephone through a fee paying system called ‘Patientline’, although on Smith ward installation had been a priority for the single rooms for some time and at the time of the study full installation for all beds had just been completed. Both wards had day rooms that doubled as dining rooms and waiting areas for visitors to the wards as required. That said, on Smith ward women were encouraged to eat around their bed area whereas on Thompson ward staff made concerted efforts to persuade women to eat together in the day room.

Access to the ward was a major issue in that both wards had locked doors with access by permission only through a call bell and intercom system. This safety feature is something that is routine across the UK, all maternity units have signed up to this practice of safety and risk reduction in terms of baby abduction
Thompson ward supplemented the bell and intercom system with closed circuit TV in order to see who was seeking access to the ward. Interestingly some staff had permission to access the wards using swipe cards and codes to open the door but not all staff had these therefore had to use the bell and intercom system to gain access. My observation was that this was mostly medical staff choosing to pass through the ward as if it were a corridor, as it was on route to another ward. In addition, an extra safety measure of electronic baby tagging was in operation on Smith ward. Therefore, an alarm system programmed to the baby identification electronic tags was in place at designated points along the ward corridor.

The women I met raised a number of concerns in relation to ward visiting and I will return to this phenomenon in due course. Before that it is worth highlighting organisational features such as ward personnel in order to understand the sheer volume of people on the wards at any given time.

**Organisation of ward areas**

A range of staff worked on the wards including: midwives, student midwives, nursery nurses, support workers, hearing screeners, ward clerks, domestic staff, and trainee assistant practitioners. Other staff visited the ward on a regular basis such as doctors (paediatricians and obstetricians), midwives (both hospital and community), academic link tutors, administrative staff, photographer (baby portraits), Bounty pack person, neonatal staff, pharmacists, physiotherapists, porters and managers. I noted on Smith ward that the staff mix appeared to be much more diverse with more students and different staff appearing at various times in the day. In addition other staff (those not working on Smith ward) frequently used the ward as a ‘thoroughfare’ to gain access to other wards within the maternity unit. During the day the volume and diversity of staff was notable on both wards whereas at night there were less staff and mostly the staff mix was confined to midwives and support workers. Arguably this ratio of staff during the day compared to that at night is a familiar custom within maternity care across the UK and is also issue for staff cover at weekends (Birth Rate Plus, 2008).
As I observed the wards the sheer volume and diversity of staff along with the visitors struck me as being rather chaotic. Significantly the wards were not quiet peaceful places; even on Thompson ward when the visitors left the ward remained full of people (staff). Interestingly staff tended to congregate in the staff offices, around the nurses’ station and along the corridors. According to Nash (2002) in her discursive paper, on the effects of visitors on the postnatal ward, she states that the postnatal ward is first and foremost a workspace for midwives and other staff, thus staff should be firmly in control of the environment in order to set the standards for women and their visitors. What I found was that the atmosphere was one of business. At a basic level the ward is a place of work for staff which connects up with the views of Nash (2002) concerning the ward as a workplace. In contrast it is also place to rest and recuperate for the women (RCM, 2000; Ockleford et al, 2004; Beake et al 2005). The fact that the ward had different purposes for the women and the staff did not alleviate their joint feelings of commotion. Like Dykes (2005; 2006) I found this sense of chaos and busyness impinged upon staff and women alike, in that, for different reasons they both revealed they felt powerless to control or influence the environment in which they found themselves. For example at staff handover a major cause of concern was workload, outstanding jobs and tasks, in other words processes such as the ‘checks’, ‘discharges’ and paperwork consumed much of the handover time and evoked what I have termed ‘hardship talks’ amongst staff.

Hardship talks

Hardship talks occurred amongst staff as opportune conversations that took place in corridors and places where staff could converse together out of public gaze. The ‘talks’ I observed were rooted in concerns regarding workload issues and reflections on the challenges experienced on prior shifts. In one sense they were recounting to one another how they had coped with the volume of work and how the ward had been managed, as I noted on one occasion:

*Some of the staff congregate in the corridors straight after hand-over to talk about how their experiences of being on the ward and their understandings of what busyness was, there was a sense of needing to*
be able to define how hard the work was on the ward compared to other times they had been on the ward, it was often harder on a prior shift or with certain people, the analogy was along the lines 'if they think this is busy they should have been on the other day, that was busy or they should work with xxxx then they would know how tough it can be'. In a way it felt like the staff were whingeing and moaning about their lot. I found it disconcerting and uncomfortable at times that these talks took priority and that hanging about say in corridors seemed legitimate. Although maybe by voicing these feelings of hardship staff feel able to move forward with impending work/tasks/jobs. I have to be careful here not to get too distracted by staff behaviours and conduct, it is how women experience such things that matters to my study. Except that if I notice these things I am sure that the women will too……

Field note

It seemed to me to be a ritualistic process in that staff needed to be able to spend some time chatting over things before meeting the women and being with the women on the ward. These hardship talks were arguably a type of de-brief session in that they sought to unify staff by comparing stories of hardships whilst working on the wards and on different shifts. I noted that these hardship talks occurred on both wards and that on occasions some staff could be less discreet about where their chats took place in that they could be overheard. For example on one occasion I noted the following:

I notice staff congregate in the corridors as I can hear them talking about how awful it was on the ward the day before, so busy, one must be a student as she seems annoyed that she got no time to work on her assignment, the other one says that she had no break not even a drink. I am finding it uncomfortable to listen, they seem to be really moaning and one of the women in the room is ringing her bell. The staff continue to talk, oblivious, it's like they are competing to tell the worst story about how busy it has been and how they have suffered. So I decide to ask the woman what she wants, as I feel embarrassed that I am in the room and they [staff] are seemingly ignoring her call bell. This woman has just
been admitted from labour ward and she would like a bath. With reservation I decide to interrupt the two members of staff to ask whether this woman can bathe, they tut at me and roll their eyes, they are clearly annoyed with me for interrupting them, they say ‘Yes of course she can’ and why am asking them, I can tell her and help her, can’t I?’. Their abrupt manner takes me by surprise and I feel annoyed but smile and enter the ward to tell the woman its fine to bathe. Her sister rather tentatively says they have forgotten to pack a towel and could they borrow one. I respond positively and realise I will need to disturb the same two staff members again to enquire about a towel. Now this time they do snap at me and say she [the woman] will have to get one from home as there are none on the ward, so she will have to wait, at this they turn to walk away. Again I feel really annoyed at their tone and conduct, this woman and her sister [and the other women in the ward] hear them and it feels awkward, a kind of uncomfortable atmosphere in the room. Then suddenly one of the staff members returns with some terry nappies and says this is all they have and if she can manage she is welcome to use them (terry nappies) until she gets a towel.

Field note

On reflection this encounter symbolised the importance of the hardship talks to staff and how they would seek to protect this created space to talk over their views about workload issues. Additionally for some staff hardship talks were a way of venting their frustration with the presenting workload. In a sense being able to express one’s feelings and views was a supportive process. Staff cared about how they were perceived by other staff members and in many ways were seeking positive affirmations that they had done their best. That said, when women had changed their feeding method, usually from breast to bottle, hardship talks unfolded in a very public way in terms of staff expressing their disappointment with such decisions as they claimed they had invested ‘huge amounts of time’ in supporting breast feeding. On more than one occasion the hand-over became a place to criticise women and their decisions most notably in relation to feeding issues. This criticism was part of the notion of hardship
talks in that explicit comments directed at members of staff would unfold, as I noted on Smith ward:

*It did not go down too well when it was disclosed that a woman had stopped breast feeding, this midwife was clearly very angry she asked outright who was on the night shift, and once the name of her colleague was disclosed she said ‘typical’. Her body language then became negative and she appeared not to listen further in the hand-over session. At the end of hand-over she announced that she would not be caring for the said woman, she said that all her hard work had been for nothing and had she worked the night shift she would still be breast feeding.*

Field note

In this instance it further unfolded that some midwives behaved in a rather evangelistic way towards breast feeding and could not comprehend why any women would cease to breast feed under any circumstance. A member of staff made this clear as we left the hand-over room, when she said to me ‘some of them [midwives] are obsessed with breast feeding, its not like it used to be on here, they force women and get cross when they stop, it’s that Baby Friendly thing you know’.

I got a sense that these hardship talks represented the staff’s frustration with the ward workload, the tasks and jobs that existed on each shift. But moreover the organisational and policy targets such as breast feeding rates posed challenges that for some staff were considered as idealistic, that is to say unrealistic in the context within which they practiced. As Dykes (2005) found the cultural setting (the wards) in which both women and staff found themselves was not always conducive to ‘caring’ and relationship building between women and the midwives. The interpersonal nature of care and caring cannot be overstated (Baker et al 2005a; Dykes, 2006). On balance the act of being able to conduct a ‘hardship talk’ thus had the potential for reflection of issues that had occurred on the wards. Recognition and commentary upon other staff’s attributes, values and beliefs about postnatal care, including feeding, were strong features of hardship talks that I
encountered. I found this to be an interesting observation as we know already that staff attitudes and encounters with new mothers have a lasting impact (Brown et al 1994; Bondas-Salonen, 1998; RCM 2000; Beake et al, 2005). How midwives understand their role and view contemporary postnatal care was explored by Cattrell et al (2005). This was a small scale qualitative study exploring midwives perceptions of postnatal care in an area of the North West of England. What they found was that priorities in postnatal care, societal influences and job satisfaction mattered to midwives. With the rapid turnover of mothers and babies on postnatal wards it is maybe no surprise that midwives also feel the impact.

Workload

Returning to workload and outstanding jobs revealed at staff handover, apologies were frequently given for not having finished the ‘jobs’ and staff handing over would more often than not offer to stay behind until they had completed outstanding work. I only observed hand-over consistently on Smith ward whereas on Thompson ward I was actively excluded apart from on one occasion. I can only speculate that this could have been to protect confidentiality. Interestingly, similar dynamics were observed with frequent apologies being offered and to some extent a sense of guilt was displayed on both wards about revealing unfinished physical work and tasks.

This finding on workload and procedural language about physical tasks resonates with Ridgers’ (2007) thesis where she found an ethos of postnatal care that had been confined to ‘task-based’ contacts between midwives and women, resulting in women being treated as passive recipients, unheard and unlikely to have their individual needs met. Additionally, this staff commitment to the workload and outstanding tasks endorses the theoretical insights previously discussed in relation to viewing women as a bio-medical machine [body] (e.g. Oakley, 1979; Shildrick, 1997; Brown et al, 1994; 2005) necessitating surveillance that becomes devoid of viewing the person as an individual. It became apparent that the wards were places, bound by institutional rules and regulations focused upon managing the collective, in this instance mothers, as ward occupants. At one level I could sympathise with the demands being
placed on midwives to attain what seemed like unattainable goals. However, what unfolded here was further evidence that conflicting needs and priorities exist. Willcocks et al. (1987) reminded me that the real challenge rests upon agreeing the function of postnatal care as it remains open to interpretation. The demands placed on staff to individualise care can be highly problematic and create tensions as running parallel to this excessive requirement of individualism is the universal requirement to conform to what Kirkham (2004) has termed the ‘rules of the game’. Some staff articulated their unease with hospital protocols and the administrative content of their jobs, as this detracted them from being with women in order to conduct their statutory duties fully (NMC, 2004). As one midwife commented:

‘we spend so much time on paperwork it’s ridiculous and I hate it, it stops me being out there doing what I like doing helping women, it can take ages to get discharges sorted and if your not on top of them it holds women up and then they get annoyed, I spend ages on the computer and less time with women, its crazy and drives me mad’.

A further dimension that impacted upon staffing arrangements was the practice of redeployment of ward staff (in the main midwives) to the labour ward. I noted this practice occurred at both hospitals equally and could apply at any time during any shift. This practice naturally formed part of the ‘hardship talks’ between staff on the ward. It troubled some of the staff as they felt it affected the quality of postnatal care and detracted from the needs of the many women on the ward whilst at the same time they were fully aware that managers presided over this practice and as midwives they had no control. It was embedded practice and the staff I met felt unable to challenge this doctrine. Interestingly, the Audit Commission (1997) highlighted the existence of this practice across the UK. In addition, I would argue that this finding upholds Bondas-Salomen’s (1998) and the RCM’s (2000a/b) assertions that postnatal care is given low priority in line with what I have described as a ‘hierarchy of childbirth’ (figure , p17) one that has downgraded postnatal care to the lowest position within childbirth. Clearly, this observed embedded practice of treating postnatal care as a low priority mirrors that discovered within past literature.
The attachment of low status upon postnatal care has been sustained over time and I would argue says something about the underlying values connected to supporting new mothers which further links up to wider thinking in society that motherhood is innate and natural (Ruchala and Halstead, 1994; Rothman, 2000; Nelson, 2003; Miller, 2007). However, for some women they encouraged their partner/father of the baby to stay all day in recognition that they ‘would have had no help otherwise’.

The women were not privy to the minutia of staffing issues although there existed awareness among them all that the staff were busy and that staffing levels were poor, much worse than they had expected. The practice of staff redeployment to the labour ward and notions of busyness were picked up on by women, so much so that some women would try to take account of these features as the following comment by Trish explains:

‘Erm,… I think the main thing for me was I just felt that the staff there wasn’t enough staff basically. Because whilst I was in there was quite a number of emergency sections and the staff that were on apparently can go over to the labour ward at any time if they are needed there, so there would only be two people manning the station, the actual bay for the women on the ward which I thought was terrible really they should have more staff available. So I think that was the main thing really not enough staff because on my notes they’d put I was reluctant to ask for help but I wasn’t reluctant to ask for help, it was just the help wasn’t always available I mean they’d come in and help you and then the buzzer would go and they’d be off again and they’d be gone for like an hour and you’d still be left with the babies. Cos that happened on one or two occasions where I’d buzzed for help and they’d come in and they might need to get stuff and they wouldn’t come back for half an hour or an hour later’.

In this context a tension existed for women between seeking help and disturbing busy staff. Their own needs and wants could be put to one side as they grappled with making a decision to ask staff for help. There was a feeling
that other women’s needs were greater than their own. This analysis by the women was somewhat speculative as they did not tend to socialise with one another to any great extent. That said, women very quickly, as did I, assessed the atmosphere of the ward, in other words ‘the feel of the place’ for its ability to meet their needs.

Transfer to the ward / Arriving on the ward
Women were transferred or admitted to the wards directly from the labour ward with their baby, unless the baby was ill and required nursing on the special care baby unit. The time scale from birth to transfer seemed to vary considerably. For example some women were transferred an hour after birth whereas for others 2 hours lapsed. To a lesser extent it could be longer if women were unwell or slow to recover following caesarean births. A dimension that I noted was how the father or birth partner were greeted upon transfer to the ward, most notably at night time they were asked to leave within a few minutes of the transfer. I assumed this was to ensure other women could sleep and reduce risk of disturbance. Alternatively in the day time staff would suggest that they considered going home to freshen up thus allowing the mother and baby some time to rest on the ward. In this scenario it seemed that staff were in a sense being thoughtful and considerate towards fathers, in advising them to take some time to recover from being at the birth.

Smith ward had a welcome booklet available that was issued to all women upon admission to the ward entitled ‘Welcome to the Smith ward’ (introduced four months prior to data collection for this study). This ten page booklet explained the ward routine, details of staff, postnatal checks, women’s health and baby health, feeding baby care, common infections and tests, going home, going out, contraception, registration of the baby, reducing risk of cot death, frequently asked questions section and list of postnatal support groups. The back page contained advice on reducing the risk of hospital borne infections and an explanation of the ward fund whereby donations would be gratefully received (rather than gifts of confectionary) to save up for equipment for the ward. The booklet had been produced by the postnatal development midwife in consultation with women and in response to feedback from a service users’
group in the locality. The lead midwife told me it was to ‘ensure women had access to consistent information, that it was hopefully condensed in a way that took them through everything’. She also told me they had a disc version so that they could convert the booklet into other languages if required in the future. I did notice that mostly the booklets were left on the bedside locker and women did not take them home. Thompson ward had no such resource or particular activity that served to welcome women to the ward and explain the ward routines. Although staff would perform a brief physical check of the woman and observations of her vital signs pulse, blood pressure and temperature this ‘check’ was performed as required on both wards, sometime close to transfer onto the wards.

The locked door
I have already mentioned the policy of ‘locked ward doors’ as a requirement to ensure women and their babies were safe and secure. However, a connected dimension between locked doors and the workload of staff was evident during my observations. It was noticeable that staff dedicated huge amounts of time and energy to managing the door, scrutinising who came in and to a lesser extent the departures. On Thompson ward the system for opening the door was more sophisticated with closed circuit TV, thus management of the door was mostly undertaken by the ward clerk from the nurses’ station. However, at hospital 1 the intercom seemed rather dated, sound was poor and the automatic lock frequently delayed requiring staff to open the door manually. This activity frequently interrupted the work of staff, most notably midwives, when verification for entry was sought.

An added dimension was noise levels created by the locked door system, for example the bell was loud, and people were often persistent in ringing the bell and would continuously ring it. On occasions staff would shout down the ward corridor to check out who people were as visitors often opened the door for people. In conversations I had with staff they were supportive of the safety feature and understood the rationale behind it but their involvement in managing and policing the locked door posed tensions and frustrations. They clearly felt that it was distracting and interrupted midwifery work, furthermore
that ‘management’ (those above, ‘the others’ who dictate the rules) had no insight into or appreciation of the operational issues. For example following a night shift I made the following field note:

I can’t believe the staff hours that are invested in the door; it rings all the time, its chaos and bedlam all day. The bell can be really loud and I thought tonight it would be quiet but it’s not, when I mentioned it to the midwife she said ‘well we have to let the smokers out and they smoke in the night usually after a feed, well at least smokers get more exercise (laugh) but yeh its rings 24/7 - you get used to it’.

Field note

Curtains
Staying with the ‘atmosphere’, in both wards I noted a range of bed curtain positioning techniques taking place. I found this both intriguing and troubling as the women sought different and subtle ways of positioning the curtains, from absolute closure to various part-closures. This activity was mimicked by women who occupied single rooms by closing the door or having the door ajar. It seemed that women predominantly controlled this activity and I assumed was related to securing a sense of privacy. In contrast on Thompson ward, whilst this curtain positioning activity took place staff actively discouraged the women from closing the curtains and would open them as they went around the ward and/or instructed women to open their curtains when they no longer required privacy.

From my perspective I initially felt apprehensive that such curtain positioning would obscure things that I was hoping to observe in my data collection. However, I drew upon the ideas of Burden (1998) and her ethnographic study on the use of curtain positioning as a means of achieving or maintaining privacy within a postnatal ward environment. Her findings indicated that curtaining positioning or as she subsequently called ‘signalling’ were found to be subtle and powerful strategies employed by women to indicate; a desire for total privacy (complete closure), help seeking for support or information (semi-closure) or seeking a period of rest or solitude (partial closure).
According to Burden (1998) this signalling emerged as a new form of non-verbal communication based upon women’s desire for contact or solitude, either with staff or other women on the ward. Concerns of midwives about the lack of social interaction amongst mothers on postnatal wards had contributed towards the rationale for Burden to undertake this study. However, in her paper Burden does not report on this aspect but concludes that this subtle form of signalling has implications for other institutional postnatal care settings in that this passive silent messaging could be overlooked or misinterpreted and on this point I would agree. She also noted that ‘signalling’ was more likely to occur in situations where postnatal women shared a room with other women using different feeding methods, were antenatal and/or were labouring women. This finding resonated with my observation of curtain usage in response to male visitors present on the ward. On the one hand it resembled a mixed-sex ward, in that some men stayed on the ward for long periods of time, up to 12 hours and would inhabit the shared space with the woman (behind the curtain) in addition to the designated communal spaces. For example, men were present in the day room, kitchen, the corridors, the bed areas, bathrooms and showers, as they helped their partner to bathe. In discussions with staff about this dimension a spectrum of views were articulated from understanding the principle of fathers’ involvement and the associated benefits to mother and infant to the presence of men being a nuisance, ‘in the way’ and hindering the hub and flow of the ward and duties of midwives. Opinions as to the usefulness of men in helping to parent and support the woman were mostly unfavourable as indicated by the following précis from a member of staff;

‘some of them [men] well they are no use, mostly they come up to the ward, do nothing really but get into her bed, fall asleep, wake up, have something to eat and read the paper and go’.

Field note (Smith ward)

Of note this member of staff did caveat her remark by saying ‘some men were great, amazing in fact’ although in her experience these represented the minority. It seemed that an aspect of having male visitors on the ward for
long periods of time impacted upon women’s sense of privacy and dignity, for some the ability to socialise with other women was inhibited by the presence of men being on the ward.

Like Burden (1998) I observed minimal social interactions amongst women, either those who shared a room or within the communal sections of the ward e.g. day room. For Teri her opportunity to talk to other women was hindered by being in a single room, as she said:

‘No, no I did not talk to other women because I was in a private room and they shut me away, closed the door and forgot about me’.

Teri

Loneliness was an additional feature of being on the ward as Toni told me:

‘it was okay on the ward, I did get a few visitors that came but at other times I was a bit lonely just in the room, there wasn’t like a TV or anything and I was in a separate room by myself the room was right at the end of the corridor and it was like quiet but quite lonely really’.

Although I did not observe women (referred to as the ‘smokers’) when they left the ward to have a cigarette in the designated smokers’ area, on reflection, this could have been a useful insight as staff inferred that this subgroup of women socialised much more. For example staff told me that often these women were known to make appointments to meet each other in the smokers’ bay. Staff also commented that the ‘smokers’ were more inclined to mobilise quicker than other women irrespective of the type of birth they had had.

I further noted that there were few (if any) group activities and staff supported this finding confirming that in the main staff interactions were based on a ‘one-to-one’ basis, this applied to both Smith and Thompson wards. In unpacking possible meanings attached to curtain positioning during the interviews with women a diverse set of views emerged. Some felt it was
oppressive, made the room hot but felt it was the norm so rather than be different copied the practice. Other women felt it was essential as a means of ensuring their own privacy but additionally that of their partner. As he had come for the day these women felt leaving curtains open was unfair to him and the other women as it could compromise their modesty and sense of privacy. Others said closed curtains made them feel lonely and isolated that they found it hard behind the curtains and longed for contact with people. For some women it was a good place to hide from the glare of staff and other people’s visitors. Sally, who had felt particularly under scrutiny from staff, in fact she told me that she felt that they ‘looked down’ on her, as she said;

‘It was just that on the ward I just think like people are watching you so I like them [curtains] round me, I know they think ‘cos of my age I am not capable to be a mum, that I don’t know what I am doing, but what do they know? They look down on me and treat me different to the others in this room’.

Sally

For Sally the curtains provided a sense of security and comfort in that she felt that negative judgements were being made of her by some staff (not all) in respect of her ability to mother due to her young age. Interestingly, she further disclosed to me that no staff member had actually watched her feed her baby or perform any baby care activity. Her interpretation was that staff had pre-judged her and attached a label unfairly. On the one hand Sally felt under scrutiny and yet at the same time she had received minimal supervision or contact with staff. Her comments were ambiguous and within my field notes I am unable to draw a conclusion.

In contrast for women who had had children previously they particularly noted this curtain phenomenon, as their past experience did not include this activity. So for these women it was about following the social norm of the ward but with reservation as Shirley and Tracey commented:

‘I thought if you’re not looking at anything else you are looking at a curtain, you know you do feel isolated when everyone else has got
their curtains shut and then you just feel like you have to have yours shut. You think pulling the curtain round gives you peace and quiet on your own, obviously you do not get peace and quiet, there is always someone tottering about isn’t there’. 

Shirley

‘it was just like that, erm I don’t know why but I felt that because the other girl had her curtains round I thought I’d put mine round’.

Tracey

A related feature on Thompson ward was the finding that the curtain phenomenon made some women feel uncomfortable, as they expected to socialise with other women yet the multifaceted curtain positioning interfered with this expectation. Indeed I similarly felt uncomfortable and bewildered at times as noted in my reflective field notes:

I really did not expect this! Curtains are fully closed/around most of the beds, why? It is making me feel quite uncomfortable as I am uncertain as to whether it would be agreeable to look behind them, mimic a knock or just speak through them. I have tried these various strategies to meet and speak with women and they seem to work which is interesting, as when I ask women how they would like the curtains mostly they wish to have them partially open. It is not clear to me what this is about, for example is it a desire for solitude, privacy or are they simply being unsociable. On a practical level I have no sense of the etiquette for dealing with this, from a theory perspective I need to check out the literature and mention it in supervision. It is absolutely fascinating but I don’t want to get distracted or side-tracked by this although I know everything is data and I will carry on noting things related to curtains, as it clearly influences the atmosphere of the ward and how women are seen (or not) by staff. .

Field note

The ways in which the curtains enabled access to women and their babies was rather complex and intriguing. Clearly the various meanings attached to
the curtain phenomenon seem to resonate with Burden’s (1998) work. On Thompson ward there was a sense that women’s privacy had been invaded when staff opened their curtains, but more often than not women would close them once the staff member had left the bed area. I noted a real tension here between staff and women in their attitudes towards curtain usage. Based upon a lack of clarity as to the purpose of the curtains each seemed to hold different views. One way of interpreting this tension and lack of understanding was in relation to knowing who owned the rights on curtain usage, the women or the staff. In defence of the staff some felt that they were acting in a woman’s best interest as the following comment highlights:

‘they don’t need them [curtains] round all day, its depressing we try to encourage women to be sociable and talk to others in their room, its good for them, its not nice being sat behind a curtain all day, would you like it? ’

Field note (midwife on Thompson ward)

I am unable to draw explicit conclusions in regard to curtain positioning, other than to say, like Burden (1998); signalling strategies were possibly occurring but were more focused upon privacy than help seeking. Compounded by staff reactions to the practice most notably on Thompson ward these subtle non-verbal communication signals were largely overlooked and marked a lack of understanding towards women’s (and their visitors’) need for privacy or quest for assistance as staff choose to open the curtains in arguably in a mishandled or non-negotiable way. A further hidden dimension I noted was linked to the presence of men and the analogy with a mixed sex ward, a feature not mentioned by Burden.

Noise

Without exception all the women I spoke to drew my attention to the fact that the curtains did not achieve noise reduction in that verbal privacy was impossible to attain. Conversations, televisions and the cry of babies were all overheard and obviously the curtains did not protect against such noises. Some women found noise levels in their room to be quite disruptive and an infringement of their own privacy and ability to rest in the context of peace
and quiet. This finding was particularly notable in a previous study I undertook (Wray 2002; 2006) and again on Smith ward where visiting was less controlled. As one woman noted to me in a hushed voice:

‘honestly…. he’s been here all day, he shouts and argues with her, it’s very annoying, is there no escaping this? I don’t even think he helps her with the baby, I’d be embarrassed if he was mine’

Field note

In discussions with women I noted repeatedly that they would preface examples of ‘people’ noise with ‘other’ people’s visitors, partners/fathers or babies, not their own. The notion of ‘othering’ seemed to reflect a one dimensional view of noise and disregard towards communal room sharing. That said, one woman did point out to me the possible dilemma facing women as to whether or not to intervene. For example she told me she had felt perplexed about hearing a woman in the room crying behind the screens and feeling uncertain if or how to help her. She felt empathy towards her as her baby cried frequently. She said; ‘I feel really sorry for her that baby never stops crying it must be hard work for the lass’. She disclosed that she took the decision to inform a staff member. In the light of having had no prior interaction with this particular (crying) woman, she conceded that under the circumstances this had been the best option. Clearly here lies a tension between achieving a balance in relation to privacy, peace and quiet with tranquillity being the ideal for many women (Walsh, 2004), certainly minimal noise and interruptions, and that of social interaction between women on the ward (Burden, 1998). Being able to help other women and feeling empathy towards them was a concern for some women and regardless of curtain positioning some women would respond directly to noise and things they heard from behind the curtains.

I picked up on the noise levels on each occasion that I observed on the wards. In fact I found the entire ward to be generally noisy. Most obviously during the day (early and late shifts) as a plethora of noises cropped up from the door bell, patient bells, babies crying, staff activities, talking, telephones
and visitors. In pointing out the noise levels on occasions to staff and asking how they coped with such a complex array of sound and volumes, the responses were either ‘what noise?’; ‘you don’t notice after awhile, you get used to it.. I think we are immune’ or ‘it’s just that one bell, that front door I really won’t get used to that one’; ‘the door bell is the one for me very annoying’.

At night time
Distinctly the atmosphere of the ward was different at night time, arguably this finding is not a unique feature as normal practice on any ward is to encourage peace and quiet so that women and their babies can rest and sleep. However, I was fortunate to be invited by the night staff on both wards into the handover sessions, I was struck by the motivation of staff to know more about labour ward activity than the women on the ward. Throughout both handovers the night staff explicitly sought out information connected to the workload of labour ward. Clearly redeployment of staff to labour ward was the norm on both wards, there was a sense of needing to ‘settle down’ the women as soon as possible to ensure that they were comfortable and that the women knew exactly what to do if they required any help from the night staff. A goal for the night staff that I met was to achieve peace and calm on the ward so that they could be available to help out on labour ward as and when required. Additionally, the staff believed strongly in women having a decent night’s sleep. To this end they made it clear to me that offers of baby-minding was normal practice at night. The context of baby-minding was that staff cared for a baby so that the mother could sleep. Typically the baby was brought in its cot to reside overnight in the staff office. This happened irrespective of whether a baby was breast or bottle fed. Staff negotiated with the mother what course of actions to take when the baby needed feeding. The staff made it very clear that ‘they did their own thing at night’ and in their view ‘did what was best for the mother not the hospital policy’ as they expressed strong beliefs to me that ‘achieving sleep was of paramount importance to new mums’ and it was considered to be a kind and thoughtful gesture from staff to care for their baby in order to ensure that some women could achieve a good nights sleep. As the following field note highlights:
The night staff very quickly assess the situation on the ward, moreover the entire maternity unit, they seem to be able to suss out how the night is going to be very quickly. It’s not too long before I see several women pushing their cots towards the office asking politely if we can mind the baby as they are shattered. The staff ask direct questions as to what they want to happen when the baby needs a feed and write down on scarps of paper the woman’s request, this is then attached to the baby’s cot for all to see. When I say to a midwife ‘I didn’t know this still happened’, she replies ‘Oh yeah I know what you mean, but to be honest these women are shattered and these wards are absolutely mayhem during the day, anyone with any common sense knows that sleep is vital, a basic need, without it how can you cope? Some of these women need a break and actually help with their baby there is nothing wrong with us caring for their baby, women have a choice, we respect their wishes’. It feels like a kind thing to do and I am struck by how quiet the ward becomes within a short time of the day staff leaving.  

Field note (Smith ward)

Similarly the ethos of enabling women to sleep is expressed on Thompson ward, as is the assessment of workload. Although in this following extract I am challenged once again as to my purpose for being on the ward, it is still the case that the principles of settling women down and baby minding are the same:

When handover is complete and the day staff leave, the staff quickly sort out who is doing what, someone pops round to labour ward to find out what’s going on there, another says she will go round the ward and check on the women, someone goes to make the drinks (for the women and ourselves) and I am just left sitting in the office. Then a midwife returns and asks me what am I planning to do all night, I clarify that I am not there as a practitioner but as a researcher that I am observing the ward and am seeking to understand the ward from the woman’s perspective. She asks me is it not boring just watching
what happens and that nothing much happens here at night as the number one priority is to encourage women to sleep a part of this is baby-minding and if I want to feed some babies then I am more than welcome, as the office will soon fill up with babies'. I am not troubled by this line of questioning in fact I have come to accept it here, but what I do find fascinating is how different they are with me compared with hospital 1, there I am accepted warmly onto the ward. It is very curious to me that it seems my presence here is threatening in some way, maybe it's the classic insider/outsider concepts at play.'

Field note (Thompson ward)

In summary it is significant that the atmosphere of the wards set the context for how these women experienced service provision and being postnatal in the first instance. As discussed, my observations exposed a tension between the ward as a work space against that of a place to receive postnatal care, thus a personal space to facilitate the celebration of birth. On reflection there was no escaping the fact that the atmosphere of the wards impacted upon midwives and women in different ways as did the meanings and expectations as to the purpose and function of the wards. The result of these tensions was contested views about the power of place and its impact upon celebration of birth.

**Reflexivity**

Before moving on to explore the impact of these contested views upon celebration I wish draw attention to an aspect of how the atmosphere of the wards impacted upon my role as a researcher. It was the case that as an observer I too experienced a range of tensions and emotions in response to being on the wards. Distinctly on Smith ward I was treated as an insider in that I was regarded as someone familiar and non-threatening to the staff, whereas on Thompson ward the concept of an outsider was borne out in how staff engaged with me. Interestingly I perceived on Thompson ward that staff were somewhat hostile towards me. On the hand these differences in how I was treated between the two wards were fascinating. I questioned whether
the same ethos transferred across to the women as the following exert from my field work diary suggests:

‘It is incredible how different that staff are with me, here [Thompson ward] I really do feel like a spare part, in that the staff just ignore me and get on with their jobs. When I arrived again today, they just looked at me and one said ‘it’s her again’ and they proceeded to enter the office and shut the door ready for handover. I sat in the reception area and the ward clerk asked if I needed anything, she was quite pleasant but I think she was embarrassed. It feels rather tense here, a bit strict, it reminds me of an old-fashioned styled way of running a ward, quite formal and the mangers are always popping round to see what’s going on. Some of the staff even look miserable and stern, maybe they are tired and overwhelmed by the workload, maybe stressed out! I ought not to assume but then again when I am on Smith ward I feel really welcome, comfortable and the staff always ask me if I need anything and they seem less stressed out. I keep wondering if how I feel is the same for the women? Are they picking up the same vibes? As I wander round the wards I have to confess that I feel more comfortable on Smith ward but how do I explain this? What’s that about? I need to take care not to get distracted with how the staff are with me, it’s how women feel that really matters although in terms of doing fieldwork I do think these feelings could be useful’

Field note

Clearly, it unfolded that staff held contrasting views in relation to my presence on the ward, it made some feel uncomfortable and on an individual basis they were expected to accept my reasons for being there. Their managers and leaders had given consent to my presence and whilst I sought to negotiate and re-negotiate each time I entered the ward with whoever was in charge of the ward staff developed their own views and ways of being with me. From my perspective this resonated with Kirkham’s (1992) experiences of observing in practice in that she was viewed at one point as ‘big brother’. She emphasises the importance of building relationships with those being
observed. At the same time it was here that I was able to draw upon Pearsall's (1965) continuum-based approach in that I could see the benefits of moving along a dynamic continuum one that allowed movement between being an active participant as well as being less active. In other words I sought to establish a relationship with staff which I felt was responsive and respectful to them.

Celebration of birth

Having presented something of the atmosphere of the wards I now turn to discuss specific issues in respect of celebration of birth and the connectedness with place. As outlined there existed numerous rules and rituals embedded within the wards, which played a role in creating the atmosphere of the wards and the order of things. The importance of celebration of birth cannot be overstated. Walsh (2004) found in his ethnographic study of a free-standing birth centre that notions of celebration were more conducive in a ‘home like’ environment. In this context Walsh was highlighting how both staff and women felt comfortable with families being in the birth unit. Moreover, the ‘feeling of home’ enabled staff to treat women as individuals and in a holistic manner.

Celebration of birth was of paramount importance to all the women that I met and yet there existed contested views as to how this could happen within the confines of a hospital ward. As Dykes (2005; 2006) noted when women are admitted to a postnatal ward they become separated from their family and friends. This leads onto the finding that central to the celebration of birth experience were the visiting arrangements targeted specifically at family and friends.

Visiting arrangements

The two wards approached visiting arrangements in polarised ways with strongly held views about their chosen arrangements. Smith ward claimed to have adopted what they termed a ‘family friendly’ approach whereas Thompson ward had taken a more traditional approach as follows:
Smith ward: 9am - 21.00 hrs for father/partner, 14.00hrs - 20.00hrs open visiting for all, the extra hour from 20.00hrs - 21.00hrs was designated for fathers/partner only.

Thompson ward: 14.00hrs - 16.00hrs and 18.00hrs - 20.00hrs open visiting for all, with an extra hour for fathers/partner 20.00hrs - 21.00hrs.

I was struck by these differences in visiting arrangements, given the identical provision of postnatal care. In discussions with staff it unfolded that irrespective of the visiting policy there was a consensus that visitors were a potential nuisance and to some extent could be burdensome. Nash (2002) reiterates this finding in her discursive paper and stresses the need for vigilance in reducing risks posed by visitors, staff and clients alike as they verge together in the shared space of the postnatal ward. Nash states that ‘visitors can have quite dramatic effects on our working environments and the women in our care’ (2002: 20). The following comment from one midwife (Smith ward) highlights a tension felt in regard to visitors:

‘Yeh, we do have long visiting hours and it can be awkward when you’re trying to do things, some men just lay on the bed and do nothing and you can’t help wondering why they bother really and it can get noisy so we have to say something because we have to think about other women, it can get on your nerves but we were told we had to do it this way and who are we?’

Field note

Curiously, staff on Thompson ward were expected to control and monitor visitors so that they adhered to the hospital policy by ensuring that both entry and exit within the designated timeframes occurred. Staff also policed the volume of visitors by walking around the ward to check only four visitors were present at each bed side. This was supplemented by staff calling an end to visiting by ringing a bell and going around the ward shouting ‘time.... time please’. In discussions with staff there existed a genuine belief that this visiting regime was highly beneficial to the wellbeing of mothers as it facilitated rest and recuperation. This finding confirms what Abbott and Payne (1992) found in that
staff can feel excessive visiting times and numbers of visitors can be problematic and interfere with patients’ wellbeing. In addition Abbott and Payne discovered that some staff believed that restricted and strictly enforced visiting had scope to enable adjustment to motherhood. In my findings exceptions to this premise were few as staff I met believed that the existence of these visiting rules were essentially sensible and accommodating as they benefited mother’s recovery.

In contrast, on Smith ward staff I met were more likely to express ambiguity about the benefits of their visiting hours while at the same time they felt less inclined to enforce a regime and thus be responsible for monitoring visitors. Their system for gaining access to the ward was highly monitored as the door remained locked at all times. However, as highlighted, the staff logistics invested in dealing with the locked doors consumed staff time and energy and provided a distraction, often a wasteful one. For the most part women were oblivious to this activity undertaken by staff as for women their own visitors took pride of place and were the most important ones on the ward. The dimension of ‘othering’ could be seen here as women considered other people’s visitors to be noisy and a nuisance. Whereas, they perceived their own to conduct themselves well and not interfering with the smooth running of the ward or other women’s recuperation. An interesting observation linked to visitors was the amount of gifts, flowers, cards, balloons and clothes that were brought to the ward, clearly symbols of celebration. Therefore, many of the bed areas were physically cluttered as the array of gifts became obstacles to the point that drawing the curtains and being able to move around the bed and cot was a physical challenge.

Overwhelmingly the culture of the ward was at odds with notions of celebration of birth with visiting arrangements determining how celebration could be experienced. This finding was polarised from the ways in which Walsh (2004) reported notions of celebration of birth within a birth centre, but also resonates with Dykes (2005) on the impact of structural constraints within postnatal ward. That said on Smith ward there was a sense that visiting arrangements went some way to harness a flexible and family friendly approach. This was in
contrast to Thompson ward where the visiting rules reflected a stricter approach, were abided by and the underpinning rationale for their existence hinged upon a genuine belief that women would benefit. Once again contested views existed between women and staff in relation to the meaning and purpose of visitors.

Feeling trapped
The notion of being postnatal (confined) translated for these women into feeling trapped, a mantra for women was ‘this was not what I was expecting’ supporting the argument that place mattered to them as found by others such as Singh and Newburn, 2000; Lock and Gibb (2003) and Bhavnani and Newburn (2010). Whereas for staff a different and yet connected perspective of feeling trapped emerged. This was in the format of what I have termed as hardship talks by staff as they strived to cope with the work volume and rapid turnover of women. The discovery that the ward made some women feel trapped corroborates with Baker et al’s (2005a) qualitative study of the impact of maternity care staff on women’s (n=24) experiences and feelings associated with childbirth. Although they only looked at immediate postpartum experience and the study was retrospective seeking women’s views some years after childbirth, they coined the phrase ‘I felt like I’d been in jail’. Women expressed similarly to me saying that at times the ward felt like a prison with its rules and rituals. It was not always homely and conducive to celebrating the miracle of life.

The relationship between celebration of birth whilst being on a hospital ward and that of the ward ethos and rules was a delicate one. For Tracey her experience of being on the ward resulted in her feeling that the ward not only made her feel trapped but spoilt her opportunity to celebrate the birth of her second child, she told me:

‘it’s awful in here, they made him [boyfriend] go home as soon as I came round here, I know it was late but there were no other women in here, he has to wait now till 2pm before he can come back, how can we enjoy our new baby together? I don’t think they [staff] understand how special this
is to us and why do I have to be alone for so long? I wanted to go after 6 hours anyhow and now I feel like our celebration of our baby has been ruined, I just want out of here’

In addition, Tanya felt that her husband and son had been excluded from getting to know their new baby not just because of the inflexible nature of the visiting hours but also staff attitudes towards her circumstances. Tanya experienced some chest pain after the birth and with a family history of Pulmonary Embolism was encouraged to stay in hospital until a CT (computerised tomography) scan could be performed. She had been told by staff that it was not safe to go home early and that her health was of some concern. Tanya told me that she was more than happy with this decision to have a diagnostic test, although she questioned whether being on the ward was the best place for her wellbeing:

‘But then they said it’s too risky really because if you were at home and anything happened you’d have the long journey to do before you got here. So obviously once they told me that I thought well I best stay really. But I was frustrated because after you saw me on the Saturday, I didn’t see anybody else until 7 o’clock or 8 o’clock the next morning. And I was on my own in a room, I was supposed to be in there for observation and to have all these things, you know, blood pressure tests and all this about needing to be near oxygen and suction things and nobody saw me until the next morning and I felt as if I could have been at home for all the observation I’ve had and also I could easily have had a clot and not been able to reach the buzzer and the first thing they would have known about it was when Matthew was crying for a feed and I was sort of collapsed out on the floor, that would have been the first thing they’d actually have known about it. So I was a bit annoyed about that really, that nobody even popped their heads round the door just to see if I was okay’. Tanya

For Tanya this situation made her feel trapped between ensuring her health was not at risk alongside the opportunity to celebrate the birth of her new son
with her family, most notably her husband and older son. Tanya having had a child before felt that her past experience of including her husband in celebrating the first few days of the babies life made her realise how special, intense and deeply personal this was to them. She felt that time was of essence in that this special time could not be regained. According to Castle et al (2008) support from fathers (in its broadest sense) can boost a new mother’s self esteem and confidence in their transition to parenting.

Sue’s partner was away fighting in Iraq and so was obviously unable to visit her and the baby. She felt alone in her celebration and envious of other women. Although she rationalised the situation by saying:

‘I had my camera phone, I keep sending photos, you know like emailing, so he gets all the pictures and I speak to him every couple of days anyway, so even though he’s not here I mean, the early days with a baby they won’t notice so much as when he’s older’

Sue

In addition, Sue further shared with me that she was going to put the real celebrations on hold for when her partner had leave and that their celebrations would be amazing. She concluded that it would be worth the wait and that she was not ‘going to get down about it’. As Wiggins et al (2004) have shown meeting social and psychosocial support needs after childbirth can enhance a mother’s health and wellbeing. For Sue it was her family and friends that she was drawing much support and consolation from.

Visitors appeared on the one hand to be a crucial feature of celebrating the birth and the congratulatory processes of the woman’s major achievement and also were an essential component of help and support. Visitors and family members seemed to be aware of how busy the wards were and I would hear people saying ‘I can do that we don’t need to bother the staff’ or ‘tell us what we can do while we are here’ and ‘do you need us to do anything before we go’. Visitors and family displayed caring attitudes in that they seemed to want to pamper the woman and were eager to give praise and
positive feedback about her achievement. There were many revelations of joy, happiness and laughter. Indeed I found visiting times to be an emotional and vibrant time whilst on the wards. Upon closer inspection particularly on Thompson ward, the restrictedness of visiting resulted in some women feeling that such a regime hindered their opportunity to celebrate with family on occasions. It was Tina who summed up the negative impact of a restricted visiting regime, when she told me that her son had arrived before the official visiting time to see her and the baby, he was desperate to see her. He was 17 years old and had to appear in court that afternoon when he knew (and so did she) that he would be convicted. Hence his attempt to see his mother was exceptional. Tina had no idea that he was outside, the staff did not consult with her and unable to convince the staff of his need to see his mother despite pleading with them he was not allowed onto the ward. She said to me that she was surprised that the staff opted not to consult with her. When I later met Tina in her own home to interview her, she expressed to me that this experience had been an emotional ordeal which made her feel quite angry towards the hospital and the staff in that they refused to allow her to see her son. She said:

‘This really did upset me and of course my son, it was not something we wanted to tell the staff, why should we? They could see he was distressed, anyway they didn’t even tell me he was trying to see me and had I not had the caesarean I would have gone outside to see him. They were really strict in there and to be honest it wasn’t right, most of the time we were on our own and we had to get on with it on our own too, he would not have interfered with anything’

**Tina**

**Good or bad mum? Doing it right**

It was particularly during the handover sessions that I first became aware of judgments of mothering in that staff would infer whether a woman was doing it right or not. Such judgments were sometimes rather superficial and at others very useful. However, it was the sub-text that accompanied these judgments that I found intriguing in other words notions of good or bad mothering. This observation aligned with Miller’s notions of doing good
mothering and the deeply embedded constructions of the ‘good mother’ held within contemporary society (2007: 340). A distinct feature of doing it right was observed in connection to baby care, feeding and handling their baby, in the past there were ‘tests’ that women had to perform on the postnatal ward, for example a bath demonstration. Women were expected to observe one, then do one under supervision and to put it simply how they performed informed decisions on going home as typically this was seen to demonstrate competence.

How women learn baby care and baby handling is situated under the banner of individualised care and one to one care. However, during my observations I saw few interactions with staff and women concerning baby care and baby handling. Staff attitudes on both wards rested upon women ‘opting in’ to seek help in these skills and yet there was also a tension in such help seeking by women. For example if a woman had had a prior child there was a sense that she had knowledge and skills thus was competent in baby care and handling. Interestingly women picked up on this and told me that from their perspective each child is different so it should not be assumed they would always be able to manage. Here the findings distinctly echoed theoretical analysis as presented by others (such as: Smith, 1999; Baker et al, 2005a; Miller, 2005; 2007) on deep-rooted and widely held assumptions that being a mother is innate and natural.

Furthermore the women said that they felt like novices in baby care at first and had expected more help from staff in adjusting to, and learning about baby care again. This assumption of their natural aptitude disappointed some women in that they had understood the purpose of being on the ward was to learn about and be supported in baby care. As noted by Wiggins et al (2000), McCourt (2006) and Castle et al (2008) support is vitally important to new mothers and being left to your own devices to coin the phrase by Bhavnani and Newburn (2010), whilst not ideal, became a reality for many women. As Teri told me:

‘If that was my first child it would have put me off for life if I had another baby. No matter how easy the birth was or anything the care
afterwards is absolutely appalling, it’s horrendous I had no contact with anybody apart from the cleaners coming in cleaning the floor and yourself and a woman came in from the hearing department to do his hearing test and she actually went and got me some toast. And it wasn’t her job or anything; she just said you look a bit weak.’

Teri

In discussions with women about how they were supported in learning about baby care a range of experiences unfolded. In Trish’s case she said that in relation to baby care she was left to get on with it and raised the issue of knowing staff beforehand:

So you’re saying you were left to get on with baby care? (JW)

‘Baby care, definitely yes and no, to be fair as well, maybe like keeping on top of my painkillers and they wouldn’t come and regularly check and you’d forget that you needed to keep taking them and it was a case of when they came to do the medication that’s when they you know perhaps and remembered it. Checked to see if I’d had enough painkillers and ‘cos I mean when you think I had enough to think about with having the babies, I wasn’t really on top of myself and how I was coping. But the one consolation was, there was a midwife who from about 28 weeks of my pregnancy I had to attend the antenatal assessment unit and I built up a friendship with the midwife there, Julie. And she was on a few nights while I was in and she really was the only person I felt, because I knew her beforehand, I felt as if she was taking a bit of a personal, you know interest in me and come and help and what have you. Compared to the other different midwives you see. So that helped in a way that I had a little friendship with one of them beforehand and she knew what I’d been through’

Trish

Trish had twins and felt that staff judged how she coped with them intermittently and this sought to affect her confidence during her time on the
ward. However, a rather different picture unfolded as I sat in handovers. There was lots of recognition by staff of women’s needs, unmet needs, how tired they were and the kind of things that could help them. As the following field note highlights:

There is genuine concern for women’s wellbeing, they talk about a woman suffering today as she did too much for herself yesterday and today is she paying for it, they seem to primarily blame the visitors as the midwife says ‘she had six million visitors yesterday and so she is shattered’. Pain tolerance is discussed and whether women are having analgesia or not, there is discussion about how coping with pain on the ward correlates with the woman’s performance in labour, there is real sense of knowing how women have been on labour ward, it’s like their whole story goes with them. There is much made of women who rest and women who don’t rest and how they advise them to rest but they don’t listen and ignore advice. It is often said we have a nice set of ladies on the ward. When names of babies are disclosed it causes heated debate amongst staff who make no reservation about judging such a choice in that they comment on how nice or ridiculous the name is and whether the parents have thought through the repercussions of such a name (this is only if they don’t like it). The names Pagen and Maverick stirs up much debate (over 5mins) and I am asked on my view and manage to not get embroiled

Field note

In summary these findings centred on power of place revolved around the interplay between the ways in which the ‘rules’ connected up with the ‘clinical gaze’ and care context on the wards. It became increasingly clear, similar to the findings of Lock and Gibb (2003) and Dykes (2005) that the atmosphere and culture of the wards impacted considerably upon women’s early postnatal experiences. Perhaps this should not be a surprise in view of the literature presented in connection to power of place. As Barclay et al (1997) reported, adjustment to motherhood can be impeded by a number of obstacles. In the current study it would appear that being on a hospital ward
served as an obstacle for some women. My findings additionally reveal discontentment amongst some staff with their ‘hardship talks’ about the state of postnatal care work. Moreover, as will be seen in the next chapter, the experience on the wards influenced women in different ways.
7. Theme (2)

Reclaiming the self: Insights into the self and getting back to normal

Introduction

In this chapter I present findings on reclaiming the self and how, along with insights into the self, women started to take ownership of their own wellbeing and transition to motherhood. What became clear was the concept of time as noted by McCourt (2009) in that a trajectory of recovery unfolded for these women as they experienced ‘self care’ and managed their own health and wellbeing as a way to *get back to normal* (whatever that is). In previous chapters I have already made reference to the medicalisation of childbirth and the existence of a prevailing dominant knowledge base that rests upon using a form of power and control (Oakley, 1986; Dykes, 2006). In thinking about how this doctrine translates into practice the theoretical ideas discussed earlier in the literature review (such as Oakley, 1979; Shildrick, 1997; Barry and Yuill, 2002; Kirkham, 2007) offered insights into the ways in which medical practitioners adopt behaviours and attach meanings that uphold the biomedical framework. My point in returning to this debate here is to reinforce how authoritative knowledge and power relationships between health care professionals and women (patients) remains embedded within contemporary postnatal care. This relationship phenomenon and dynamic ways in which it impacts upon mothers has been commented upon previously (such as Brown et al, 1997; Baker et al, 2005a; Dykes, 2005; 2006). Whilst ‘relationships’ of staff with women was not part of my research focus I found that the women could not disentangle their recovery journey from their experiences and encounters with staff.

It did become clear that the women involved in the current study gave themselves over to ‘medical power’ in view of the apparent benefits that ensue. All of the women were under the impression that entry to the ward for example would be beneficial to them, facilitate their recovery and enable their celebrations of birth. However, feelings of powerless and lack of control in relation to their own recovery and wellbeing emerged. Whilst this began in the first few days and spilled over into early weeks, as the months passed by
women sought ways to ‘re-claim the self’. This supports earlier findings from Alexander and Higgins (1993), Barclay et al, (1997) and McCourt (2006). Once formal care ceased the women proceeded to untangle and erase what had happened on the ward. For the most part women sanitised their experiences of the postnatal period using clichés such as ‘it wasn't that bad,’ ‘putting it behind me’ and ‘moving on’. Whilst this was a gradual process different for each woman it did allow them to move forward and take control of the self. It is not my intention to over-simplify this process; it was rather more complex and challenging for many of the women. As I hope to show motherhood held different meanings, it was/is hard work and yet is combined with periods of pure joy. Certainly the passage of time did help, however their journey began when they started to feel normal again.

**Getting back to normal**

In delving into the ways in which women sought to reclaim the self it is important to understand that constructs of normal unfolded during the provision of formal care giving. In searching for normality it was midwives’ engagement in body regulation processes that first made women aware of concepts of normal and the pursuit of it. This intense surveillance begins in pregnancy with antenatal care and increases during labour and birth, but is notably less so during the postnatal period (McCourt, 2006). I would argue this reflects the low position of postnatal care (Bondas-Salonen, 1998; Dykes, 2005; McCourt, 2009) and it's place within the hierarchy of childbirth described in figure 1 (p16). Importantly here the experience of intense surveillance creates dependency upon experts and expert knowledge (Brown et al, 1994; Nettleton, 1995). However, in the early weeks of becoming a mother, women both reassess their relationships with the experts and start to disengage from them. Miller (2005) argues this occurs in response to professional distancing whereby less attention and interest is directed towards women.

Whilst being postnatal includes surveillance of physiological recovery, the prime focus as experienced by the women in this study was the physical. In other words it was the performance of the ‘check’ as outlined by Baston
(2004) that women looked towards for confirmation of being normal. The emphasis on the physical endorses Shildrick’s (1997) theoretical ideas of the ‘broken body’ one that is in need of repair. However, beyond the reliance upon physical indicators women soon learnt initially to depend upon these ‘checks’ as a reliable source of contact with, and feedback from, a midwife about their bodies. As Trixy pointed out:

‘It was only really when she [midwife] checked you over that you could think about yourself and talk about how you were healing and getting sorted’

This time devoted to the mother as an individual, albeit brief, led women to consider their own health and wellbeing as being separate from their baby. Where it occurred engagement with midwives during this assessment process was highly valued. For Trish being checked over along with her twins was comforting especially in the early days:

‘I like it when they check us all over it’s reassuring, I know then we are all normal and that everything is ok. I have had to ask a couple of times but I know I am right to do that as we needed to be checked [on the ward] at home it’s been different as the midwives come less often but I still like to know everything is normal ’

Interestingly the ways in which women proceeded to rely upon and interpret these ‘checks’ varied considerably. Some women spoke of their concerns when these ‘checks’ were missed or performed in a brief manner during the postnatal period:

‘I don’t remember being checked over every day in their [ward]

Sandra

‘I hardly saw the staff, they would bob in and out now and again [room on the ward] their checking me over was hit and miss, in fact on the
At the same time a widespread premise held by staff was that irrespective of birth type, these women were for the most part healthy and normal (Ruchala and Halstead, 1994). Comments I frequently heard were ‘she has only had a baby’ and ‘she is not ill or sick’ or ‘it’s a baby she has had its all perfectly normal’. Yet, at the same time some staff felt frustrated at being unable to give the depth of care to all women such as ‘the checks’ and post-operative care to women who had had caesarean births. Staff had to prioritise in the face of their work volume. In so doing reliance was placed upon leaving women ‘to get on with it’. From my perspective it became apparent that a profound and intricate contradiction existed between the requirement of surveillance of women and that of normalising recovery. As the following field note reveals:

A midwife explains to me that they separate women by type of birth so those who have had caesarean births (c/s) are at one end of the ward and the normal’s are placed at the other end, she goes on to tell me that ‘it works as women compare like with like so that’s good although attitudes change from woman to woman’. If they have new patients they clump them together and fill rooms as this is easier for the staff to do everything by organising in this way. But I am also told that for ease this way of grouping the women makes their life easier apparently for them [staff] not only physically but that a sense of control can be achieved in how women respond and recover, the main thing seems to be that having a baby is natural as such a normal phenomenon they are not sick, they can care for themselves.

Field note (Smith ward)

In many ways this extract reveals insights into some practical issues but additionally it uncovers matriarchal attitudes held by some staff. Arguably these attitudes, whilst seemingly authoritarian, were promoted with good intention. I observed midwives and other staff disclosing how they knew what
was best for women in their care. They were the experts. As such there was frequent mention of the positive benefits for women if they adopted staff recommendations. A prime example of knowing what is best for women became apparent when staff discussed rest:

_Today it became clear to me that staff feel exacerbated when women do not listen or take up their advise on matters to do with recuperating the examples of women ignoring the need to rest featured much today, maybe its not that simple, women may well choose to be active and/or their tiredness could be more complex than simply choosing not to rest._

Field note

The process of the checks transferred to formal care at home. Once at home women experienced flexible visiting from the midwives, in other words visits that occurred in accordance with the rules (NMC, 2004). Mostly women had expected daily visits by the midwife to ensure things were normal. Some of the women spoke of being satisfied with their visits and felt that they affirmed normality:

_‘Oh yeah it’s nice, they come every day, yeah and at weekend she give me the weekend off, everything’s getting back to normal so it’s nice’._

Sarah

_‘It was fine, yeah it wasn’t a problem really, the midwives were great, they were there for you and your not normally sick are you?’_

Steph

Conversely:

_‘She [midwife] did not come everyday, even when she said she was coming she didn’t, we kept missing each other and to be honest I was hardly checked over once I got home’_  

Sally
Given that great emphasis was placed on reverting back to normal physical assessments were seen as being important. As a consequence two opposing positions emerged. Firstly some women felt a sense of disregard and/or disappointment in response to such minimal contact and unclear as to its rationale. Secondly a feeling of relief and contentment that they were left alone, to get on with it, was valued by some women. This finding highlights the enduring challenges and tensions at play in seeking to apply the principles and ideologies of individualised care as outlined in policy (NICE, 2006; Healthcare Commission, 2007; NCT, 2010). The obligation to stay in for the midwife could be perceived as restrictive and unnecessary. In this following quote Stacey explains how she felt towards staying in for the midwife:

“Well I don’t know, its been better for me at home and once I got home I was fine and my mum really helps me and I found having to stay in a real nuisance, you see the midwives come when they like which is really annoying, why do they do that? Anyway, for what they do when they are here it's hardly worth it, my mum knows what to do if anything is wrong’

Thus how women experienced assessments for normality by midwives varied and for some distorted views of being normal unfolded. All of the women believed that constructs of normal existed and that midwives could provide useful feedback on their progress. The notion of getting back to normal as implied by the regulatory definition for midwifery care (NMC, 2004) was misguided. Here again the findings reveal that women’s bodies were viewed pathologically by women themselves as well as by professionals, which resonates with feminist ideas in particular Shildrick (1997) and Oakley (1986). What I have found is evidence that a basis for judgements about motherhood, for both women and staff, commences with the physical checks and indicators. Additionally earlier research has highlighted the dominance of the bio-medical perspective embedded within reproductive health (Brown et al, 1994; 2005; Watt et al, 2005) and an over reliance on the physical (Nettleton, 1995; Baker et al, 2005a). In spite of this apparent narrow
perspective women experienced various turning points over and above the pursuit of a physical recovery. According to Trixy it is important not to feel under pressure in trying to get back to normal:

‘You just go your own way don’t you and I don’t think there’s any pressure there yeah I just go at my own pace really’.

Thus the quest for choice and individualised care about being ‘checked’ over or visited by a midwife at home rested more on chance than meaningful consultation with women. This said the doing and knowing what was best for women shaped midwives practice even though at times it could be perceived as one-dimensional.

Back to normal at six weeks?
Staying with the ways in which constructs of normal were experienced all of these women were offered a routine six week ‘check’ (with either their General Practitioner (GP) or at the hospital). Although evidence exists questioning the value of such a traditional approach, in terms of its timing and scope to assess maternal health (Bick et al, 2009), the six week check was the only option available to these women. Sam’s six week check had been organised as an out-patient at the hospital. She told me:

“They didn’t examine me or anything, they didn’t take me blood pressure, they didn’t you know look at me, all they did I saw the doctor who did the caesarean and all he did was talk me through the operation, he didn’t do anything else, he didn’t even look at my scar. I was quite disappointed actually, quite disappointed’

In support Toni, Tam and Sandra highlighted how they similarly felt disillusioned with their check ups:

“She [GP] wasn’t very good with me at all. She talked about contraception, I didn’t have a smear, and I didn’t have anything. She didn’t check my scar and she didn’t check my loss or anything’

Toni
'It just seemed really quick and not very much in depth at all, just kind of take your blood pressure, have a look at your tummy and that's it.'

Tam

'I thought because I'd had a caesarean that he'd look more closely, he didn't really look at the scar at all, he was just checking the womb had gone back down, so I expected him to check that and sort of ask me more about how that was and it wasn't until afterwards that I sort of thought he didn't really ask me anything at all. I expected it to be a bit more in depth and asking more questions of how I was feeling and things like that.'

Sandra

Whereas Tracey told me she had been looking forward to her check up. She believed that it had potential to confirm her body had returned to normal. In asking her about her six week check up, at the three month interview she said:

'No, I've not, I've not had my six week check yet. They keep putting it off; they said that you know the doctor's got to do it and had to have one in the surgery. I was supposed to go for a check on xxx and they rang me in the morning and said that they had overbooked so I couldn't come in. I'm actually having it on Thursday'.

In contrast some women simply did not attend such appointments. Either they actively delayed attendance ignored the whole issue as many told me they placed no value on having the six weeks check up. However, Shelia who said I think six weeks is too optimistic and you need a bit longer than that organised hers much later when she felt ready (three months) and felt satisfied with her choice and subsequent experience. Arguably an example of applied individualised care at play here and in many respects these positions demonstrated the ways in which women had started to take control over their own health and cared for themselves. This happened even though their decisions could be ‘at odds’ with the expectations and advice of professionals.
Caring for the self – taking ownership of their own health and well being

Through the passage of time notions of what has been described as self care (Troy and Dalgas-Pelish, 2003) prevailed. For the most part women learnt how to manage and cope with their own health as they sought to reclaim the self and adapt to motherhood. Without exception women told me that becoming a mother was disruptive to their sense of ‘self’. Whilst divergence amongst women unfolded in seeking to claim back the ‘self’ this concept has been noted by others notably Alexander and Higgins (1993), Brown et al, 1994, Lugina et al (2004) and Leahy Warren (2005). On the one hand the notion of getting back to normal was unrealistic as they were changed, physically, emotionally and as people. Therefore, health and wellbeing outcomes that mattered to these women were centred upon the ways in which they unpacked motherhood and sought ways to claim back their ‘self’.

For example in the early days women soon discovered that in the absence of visits from the midwife (they did not visit everyday as the women had expected) they assessed whether they were ‘fit and well’. It has been reported by several researchers (Morrell et al, 2000; Dowswell et al, 2001; Wiggins et al, 2004; Boulvain et al, 2004; Beake et al, 2005; Wray, 2006; Zadoroznyj, 2006) that community postnatal care from a midwife is popular with women. Skills in assessing their own wellbeing were particularly noted in their desire to go out, in other words to be out of the home rather than being confined inside. Being able to go out and about as soon as possible after leaving the hospital was an aspiration and goal for all the women. The notion of feeling cooped up transpired as a feature of being postnatal. Women were desperate to go out and about as their confinement impacted upon their personal freedoms. As Tanya said:

‘I was confined to the house quite a bit because I only had a car one day a week, because we sold our car when he was very little and I felt quite cooped up and a bit you know there wasn’t anybody around where I lived’.
Out and about
The sentiment of caring for the self through ‘getting out and about’ had much appeal and was echoed by many women.

‘It’s nice to get out and you know even if it’s only to go down the road to my mums, just to have a bit of company’
Sarah

In the early days and weeks women craved to go outdoors, to be able to drive, take walks and socialise as they had before the birth. Tanya in particular related her progress and sense of wellbeing to ‘being able to sort of get out and do things’. The following comments build on this idea of seizing the benefits of getting out and about:

‘As long as we get out for some fresh air, it’s more for the sake of the baby to get some fresh air, yes for fresh air and exercise really it’s not for the sake of going anywhere’
Steph

‘I feel more like I’ve got a bit more of a life back now that I’m getting out and about and doing more things’.
Tam

‘I think more because of the fact that I take him out for walks now. I walk more than I do in the car, so I think that’s probably helped me to recover faster and better than if I would have just sat in the house and not done anything’
Sue

Trixy had two children and found staying in most challenging, in fact we had an arrangement that I would text her before my arrival for her interviews in order that she could return to the house. As she made clear:

‘Yeah I am always out and about, you know that [laughed] and I take them to play groups and all that and yeah I am always out’.
As the weeks and months passed by getting out and about took on different meanings and contexts. The notion of being cooped up for some women connected up with their loss of independence. It was in talking to Toni for example that I became aware of not only the physical gains but the personal sense of triumph and control associated with being able to get out and about:

‘I feel more sort of energetic now that I can get out. I’ve been out with them [twins] and been across to the park, walked round the park with them, been walking up to the village’. 

Toni

Although Toni equally appreciated and took pleasure in going out without her babies, as she said ‘it’s nice to get out of the house and not be with the girls’. She, as did many of the women, supported such comments by telling me how they felt weird or guilty by going out without their baby/babies thus would constantly phone home every five minutes to check on their status.

Having some time out

In talking to women I found that on the whole there was a widely held desire to secure some ‘me time’ and ‘time out’ from the baby or babies. The personal gains were worth it especially once the perceptions of what others might think were handled. Although Sally, who had much help and support from her mum, took a pragmatic view:

‘You need a social life as well you need to go out, because I think you miss that really, cos sometimes I miss going out with my friends’

The women spoke about their efforts of balancing caring for the self alongside ‘me time’ and securing ‘time off’ from the baby. They would preface needing personal space by making clear that time with their baby was precious, special and unique. It was during this time that women felt compelled to be healthy not only for the sake of the baby but for themselves. These finding echo those of Alexander and Higgins (1987) regarding the ‘new self’ and self regulation processes that new parent’s embark upon in adjusting to their new roles. In support it was the realisation that being
healthy and feeling well by taking care of the self was part of the bigger picture. There is no doubting that the baby served as an incentive to achieve a good recovery for these mothers.

Another feature of getting out and about aligned to what was often termed ‘me time’. So in fact it might be that women craved some quiet time alone or some private time to consider the self in some way. Teri for instance recognised the need for ‘me time’ but found putting it into practice a real challenge:

‘I would love time to myself but like tonight for instance, if I do have time for myself I need to give it to the children because they’re suffering a bit, because I have to get them to bed at seven o’clock and they won’t let anybody else put them to bed’.

Where as Shirley viewed ‘me time’ in a rather different way and spoke more about having the odd break from it all:

‘It’s nice sometimes to get a break, it’s nice to feel that you don’t have to do it all the time, cos I went out with my sister and a friend the other night, so that was nice to sort of just go out and forget for an hour or so that you’ve got children’.

Intriguingly, I found that in the first few weeks, and months for some women, similar to Ribbens (1998) and Miller (2007) permission to consider the self was kept rather private and contained only to be shared with close family and/or friends who could be trusted. Leaving out their own mothers, sisters, female friends and in some cases their partner or husband, a fear lay in being found to be selfish, a non-devoted mother or thoughtless. This to me was a strong indication of the nature of privacy in relation to the subject of the self. Women made efforts to protect against public opinion concerning their desires to go out alone. As such there existed a real tension between the needs and wants of the self in having some personal space against being judged as selfish. Many of the women had invested much time and thought in
taking responsibility for their own wellbeing, such a tension added to their decision making.

To some extent, Ward and Mitchell (2004), in their qualitative focus group study of 49 mothers who had a child under the age of three, discovered elements of guilt correlated to ‘wanting their own time’ and being overly concerned as to ‘how others saw them’ (p17). Although this study was primarily focused on psychological aspects of motherhood, women were able to bring forward their experiences of early motherhood after a significant lapse of time. In doing so recalled, as did the women I met a sense of loss of the self particularly in terms of their social role. I will revisit the impact of ‘getting out and about’ and ‘me time’ in the following chapter as it both connects and endorses the issues of personal freedom and life beyond the baby.

Staying with taking ownership for the self and their own health it became clear in talking to the different women, that certain activities, events, insights and reflections created what I have labelled ‘turning points’ or as Barclay et al (1997) prefer ‘obstacles’. The notion of ‘turning points’ here represented individualised ways in which women took control of their lives in an instinctive and practical way.

**Turning points**

Over time women started to tell me stories about the extent to which they recognised a return to their ‘old self’. Feeling restored and having a sense of wellbeing were the main outcomes of their self surveillance and self care. It was during our conversations (interviews) that the women started to recognise how small but notable outcomes made a difference to their wellbeing. Sue in particular talked about having a ‘spring in her step’ and how much she was enjoying being a mother as she said:

> ‘How I was feeling after I had him to how I am now well I’m great, I’m just my normal self again a bit more of a spring in my step, which is quite surprising but no I feel great’.
For Sam, who found her time on the ward really awful and told me ‘I felt like I was dying at first’ discovered that her turning point was more to do with the passage of time, being left alone to manage and take control herself as she said:

‘I think it was just as time went by and things seemed to be getting a bit easier with the baby and stuff and like x [partner] went back to work and like being on my own, get yourself organised and stuff, you don’t feel mithered by people around you and things, you do what you want to do and you know how you want to do it. It’s all took longer than I thought. I mean like I say, I thought it’d only take a couple of weeks, but you know it took like, I think it took us to Christmas by the time I felt you know alright in myself’.

For Toni who had twins one of her turning points was learning to drive in order to support her long term independence:

‘It is just getting some time to myself as well, even though I’m not going out with my friends, only like once a week, I’ve started driving lessons again, so I’m going out like for an hour a week, one day a week for that and that’s getting me out so I’m getting out to do that which is quite good’.

An important factor for many was the support of family and friends (Morrell et al, 2000; Dowswell et al, 2001; Wiggins et al, 2004; Boulvain et al, 2004; Beake et al, 2005; Wray, 2006; Zadoroznyj, 2006) and learning from the experiences of others. Most significant to experiential learning was their mothers. I will return again to support but at this juncture a turning point of many was connected to listening to ones instincts and wise words of mothers. For Steph it was her realisation that theory and practice were polarised that enabled her to feel more in control and confident:

‘Well, I mean, I’ve never had a baby and when I looked at the books about babies, these people were obviously super mums because they
were telling you what to do. I don’t think it’s the way to tell people. I think its better when mum says, or gran’s used to do this or I used to do this with you when you were a baby. It’s far better than looking at a book which says, well by six months you’re supposed to be doing this and I just don’t think it works. I mean, I think they’ve got good advice in them but I don’t’ think well they never, ever say to you just go with your child’.

Sue brought attention to the fact that having feedback from her family was vital to every aspect of her recovery but moreover positive affirmations served to boost one’s confidence. When I first met her she talked at length about finding baby care hard work and uncertain about her skills and abilities to mother. Sue found being told by her family that she was a ‘natural’ comforting and this boosted her self belief:

‘I don’t know everything seems to come natural. I mean I know the night feeds can get tiring but I love it, just me and baby and I love playing with him and you know at first you would talk to other people about what to do, but when you’re with them 24/7 you just get used to it and playing and making them chuckle and things that make him laugh, I love it’.

Feeling and being confident was a symbolic turning point, similar to the findings of Barclay et al (1997). I found this was apparent not only for those who had given birth for the first time, but also for those had had a gap of several years since their previous births. As Shirley, Teri, and Tina often reminded me ‘each baby is different, ‘just because you have loads does not mean you’re expert or know what you’re doing’ and ‘it feels like my first all over’. As a first time mother Sam simply described her growing confidence as ‘getting more used to it’ and went on to say:

‘It was just like I was all anxious and worked up I suppose sometimes, because it’s all new to you isn’t it and you don’t know and you have to learn things as you go along with them [baby] don’t you? So I was
feeling a lot like that until I got into my own routine and everything, you know, me confidence. You know it’s a lot better now’.

‘I’m more or less back to normal yeah, think so but it’s when you’ve had the baby, it’s when you’re socialising and things like that, you lose that little bit don’t you, confidence, but it comes back’

Trixy

Embedded within feeling confident were two distinct outcomes that confirmed being in control, namely weight loss and being organised. Overwhelmingly body image was an absolute trepidation for all the women. Central to achieving this outcome was achieving weight loss in the first few weeks and months. This was not solely in terms of loosing weight gained during pregnancy but also a desire to attain the feel good factor and personal achievement. As Tam poignantly explained:

‘I feel better physically because I know I’ve lost weight too still not as much as I want to or back to what I was before, but certainly I feel like my body’s getting back to it more how it was. And I just feel like I’m enjoying things more now, not that I wasn’t before but just more relaxed I suppose and getting a bit more sleep as well makes all the difference’.

Conversely being organised brought similar feelings allied to control and self-gratification. On the one hand this further connected up with the quest to get a routine a comment frequently dispensed by family and friends. Although it has to be said getting a routine was interpreted by most of the women to include the baby but also related to themselves. In having had twins Trish felt overwhelmed at first and unable to sort herself out as she pointed out things improved:

‘As the weeks go by, I just find I’m getting into a bit of a routine in myself. I can get up and have a shower and get myself dressed whereas before I wasn’t really managing to. I was sorting these two
out first and getting the bottles done and what have you. But no I feel as if I’m getting, well coping better really’.

Even the most fundamental activities such as getting dressed brought a sense of wellbeing:

‘I just feel that I’m in a routine now and I don’t know I just feel the same as before I had him but with an extra child, I just feel completely fine and back into the swing of things really. Just you know, I didn’t even get dressed till past 12 a few months ago but now I’m just back to normal’.

   Teri

In addition, a profound effect in being organised gave meaning and purpose to the days. As well as opportunities to reflect on the priorities for the days ahead as the following comments suggest:

‘Even though I was tired and everything else, I made myself get up and go, it’s probably knocked me back into myself again and luckily with my mum helping if I wanted a night off or a couple of hours here and there. No I did, I feel better than I have done for years’.

   Sue

‘Yeah, I got an easy life really. Just need to organise it. That’s it with me really just because I’ve always had to be organised and in such a routine that you mean you could set your watch by me when I worked, you know’.

   Shirley

‘I’m still doing better that what I thought I was going to do. But there is the days when I’m too busy playing with her, or she won’t let you put her down because she wants to play with you and that. But I can’t see it’s any different to when I was at work but I think it’s getting there slowly, getting used to it’.

   Steph
It can be seen that these various outcomes embedded within the turning points; gaining confidence, becoming organised, support and positive feedback from family and friends enabled a greater sense of control. However, at this juncture a factor that played a significant role in women’s lives and thus interfered with their progress on managing the self was tiredness and fatigue.

Feeling a bit worn out
Tiredness and fatigue are known to be prevalent and of major concern during the postpartum period. As such they have the capacity adversely to affect women’s health and interfere with adaptation to motherhood (Bick and MacArthur, 1995; Troy and Dalgas-Pelish, 2003). Postnatal fatigue and tiredness can exist beyond the traditional six week period (Bick and MacArthur, 1995) and it is a symptom which has been associated with maternal depression (Taylor and Johnson, 2008). This said, McQueen and Mander (2003) contend that both the terms tiredness and fatigue are subjective and difficult to define. In response they undertook a literature review seeking to obtain insights into related concepts and their impact in the postnatal period. One of their conclusions was ‘there is a lack of authoritative research on postnatal tiredness and fatigue’ (2003: 464). They also highlight how little is known about unresolved tiredness and/or fatigue and draw attention to the complexities of coupling the terms in relation to adaptation to motherhood. Moreover they propose that midwives can play a pivotal support role alongside educational approaches based on realistic expectations about life after birth. Interestingly, Troy and Dalgas-Pelish (2003) developed a comparative study to test the effectiveness of a self care intervention (called Tiredness Management Guide TMG) that resembled an educational approach only to find no statistical difference in fatigue at 2 and 6 weeks postpartum between the experimental and control group. However, they did highlight the pervasiveness of postnatal fatigue across the 6 weeks postpartum period and noted differences between day time and night time fatigue. Troy and Dalgas-Pelish advocate raising awareness of its existence and reach but also uphold self care in assessing and managing fatigue for newly delivered mothers.
How tiredness and fatigue affected women and how they sought ways to manage it fascinated me. In fact it was mostly referred to as ‘feeling a bit worn out’ and was a dimension that all women had expected, arguably more so in the early days as a consequence of their ward encounters. In this context sleep and rest were regarded as an absolute bonus. For the most part women were happy to settle for a sense of feeling refreshed and calm. In relation to feeling a bit worn out Teri and Stacey explained that their pre-existing medical conditions affected their energy levels ordinarily. They both had incredible self awareness and insights into their own health as such had made plans to ensure good support in the early weeks. This strategy adopted by Teri and Stacey resonates with Troy and Dalgas-Pelish (2003) recommendations for raising awareness and promoting self care.

In contrast other women like Toni (and her mother) found caring for the twins very tiring:

‘I’m feeling okay; I just have the odd days when I get dead tired, just dead tiring. I know I’m still living with my mum but we take it in turns for a lie down when the girls are asleep, because I don’t know. I just get tired during the day, so I can’t cope unless I go to bed. But I’m always tired anyway’.

Other women recounted their tiredness in relation to energy levels and in connection to their babies sleep pattern as the following comments highlight:

‘I just couldn’t I just didn’t have the energy. I didn’t want to do anything, I didn’t want to go anywhere, didn’t really want to see anybody. Just couldn’t be bothered but now I’m just back to normal’.

Sally

‘I’m getting tired again whereas at first I was alright, but because he’s getting up more now, so you know to get him sorted out’.

Trixie
‘I actually feel great, just very tired cos I need a lot of sleep, which obviously I’m not getting as much, but erm, she’s great, she only gets up once during the night, so I get quite a lot of sleep from 12 o’clock’.

Steph

Clearly there are negative effects of postnatal fatigue such as postnatal mental health issues (Bick and MacArthur, 1995; Bick et al, 2009) and women were aware of this link. Overall women talked about tiredness as a normal feature rather than something to be unduly concerned about (Smith, 1999; McCourt, 2006; Miller, 2007). Interestingly, with the benefit of hindsight many wished they had capitalised on the opportunities to catch up on sleep. On occasions women were contradictory about the conclusions they drew from looking back and reflecting on the early days. Sheila raised some interesting points in reflecting back and thinking about what she would advise pregnant women:

‘Stay in hospital, but I know so many people just aren’t into that at all. Definitely stay in even if it’s only for a night or two nights. Fob off anybody that you can get rid of visiting wise. Sleep when the baby sleeps if you can manage to do that and get as many people doing housework so that you don’t have to do it and eat well, try and eat well’.

In summary these women were able to voice aspects of their adaptation to motherhood in the context of talking to me, as a researcher and mother. Like Barclay et al (1997) and Miller (2005) I found women were able to challenge the constructions of normal transition to motherhood. Although it was through the process of participating in this research study that women mainly voiced their experiences. In doing so they began to recognise the self, seek ways to reclaim the self and engaged in reflexivity (Ribbens, 1998). On the one hand my findings support others such as Smith (1999), McCourt (2006) and Miller (2005) that for these women the impact of motherhood was huge, daunting and hard work. However, at the same time it was also pleasurable, rewarding and worth it. Some of the women did feel unprepared and expectations were
in part informed by myths and ideologies about motherhood. It is noteworthy that Choi et al (2005) in their findings from interviews of 24 mothers as part of a larger study on postnatal depression, found the realities of unprepared motherhood led to feelings of inadequacy.

Nevertheless the women I met appeared resilient and soon recognised the realities of motherhood. Whilst they grappled with the profound changes to their bodies and lives, over time the women began to take responsibility and worked out the outcomes that mattered to them. Thus it became apparent that the notion of timeboundness and a recovery trajectory aligned to the mothers’ realities (McCourt, 2009). This aspect of reclaiming the self was helped by ‘self surveillance’ and mirrors what Alexander and Higgins (1993) refer to as normative orientation and Miller’s (2005) reference to ‘self-governance’. But becoming a mother also forced a re-evaluation of life as most of the women I met reflected on their priorities and ambitions as outcomes that mattered to them. I will re-visit these concepts in the forthcoming chapter but for now wish to emphasise how these women became experts on their own wellbeing and recovery. As Shirley articulated:

‘It does take a lot longer than what they say, because they say oh you’re back on your feet in you know so many days and you’re back to normal. But it’s not as simple as that’.
8. Theme (3)
Bouncing back? Unpacking health and wellbeing

‘I just bounced back’

Introduction
In the previous chapters I have described the impact of place upon women’s recovery and how women sought ways to claim back the self. Embedded within these experiences and women’s stories has been an array of coping strategies to deal with the reality of early mothering (Barclay et al, 1997; Miller, 2006). Whilst I have observed and heard diversity in talking to these women, it did not unfold that the birth experience and the early days afterwards became a ‘distant memory’. I detected no evidence of memory decay (Waldenström, 2004). The opposite transpired as they defined and re-defined their recovery; as they went along their needs and wants changed over time. In listening closely to women, there was a sense of relief at being able to leave behind the early days and weeks after birth. At a glance based on their experiences women had endured postnatal care and for the most part the reality had not matched their expectations (Singh and Newburn, 2000; Baker et al, 2005a; Bhavnani and Newburn, 2010). As established already a relationship existed between the outcomes getting back to normal and feeling like my old self again. This was an aspiration and goal for all women. However, in talking to women it became apparent that it was not easy for them to untangle their own health and wellbeing from that of their infants (Leahy-Warren, 2005). This resonates with Albers’ (2000: 55) comment that: ‘the health of infants is so intertwined with the health and functional status of their mothers’. Although during the process of undertaking the three interviews with the women, separation from being seen as two (mother and baby) (Ellberg, 2008) and permission to focus upon the self did happen which became easier for women over time.

It has to be said that the powerful messages surrounding motherhood and mothering impacted upon these women in different ways. For example in a short space of time it became apparent to these women that motherhood is
about performance and highly connected to moral discourses (Barclay et al, 1997; Smith, 1999; Miller, 2005; Baker et al, 2005a). In response all women wanted to do their best and were content at times to be viewed as ‘good enough’. They all pointed out that becoming a mother was a major life event one that filled them with feelings of deep happiness and love for their baby. At different points in time they experienced a sense of personal pride and fulfilment. Conversely some felt vulnerable, overwhelmed and uncertain about their skills and abilities to mother. Women talked much about getting used to it (mothering) following the ‘shock of it all’. A recovery trajectory did exist but it was one with huge variations and was individualised thus the notion of ‘bouncing back’ had a several connotations. This was reflected in the outcomes that mattered to each woman therefore, in this chapter I aim to unpack what these were. I will also present findings on why some women chose to participate in this study in support of the methodological discussions presented earlier in the thesis.

Unpacking ‘bouncing back’
The notion of ‘bouncing back’ was a common term used by most women at different intervals. It was used by women in a flippant manner to explain how a woman was feeling in relation to time and place (in the moment). Conversely, it was used to explain a perception of a ‘must do’ in other words an expectation of all women. Broadly speaking the term symbolised recovery, adaptation to motherhood and responsibility for the self (self care). For some the notion of bouncing back was an immediate response associated with the euphoria of birth as Sheila explained:

‘I just feel amazing, nothing like last time. I feel great and am really enjoying it, I am over the birth and all that, and it’s been so quick for me to feel like this its great. I am just over it [birth] and getting on with things’.

On the one hand Sheila related her initial assessment of wellbeing to how she felt physically. It was her second child and she had expected a long and arduous birth, she had prepared for the worst, but to her delight this did not
happen. She was elated about her birth and whilst she intended to stay only a few hours postnataially, chose to stay for two days. Not unlike other women at three and seven months post birth Sheila had altered her views and attached different interpretations to the notion of a speedy ‘bounce back’.

Getting there
Through the passage of time life with, and beyond the baby, became all consuming as women began to work out for themselves the realities of motherhood and what it meant for them as individuals. The notion of ‘working it out’ was a feature of Rogan et al’s (1997) qualitative grounded theory analysis of experiences of 55 first time mothers in Australia. In this study data were obtained from focus groups (9) conducted with first time mothers during their attendance at childhood centres, between two and 26 weeks postpartum. Whilst these first time mothers participated in one focus group each i.e. data collected at one point in time Rogan et al did uncover a process of change in becoming a mother. Overall their data reveal how unready women were for the impact of birth and experience of motherhood upon their lives. As Rogan at et al state and I would agree:

‘Realising the impact a baby has on one’s life, the enormous and unrelenting responsibility and considerable learning required, the women in this study embarked upon a process of working it out’ (1997: 883)

Central to Rogan et al’s study was role attainment and the challenge of adapting to change in early motherhood by first time mothers. Arguably the impact of becoming a mother for the first time can be overwhelming. Indeed, over forty years ago Oakley (1980) highlighted the fact that easy adaptation to first time motherhood is unusual and others such as Brown et al (1994), Barclay et al (1997), Bondas-Salonen (1998), McCourt (2006) and Miller (2006) have since confirmed this to be the case. However, what I discovered was that all women engaged in the process of ‘working it out’, and took place along a continuum, and this applied whether it was a first or subsequent child. At times the continuum of working it out was a shared process with partners, friends and family. I will return to Rogan et al’s study in the discussion chapter.
It is worth pointing out that for some at six to seven months the quest to ‘bounce back’ remained an attainable goal but for the most part many were ‘getting there’. As Tina pointed out as an experienced ‘older mum’ (her words) she was totally unprepared for how demanding and disruptive her fifth baby would be. With her other four births she had recovered ‘really quickly’. Whereas this time her recovery and sense of wellbeing was impeded due to the fact she had her first caesarean birth. In her view this birth was ‘major surgery’ and as such the whole experience had overwhelmed her. For example her scar remained tender at 7 months and along with her ‘quite demanding’ baby she felt:

‘A bit fed up, a bit angry you know sometimes the other kids cop for it but then like I say I am sorry and say I’m tired and what have you. The other kids are great and actually it’s not that bad. Yeah I’ve had four children and I can’t remember how I did it’.

At a glance much of what Tina talked about in terms of her health was understandable. Moreover, her story endorses research that shows health problems after birth are very common, persist over time and tend to go unrecognised (MacArthur et al, 1991; Albers, 2000; Bick et al, 2009). Although she had sought medical help but preferred not to take pills, her GP had prescribed antibiotics and reluctantly she had taken them. Tina expressed that she could take good care of herself, she was a determined person and said it would take her 12 months: ‘it’s going to take me a lot longer this time round’. An aspect that did perplex her was learning that celebrities actually preferred to have sections (caesarean births). Victoria Beckham had recently had a baby according to Tina newspapers and magazines reported that she had opted for a section, Tina said:

‘I mean how can anyone opt to have a section, I’d much rather have a normal delivery, after it’s all quicker and fine’.

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I received plenty of comments about celebrity mothers and the media frenzy directed in particular at Victoria Beckham. On one level some women talked about how media portrayals of motherhood were disconnected from the *real world* and *reality*. In other words these women revealed different understandings from the representations and images that depicted motherhood as wholly positive and easy (Ball, 1989; Barclay and Lloyd 1996; Miller, 2006). Pointing out that the sheer thought that ordinary women could bounce back and look glamorous within weeks was a ridiculous notion and at odds with the notion that women are capable of perfect mothering (Nelson, 2003; Ward and Mitchell, 2004). Ironically, such talk often extended into issues about body image and weight loss. Critically there is a link here in terms of the impact of media portrayals on the outcomes that unfolded within the earlier findings presented within ‘turning points’ alongside the grounded social norms and cultural and professional rhetoric attached to motherhood that it is innate and naturally occurs (Ruchla and Halstead, 1994). Tam for example best illustrated the competing tensions and dominant representations in her words ‘pressures’ for looking good, feeling good and being a good mother whilst attempting to ignore the external pressures ‘out there’ such as the media, when she commented:

‘Yeh, the media probably does play a role, not too much for me because I am not that sort of person to read Hello and things like that, but thinking sort of Victoria Beckham has just had another baby, looking glamorous again however many weeks after giving birth, so I think this sort of thing could be a pressure. But I think its more pressure I’m putting on myself than anything else, cos yeh I feel quite self conscious about the way my body looks and things like that. I think it’s all different for different people as well, like my sister in law who had a baby a month after me, well she was back into the clothes she was wearing before pregnancy and I feel envious of that, I thought what’s wrong with me? Why is it taking so long but you have to give yourself time and sort of accept it’s going to take longer than you might have thought it was going to. It’s more pressure on myself, yeh it’s nine months what a lot of people are saying to me, if you
come back in 9 months I will be happier about my body’ [then she laughs a lot].

Looking good

Central to looking good and feeling good was body image, not unconnected from feeling confident as discussed within the section on ‘turning points’ (page 104). In truth women talked consistently about the need to loose weight and get in shape. Almost immediately after birth, most women embarked on a mission to loose the weight. Various dieting regimes such as Weight Watchers and Atkins were mentioned as the way to success. Toni who had twins was ‘fed up of feeling enormous’ so was delighted when her mother joined Weight watchers with her. She was passionate about getting her figure back, to look good and ‘get into her jeans again’. Combined with gentle exercise each day as mentioned within the previous chapter within the context of getting ‘out and about’ some women formed a regime to improve their image in the early weeks. Steph, a first time mother, talked about her image and weight in ambiguous ways when she commented:

Well I’ve always been on and off diets and I am feeling better now that I am starting to lose it because it gets me down. You just look better when you are thinner, so if I get some weight shifted and get to the gym and then I’ll feel a bit better’

‘I mean sometimes I just can’t be bothered and I think well we are only here for a short time. I’ll probably get there and it won’t make any difference’

Interestingly, discontentment with body image was most profound at the final interview. Given that Christmas fell in between our contacts expectations ran high that maximum weight loss would be achieved. Being able to wear certain pieces of clothing and outfits over the festive period had been a goal for many. Success was associated with feeling good and satisfied versus a continued discontentment about body image. On both counts women compared themselves to other mothers. Either they chose random mothers, often high
profile celebrities, or they picked out mothers who were family and friends. Sally for example described how on a trip to a local shopping centre she compared her figure and appearance to almost every passing woman saying:

‘Every young mum I saw pushing their baby were really thin and you think gosh she’s got her figure back and you’re still trying’

Others commented:

‘Well I would like to find my tummy back in place and shape. I still feel like I’m four months pregnant and that doesn’t please me’. Stacey

‘I would have preferred to have been able to be one of these women who lose weight quickly, get up and go out, put their makeup on and their hair’s done every weekend. But it’s not important, as long as she’s [baby] healthy’ Sandra

It was evident that some women did feel under pressure to look good by ridding themselves of the pregnancy look thus embarking on weight loss in order to feel good and wear ‘nice’ clothes. I would argue this finding supports feminist theory that has drawn attention to the ‘power of cultural presentations that depict positive images only’ (Choi et al, 2005). In response women very soon recognised and appreciated it when they felt good about themselves. Alternatively for Tracey looking good and weight loss were not her priority as she said: ‘I didn’t really put on any weight when I was pregnant and so not to lose any, I feel fine in myself, you know I feel fine’. She was much more focused upon her feelings and desires for a more meaningful purpose in her life in addition to motherhood. These outcomes mirror claims that the demands of motherhood disrupt personal goals and aspirations and life plans change (Alexander and Higgins, 1993; Smith, 1999; Miller 2006).
Feeling good
In the early days and weeks regardless of past experiences of motherhood, type of birth and personal circumstances, nearly all women experienced emotional ‘up’s and downs’ (Barclay et al 1997; Morse et al, 2004; Maher and Souter, 2006; Forster et al, 2008). As already discussed there was a connection between feeling good, looking good and being a good mother. However, I need to emphasise that body image and weight loss influenced emotional wellbeing thus a sense of ‘feeling good’. The synergy between these two factors was strong, although I would argue in ‘reclaiming the self’ many women took control over their body image and looking good in pragmatic ways with an absolute passion. Whereas feeling good brought with it emotions and responses that some women felt less able to control for, they just happened. There was a heightened awareness of emotional wellbeing as women expressed their feelings over the course of our three conversations.

Mothering for some could be mundane and boring, as well as frustrating and unpredictable. This finding supports previous research that has revealed feelings of misery (Barclay and Lloyd, 1996), suffering and loneliness as women seek to deal with the overwhelming nature of ‘mothering’ (Barclay et al, 1997; Rogan et al, 1997; Bonda-Salonen, 1998; Miller, 2006; 2007; Ellberg, 2010). Women did question their responses to mothering and their blend of feelings but what I noticed was the changing nature of such dialogue. For example, Tracey tentatively discussed as the months passed her changing feelings and desire for a more meaningful purpose in her life in addition to motherhood, as the following comment highlights:

‘Have you ever seen that film Groundhog Day? I feel like that. I feel like every day is the same and I mean I don’t dislike it, but I just feel bored, very bored. Extremely bored to be honest I don’t know it’s not that I don’t enjoy the baby, but its, I don’t know I can’t wait to get back to work’.

Tracey
Here Tracey highlights a desire to return to work as a feature of her emotional wellbeing and desire to enhance her sense of feeling good at seven months. What Tracey also disclosed was much about her feelings regarding the fact that she had her first child aged 16yrs. Her mother had played a ‘massive’ role, so much so that she felt as if this current baby was really her first. She spoke initially about being totally ‘shocked’ at the amount of energy and planning in caring for a baby. Whilst her circumstances had changed in that she was now living with her partner (father of this child) their relationship had been affected in a negative way by the arrival of this baby. She craved adult company and the world of work as a means to enhance her self-identity and image.

Sarah told me that staying at home was challenging for her emotionally as:

‘You don’t really get to see a lot of people, you know adults and I like to be around talking to them and it’s a bit of a break for me’

Other women also experienced periods of loneliness. Sam, a first time mother, talked much about missing her job and how being at home with her baby was quite lonely in the early months:

‘At first I found it very lonely you see, you know, because everybody else is working and you’re here on your own with the baby. I found it very lonely at first but not so bad now’.

Women craved a sense of meaning and purpose in their lives as mothers and in their other roles as women. In support Choi et al (2005: 168) have argued that ‘it is hardly surprising that some degree of unhappiness and negative feelings occur’ as women grapple with their expectations and realities of motherhood. The ideologies and myths of motherhood are influential and powerful, so being faced with the realities leads women to experience conflicts (Brown et al, 1994; Choi et al, 2005; Miller 2005). An influential factor that women highlighted as being helpful in feeling good was their support from and relationships with the people closest to them.
Aspirations and concerns surrounding the world of work cropped up more towards seven months as women mapped out their goals and plans for the future, an issue I will return to.

Another issue was energy levels associated with feeling good, whilst not detached from tiredness and fatigue was portrayed as being different in many ways. Shirley in asking how she was feeling at three months with her fourth child told me:

‘Fed up some days, but I think that’s the weather as well isn’t it, makes you feel a bit, especially when you feel oh some days it’s all you can do to get organised. I wouldn’t say depressed but you know I’m getting there. The baby’s great, she’s dead good, she sleeps right through. I’m just saying that, she was awake the other night, all night, and when you just want to lie there and I’m thinking she never even gets me up and I’m moaning because of one night’

By seven months there was little talk about professionals and accessing professionals for help. Some women indicated unease towards being labelled if they declared negative feelings to professionals e.g. health visitors. Like Ward and Mitchell (2004) who conducted focus groups with 49 mothers who attended support groups, some women were unable to talk about their feelings for fear of being judged negatively. Both Tanya and Trixy disclosed that they had shared some concerns in relation to their wellbeing with their GP’s and health visitors over the past few months. In seeking professional help and guidance regarding ongoing physical discomforts they both summed up their experiences as being ‘fobbed off’. Their interpretation was that health concerns were trivial to professionals and that self care prevailed as Tanya noted:

‘I guess I just have to get on with it and take pain killers when I need to, they’re probably right there is nothing wrong’.
These encounters were clearly disappointing and exposed how some women perceived the ways in which maternal morbidity can be overlooked or discounted by professionals. This, adds further credence to research that has revealed the existence women’s health problems well beyond six weeks postpartum (e.g. Albers, 2000) but moreover the unacknowledged and invisible nature of health problems beyond official postpartum period (McArthur et al, 1991; Glazener et al, 1995; Bick et al, 2009). In contrast though Maher and Souter (2006) found in their research what women do identify health issues (minor) but avoid addressing them as they concentrate more on adjusting to motherhood. Despite the fact that this sample of first time mothers (n=32) were accessing postnatal groups on a regular basis, help seeking concerning their own health was limited.

What I found was most women did not dwell on such experiences and would sanitise these happenings by reiterating the benefits of personal growth and self care as ways to handle their own welfare. This form of reasoning was cited frequently as time passed by in relation to how they felt about their physical aspects of recovery.

I have to point out, as did the women, by seven months the ‘up’s and ‘downs’ or as some women called them ‘good and bad days’ occurred less often. Finally in relation to emotional wellbeing, support, however this was described and experienced, was invaluable to women. As I will go onto discuss, however support of an interfering nature was unwelcome and annoying to many women.

Support
It has been well documented that support enables transition to motherhood and improves postpartum health (Ball, 1994; RCM, 2000a, 2000b; Dowswell et al, 2001; Nelson, 2003; Boulvain et al, 2004; Dykes, 2006; McCourt, 2006; Zadoroznyj, 2006). In particular Oakley (1986, 1992) and Wiggins et al (2004) have contributed greatly to providing much evidence to show lasting benefits of social support to mothers’ health. In 2000 Wiggins noted that:
‘In the postnatal period many mothers experience great stress as they struggle to adjust to the extraordinary life changes they may be experiencing’ (2000: 12)

I found that all the women had access to support and built up a ‘scaffolding’ of support over time that best fitted their circumstances. In listening to women there was no doubt that their support mechanisms, albeit a partner, family or friends naturally unfolded and were greatly valued. This mirrors epidemiological evidence supported by Wiggins et al (2004: 2) that ‘people’s naturally occurring social support is health promoting’. Interestingly, in the sampling frame (see appendix 5), in considering the item of support I realise that I adopted a conventional perspective in relating it to marital status. Having reflected upon this I wish to point out that my intention had always been to understand support from the woman’s perspective.

All women talked about support in far reaching ways, for example some gained much from practical offers of help that concerned household chores such as dealing with laundry and cleaning. For others it rested more upon people just being there, making it known that they were available if and when required. This finding compares favourably to Bondas-Salonen’s (1998) longitudinal study where she exposes the long term nature of support from families and other mothers. As I have previously indicated women in my study placed value upon maternal mothers, sisters and female friends in enabling recovery, in relation to support this involvement was central for some women:

‘What’s helped me is more or less my family they have been quite supportive and my sisters have been like great’  

Trixy

‘My mum has been there for me, she always is and couldn’t do it without her’  

Sarah
‘My sister she helps me out, so that’s quite nice because she really helps me out’

Tanya

There was little talk of support from professionals. In part I would argue this relates to the fact that women became aware of professional disengagement from them as individuals. How they had understood contacts with midwives revolved around the baby and focused more on their physical wellbeing, than a source of support. Thus reliance fell to family and friends for their support needs which included practical help, advice, information and feedback as the following comments by Tracey and Trixy highlight:

‘I hadn’t realised this time how much more work it was going to be, sometimes I think all there is, is just washing, ironing, more washing and ironing and my whole life revolves around laundry you know, its unbelievable but she helps me out quite a lot’

Tanya

‘But my partner as well has supported me through it all everything. He’s is understanding and like helps me with the kids in the evenings’.

Trixy

Women talked about their partner’s support alongside how much the baby had impacted upon them as an individual and in terms of their relationship. Comparisons between their lives and that of their partner were made, this covered workload issues, loss of freedoms and levels of tiredness (Castle, et al 2008). In contrast Choi et al (2005) revealed that for some women feelings of resentment were directed towards partners due to the impact of a baby and changes in women’s lives. In contrast Sue and her husband had made plans that he would be a ‘house husband’ for the next four years. In speaking about their plan Sue articulated her concern that:

‘I don’t want him to feel trapped, you know’
She also jokingly said she felt ‘jealous’ that he got to stay home with the children as for her maternity leave had been like an extended holiday. At seven months she was close to returning to work and about to put their plan into action.

In talking to other women partner support appeared to fall into two distinct categories by the descriptions offered. Either they were amazing, helpful, ‘hands on’ and very supportive or were described as being distant, less involved, more ‘hands off’. Interestingly, it did change and many moved across the spectrum. Sue had said at first her mother played a bigger role in supporting her as her partner was ‘nervous at first’ but overtime this changed. They both had a lot to learn about baby care, their baby as a person and themselves as she said:

‘It’s a lot to take in and we were stressed a bit at first, he thought mum was taking over but yeh know she wasn’t and now it’s not like that’.

For Trish, who had found the impact of caring for twins overwhelming at first and when her husband returned to work after a short period of paternity leave felt indifferent about her mother-in-law ‘electing herself’ to help her.

‘I don’t have to deal with my mother in law. I didn’t tell you that I think for the first month or so my mother in law must have come every day, just to help me, I didn’t know what to do at first, but now its okay’

Trish went on to disclose that she did not want to appear ungrateful, she had needed help but the help provided did match what she wanted. In her view this was interference and in many ways it reflected her prior relationship with her mother-in-law. Trish attended a twins club and a mother and baby group which she drew positive support from. For Trish this included information and emotional support, as well as an opportunity to socialise, which facilitated her social networks. In fact Toni and Sally, who were ‘younger’ mothers in accessing teenage mother groups talked about how they valued ‘the support
from other mums in the same situation’. Support was highly connected to women’s needs for positive affirmations. As Toni went on to say:

‘I think it’s positive vibes from your Mum that helps and saying you are doing well and even my Dad said I am doing well. I mean people like my friends will say well done, you’ve done well, really well’

Hearing positive comments like this where they occurred was noted as most women needed to know that they were doing a good job and that they were good mothers. Indeed, Leahy Warren (2005) who surveyed 135 first time mothers six weeks after birth found that respondents husbands/partners and their own mothers were primary sources of appraisal support. As Sam pointed out despite making preparations by obtaining information by reading books and attending antenatal classes said ‘you can never be prepared’ She went on to explain how important it was to receive positive affirmation as she said:

‘It’s a lot harder then you think I found it was anyway especially at the beginning but now its not too bad you know I am coping with it anyway, well enough and everybody else says I’ve done well which is good to hear’

Being a good mother
There was no disputing that fact that nearly all women spoke about motherhood in differing and unique ways. For example, at times it could be boring, lonely, fun, satisfying, shattering, unpredictable, hard work, fulfilling and more. In addition, as I have discussed it unfolded that a mismatch between their expectations and the subsequent realities existed. These findings are consistent again with research undertaken by Barclay et al (1997), Smith (1999) and Miller (2005; 2007) in that they have exposed a disjuncture between expectations and experiences as first time mothers attempt to make sense of motherhood.

Crucially the women in my study reinforced what many authors have pointed out previously that ‘motherhood is and was life changing’. Despite this
realisation these women wanted to be good mothers in the early days: good enough’ But as their confidence grew they raised their standards towards being ‘the best’ and many took their new found role seriously. A feature of this commitment could be seen in how some women expressed reluctance to allow other people to care for their baby. This could be their partner, family or friends. Cronin (2003) found that for some mothers it was difficult to ‘let go’ of their baby and accept offers of help. As Steph said in leaving the baby with her own mother:

‘So it is a case of asking mum to baby sit which we don’t particularly want to do but we do it, it’s not ideal but it’s not a bad thing’.

This sentiment was rather contradictory as previously Steph had placed great value upon her mother’s support and knowledge of raising children. I assumed therefore that she trusted her completely with the baby. In reflecting upon this afterwards I realised that for the first time her husband remained in the room throughout the interview (I had sought consent, Steph stated she was happy with him being there and he did not wish to contribute or add anything). I can only speculate that perhaps Steph’s negative comment was influenced by her husband’s presence, as before she had indicated much respect and confidence in her mother. In fact I made the following field work note:

*Today it has struck me that I have not included men, in any aspect of the study, it’s funny but when I arrive they go out, I have no idea why this is and have not asked. They are pleasant, offer me drinks and seem to greet me nicely. Maybe they think being “woman’s talk” best to be out of the way. At some homes mum’s mother in laws, sisters and children stay in the room and I go with the flow.*

Field note

Indeed other women spoke on occasions of their partners’ and husbands’ concerns regarding baby sitters and child care plans for returning to work. For the most part this did not seem to deter women and their plans as the following as Tracey told me:
‘He is particular about who cares for him [baby] but to be honest, its in one ear out the other, I need to make my own plans, I want to be busy and have a job and make a good life for us’

Consequently, for some women securing personal freedom and a life beyond the baby was a priority of being a good mother. Aligned to the previous discussions regarding ‘me time’ and self identity many women set goals and milestones by which to measure their progress towards achieving personal freedom. These findings add further support for Alexander and Higgins (1993) theory of normative orientation and Miller’s (2005) notion of ‘self-governance’. Returning to work was one way forward, as was finding a new job or a course to study. Sarah for example in learning that I was a nurse and midwife asked a lot about nurse training. In fact at times Sarah’s interviews were the most difficult for me as she always seemed pre-occupied and our conversation seemed stilted at times. But when the tape was switched off she became enthusiastic and quizzed me intensely about how to prepare for nurse training.

I have explained earlier in the thesis that a process of re-evaluating ones life was multi-layered and took place along a continuum. However, in listening to women having a child on another level ‘forced’ them to put life into perspective. For example Sue who said her life now revolves around her baby spoke about her personal growth:

‘The most important thing is I have grown up, I have a baby it’s more responsibility and when people tell you what it’s like being a parent you don’t believe them until it actually happens to you…. I look out now for my baby’.

There was a strong thread notably more towards the final interview (at seven months post-birth) that revealed the depth of readjustment about the things in life that mattered and the amount of questioning of ones perspective on life (Alexander and Higgins, 1993; Ward and Mitchell, 2004). There was much
talk of personal growth and women putting life into perspective as the following comments highlight:

‘I have learnt more for myself probably more than in my whole life ever, yeh I am looking forward to the future, we are going to get married next year, this little one has taught us what matters’.

Sue

‘This little one means the world to me and I am going to get sorted, get a job and make them proud, I want his life to be good, very good, that’s all that matters to me right now’.

Sally

‘Having these two, I know that I am lucky, you know blessed and well it has really put everything into perspective’.

Trish

In reflecting on life before birth nearly all the women appreciated the importance of keeping life simple. Whilst pointing out their altered perspectives on life many women aligned such talk in relation to their commitment to ongoing self care in other words ‘look after number one’. A metaphorical phrase used to explain how the welfare of baby relied upon the state of their own wellbeing and health. In a contradictory way they could not disentangle their own well being from that of their babies. Although this finding alludes to something different it does reflect what Brown et al (1994) refer to as ‘balancing acts’ in handling motherhood alongside work and family life. At this stage and in this context, it seemed to me that the women I talked to were forging ahead with their own plans for the future. However, I am unable to draw conclusions from the transcripts about how these ‘balancing acts’ achieved their desired outcomes. For example I have no sense of the division of labour between men and women in the home and in relation to baby care. Yes, women mentioned in passing that the reality of family life was that they felt ‘on duty’ all of the time. It is true to say that people closest
to them influenced and contributed to the ways in which women constructed ‘being a mother’ and their recovery experiences.

Health and Wellbeing

I have attempted to weave issues related to health and wellbeing throughout the thesis and within each chapter on the findings. At this juncture I am seeking to reiterate that my findings support the claims that health is a socially constructed phenomenon and as such has different meanings for different people. Curtis suggests that ‘our understanding of health relates strongly to our individually and collectively constructed ideas of identity, the nature and significance of the body’ (Curtis, 2004: 3). This assertion was in many ways supported by what I found in observing what was happening on the wards and in talking to the women. In the background chapter I highlighted notions of constructing the body as a baby making machine, the hierarchy of childbirth (figure 1) and underlying the policy context (at the time of data collection) that has consistently sought to shape what counts as health and acceptable outcomes, from a bio-physical perspective.

In support I found in talking to women that notions of health and wellbeing were individually and to some extent collectively constructed. Certainly outcomes that mattered were more than those labelled as bio-physical, they extended wider to include social, emotional and material issues. Preservation of the self and personal identity became stronger as time passed by. These women wanted to be free from the physical impacts of their births, such as tiredness, pain and discomfort as soon as possible. But soon realised that in pursuing a full recovery the time period was much longer than had been expected or prepared for. As Bondas-Salonen (1998) has stated postnatal recovery is on a continuum, it is slow and intense. At different times certain things mattered and then as time passed by it changed as other things mattered more, in other words views and opinions changed over time (Waldenström, 2004). Before I move onto the discussion chapter I present data on why the women participated in this study.
Why did you participate in this study?
As I have argued this ethnography rests upon confronting both the biomedical gaze and assumptions that women are a homogeneous group. Consequently it has been my aspiration to take account of each woman’s own and unique circumstances. These women shared their stories, invited me into their homes and gave generously of their time. I therefore asked all of the women during the final interview why they had agreed to participate in this study. On the one hand this decision was informed by my experience at the local research ethics committee where concerns were expressed about women becoming ‘upset’. I have mentioned in the methods chapter that this was in my view a protectionist response. Their approach was similar to Brown et al’s (1994) claim that ‘the problems reside within the woman’, the inference being that she is of a delicate nature due to her endocrine system (‘her hormones’) and her psyche following childbirth.

In response I provided what I considered to be an ‘insurance’ discourse: one that satisfied the ethics committee and secured permission to undertake the research. To be clear I am not saying that signposting women to appropriate support services is not good practice, it is. My point here is that such anxiety concerning the potential for women to become ‘upset’ was misplaced and rested upon heightened bureaucracy following publication of the NHS research governance policy (DH, 2001). This paternalistic stance did in my view mirror evidence that women are often treated as passive recipients of health care (Oakley, 1986; Miller, 2005; Baker et al, 2005a) and are often hidden with minimal voice in health research (Anderson and Podkolsinski, 2002; Baker et al, 2005b). As such this perpetuates the trend in undertaking research to capture women’s experiences as an ‘add on’ (Lock and Gibb, 2003).

In truth, as Baker et al (2005b) highlight, little is known about why women agree to or decline to participate in research. Therefore, I felt confident in designing this study that giving voice to women about their subjective experiences would highlight often invisible aspects of women’s recovery. Such insights, as I have argued, are minimal within maternity care related literature. I therefore wanted
to shed some light on why these women had participated and to uncover
something of their views as participants.

To reiterate: all seventeen women made an informed decision to participate in
this research study. As I have pointed out previously three women opted in and
then later changed their minds. Those who stayed were interviewed at three
points in time for which I sought on-going consent and re-negotiated access.
For clarity I framed the question thus: *The other thing I've been asking
everybody on the last interview is why did you agree to be in my study?* The
following section offers a summary of their responses.

Universally, the reason could be described as altruism. Examples cited were
that women wished to help others, to contribute towards improving postnatal
services and to be able to pass on their experiences so that other women
could learn from them. However, this was not the only reason. There were
other factors that influenced women’s decisions. For some, little thought was
given initially, but as they became involved enjoyed the process. As the
following comments highlight:

> ’I don’t know at the time, but now I know that I’m glad that I did
because I mean it’s something that’s not out there that needs to be out
there. I mean nobody knows what to expect. So what you’re doing I
think is a worthwhile thing’.

  Sue

> ’Well because I just thought I’d like to help other women, you know,
they can learn what it’s like after you’ve had a baby and you know,
what you go through. I just like to help that’s all.

  Sam

Others articulated a good understanding of research and held a
predisposition in favour of it with its potential to influence and change
practice. Toni and Tam disclosed that they gained much from having the
opportunity to talk and that being involved in the process of research had
struck a chord with their own studies:
'I thought it might be an experience really, because I’ve not really been interviewed about myself about the birth experience and I just thought it would help with my dissertation really. I hope I’ve helped you because usually I just blab, like go on about myself and but no, I wanted to do it, I wanted to take part and I’ve enjoyed like chatting and talking in these interviews’.

Toni

I think partly probably I wanted to talk. I felt after he was born that I wanted to talk about it and I don’t know whether all people feel like this. That some people might not want to talk about the birth at all and I found it was helpful to talk about it. That’s probably one reason, but a completely different reason is probably that from doing my own post graduate course, we did research as part of that and it’s quite interesting to actually be involved in some research so I was quite keen to do it from that point too.

Tam

Baker et al (2005b) conducted an exploratory study to obtain insights into why pregnant women participate in research and found that additional human contact and treating women as individuals were appealing dimensions in choosing to participate in research studies. This contact with an external person translated for some women as a way to obtain information about the conventional recovery trajectory and find out whether other women involved in the study were generally having similar experiences to them. To me this was a form of ‘checking out’ although the manner in which women sought such information was very general. For example asking if other women felt like them and whether their everyday concerns echoed those of other women.

Sue, in particular, enjoyed being in the study and looked forward to our meetings. At the final interview she said ‘I’m going to miss you’. Interestingly, some women were essentially just curious about the whole research process.
This combined with a desire to chat over things and have some company as the following exert illustrates:

‘Oh gosh I suppose I’m a bit nosey, I don’t know, I also just feel like I want to help you and it’s interesting just chatting to somebody and nattering about your life and what have you’.  

Sheila

A dimension that I had not foreseen was the way in which some women became attached to me as a person and placed value on our time together. To know that they would be seeing me at different stages over the first few months was something that was looked forward to as the following comments reveal:

Because I thought it would be interesting and obviously to help you with your study, erm, I don’t know the company I suppose, when you come round, so.

Tina

I mean I’ve enjoyed talking to you anyway and it’s given me a bit of comfort and something to look forward to as well, you know.

Shirley

I think I was intrigued what it was all going to be about yeah. I don’t know I think because I wanted to take part in something that I thought might be useful or you know other people might learn from it. I don’t know, I just like, it’s been nice for me for you coming round and having a chat and things.

Trish

Finally, Stacey who undertook research as part of her academic career raised a salient point in relation to her understanding of the adopted method when she said:

The only thing that I was wondering about, erm I am still thinking about this really, am I going to help you by being individual? I’m not sure and hope I have not wasted your time with me. You were asking about my experience and I think that the more complicated you are, the more
accurate your study will be and the more information you will get really.

This comment resonates with Baker at al’s (2005b) finding that women who often agree to be involved in research do so in response to favouring a methodology. According to Baker et al (2005b) methodological issues that women consider in making their decision cover timing of the approach, the number of studies they are approached about, the manner and status of the researcher, research design and method of communicating research information. Notably, Stacey who had disclosed feeling under pressure to return to work early and undertake parts of her work whilst on maternity leave, was able to use her role as a research participant to avoid going into work. As the following field note explains:

After talking on tape that she felt she was not so interesting to be able to help my research she had not known research like this before (mathematician). She then said that she wanted to help me as otherwise she would have gone into work today and worked all day. She told me that she gets drawn in, that they [employer] expect her to do her bit; she went to lengths to thank me for coming and for the opportunity to be in the research as she would not have rested today at all. She also said that I had her think about herself and for this she was grateful as she said ‘I don’t do this’.

In conclusion, the women who agreed to be involved in my study welcomed the method of ‘talking’, the underpinning philosophy of individualisation and the nature of the topic. As I discovered these women enjoyed our sessions and placed value on the fact that I was interested in them as a unique individual, as a woman and mother. I recognise that the topic of birth recovery coincided with disengagement from formal care, and as such could go some way to explain women’s attachment and reduced attrition rate. In the following chapter I will take into account this dimension and the women’s responses in reflecting upon the research process and my role as a researcher.
9. Discussion: Pulling it all together

Introduction
This study has explored the nature of postnatal care and recovery from the mothers’ perspectives, with specific reference to the provision, nature and context of their care. In observing the two postnatal ward environments and in talking to women I have provided insights into their experiences of, and meanings attached to, recovery during the first seven months after birth. Additionally, the outcomes that mattered to these women in their ‘journeys of recovery’ have been revealed. Crucially these women have uncovered the importance of looking wider than the restricted bio-medical parameters of recovery after birth.

In this final chapter I discuss the use of ethnography and consider the three main themes identified from my study as described in the previous chapters. As a developing ethnographer I am aware that I engaged in sense making from the very outset of collating my study data (Spradley, 1979; Ribbens and Edwards, 1998; Barton, 2008). As the study progressed I became more reflexive and began to understand postnatal recovery as an ethnographer rather than as a midwife. There were some dilemmas that I had to face during my field work. I have revealed some of the stories in the findings chapters and will revisit them shortly. Talking to women did not cause me any real dilemmas, it was interesting and I learnt a great deal about early motherhood and the recovery trajectory. Having been guided by Spradley (1979) and Brown et al (1994) I was committed to learning from people rather than studying people. For this reason some space will be dedicated to reflexivity: that is being in the field, how I have presented the women’s experiences and on being with the women.

As I have clearly articulated throughout the thesis, as a researcher in the field, I took an opposing position to that of the bio-medical ethos. I rejected the restricted view of the broken body of sickness (Shildrick, 1997) and the notion that the female body is constructed as ‘fragile, a passive vessel and requiring medical assessments and interventions’ (Nettleton, 1995: 7). I also
argued that notions of health are socially constructed and as such have different meanings for different people (Nettleton, 1995; Smith, 1999; Curtis, 2004; Miller, 2007). Most notably in seeking to look beyond a constrained and one dimensional perspective I have drawn upon the work of social scientists and feminists as well as the contributions of authors who have published in the midwifery, nursing, psychology, medical and social science literature. In setting the scene for this study I started out with the preconception that ‘problems’ do not reside within a woman’s psyche or endocrine system (Brown et al 1994:7, Smith, 1999) rather that an individual is located beyond mere pathological factors and as such should be viewed within a socio-environmental context (Nettleton, 1995). A growing body of evidence has confirmed the low status of women’s health around pregnancy and birth recovery (Oakley, 1992; Nettleton, 1995; Barclay et al, 1997; Barry and Yuill, 2002; Walsh, 2004; Kirkham, 2007) which in part has impacted upon the sustained low priority accorded to postnatal care (Bondas-Salonen, 1998; Dykes, 2005; McCourt, 2009) as described earlier in this thesis. In common with Brown et al (1994), Oakley (1980, 1992) and Miller (2005, 2007) I have agreed that care-givers can influence and contribute to the ways in which women construct their postpartum experience. I identified a distinct thread connected to relationships with staff which emerged in the theme ‘power of place’ and to some extent in the theme ‘reclaiming the self’. Furthermore, the same concept had relevance for those closest to the women, including their husbands, partners, family and friends (Singh and Newburn, 2000; Bondas-Salonen, 1998; Leahy-Warren 2004, Castle et al, 2008, Ellberg et al, 2010). Other influences such as the media, social and cultural attitudes and beliefs surrounding birth, motherhood and wellbeing can also have a significant impact on women (Choi et al, 2005; Miller, 2005; Wood, 2008). By focussing on women’s health and wellbeing as an entity separate from that of their baby, it unfolded in the early days post-birth that women struggled to consider their own health and well-being. However, over time the ‘self’, together with other turning points in their birth recovery coalesced to enable women to bounce back.

Overall the findings that I have presented account for these perspectives.
My findings broadly comprise the following three themes:

1. Power of Place: The impact of place upon celebration of birth
2. Reclaiming the self: Insights into the self and getting back to normal
3. Bouncing back? Unpacking health and wellbeing

**Blending the findings with the research questions and literature**

The central focus of this study was to explore the nature of postnatal care and recovery from the mother’s perspective during the first seven months following birth. Women’s perspectives of their experiences of postnatal care and the outcomes that mattered to them in their recovery journey were captured.

In the following sections I draw together my findings with the research focus. I discuss the relevant literature to highlight the contribution of my thesis to further understanding of how women experience recovery after birth and consider implications for postnatal care, the role of the midwife, current policy and recommendations for future research.

**Power of Place: The impact of place upon celebration of birth**

For the majority of women in the UK and in other developed countries, care following birth will usually commence on a postnatal ward, an environment known to raise more negative comments than any other aspect of maternity service provision (Ball, 1994; Audit Commission, 1997; Brown and Lumley, 1997; Singh and Newburn, 2000; Beake et al, 2005, 2010). From my review of the literature I identified consistent negative reporting of hospital based postnatal care (Martell, 2003; Ockleford et al, 2004; Dykes, 2005; Lof et al, 2006; Rudman and Waldenström, 2007; Bhavnani and Newburn, 2010; Ellberg et al 2010). As Willcocks et al (1987) found in their critique of residential life in local authority old people's homes, the function of place of care is open to interpretation. Moreover the environment of postnatal care has been acknowledged for its capacity to impact upon women in the early days after birth (Lock and Gibb, 2003; Dykes, 2006; Walsh, 2004). Clearly, ‘place’ of care matters.
My findings showed that in relation to women’s experiences of the postnatal ward, the overall sentiment expressed was one of disappointment. Women were most critical of the mis-match between their expectations of care and the reality of being on the ward. Captured within the theme the ‘power of place’, the women in my study highlighted features of the ward areas (p118) including; the locked door, the curtains around the bed, the workload of the ward staff, visiting arrangements and noise. These features together created an ‘atmosphere’ that was inhibitory towards the celebration of birth, supporting the findings of earlier studies (Ockleford, 2004; Walsh, 2004; Dykes, 2005). The experiences of the women in my study concerning peace and quiet on a postnatal ward are polarised from the experiences of women who were admitted to birth centres (Walsh, 2004) or gave birth at home (Boulvain et al, 2004; Beake et al, 2005). This is perhaps no surprise as the nature of being on a ward separates women from their family and friends (Dykes, 2005) and subjects them to care which has to reflect the service delivery model of a large acute medical organisation. Understanding the complexity of care within the context of the relationship between space and place has been an interest of other researchers, not just those interested in maternity care. For example from the study by Willcocks et al (1987) I can draw parallels in that ‘residents’ (in this instance older people in care homes) expectations of place were of immense significance to their sense of wellbeing.

In the current study the relationship between the ‘rules of the game’ (Kirkham, 2004), the institution and the staff created contradictions and tensions for all concerned (Walsh, 2004; Baker at al, 2005a). As highlighted previously, the wards were busy and chaotic, and similar to Ockleford et al (2004) and Dykes (2005; 2006) I found this impinged upon staff and women alike. For different reasons they both revealed they felt powerless to control or influence the ward environment. For women, whilst they were sympathetic with the requirement for some degree of order and control regarding, for example, visitors to the ward, having their loved ones with them to share in the ‘celebration’ of birth was of paramount importance (Walsh, 2004).
Women became wrapped up in their baby, their achievement and wished to share in this experience. As Tanya and Tracey articulated (p142/143) the exclusion of loved ones created animosity towards the institution and staff. More importantly the atmosphere and ‘rules’ of the wards spoilt and disrupted their early memories of celebrations and opportunities to involve loved ones in their achievement. It is here that a clear analogy with Foucault’s (1978) theoretical perspective that the female body is the ‘object and target of power’ can be drawn. From my observations and in listening to what women said, assumptions and perceived constructs of motherhood (Rothman, 1989; Hubbard, 1990; Alexander and Higgins, 1993; Barclay et al, 1997; Miller, 2006) dominated from the outset of ‘being postnatal’. A prime example of power and control over women is best highlighted in the discussions concerning visiting arrangements. As discussed the postnatal wards in the two study areas had very different visiting arrangements (p139) which appeared to reflect assumptions about the need for dedicated time for fathers to spend with their partner and baby (Castle et al, 2008). To recap Smith ward had a twelve hour time band, whereas Thompson had just one hour protected time. What I found were polarised behaviours and attitudes on display from both staff and women in response to these visiting arrangements. For example visits were ‘policed’ by staff on the Thompson ward whilst in contrast on the Smith ward visitors were blamed by staff for making women tired. These findings resonate with Abbott and Payne’s (1992) study of maternity hospital visiting where they found that staff can view excessive visitors to be problematic and capable of interfering in patient wellbeing. I found examples in my study of women sharing the same sentiments in that ‘other’ women’s visitors were the noisy ones and a nuisance, not their own. The tension in the differing philosophies between the wards towards visiting was observed and commented on extensively by the women beyond the first few weeks. Thus the concept of adhering to the rules was a source of difficulty and unease for many women. Research that has looked specifically at visiting per se on postnatal wards is sparse. Abbott and Payne (1992) offered some insights in that staff can feel excessive visiting times and numbers of visitors can be problematic and interfere with patients’ wellbeing. Other research literature that I explored offered a different
perspective in that the role of the family seems to fall under the category of ‘support’ (e.g. Ball, 1987; Morrell et al, 2000; Singh and Newburn, 2000; Wiggins et al, 2004; Shaw et al 2006; Forster et al, 2008). In addition, the policy context advocates involvement of fathers and partners alongside family friendly practice (e.g. DH, 1993; RCM, 2000a; NICE, 2006). My findings demonstrate that “visiting” on the postnatal ward represents a form of social action and control. How visiting is handled can enhance or inhibit celebration of birth as mixed messages can unfold about the value of foundational social support for new mothers (Walsh, 2004; Wiggins et al, 2004; Dykes, 2005).

Kirkham (2004) has pointed out that rules and rituals in maternity care enable planning and exist to allow for a degree of predictability. Arguably there is some sense in this. However, my findings have exposed real tensions between the meaning and purpose of the ward rules to the occupants; women and staff, in that their application created a particular ‘atmosphere’ on each ward. Having briefly taken account of Foucault earlier, the construction and organisation of maternity services is, I would argue, a bed rock for power struggles (Smith, 1999; Dykes, 2006). As previously noted by Oakley (1980), Brown et al (1994) and Miller (2005) health professionals seek to claim the real power and control women. The thrust of Foucault’s (1963) argument is that people do not 'have' power implicitly; rather, power is a technique or action which individuals can engage in. Power is not possessed rather it is exercised and where there is power, there is always resistance. Within the sphere of postnatal care these power struggles and resistances impact upon women as beneficiaries of care and upon staff as they attempt to provide care.

Applying this argument to examine length of stay on the postnatal ward, what my findings show is that this was not based on a woman’s choice but on chance. Most women’s length of stay exceeded what they had anticipated (except for Teri and Trish: see table 6, p116). Some of the women were uncertain as to what to expect and took an ‘open-minded’ view. However, I did find parallels to Brown et al’s systematic review on early discharge (2005)
in that widely held beliefs prevailed amongst staff that short in-patient stays were the ‘gold standard’. In a contrast women’s reasons for wanting a short stay aligned to feeling trapped, which resonated with Baker et al’s study (2005a) on women’s experiences of maternity care.

From my observation of staff interaction on the postnatal ward I identified staff engaging in *hardship talks* (p118) and experiencing redeployment to other areas of the unit which corresponded intriguingly to staff also feeling “trapped”. Redeployment of clinical staff has been reported elsewhere e.g. Audit Commission (1997), Ridgers (2007) and I would argue is an accepted norm in current maternity service provision. Importantly, in my view, this continued practice sustains the low status accorded to postnatal care by maternity care institutions (Bondas-Salonan, 1998; McCourt, 2006). However, I suggest the discovery of the *hardship talks* (p119) symbolised deep seated frustrations with the systems in which staff practiced. On one level staff complaining about their workload was perhaps a coping strategy no more than that. However, an alternative view aligns to Foucault’s argument that staff were struggling to attain a sense of power and control over their working day and the activities they faced whilst on the ward. From being in the field and observing the wards, I can support this theory. There was a sense that some women picked up on this too, and whilst subtle, many accounts highlighted an awareness of such struggles. Brown et al (1997), Baker at al (2005a) and Dykes (2005; 2006) have all commented upon how authoritative knowledge and power relationships between health care professionals and women remain embedded within contemporary postnatal care.

I would further argue that the recommendations for individualised care embedded within current policies (DH, 1993; RCM, 2000a; NICE, 2006; DH, 2007; NHSII, 2008) do not take account of the need to address the deep seated impact of power as it relates to place, in the context of hospitalisation after birth (Dykes, 2005). Whilst laudable, individualising care on a busy postnatal ward with all the institutional systems and rules of the acute medical sector is in my view unrealistic. It begs the question of whether this
principle is warranted or attainable, as we know fiscal constraints and under-resourcing (Baker et al, 2005a; Dykes, 2005) already impinge on postnatal care. Moreover it also begs the question of why maternity care should be organised along the lines of an acute medical ward (Beake et al 2010).

In addition, I observed that the workload of staff on the wards required a disproportionate amount of on administration such as paperwork for transferring women home (Wray, 2006; Dykes, 2005; Ellberg et al, 2008). A recent policy document entitled ‘The Productive Ward: Releasing time to care’ (NHSIII, 2008) has been circulated across the NHS to address the balance between administrative duty and spending time with patients and is a key priority for the NHS. How this will impact upon postnatal wards has yet to be seen. Based on my findings I am sceptical as to how the various embedded issues entwined within the context and ethos of postnatal care will be addressed by another policy recommendation. The current NMC consultation regarding the midwives rules proposes to reduce further the sphere of midwives’ practice with respect to postnatal care (RCM, 2010a). Arguably, the evidence for adopting alternative models of postnatal care is strong if women’s accounts are being taken into consideration (e.g. Garcia et al, 1998; Singh and Newburn, 2000; Bhavnani and Newburn, 2010).

It is important at this juncture to emphasise that women in my study were not complaining per se, it was more that they felt ‘let down’ and ignored. Women were sympathetic towards the workload on the wards and could understand the complexities that staff faced both in hospital and community. However, based on their experiences of place and content of care the findings substantiate the low status of postnatal care (Bondas-Salonen, 1998; McCourt, 2006) and separatist view (Oakley, 1980; Nettleton, 1995), that this aspect of childbirth is an end point. Taken for granted assumptions were made that mothering is innate and women are expected to just ‘get on with it’ as there is a right way of doing things (p144). Alongside celebration of birth, being praised and having positive feedback about birth achievement is essential to caring and early motherhood (Barclay et al, 1997; Smith, 1999, Beake et al, 2005; Miller, 2007; Bhavnani and Newburn, 2010).
Given that a major purpose of postnatal care is to facilitate maternal wellbeing and reduce morbidity (MacArthur et al, 2003) the fact is that this is poorly understood and its translation into practice is mostly burdensome and challenging (Bondas-Salonen 1998; RCM, 2000b; Ridgers, 2007). The opinions expressed by the women involved in this study are clear, that they felt forced to learn self care, a finding supported by others (Alexander and Higgins, 1993; Troy and Dalgas-Pelish, 2003; Leahy-Warren, 2004), perhaps sooner than they had expected. However, taking control over their own wellbeing was reliant upon several turning points (p159) which emerged over time for example gaining confidence, support, and positive feedback from family and getting a routine.

Reclaiming the self: Insights into the self and getting back to normal
It was within this theme that the impact of place and the ways in which women sought to ‘get over’ their early days post-birth became much more apparent. There was no getting away from the fact that being on the wards influenced women’s recovery (Lock and Gibb, 2003; Lugina et al, 2004; Boulvain et al, 2004; Beake et al, 2006) and the pursuit of ‘getting back to normal’. However, in reclaiming the self the outcomes that mattered to women about their own recovery started to emerge. Crucially the concept of a recovery trajectory and notions of time boundedness (Barclay et al, 1997; McCourt, 2009) were central within this theme.

Reclaiming the self and getting back to normal were critical to the women over time. Influenced by professional surveillance and bias towards physical ‘checks’ (Baston, 2004) this form of control over the female body resulted in women being uncertain in the early days about their own wellbeing and what counted as normal for them. In the first few weeks ways to self care soon prevailed as women sought to reclaim the self and take ownership for themselves as they embarked on a series of turning points (p167) in their recovery trajectory (Barclay et al, 1997; McCourt, 2006). Both Rogan et al (1997) and Ward and Mitchell (2004) found that mothers experienced a loss of identity and were aware of a ‘silence’ surrounding articulation of the realities of motherhood. Both studies collected data at one point in time.
through focus groups but what they both add is an insight into early motherhood and the social context. For example the enormity of change that women experience in becoming a mother is far reaching (McCourt, 2006) and life changing (Alexander and Higgins, 1993). In Rogan et al (1997) and Ward and Mitchell’s (2004) studies women were not followed up and their analyses relied on retrospective data, in others words women were asked to reflect back at one point in time months after birth. In contrast what I found in my study from being with women over time (at two wks, three and seven months) was the reality of being postnatal was partly sequential. However, crucially the time span within which these women felt ‘recovered’ varied hugely and was totally disconnected from formal clinical definitions and understandings (Martell, 2001; NMC, 2004; NICE, 2006) and physical indicators (Alexander and Higgins, 1993). The women in my study did articulate negative and positive feelings about being a mother and their recovery, on each occasion that we met.

As individuals each woman embarked upon a different journey and managed to reclaim the self in their own unique way. Their accounts of recovery revealed divergences in how they interpreted their wellbeing and could change over time. However, several threads emerged that were common to all women, namely; awareness of professional distancing, pursuit of normality and back to normal by six weeks. In particular securing ‘me time’ and ‘getting out and about’ converged to symbolise progress towards claiming back the self and having some personal ownership. Drawing again on Foucault’s (1978) explanations of power and surveillance, I found this translated into a mis-match between expectations and the realities of formal postpartum care. Coupled with notions that the female body is a ‘baby making machine’ (Rothman, 1989; Hubbard, 1990) women had come to rely upon surveillance in the early weeks and were familiar with the search for normality through the clinical ‘gaze’ (Foucault 1978). These explanations may well be a legacy of women’s experiences of being monitored during their pregnancy, labour and birth (McCourt 2009); however women’s postpartum experiences over time were distinctly different and contradictory. As I found some women engaged in sanitisation of their early experiences as a way to move forward and wipe
out negative memories encountered mostly on the wards in order to embrace motherhood on their own terms.

I found that women developed their own views of reverting back to the pre-pregnant state and notions of ‘back to normal’ (Beischer and Mackay, 1986; Singh and Newburn, 2000; Marchant, 2003; Bhavnani and Newburn, 2010). Women accepted that their bodies were changed after pregnancy and birth but the dominant biomedical perspective conveyed by professionals (midwives) was misplaced. For example women attached different meanings to their ‘checks’ and in ‘getting back to normal’ (p156). My findings showed that for the women as the months passed by, feeling good, looking good and being a good mother were the priorities they most concentrated on (Miller, 2005). The findings on body image, in particular weight loss (p181) illuminated the dissonance between women’s outcomes and those of concern within the biomedical perspective. However, findings on body image emerged as a thread not only in reclaiming the self but in the broad theme ‘bouncing back’. The point I am making here links to the finding that some women felt under pressure in the face of dominant positive images of motherhood (p163). Like Choi et al (2005) and Rothman (2000) I found the pursuit for female body perfection after childbirth was everywhere. For example Victoria Beckham’s post childbirth image and other celebrities created debate as most women found such images unavoidable in their everyday lives and yet recognised the alignment to the underpinning ideologies of motherhood. Interestingly in 2010 Netmums.com (web based parenting organisation) and RCM undertook a UK wide survey of 6,226 mothers’ experiences of weight management, healthy eating and obesity issues and highlighted the existence of intense pressure on mothers from media coverage of ‘svelte celebrities’ to lose their post-pregnancy baby weight (RCM, 2010b).

To recap, reclaiming the self among the women in my study rested upon the ways in which constructs of normal were understood. Without doubt these were influenced and informed to some degree by relationships and interactions that had taken place with care givers (Willcocks et al, 1987;
Wiggins et al, 2000; Dykes, 2005; Beake et al, 2010). Where women experienced dedicated time and interest focused solely on their wellbeing this was noted. I feel unable to conclude much about relationships with staff based on my observations on the wards other than I found a tendency towards the quest for normality hinged on the regulatory definitions (NMC, 2004). An analogy to Shildrick’s (1997) notion of ‘healing and repairing the broken body’ was evident within getting back to normal. I had no encounters with staff in the community and so I relied on women’s accounts.

My findings revealed contradictory perspectives held by women about the landmark six week ‘check up’ (p161). For example for some of the women full recovery from giving birth within six weeks was considered too optimistic. In contrast, for those women who had attended the six week check, genuine value had been placed on the scope of the assessment for its capacity to provide in depth feedback regarding their reproductive health. Instead such encounters fell short of meeting expectations. Consequently some women felt disappointed and unconvinced that an adequate assessment had taken place. While other women ‘opted out’ completely as their way of taking control of the self. The rationale and evidence to support the fixed timeframe of six weeks has not exactly been that clear and debates are ongoing as to the usefulness of this definition and its rigid application in practice (Bick et al, 2009).

Time was certainly a factor in reclaiming the self, allied with a series of what I have termed ‘turning points’ which I found most women encountered (p167). These various ‘turning points’ served as discreet milestones by which women measured their progress over time. Notably it has been Miller’s (2005) narrative approach in researching motherhood that I feel best connects with the broad concept of my findings on ‘turning points’ (chapter seven). Although based on a particular type of woman (defined as white middle class women and first time mothers), and a homogeneous group, Miller found women engaged in a range of social actions as they grappled with motherhood. Miller found women reluctant to present a ‘convincing’ self (one that displayed a happy coping mother) particularly in the public sphere as this
could be problematic in the first few weeks. My findings showed women’s eagerness towards ‘getting out and about’, being organised and achieving some ‘me time’ symbolised turning points in their recovery. Although, taking control and gaining confidence underpinned such progress a strong thread connected to feeling like *my old self again* relied on reflexivity by women as part of their goal to claim back the self and engage in self governance (Troy and Dalgas-Pelish, 2003). In summary motherhood was life changing and I found women re-examined their perspectives on life (Alexander and Higgins, 1993; Rogan et al, 1997), all of which enabled a sense of control over their own recovery.

**Bouncing back? Unpacking health and wellbeing**

In unpacking the notion of ‘bouncing back’ I found that the time after birth was profound and overwhelming as women embarked upon their adjustment to mothering and attempted to recover from the whole birth experience. In many ways women were recuperating or rehabilitating, in that their recovery was a continuous and multi-faceted process requiring a range of skills, information and knowledge (RCM, 2000a/b; Hunter, 2004; Ockleford et al, 2004; Maher and Souter, 2006; McCourt, 2009). My findings showed that in being able to ‘bounce back’ different outcomes and strategies mattered to different women in ‘getting there’ (p178). This meant a whole complex set of processes and issues were going on for women during their recovery journey as they worked out life with a new baby. This finding resonates with Rogan et al (1997), albeit that their study focused purely on first time mothers, where they found being unprepared took its toll on how first time mothers took responsibility and attained mothering skills.

I found ambiguous views as to what counted as being healthy. Some women discounted persistent health problems, for example Tina (p179, chapter 8) who on the one hand found recovery from her caesarean birth challenging but was reluctant to seek professional help. Conversely, looking good and feeling good were outcomes that mattered to all the women. My findings revealed that most women had embarked on a mission to lose weight and set themselves goals regarding their appearance to enhance their sense of
wellbeing (181). Appearance and body image alone, whilst features of how women unpacked health and wellbeing, also included the notion of ‘feeling good’ and were all part of the dynamic nature the recovery continuum. Miller (2005) and her finding that women can struggle to put on a ‘convincing’ persona for display in public, urged me to seek out feminist explanations.

For example Rothman (2000) drew attention to the possibilities that women ‘can have it all’ and that perfection within motherhood is an attainable goal. The ideology of motherhood is a social construction that requires women to be feminine and thus mothers. I argue that powerful messages are attached to how motherhood ought to be. Within the ideological portrayals of motherhood the dominant views are that good mothers cope, look nice and get on with it (no complaining) as they are in control and happy (Choi et al, 2005; Miller, 2005, 2006). The reality is highly disconnected from this and yet women are influenced by such myths and ideologies (e.g. Oakley, 1979, 1992; Baker et al, 2005a; McCourt, 2006; Miller, 2005, 2007). According to Choi et al (2005) being able to voice any negative feelings or issues about the difficulties of motherhood tends to be associated with feelings of guilt or fear of being considered a ‘bad mother’. In part my findings expose a hint of this sentiment as periods of loneliness and boredom were expressed by some women (p183). There was a sense of women being cautious in accessing professionals at the risk of being labelled if they had negative feelings and this finding was most notable at seven months after birth.

However, my findings also showed that the ‘scaffolding’ of support that these women put together was vital to their wellbeing and recovery (Wiggins et al, 2000). In particular, this support was from their maternal mothers, sisters and female friends. My findings on support are not unique as previous research has shown the value and benefits of social support to mothers (Bondas-Salonen, 1998; Morrell et al, 2000; Lock and Gibb, 2003; Wiggins et al, 2000; Shaw et al, 2006). I also found the ways in which partner support was experienced varied (Castle et al, 2008). Overwhelmingly though for women in my study it was feedback and positive affirmations that women thrived on. Interestingly participation in my study added to this process as women
secured ‘permission’ to both focus upon, and talk about, themselves and their experiences (p193).

My findings show that the provision of postnatal care and women’s experiences fell short of what was expected. For all of the participants, journeys into motherhood unfolded in ways that they had not anticipated: the ways in which they had imagined themselves as mothers did not always match their experiences in the early weeks and months. The varied recovery experiences illuminate how professional ideas, practices and time-frames around transition and recovery from birth can be narrowly conceived. Although the study was confined to two NHS Trusts in Northern England it is not unreasonable to expect that these findings reveal, and align to, women’s experiences throughout England. Therefore, my findings do have important implications for policy and practice. In conclusion it is vital that we listen and respond to the needs of women in their adaptation to motherhood, in my view the days of professional rhetoric should be over.

Re-visiting the Policy Context
Before I reflect on doing ethnography I feel it is worth re-visiting the policy context. In recognition of the fact that this study was designed and undertaken between 2003 - 2005, it is interesting to note that in 2007 the Healthcare Commission (now the Care Quality Commission) published a review of maternity services based on information obtained from all maternity units in England. This review included findings from surveys of 26,000 mothers. Overall, the majority of women reported a positive experience of care received during pregnancy, labour and the birth. However, women were once again less positive about their experiences of postnatal hospital care. For example 20% of women rated the overall care received after the birth of their baby as either “fair” or “poor” (Healthcare Commission, 2007:5). More importantly for women who stayed in hospital after birth, familiar and recurring themes very similar to those I have highlighted were reported. For instance, 42% of women who stayed in hospital after the birth said that they were not always given the information or explanations they needed and 37% felt that they had not always been treated with kindness and understanding.
by staff. In addition, a fifth of women reported a lack of consistent advice, said they had no practical help and experienced poor levels of active support or encouragement. Another policy report also published in 2007, aimed at improving maternity services for women and their partners by offering wider choices of type and place of maternity care and birth (DH, 2007). Entitled ‘Maternity Matters: Choice, access and continuity of care in a safe service’ four national choice guarantees were published with the commitment that these would be available to all women and their partners by the end of 2009. The fourth choice guarantee was ‘choice of place of postnatal care’ which was a commitment that each woman would be supported by a midwife she knows and trusts throughout her pregnancy and after birth (DH, 2009:5). The extent to which all of these commitments have been achieved in practice appears to be negligible, for example a recent report from the NCT which focused on choice of place of birth found that only around 4.2% of women currently have a full range of choice of place of birth (Gibson and Dodwell, 2009).

It would be true to note that these recent policies connect to the wider health reform agenda in England, aimed at developing a patient-led NHS to promote health, reduce health inequalities and improve access to safe healthcare (DH, 2006) and, with respect to maternity care, services that are both women focused and family-centred (DH, 2004; DH, 2009). I would argue that while the more recent maternity policy publications provide a clear focus on the need for high quality, woman-focused maternity care, what they offer in reality could be perceived as merely a ‘healthy boost’ to what has gone before. In other words in terms of policy, my view is that the ‘list goes on’ as postnatal care remains an area of concern for women (DH, 2007) with little discussion of the practical implications of how to address the ‘policy to practice’ gap from the perspective of service users or service providers. My rationale and purpose for seeking to explore women’s experiences of postnatal care, a journey which commenced before recent policy changes was, in retrospect, extremely timely as it had the views and voices of women at its core. Given the current policy context I would argue that my study
findings provide a useful and timely reminder that until women’s voices are ‘heard’, the changes outlined in policy reports may not be achieved.

Reflexivity
In this section I briefly discuss key issues in relation to being in the field, how I presented the women and something of my own learning as an ethnographer.

In seeking to adopt the ethos of ‘researching up’ (Brown et al, 1994) I sought methods that were more likely to be conducive and appealing to women. I also made the decision informed by Spradley (1979) ‘to learn’ from women about their recovery trajectory over several months. Therefore I was keen to avoid capturing a ‘snap shot’ view of women’s recovery and so met up with, and listened to them, at three points in time. In the literature I identified gaps in knowledge regarding follow up of women, the time-frames attached to recovery and a tendency towards research based on a more homogenous sample of women. Thus my intention had been primarily to respond to these issues and provide an alternative evidence base for the benefit of practice and policy. One of the main learning points of doing of this ethnography has been the isolation as a researcher. I have been totally overwhelmed at times by the nature of doctoral study. For example making decisions on my own at different stages has been challenging. Of course I acknowledge my supervision support for which has been invaluable. In addition, I found Diana Leonard’s book (2001) on doctoral studies very insightful and reassuring. Indeed the various study days and training events I have attended useful too. I feel that my confidence in doing fieldwork has grown and with a colleague presented a seminar on doing fieldwork to a group of post-graduate students to shed light on practical issues. One of the issues I grappled with during the period of observing on the wards was in relation to problem solving dilemmas. I highlighted a field work dilemma surrounding a request for a towel for a woman (page 120) and at the time I found this incident disturbing. Several dilemmas unfolded, first of which was the fact that in my view these staff were rude to me and I found their manner offensive. Reflecting ‘in action’ I took a deep breath and did not respond. Secondly, what they
actually said was overheard and this I found embarrassing as the bottom line was these were colleagues (in the broadest sense) and their conduct was unprofessional. Thirdly, I felt their attitude towards the woman who needed the towel was disrespectful. Whether my decision to treat this encounter as ‘data’ was the right one I remain uncertain. However, observing as an ethnographer was a first and I wanted the challenge. It was during the course of such dilemmas on the postnatal wards that I faced what Hunt and Symonds (1995) refer to as treating the familiar as strange and what Spradley (1979) advises as grasping the native’s point of view. Therefore, in applying this theory I was able to capture rich and invaluable data, an example of which can be seen within the findings on hardship talks (118).

In thinking about how I have presented the women I have embraced the ethos of ‘researching up’ (Brown et al, 1994) by giving voice to women’s experiences. I have attempted to be authentic to the many dialogues we had in order to give meaning to their understandings of postnatal recovery. On a practical note by choosing pseudonyms and brief details as to their circumstances was out of respect for their anonymity. However, had I been able to meet up with them as I had initially planned, at one year post birth, I would have consulted with them on their preference regarding presentation. Out of curiosity and my experience at the ethics committee to produce an ‘insurance discourse’ (see p106) I asked the women why they had chosen to participate in my study.

I originally planned to organise a feedback session with women and local NHS Trusts 2006, but due to sudden personal illness this was impeded. On my return to work in 2007, despite writing to the women to resurrect an event this resulted in no feedback and a lost opportunity with the women. In respect of the local NHS Trusts they became heavily involved in a local consultation processes as part of rationalisation of maternity services in the health region. Hospital closures were perceived to be looming and the climate would seem to be not conducive to a feedback event. That said I did contact each NHS Trust on numerous occasions, and their response was positive. However I have yet to have confirmation of dates or ideas as to how they would prefer
for this to happen. Undeterred I have proceeded to disseminate the findings and presented at several study days locally for midwives (some work at the two NHS Trusts) student midwives and at numerous national conferences (see Appendix 1).

Limitations
As with any research and having reflected on the process I recognise limitations exist. Without question my findings pertain to the context in which data were collected in other words the places and in relation to the women who participated. However, throughout this ethnography I have been engaged in defining and redefining postnatal care along a continuum. In doing so I feel convinced that the findings portray authentic voices and trustworthy evidence base that can be informative and applied elsewhere.

In addition, I mention in the chapter called ‘bouncing back’ that I became aware of the absence of the male perspective from within the study. This realisation was brought to my attention in two ways; one was in response to Steph’s husband’s presence during the final interview as noted on page 181. Secondly, as time passed some women told me that their partner had begun to play more of a role in caring for the baby and an opportunity to have captured a sense of this could have enhanced insights into the longer term aspects of women’s recovery.

In some ways I wonder if like Dykes (2005, 2006) I ought to have involved staff as care givers on the wards an opportunity to share their views on postnatal care. In the literature several studies report evidence from the perspective of midwives and re-occurring themes about the status of postnatal care have been described (Bondas-Salonen, 1998; Singh and Newburn, 2000; Beake et al, 2005; Ridgers, 2007; Bhavnani and Newburn, 2010). As mentioned Cattrell et al’s (2005) study found job satisfaction mattered to midwives who practiced on a postnatal ward. McCourt et al (1998) found continuity of care and continuity of care giver was linked to a woman’s greater preparedness for the time after birth i.e. adaptation to motherhood in the early weeks. I found minimal references made to
continuity of care amongst the women I interviewed. Trish highlighted succinctly her pleasure when she was cared for by a midwife who was familiar to her. This example does shed some light on the value of continuity for women. However, I am unable to draw detailed conclusions on the role of continuity of care and care giver based on my findings. I realise with hindsight that if I had asked women about their perceptions of caregivers and notions of continuity it could have provided insights. The two NHS Trusts had no systems in place dedicated to the principles for continuity of care and care giver specific to postpartum care. That said on reflection I could have collected more detailed information on staffing arrangements for community based postnatal care.

Concluding comments
I recognise that national guidance dedicated specifically to postnatal care exists and a number of other policy documents include specific recommendations for postnatal care (DH, 2004; NICE, 2006; Healthcare Commission, 2007). On one level these are to be commended but in my view they have only made discretionary changes and have not fully embraced the re-occurring sentiments expressed by women over the past decade or so. More importantly I suggest that the real challenge for the future is to address the relationship between policy and practice. Moreover to be able to understand how policy is interpreted and subsequently translated into practice. I say this as it remains the case that women will continue to experience care on a postnatal ward within a hospital environment. Therefore all the constraints, systems and rules that apply to an institution will prevail unless the organisation of systems, rules and processes are dealt with. The tension between upholding and attending to standardised care (Kirkham, 2004) has in my view impacted upon women when they are vulnerable. In taking this argument forward caring for women on a hospital postnatal ward is thus a collective responsibility and postnatal care in the context of the ward setting is not exclusively the domain of midwives. Of course the NMC rules apply (NMC, 2004) but given that there is less influence from medical staff in this area of childbirth midwives seem to have difficulty with practising
autonomously (Dykes, 2005; Kirkham, 2004; Ridgers, 2007). From my perspective here lies a deep rooted contradiction as postnatal care offers the possibility for midwives to be with women, enabling choice and control with women. The possibilities for continuity of care and care-giver exist and yet there is minimal evidence that this was embraced within postnatal care in my study.

My view is that in looking backwards we need to bring forward a review of the state of postnatal care. If NHS policy is serious about listening to the voice of the service user, then what women have been saying for many decades about postnatal care needs to be believed and acted upon. Celebration of birth and a positive sense of wellbeing is the right of every mother. Postnatal care is not the end point but the beginning. Women should be supported through feedback and positive affirmations so that they feel confident at all stages of their mothering experience. In my judgment carrying on as we are only upholds the re-occurring situation and it would seem that there are no gains for women and the profession of midwifery. I believe caring for women after birth is a collective responsibility. Therefore, I conclude with a question as to the basis for continuing with postnatal care: If we concentrate on women’s views and their experiences, then on what grounds should we carry on as we are?

The implications for postnatal care
Contemporary maternity care has become increasingly complex and diverse. The NHS has finite resources and yet postnatal care remains unplanned along a continuum (Beake et al, 2010), is unpopular with staff (Bondas-Salonen, 1998; Dykes, 2005) and women remain dissatisfied (Bhavnani and Newburn, 2010). The challenge for midwives in particular seems to be how to support and contribute to women’s preparation for mothering in ways that meet individual needs and are grounded in practical realities as far as is possible. Although my findings hinted at the nature postnatal work being seen as a burden or low priority amongst midwives Dykes (2005) certainly revealed the impact of resources upon postnatal practice. My findings such as hardship talks and redeployment of staff appeared to reflect the deep
seated frustrations with the institutional systems. Therefore staffing, in terms of the nature and skills needed requires some serious attention and debate. Controversially, there are grounds to abandon postnatal care within the sphere of midwifery and create a new skill mix within postnatal provision.

In my view the priority is to get away from organising in-patient postnatal care within a culture that harnesses the medicalisation of women’s recovery, as we know it is not appropriate for the majority of women recovering from birth. My findings support looking beyond a narrow timeframe and acknowledging that postnatal care ought not to be prescriptive as recovery from birth and transition to motherhood is highly individual. Ways to make clear the nature of self care along the recovery continuum requires urgent consideration. Planning for postnatal care could start during pregnancy so that women are prepared and informed. There is no doubt that postnatal care requires innovative changes to how it is designed and delivered. Arguably the time is right to support change with the NMC consultation (RCM 2010a) as opportunities exist. Current policy needs tackling so that a more realistic and woman friendly postnatal policy in line with what women expect can emerge. The midwifery profession alone has not got the power to change the organisation, structure and funding of care. Therefore new innovative ways of addressing care after birth requires a collaborative approach with all stakeholders involved one that takes into account what women say. Thus involvement of service users in any re-design is crucial (Dorfman, 2007; NCT, 2010). This study has revealed that the current purpose and routine provision of postnatal care requires urgent attention. We could learn a great deal from the places of care such as birth centres (Walsh, 2004) where celebration of birth in particular is embraced and acknowledged as important. Likewise transferring women home in a more planned and considered way could be implemented more systematically (Beake et al, 2010).
Contributions to midwifery knowledge

I have argued that postnatal care on the wards, as encountered by the women in this ethnographic study, is in need of urgent attention. Power of place matters and there is no escaping the fact that together the ‘rules’ and atmosphere of wards impacts on staff and women a like resulting in a sense of feeling trapped on the wards. Moreover, contested views between women and staff emerged in particular around celebration of birth and the care ethos. I have shown that there is a lasting impact and legacy on women as a consequence of being on a postnatal ward. In seeking to ‘reclaim the self’ I have revealed that women’s health and wellbeing after birth, differs from that understood by professionals. In taking control of their own recovery women experience a series of ‘turning points’ which I found converged into discreet and important landmarks for women in their own recovery journeys. Bouncing back is possible, it is different for each woman and it takes time but due regard needs to be given to how women are treated in those early days and weeks. Clearly, a more realistic and informed approach towards care giving after birth and along the recovery journey is required.

What these women have revealed is additional evidence to support seeing postnatal as beyond 6-8 weeks after birth, then treating women as individuals capable of ‘self care’ after adequate care giving by care givers, in other words midwives. Postnatal care as an entity is not an end point. In fact the reverse is true, as women see it as a beginning and as part of the childbirth continuum. In order to encourage and sustain ways of ‘self care’ by women and those closest to them I suggest that on a macroscopic level the midwifery profession is responsible for raising the profile and status of postnatal care to one of high worth and value. On a microscopic level midwives need to be more aware that their social actions have consequences. Critically the profession as a whole needs to be supported to take on the challenges voiced by women in order to be successful in taking positive action. A whole system approach is required to support midwives and midwifery.
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Appendix 1: Dissemination Events and Papers published

**Dissemination events:**
1st-3rd September 2010, Giving meaning to postnatal care through women’s experiences: An ethnographic study. Doctoral Midwifery Research Society (DMRS) 1st Global Conference Ulster.

27th November 2009, Invited to present by RCM general secretary within Pioneering the mother and baby pathway. Title: Post-natal care culture and women’s experiences of birth recovery Royal College of Midwives Annual Conference at Manchester Central.


30th June 2009, University of Salford CPD study day for Midwives: Contemporary Post-Natal Care-Research and Development – 3 hour workshop.

July 2007, Birth recovery: a longitudinal study of women’s health after birth. Poster UKGrad Postgraduate Researchers in Science and Medicine (PRISM) Conference University of Chester

20th July 2005, Birth recovery: talking with women some insights. Invited to present at Seminar Research Centre for Clinical Practice, School of Nursing, Griffiths University, Brisbane, Australia.

**Publications:**


Wray J (2005) Care after birth – some insights of data collecting. RCN Research Society, PhD Student Network, Swansea University Wales


PhD study registered with INVOLVE database [http://www.invo.org.uk/](http://www.invo.org.uk/)
Appendix 2: Example of keyword for database searches

Database: CINAHL <1998 to October 2008>
Search Strategy:
1 exp postnatal care
2 exp postpartum period
3 1 and 2
4 maternal health/
5 womens health/
6 mothers health/
7 puerperal health/
8 4 and 5 and 6 and 7
9 3 and 8
10 satisfaction/
11 patient views/
12 10 and 11
13 9 and 12
14 research.pt.
15 exp midwifery practice, research-based/
16 14 and 15
17 13 and 16
18 limit 17 to English
19 limit 18 to yr= 1998-2008

Database: Journals@Ovid, PsycINFO, MWIC, Your Journals@Ovid
Search Strategy: 30.1.2009
1 POSTNATAL CARE {No Related Terms} (257)
2 BIRTH RECOVERY.mp. [mp=ti, ab, tx, ct, hw, tc, id] (37)
3 Puerperium.mp. [mp=ti, ab, tx, ct, hw, tc, id] (6882)
4 postpartum.mp. [mp=ti, ab, tx, ct, hw, tc, id] (39763)
5 womens views.mp. [mp=ti, ab, tx, ct, hw, tc, id] (688)
6 mothers views.mp. [mp=ti, ab, tx, ct, hw, tc, id] (295)
7 womens experiences.mp. [mp=ti, ab, tx, ct, hw, tc, id] (3197)
8 mothers experiences.mp. [mp=ti, ab, tx, ct, hw, tc, id] (600)
9 postnatal.mp. [mp=ti, ab, tx, ct, hw, tc, id] (61709)
10 (health and well being).mp. [mp=ti, ab, tx, ct, hw, tc, id] (710307)
11 4 and 1 and 3 and 9 and 2 (0)
12 8 and 6 and 7 and 5 (0)
13 10 and 9 (16791)
14 8 and 13 (40)
15 7 and 13 (117)
16 15 and 14 (11)
17 6 and 9 (29)
18 10 and 5 (341)
19 4 and 9 (7569)
20 19 and 10 (2659)
21 8 and 6 and 7 and 20 and 5 (0)
22 8 and 20 (24)
23 from 22 keep 2,7,9,12,21-23 (7)
24 health outcomes.mp. [mp=ti, ab, tx, ct, hw, tc, id] (40312)
25 22 and 24 (3)
26 1 and 24 and 9 (7)
27 from 26 keep 2,4 (2)
Appendix 3: Screening tool used to assess literature for inclusion and appraisal

Screening tool for including studies

Guided by the research questions, aims and objectives of study

<table>
<thead>
<tr>
<th>Literature Chapter</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insights into hospital postnatal service provision</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Insights into the nature and context of postnatal care/birth recovery</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Experiences of mothers regarding their health and well being after birth*</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Postnatal outcomes in the shorter and long term that women consider to be important to them</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**Notes:**

* exclusively studies about post-birth/after birth
Appendix 4: Sampling frame (for interviews)

To capture the range of different socio-demographic and obstetric factors experienced by women who commence their birth recovery on the postnatal ward, the following sampling frame will be applied when selecting women for interview.

1. Age above 16years

   16 - 25  □
   26 -35  □
   36 - 45 □

2. First live birth  Y/N  If no, birth order of this child □

3. Birth outcome:
   3a. Single birth  □  Multiple birth □

3b. Live birth Y/N  No live birth □  Ill baby □  Baby on NNU Y/N

3c. Type of birth (plan to cover normal to LSCS)

3d. Other delivery factors (analgesia, induction, augmentation etc)

4. Single □  Married □  Supported □  Lives with partner Y/N

5. Ethnic group

6. Pregnancy complications  Y/N

7. Communication:
   English speaking □  Need interpreter □  (list first language)

8. Anticipated/actual length of postnatal ward stay.

9. Comments

1. Exclude all women under 16years old, consent complexities, respect for privacy at such a young age and intrusion aspect. This is an important group that is worth exploring but I would suggest by other research approaches/methods linked to specific aims. 2. An interpreter will be involved to facilitate data collection (funding will has been secured to support this aspect of the study).
Appendix 5: Patient Information – letter of invitation

Verison2

Date ...............  

Dear

I am undertaking a study looking at women's experiences of birth recovery. To do this, I want to collect information from local women about their recovery after birth and what matters to them.

The overall aim of the local study is to understand more about postnatal care from a cultural and health viewpoint. And to explore birth recovery from the mother's perspective during the first year following birth.

I am inviting you to participate in this study, which will involve 3 interview discussions about your experiences. These interviews will span over time and will fit in with you and your wishes.

With your permission I hope to tape-record the interview discussions so that I have an accurate and precise record of the discussion. I will be the only person who knows whom has been involved in the study and I will ensure that your name will not be linked with any data that appears in any reporting of the research. In other words, privacy and concealment of your name and details will be secured and maintained. Your decision to play a part is yours and should you agree and then later change your mind that is your right and I will respect your wishes. If you wish to participate I will contact you to arrange an agreed and suitable time.

The tape recordings of the interview discussions will be numbered and stored separately from any list that links your name or details. They will be stored in a locked filing cabinet in a room at the University of Salford. The tapes will be destroyed after the study has been completed and you can have your own copy.

I would be happy to discuss the study with you at anytime and thank you for your time and support.

Best wishes

Julie Wray

Direct line 0161 295 2974

Email j.wray@salford.ac.uk
Appendix 6: Patient Information Sheet submitted to and approved by research ethics committee

Birth Recovery – women’s experiences Participant Information Sheet (1)

What is this study about?

Care after birth and what matters to women as they recover from birth are important health and care social matters. There have been some studies done to look at postnatal care in the UK but mostly these have been by questionnaire and asking about organisation of postnatal care. But very little is known about what birth recovery is, the views of women about care after birth and what matters to them. This study aims to tease out these issues by undertaking an in-depth study of birth recovery by inviting recently delivered mothers to share their experiences over time rather than asking once.

This study is planned around three aims and will undertake:

• To conduct a detailed enquiry within a local area, with particular emphasis upon the provision, nature and environment of postnatal care/birth recovery
• Critically to explore experiences of mothers regarding their health and well being after birth
• To identify what birth recovery outcomes matter to women

Why me?

Two maternity units in the North West region of England (Salford and Trafford) have been chosen for practical reason to be involved in the study and have agreed. I am asking women who have had their postnatal care at either of these two hospitals and live in Salford or Trafford to be involved.

What does it involve?

I am inviting local women to talk to me on a one to one basis about their experiences and what outcomes matter to them about their birth recovery. I would like each woman to be involved in 3 interview discussions. These discussions will with permission be tape recorded these recordings of the interview discussions will be numbered and stored separately from any list that links your name or details. Your name or anything that identifies you will not be recorded or used in any part of the study.

What should I do now?

The choice and decision to be involved is yours but you may wish to discuss this with your partner, family or friends. If you do not wish to be involved then there is nothing for you to do and it will not affect your care, as the information is private and known only to yourself. If you do wish to be involved then please either contact me direct or I will take your name and arrange to meet up with you at a time of your choosing.

Ethical approval has been given from Salford and Trafford Local Research Ethics Committee and the University of Salford Research Ethics Committee.

Contact

Julie Wray, Lecturer, The University of Salford, School of Nursing, Peel House, Eccles, Manchester, M30 0NN. Tel:0161 295 2974 or Mobile: 07946 316390 j.wray@salford.ac.uk

j.wray@salford.ac.uk
Appendix 7: Salford & Trafford Research Consent Form

Title of Project: Birth Recovery – women’s experiences

Name of Researcher: Julie Wray

Please initial box

I confirm that I have read and understand the information sheet dated.................... (version...................) for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

I understand that sections of any of my medical notes may be looked at by responsible individuals from [company name] or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.

I agree to take part in the above study.

_______________________  ____________________________  __________________
Name of patient          Date                        Signature

_______________________  ____________________________  __________________
Name of Person taking consent  Date                        Signature

_______________________  ____________________________  __________________
Researcher              Date                        Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes.

Mast5/consent1
Ethical Approval Form for Post-Graduates

**Ethical approval must be obtained by all postgraduate research students (PGR) prior to starting research with human subjects, animals or human tissue.** A PGR is defined as anyone undertaking a research rather than a taught degree, and includes MRes, MPhil and PhD. The student must discuss the content of the form with their dissertation supervisor who will advise them about revisions. A final copy of the summary will then be agreed and the student and supervisor will 'sign it off'. The applicant must forward a hard copy of the Form to the Contracts Office once it is has been signed by their Supervisor and an electronic copy emailed to the Research Governance and Ethics Committee through Max Pilotti m.u.pilotti@salford.ac.uk.

*(The form can be completed electronically; the sections can be expanded to the size required)*

**Name of student : Julie Wray**

**Course of study : PhD**

**Supervisor : Professor Martin Johnson**

1. **Title of proposed research project**

   Birth recovery - women's experiences

2. **Project focus**

   The overarching aim of the study is to strengthen the evidence base for quality postnatal care by increasing our understanding of care from a cultural and health viewpoint. And to explore birth recovery from the mother’s perspective during the first year following birth.

3. **Project objectives** (maximum of three)

   1. To conduct a detailed investigation within one case study area, with particular emphasis upon the provision, nature and context of postnatal care/birth recovery
   2. Critically to explore experiences of mothers regarding their health and well being after birth
   3. To identify what birth recovery outcomes matter to women

4. **Research strategy** (for example, where will you recruit participants? What information/data collection strategies will you use? What approach do you intend to take to the analysis of information / data generated?)

   **Part 1 Background literature**
   The research will begin with a literature review of health and social science research around the nature and context of postnatal care, maternal health and outcomes. Alongside this, an analysis would take place of the construction of health birth recovery outcomes, as promoted through maternity care (midwifery and obstetric) health literature, policy and health promotion strategies.

   **Part 2 An in-depth study of birth recovery**
A period of observation (participant 1) of the postnatal ward environment, this will cover the 24-hour cycle of care across 2 maternity units in the North West region of England. Two maternity units have been chosen as they neighbour one another, have a history of collaboration and offer the potential to include a diverse and contrasting sample of women. This phase of the study will capture data upon the provision, nature and context of hospital care. This will then be followed by interviews with a purposive sample of 20 women within contrasting geographical locations, ages and backgrounds. I will explore in depth the nature and experiences of birth recovery from the woman's perspective, and what outcomes matter to them about their birth recovery. The most efficient means of access to these women would be through midwives and health visitors working for two primary care trusts in Manchester. Ethical approval is being sought from Salford and Trafford Local Research Ethics Committee and the University of Salford Research Ethics Committee.

Recruitment and access:
(i) Women will be identified from the postnatal wards. A sampling tool will be used to select woman.
(ii) Women will be approached by myself on the postnatal ward (this will be piloted and evaluated). And during the first week at home. An information sheet will be used with contact details so that women can indicate their participation.
(iii) Women will be recruited by myself using the sampling frame and information sheet. This study aims to be as inclusive as possible about birth recovery and women's experiences. It will include women who have had a range births e.g. Lscs, women whose babies are ill and are in special care bay unit and women whose baby has died. The nature of previous study designs has often excluded such women and this design is sensitive and has the support of midwifery managers to be inclusive.

Data will be collected longitudinally by undertaking an initial interview, a follow up interview at 3 months and a final interview at 6 months. In addition, women will be able to document notes and comments about their recovery process in a diary.

Part 3 Signposting new directions in maternity care policy around postnatal care and maternal well being

The final stage of the research will be to link the initial review of current maternity care policy with the observational data, experiences of mothers and data obtained from the interviews and diaries. The findings could point the way to new directions in maternal health and support strategies, which could then be developed and piloted in a further research project in partnership with appropriate health professionals and other agencies. A dissemination workshop will be held towards the end of the research period to explore this possibility.

1. I am a registered and practising midwife but in this context I will act as a 'volunteer' offering to help with simple activities in busy times.

5. What is the rationale, which led to this project (for example, previous work – give references where appropriate)

Midwives and mothers know that after pregnancy and birth the postnatal period can be the most challenging, exciting, and yet demanding, even difficult final phase of the procreation journey. The adjustment and transition to parenthood can be a hybrid of emotions from pleasure to despair, often overwhelming mothers and fathers immediately after birth and beyond. Postnatal care should be unique, special and delivered to mothers in a sensitive and caring way so that they feel able to recover, adjust and even enjoy themselves. Yet postnatal care is often referred to as the 'Cinderella' of maternity care. This accepted metaphor is bandied around in ordinary and everyday speech within midwifery and I wonder why this metaphor has been sustained in our every day discourse. What does such a negative term really mean within contemporary midwifery?

For example is it connected to reluctance from staff (including midwives) to do this type
of work or do midwives perceive that postnatal care is dull and lacking in excitement or drama compared to antenatal care or birth. Or has - Cinderella, just become one of those words that we are all comfortable with or maybe it symbolises that this aspect of the service is an ‘after thought’. More importantly if this is the professional context then how is this impacting upon women and their families? We do know that women make more negative comments about postnatal care than any other aspect of their maternity care. (Audit Commission 1997) and in particular the women cite that their hospital stay was their least satisfying experience (Wray 2000, (Audit Commission 1997).

Recovery from birth is assumed to be a natural progression to a good state of health for most women in the UK. Additionally, it is suggested that women in the UK normally make a full recovery from the physical, emotional and psychological impact of childbirth by at least six weeks (UKCC 1998). Little is known about what outcomes matter to women and what they would regard as an outcome in terms of their own recovery. We know very little about whether different outcomes matter or count more to some women than others. For example is age a significant factor, do younger women have different expectations than older women? How much does the type of birth impact upon women? In what ways does the hospital stay and care provision affect women?

This study aims to capture data that will provide insight into what constitutes birth recovery from the mother’s perspective and what matters to them in this process such as outcomes. In addition, it will enable practitioners to consider the provision, nature and context of postnatal care/birth recovery based upon the experiences of mothers. It will further provide insight into the outcomes that matter and count to women to create a body of knowledge that has the potential to inform and shape practice.

Refs:

6. If you are going to work within a particular organisation do they have their own procedures for gaining ethical approval – for example, within a hospital or health centre?  
YES / NO

If YES – what are these and how will you ensure you meet their requirements?

I have applied to Salford and Trafford LREC (March 2004). I have fulfilled the research governance documentation for the 4 NHS Trusts; Salford Royal Hospitals NHS Trust, Trafford Healthcare NHS Trust, Trafford PCT AND Salford PCT. I have secured support from the Salford and Trafford Heads of Midwifery and their respective governance committees. I am awaiting an honorary NHS contract from Salford PCT.

7. Are you going to approach individuals to be involved in your research?  
YES/ NO

If YES – please think about key issues – for example, how you will recruit people? How you will deal with issues of confidentiality / anonymity? Then make notes that cover the key issues linked to your study

Recruitment and access:
(i) Women will be identified from the postnatal wards. A sampling tool will be used to select woman.
(ii) Women will be approached by myself on the postnatal ward (this will be piloted and
evaluated). And during the first week at home. An information sheet will be used with contact details so that women can indicate their participation.

(iii) Women will be recruited by myself using the sampling frame and information sheet. All data will have anonymity. All quotes will be anonymous and have no identifying markers.

Tapes and transcripts will be coded with no personal details.

The analysis will take place at the researcher's place of work - University. I have a locked office and locked filing cabinets. My computer has a secure password. I will undertake full analysis but will discuss issues in the context of supervision.

8. More specifically, how will you ensure you gain informed consent from anyone involved in the study?

Consent:
All participants will be given an information sheet and consent from that will be backed up by verbal explanation.
Participants will be able to consent for themselves.
During the process of the study this will be revisited and consent agreed at each stage, on an ongoing basis.
I plan to provide copies of each participant's transcript for verification and this will supplement their consent.

9. Are there any data protection issues that you need to address?

YES / NO

If YES what are these and how will you address them?

Only the research will know who the participants are. Their details will only be accessible to the researcher and destroyed once the study is complete (estimate 2006).

10. Are there any other ethical issues that need to be considered?

In the main I consider that the main issues are consent, securing anonymity and data protection. As outlined I will be ensuring that each participant gives written and verbal consent throughout their involvement.

I will remove identifying markers from data, code transcripts and provide minimal access to such data.

Women will be invited to talk about their own experiences of birth recovery, which may invoke emotions that could be sensitive and upsetting for them. The context of the interviews will be one to one and at any stage they can be terminated and discarded at the women's request. Referral to appropriate professionals (such as health visitor or general practitioner), self-help/support groups (National Childbirth Trust or local groups) and or counsellors.

The nature of the data is such that participants could disclose sensitive issues and these will be treated with respect confidentiality and used only within the context for which data were collected. I will inform participants that my duty as a professional is such that it could be the case that information requires sharing and this will be made clear should this arise.
11. How many subjects will be recruited/involved in the study/research? What is the rationale behind this number?

20 – 30 purposive sample. Rationale is pragmatic in terms of time and resources for sole researcher. It is anticipated that the data set will be large as interviews will be conducted up to 3 times with each participant.

Please attach:

- A summary in clear/plain English (or whatever media/language is appropriate) of the material you will use with participants explaining the study/consent issues etc.
- A draft consent form – again in whatever media is suitable for your research purposes/population.
- A copy of any posters to be used to recruit participants.

Remember that informed consent from research participants is crucial, therefore your information sheet must use language that is readily understood by the general public.

Projects that involve NHS patients, patients’ records or NHS staff, will require ethical approval by the appropriate NHS Research Ethics Committee. The University Research Governance and Ethics Committee will require written confirmation that such approval has been granted. Where a project forms part of a larger, already approved, project, the approving REC should be informed about, and approve, the use of an additional co-researcher.

I certify that the above information is, to the best of my knowledge, accurate and correct. I understand the need to ensure I undertake my research in a manner that reflects good principles of ethical research practice.

Signed by Student ..............Julie Wray ........

Date ......14.3.04 .................

In signing this form I confirm that I have read and agreed the contents with the student.

Signed by Supervisor ......Martin Johnson .....................

Date ......14.3.04.................................
*Please also complete and sign the attached Risk Assessment Form.

UNIVERSITY OF SALFORD

Research Governance and Ethics Committee
HEALTH AND SAFETY
RISK ASSESSMENT OF STUDENT PROJECTS

All student projects should undergo risk assessment. It may be that the assessment of risk is minimal and no further action would be necessary, but you are required to demonstrate that risk has been considered.

Please answer the following questions with regard to the project.

1. What is the title of the project?

   Birth recovery - women's experiences

2. Is this project purely literature based?
   YES / NO

If YES, please go to the bottom of the page and sign where appropriate.

3. What are the ethical issues to be considered?

   In the main I consider that the main issues are consent, securing anonymity and data protection. As outlined I will be ensuring that each participant gives written and verbal consent throughout their involvement.

   I will remove identifying markers from data, code transcripts and provide minimal access to such data.

   Women will be invited to talk about their own experiences of birth recovery, which may invoke emotions that could be sensitive and upsetting for them. The context of the interviews will be one to one and at any stage they can be terminated and discarded at the women's request. Referral to appropriate professionals (such as health visitor or general practitioner), self-help/support groups (National Childbirth Trust or local groups) and or counsellors.

   The nature of the data is such that participants could disclose sensitive issues and these will be treated with respect confidentiality and used only within the context for which data were collected. I will inform participants that my duty as a professional is such that it could be the case that information requires sharing and this will be made
4. **Does the project involve the use of ionising or other type of “radiation”.**
   
   YES / NO

5. **Is the use of radiation in this project over and above what would normally be expected, for example, in diagnostic imaging?**
   
   YES / NO

6. **Does the project require the use of hazardous substances?**
   
   YES / NO

7. **Does the project carry any risk of injury to the participants?**
   
   YES / NO

8. **Does the project require participants to answer questions that may cause disquiet / or upset to them?**
   
   YES / NO

If the answer to any of the questions 4, 5, 6, 7 or 8 is YES, a risk assessment of the project is required.

Signature of student …………Julie Wray … Date 14.3.04

Signature of supervisor ……..Martin Johnson . Date 14.3.04
Appendix 9: Example of field note jottings

1. Early jotting
Record July 2004 – observation
I have undertaken a single observation (felt to be a novice) – a pilot say, and interestingly many issues that Jennifer Mason highlights emerged – e.g. deciding what to observe, my own role, identity and conduct, how to record and document – what to document, how to make sense of it and reflective nature of being there and how it all links to the research questions. I visited one care setting (the other to be organised in due course). I was struck by two unexpected matters (i) the entrance/exit to the ward area, which is locked and ‘people’ managed by the ward staff and (ii) the use the curtains around the bed areas, women tend to keep the curtains around their bed 24hours a day i.e. no public viewing!

2. Later jotting
Record 22.4.05 – leaving an interview
TN
Thought about how the bio-medical model of care and p/n recovery is dominant. For these women that I have interviewed it is about social/environmental and lay beliefs about recovery. How much friends and family influence, support and impact but also ‘self’ plays a huge role. These women are resistant, resourceful and self aware. By the end of 3 interviews they are thinking more about own futures, jobs, skills and external stimuli – setting goals.

MN
Noted that televisions are on a lot when I visit women, some women are aware of this when I start the digital tape and others are not, so have to ask for TV to be turned down, they don’t notice the noise and struck me same as on ward ….. so what is this about? (issue of self in this – it bothered me and wonder why?) Struck by notion of ‘memory decay’ often cited in medical literature (Oakley maybe refers to this). No woman I have spoken with had forgotten about birth or the first few days after – events and issues were very clear, certainly the hospital stay was clear as a bell, though not foci of talk after a few months have passed – bouncing back concept.

AN
At 6/7 months – things that are cropping up amongst all the women are: Figure, body image, exercise, socialising, looking good and feeling firm, having control, having fun and pleasures away from motherhood. Identity seems to be key here, certainly takes longer than 6 weeks for physical recovery. The outcomes that seem to matter to women covers, establishing a Routine – for self, baby, family and social life, social outcomes matter and not all are bio-medical. For example I have heard women saying that they desire to be treated with respect as an individual – not just a mother. How they were cared for (or not) in hospital seems to have an impact of self belief and confidence in those early days.

Each time I meet and speak with these women I remember that being in hospital is fraught, not that useful to women. I am questioning the reasons for and function of postnatal care. So far it appears that policy dictates – but then it is old, original reasons were to prevent puerperal infection, supporting and
instructing mothering. Rituals of undertaking surveillance / checking on both health and well being of mother and infant, I guess based on tradition and convenience. Some of things women say are amazing and could have potential with themes, I think I have read that what participants say is called invivo – check theory on this. Like the woman who said she felt like she was in ‘prison’, it was not what she expected at all, restrictive with her partner and not shown about mothering, how to do baby care, she had no rest/sleep/help Completely left to her own devises she also said that the whole experience spoilt the ‘celebration’ of birth, she felt lonely/isolated, disappointed, uncertain and no-confidence – other women made similar comments. I am wondering what women expect and how there is a distinct mis-match between expectations and what happens – representation vs reality arguments.

AN
Maybe postnatal care should be highly selective
Let most women go home immediately after birth?
Provide home-based support
Nursing homes?
Nursing care assistants
Enable piece and tranquillity
All of above provided in a mother/baby friendly place that fosters rest and routine
Benefits of the hospital stay are limited
Observations were that midwifery staffing unable to cope with workload and admin and diversity of care needs, can midwifery be expected to meet them all?
Criteria for staying would be c/s or ill baby
Or have a structured care plan and set of outcomes that are met for all women??

TN
Foucault p112, disciplinary power
The way in which bodies are regulated
P113 - Bodies are examined and information is processed about them
(Foucault says this is a process which is unique in modern societies)
Disciplinary power – hierarchical observation
Normalising judgement
Examination – assessed and corrected
P113/114 - P/N is only time where all women are ‘pooled’ together into one space /place for ‘clinical gaze’ within the panoptic structure (115)
As a means of ‘seeing mothering’ not bound up in ‘seeing recovery’ from a positive and enabling perspective. Indeed, some staff ‘don’t like babies’ this job would be alright if it weren’t for those babies, women’s recovery as women as themselves to some the babies are trivial and peripheral to midwifery

Key: TN=Theoretical note, MN=Methodological note, AN=Analytical note