

A New Postnatal Home Care Worker: Challenges for Training, Implementation and Policy

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Abstract

The rise in paid care workers has not, until very recently, included carers specifically trained to provide domiciliary postnatal care. In 2002 a new occupation of domiciliary postnatal carers was introduced in the catchment area of a large metropolitan hospital in Adelaide, South Australia. The carers work with professional midwives to provide home based postnatal support to women discharged early from hospital following childbirth. Carers were trained in a short, six month program, and were recruited from long term unemployed young women from the same geographically disadvantaged catchment area as the hospital. In this paper, findings from the evaluation of the program are described and analysed. These include its implications for the postnatal care workers themselves and for the professionals involved in training and working with them. In addition, the implications for birthing women of a program using young, minimally trained carers are considered. Finally, the more general lessons for the training and 'insertion' of paid carers into domiciliary work with professionals are reflected on.

Keywords: postnatal-care, domiciliary, training

Introduction

The growth in paid care work is an important contemporary development with significant implications for care givers, the recipients of that care and for the organisation of care services (Meagher 2006; Kirk and Glendinning 1998) There has been significant growth in domiciliary paid care, particularly for the aged, disabled and those discharged early from hospital with acute and chronic health conditions (Boris and Klein 2006; Solari 2006; Stacey 2005; Pickard et al. 2003).

The shift to home based care work reflects important trends toward de-institutionalisation, economic rationalism and the de-medicalisation of some areas of human experience. The provision of postnatal care is increasingly subject to these trends, with significant reductions in the length of time women spend in hospital following childbirth being reported in a large number of Western countries including Australia, Canada, Switzerland, the U.K. and the U.S. (Brown et al 2004; D'Amour et al 2003; Boulvain et al 2004; Dato et al 2000). In Australia, the proportion of mothers discharged less than two days after delivery rose from 3.2% to 11.4% between 1991 and 2000 (AIHW 2003).

These increasingly short hospital stays raise the question of who will provide postnatal support and care to new mothers and their babies. Although well developed programs of postnatal support are available in some parts of the world such as the Netherlands and the U.K., the provision of home based postnatal care in Australia has generally relied heavily on the informal care provided by family and friends with varying degrees of professional oversight and care from domiciliary midwives (AIHW 2003; Cooke and Barclay 1999).

The provision of postnatal care utilising specifically trained paid carers is a novel innovation in Australia, and was introduced for the first time in 2002 in Adelaide, South Australia. The program and its aims are described in this paper. Their implications for the training and youth of the carers, for birthing women, and for the professional midwives with whom the carers work, are analysed.

Background to the Australian Mothercarer Program

A new postnatal home care support worker, believed to be the first of its type in Australia, was introduced in a geographically defined catchment area of a metropolitan hospital in Adelaide, South Australia in 2002. The pilot project utilised elements from home based postpartum care in the Netherlands and the UK (Spilby and Crowther 1999; Francomb 1997; Benoit et al. 2006). In particular, the Australian home care worker, known locally as a Mothercarer, was modelled on the Dutch *kramverzorgende* (postnatal care givers), who work in conjunction with midwives to provide home based care to women following the birth of a baby. The nature of the care work included light domestic duties (which might include cooking and laundry tasks), assistance with childcare of other children in the home, support with feeding and other aspects of baby care, and social and emotional support to new mothers as appropriate. In short the type of assistance provided depended on the needs of the individual mother.

Program Structure and Implementation

Funding and Broad Aims

The Australian innovation described in this study received funding from two sources. The first, the Foundation for Young Australians (FYA), is an organisation whose aims are to address the needs of young people. It provided funding for the design and implementation of a six month training program to be delivered twice. The participants in these training programs were therefore to be drawn from the young: an age criterion of between 18 and 25 years was stipulated for potential trainees. In addition, training was limited to females who had been unemployed and who were from the hospital's catchment area. Desirable outcomes of this component of the program were the provision of quality training, with measurable improvements in life skills and self esteem, and sustainable employment.

The second source of funding was the Department of Human Services (DHS) South Australia. The financial commitment from this source was toward the employment costs of the Mothercarers for a 2 year period in the first instance (this has since been extended). The objectives of this part of the program included various indicators of maternal and infant health and well being which might be expected through the provision of systematic postnatal support.

Recruitment, Training and Employment

The first group of trainees were recruited following extensive advertising, with the result that approximately 150 young women attended an initial information session. Ultimately, 27 of them were selected for training. Of these, five identified as indigenous.

Although the initial training program was fee free, it was not accredited by Centrelink and therefore participants were not able to simply move onto an education based form of income support such as Austudy, Abstudy or Youth Allowance (Student). For many of the young women, eligibility for benefits had to be individually negotiated with respect to the activity test for continued receipt of Newstart and Youth Allowance (Unemployed). The training program has since been accredited through the Vocational Education and Training system as a Certificate Three course 'in line with childcare and domiciliary home support' (Postpartum Household Assistants 2002).

The first group of trainees were guaranteed employment following graduation on a short term contract basis, paid for the hours worked. The evaluation period did not allow an examination of the employment for the second group of trainees. Unlike the first intake, there was no guarantee of employment for this group: their employment depended on demand for the service.

Service Provision and Program Structure

The program was structured to provide postnatal women opting for early discharge from hospital with support in their own home for up to six days following discharge. Early discharge was defined as up to 24 hours following delivery. Eligibility for the Mothercarer service has since been expanded to women with somewhat longer periods of hospital stay, generally up to 48 hours for a normal delivery, or 3 days following Caesarean section. Women discharged early, or those with any other indications for

follow up care at home, received visits from the hospital's domiciliary midwifery service. Both the domiciliary midwife and Mothercarer service were provided free of charge.

Women in the program therefore received, in their homes, general support from the Mothercarer as well as postnatal care from trained and experienced midwives. The midwives provided daily home visits for up to seven days. They checked the physical condition and wellbeing of the mother and baby, provided advice, support and referrals as required, and their visits would rarely last more than an hour.

On the Job Training and Supervision

From the outset, the structure of the program was built on domiciliary midwives being the main resource for clinical support and on the job training of the Mothercarers, who were instructed to '...notify the Home Midwife...' in case of any of a range of medical, social and / or emotional states pertaining to the mother and the baby (Policy and Procedure Manual 2001). Throughout the program's implementation and establishment phase, domiciliary midwives took primary responsibility for program management on weekends and public holidays, as well as providing crucial clinical support, consultation and training to the Mothercarers in their training and in their practice. In essence, then, the introduction of the Mothercarer program resulted in the expansion of the role and responsibilities of the domiciliary midwives from the provision of postnatal care to include a significant role in on the job training and supervision of this new category of care workers.

Level of Program Uptake

The proportion of women taking up the Mothercarer service grew steadily to plateau at approximately 30% of those eligible for the service, somewhat lower than projected levels of uptake.

Methods

The material reported in this paper derives from a two year evaluation conducted by external researchers. Approval for the evaluation research was obtained from the Social and Behavioural Ethics Committee of Flinders University, and the North West Adelaide Health Service Ethics of Human Research Committee. Detailed information about all aspects of program implementation and structure were made available to the evaluators. In addition, the evaluators collected a wide range of data, three sources of which are drawn on for this study and are detailed in the next section.

Interviews with Mothercarers

Several forms of data were collected regarding the Mothercarers. Researchers obtained information about training intake numbers, completions and attritions. Between February and March 2003, all the young women trained in the first cohort, and subsequently employed as Mothercarers, participated in semi-structured in-depth interviews focusing on their early life; schooling and previous employment experiences; their experiences in applying for the Mothercarer positions; their training as Mothercarers; and their feelings about their training and work as Mothercarers. Interviews were also conducted with two of the women who completed the training program but had chosen not to work as Mothercarers. Interviews were transcribed and

analysed thematically. In addition, the life and career trajectories of the young women trained as Mothercarers in the first cohort were mapped, as were their aspirations for future employment and training.

The second cohort of trainees completed their training in December 2003. Focus group interviews were conducted separately with this group as well as with the first cohort of trainees. Themes addressed in these focus groups included issues raised in other stakeholder interviews, and a range of questions regarding the training program, the organisation and experience with work placements, awareness and understanding of mandatory reporting and management of client records.

Interviews with Birthing Women

Two groups of postnatal women were recruited into the study to include a sample of both users and non-users of the Mothercarer service. A random (1 in 4) sample of all women who had given birth to a live infant at the hospital in a defined time frame (April to September, 2003) and who had declined the services of a Mothercarer was drawn from the hospital's birth records. These women were sent information in a cover letter with a response slip to provide contact details if they wished to participate, and a reply-paid envelope. One reminder was sent to non-respondents. The response rate for this group was 25.8%. Interviews were generally conducted face to face, although in some cases telephone interviews were conducted where this was the woman's preference. Thirty three interviews lasting on average one and a half hours were conducted with this group.

The sampling frame for the second group of postnatal women comprised all postnatal women who had given birth to a live infant in the same period as above and who had used the Mothercarer service. They were contacted in the same way, with one reminder sent to non-respondents. The response rate for this group was somewhat higher, at 34.6%. Thirty in-depth interviews lasting between one and two hours were conducted, either face to face or over the telephone, with this group of women.

Both groups provided detailed qualitative information about their perinatal experiences, their knowledge of and attitudes to the Mothercarer program, and their experiences of and feelings about their transition home. Women who had used the Mothercarer service were asked about their specific experiences, and were also asked a series of closed ended questions asking them to rate various aspects of the service.

Both groups were asked for suggestions about how the service might be improved. The responses to the open ended questions were recorded verbatim by trained interviewers, and transcribed immediately following interview. The qualitative components of the interviews were analysed according to their content and the themes and issues that emerged. The data from the closed ended, quantifiable questions was coded and entered into Excel spreadsheets for descriptive purposes.

Interviews with Midwives

A total of fourteen individual interviews were conducted with the midwives in the domiciliary midwifery service, with the program administrators and managers, and with a sample of midwives from the hospital's birthing centre. In addition, a focus group was held with five community based maternal and child health staff who had contact with

the Mothercarers in their training and in their work. The midwives who participated in the focus group were a self-selected sample recruited through their employer, an organisation known as Child Youth Health (CYH). Recruitment was limited to midwives working in the hospital's catchment area with experience in the training and / or work of Mothercarers.

The researchers developed semi-structured, in depth interview schedules relevant to each of the groups. Domiciliary birthing centre midwives were asked for a brief synopsis of their backgrounds in midwifery, and a series of questions about their individual experiences of the Mothercarer program. The interviews were tape recorded, and responses analysed thematically and in terms of specific issues regarding training, program structure and implementation.

The focus group interview with the community based maternal and child health workers was not tape recorded, but extensive notes were taken by the researcher. This interview focused entirely on the type of contact these midwives had with Mothercarers, their global assessments of the program as well as specific aspects of the Mothercarer's training and work.

The program managers and administrators provided information about the program's history, implementation, structure, administrative procedures such as everyday management, reporting and quality assurance and human resources issues.

Findings

Implications of the Program for the Mothercarers

Interviews with this group revealed the extent to which the trainees were from disadvantaged backgrounds. Of the 13 interviewed, only seven had completed Year 12, and at least two of these had not achieved a SACE score. Six had begun, but none had completed post-secondary qualifications such as TAFE courses. Six had become pregnant either as teenagers or in their early twenties. Most came from families in which there has been some form of family breakdown such as divorce, separation or death of a parent; four of the Mothercarers spent a significant part of their childhood without their mother.

These young women's evaluation of the opportunity to be a Mothercarer was extremely positive. At a personal level, many described the experience of being trained and subsequently employed as transforming their lives, improving their self image and providing intellectual stimulation. A recurring theme in a number of the interviews was that the Mothercarer training had 'changed my life.' One young woman said

...before I always felt like a failure and I'm not...I can get my life back on track, it [the training] ...made me feel differently about myself...
(*employed Mothercarer, interview #1*)

The relative disadvantage of the group as indicated above no doubt contributed to the high level of demand for the program with its fee free provision of a training program and guaranteed employment.

In terms of career aspirations, planning and trajectories, the interviews with the Mothercarers also provided strong indication of the transformative impact of the

program. Discussions regarding their career plans or the actual destinations of those who had left the program revealed the extent to which the training and subsequent employment served as either the first step in a longer pathway of skill and career development, or as a springboard into a wider labour market. Many of the young women were able to articulate future career goals and understood what was necessary to achieve them. A number of the Mothercarers expressed an interest in undertaking further training and / or education, particularly in the area of midwifery. Some indicated that they would like to be running the Mothercarer service, reflecting self confidence, engagement with the labour market and the attainment of human capital.

Although the focus of the positions was postnatal care work, broader skills related to communication, promotion and marketing, business administration and information management were also developed through participation in the program. One former Mothercarer, employed elsewhere at the time of interview, was confident that being employed (as a Mothercarer) had enhanced her chances of getting a different job, a finding replicated in other studies (Brotherhood of St Laurence 2005).

Implications for the Training Program

Despite the general consensus that program participation had been beneficial, there were a number of criticisms that were raised. There was some disappointment, for example, in the perceived lack of legitimacy or external recognition of the training program in relation to the welfare system on which most had depended. This highlights the importance of formal recognition of training programs for care workers.

In relation to the content of the training program itself, several issues emerged that are of relevance to the training of paid carers more generally. First was the pedagogical mode, with many trainees expressing a preference for practical as opposed to abstract knowledge. The training course included a one month 'placement', the aim of which was to provide Mothercarers with work relevant experience. Mothercarers rated this as the most valuable part of their training *if* their placement was with professionals such as the domiciliary midwives, the midwives in the hospital's postnatal wards or birthing unit, or with CYH midwives.

A frequently mentioned example that illustrates the importance of work based learning with experienced professionals relates to the provision of support to mothers learning to breastfeed their babies. The primary means through which Mothercarers were taught about this topic was through texts and video recordings. Not surprisingly, many of the Mothercarers found this to be quite inadequate, a view reiterated by professionals with whom they worked. However, for the Mothercarers whose placement was with a professional such as a domiciliary midwife or CYH nurse, the situation was very different. In these cases, the practical experience enhanced their competence and confidence in their role.

Other placements at locations such as child care centres were often problematic, at times being seen as irrelevant, at other times exploitative, as for example at some child care centres where their tasks included bleaching sandpits. These findings suggest very clearly that from the perspective of trainee carers, on the job training by professionals in the field is not only valued but necessary to their successful socialisation and training.

In sum, the improvements to the training program suggested by the Mothercarers included a faster paced training program, more relevant, intensive, timely and frequent placements, and more practical experience with professional care givers such as midwives, or with experienced Mothercarers.

The evidence from the Mothercarers certainly demonstrates that this training program with its employment opportunities for young, disadvantaged women has had clear benefits for the program participants in terms of their self esteem, career trajectories and labour market prospects. These are undoubtedly important given that young workers, particularly young women, are more likely to be in part time casualised positions than adult (25 – 64 year old) employees (Dusseldorp Skills Forum 2006: 26).

Yet despite the obvious advantages of such a program for young, disadvantaged women, the response of birthing women to the youthfulness of the Mothercarers, discussed in the next section, was often less than positive.

Birthing Women's Perceptions of a Young, Minimally Trained Carer

Interviews with birthing women indicated that the vast majority were supportive of the implementation of a domiciliary postnatal support program. Despite high levels of in principle support for the program, a large proportion of the birthing women eligible for the service chose not to use it. Some of the reasons for this have been explored in detail elsewhere (Zadoroznyj 2004). However, of relevance to this paper is the extent to which women's reluctance to use the program is informed by their concerns about both the youth and the minimal training of the Mothercarers.

The youth of the Mothercarers was generally cast in a negative light and was the most common concern expressed by the postnatal women about the program. Over half the birthing women interviewed considered that there should be a wider range of ages recruited into the Mothercarer training program.

For a number of women, the relative youth of the Mothercarers was significant in influencing their decision to not take up the service. For some women, this rejection was informed by concerns about a young person's ability to manage the domestic domain of a household. For example, one woman said

I didn't want someone younger than me coming in and running *my* household..... (*postnatal non-user, interview # I 4*)¹.

Many women talked explicitly about being unable to accept the idea of a young person managing their domestic domain, and rejecting the service for this reason.

For others, youth was assumed to imply lack of relevant experience in relation to household management or childrearing. If Mothercarers were mothers themselves, their experience was generally highly valued and gave the Mothercarers status and legitimacy otherwise lacking due to their youth and minimal training. For birthing women who used the Mothercarer service, there were clear differences in approach to Mothercarers depending on their parental status. A number of birthing women indicated that they felt comfortable asking their Mothercarer about baby care if the Mothercarer had children of her own, a typical comment being

I felt comfortable asking the Mothercarer about baby stuff...because she already had a baby... (*postnatal user, interview #J 18*)

In contrast, a mother of a two year old toddler and twin babies who used the Mothercarer service made the following observation

I had a very young Mothercarer so it is hard to take advice from people who have not had children themselves. They have learned these things and want to put it into practice, but every child is different, so there cannot be set rules. I only had the Mothercarer for two days. I was not confident or comfortable asking her for help or advice (*postnatal user, interview #I 18*).

While the personal experience of parenthood may have counterbalanced the perceived disadvantage of youth and its concomitant lack of experience, there was a consistent perception amongst birthing women that a six month training program was basically inadequate. Thus for many women having a baby, relying on a 'teenage' or very young woman, especially one with little training, did not have much appeal. This was reflected in comments such as "I would not want a young girl with six months' training..." (*antenatal non user, interview #AN 13*)

Of the women who did use the Mothercarer service, generally similar concerns were expressed, even though their personal satisfaction rating for the service might have been quite high. This is exemplified in the following comments of one postnatal woman who said:

All those who are trained are between 18 and 25, they have too little experience. I was lucky with mine, she was a natural with the baby; I felt confident leaving the baby with her. The Mothercarer should be 40, 50, to me the service is aimed at the wrong age group. 18 - 25 year olds would not have had much cooking or cleaning experience let alone know anything about children. I was very sceptical...but I met her in hospital and she turned out to be very, very good, much better than I expected...[but they should] employ people with experience, with children, older women. The service is important but the women are too young (*postnatal user, interview #I 6*)

Another woman said simply

...I think some of them are too young...I knew my Mothercarer's life better than she knew mine... (*postnatal user, interview #J 3*)

The youth and relative lack of experience together made many postnatal women reluctant to rely on Mothercarers for advice, as typified in the following comment

I didn't feel confident asking for help or advice as I wasn't confident in the Mothercarer's level of expertise (*postnatal user, interview #J 3*)

Despite having a Mothercarer, most users of the service relied on professionals, either domiciliary midwives, CYH midwives, or a parent help line run by CYH for advice.

For a few women, the youth of the Mothercarers was seen as an advantage. One woman said she liked the fact the Mothercarer was young, saying

...she was young, that was good...she [got on well with my other children...] (*postnatal user, interview #I 20*)

In addition, young mothers who used the Mothercarer service were able to relate easily to a young worker, and develop affective ties of friendship, so for this group young workers were an advantage.

Implications for Home and Community Based Midwives

The role of domiciliary midwives expanded in a number of ways with the implementation of the Mothercarer service. First, they were called on to provide support and training to individual Mothercarers during the placement component of their training program. And, as discussed above, Mothercarers considered these placements to be the most useful in their training experience.

Second, domiciliary midwives also provided on the job support and sometimes instruction to Mothercarers in handling the complexity of clinical and domestic situations which exist in the area. As already noted, the domiciliary midwives were 'written in' to the program's policy as a crucial resource and key point of consultation for the Mothercarers about a wide range of situations and/or conditions (Mothercarer Policy and Procedure Manual 2001).

Third, the domiciliary midwives also provided some degree of monitoring and supervision of Mothercarers. On weekdays this monitoring and supervision was relatively informal and generally opportunistic, occurring when both Mothercarer and midwife are in the same woman's home at the same time. For instance the daily visits of the midwife provided an opportunity for Mothercarers to consult with the midwife, and for the midwife to keep an eye on how the new mother, baby, and the Mothercarer were managing.

It is also important to note that in the initial period of the program's implementation, the program manager, who was not a midwife, also relied on the domiciliary midwives for advice and support of a clinical nature. This situation has now changed with the appointment of a trained midwife as the program manager. In essence, then, the domiciliary midwives not only provided care and support to postnatal women and their babies but also to the Mothercarers whose work they supported, supervised and monitored, albeit semi-formally.

Despite their pivotal role in program implementation, interviews with the domiciliary midwives revealed their perception that they had not been adequately consulted about several key aspects of the Mothercarer program. The first is in relation to the training program and curriculum design. In the words of one domiciliary midwife, this '...was one of our issues....never saw any of the curriculum..' (*domiciliary midwife, interview # 3*). Given that these midwives work in the same homes as the Mothercarers, and that their roles intersect to a significant degree, the lack of their systematic input into the training program curriculum emerged as a notable problem.

Domiciliary midwives also expressed their concerns about not being systematically involved in the design of the structure of the service. This was particularly problematic given the extent to which their input was required in the implementation and management of the Mothercarer program. Midwives said they were surprised at the extent of their role, indicating that they ‘..didn’t expect our role to be as big as it was...’ (*domiciliary midwife, interview # 5*).

Another issue relates to the line management structure. Domiciliary midwives have the closest ‘hands on’ appreciation of the capabilities and the work performance of Mothercarers, yet in structural terms had little formal opportunity or mechanism for providing performance appraisal (even though this could be done informally). This resulted in frustration for the midwives who were concerned about the performance of some Mothercarers in the program’s implementation phase, yet who felt there was little they could do to enhance or develop performance where it was needed.

The day to day supervisory role that domiciliary midwives took on with the implementation of the Mothercarer program has meant, for most, an overall increase in their workload. Some added that the youth and relative lack of experience of the Mothercarers exacerbated this problem. Organisationally there was little provision to take these additional responsibilities into account.

Despite these considerations, domiciliary midwives were supportive of the Mothercarer program and wished to see it continued because of its benefits to postnatal women and their children. In particular, the midwives from the hospital’s long established birthing centre were enthusiastic about the program because it offered a structured (and reassuring) extension of hospital support services to women and children most ‘at risk’.

In contrast, a focus group of maternal and child health nurses who had contact with the Mothercarers, either on placement as part of the Mothercarer’s training program, or working in the homes of postnatal women, were far more ambivalent about the program and its implementation. These nurses provided a combination of clinic and home based support to mothers and their babies. They expressed concerns including inadequate professional socialisation in the short six month training program. They were also concerned about the youth and limited experience of the Mothercarers and about the ambiguity of their role, especially with regard to the provision of breast feeding support. While Mothercarers were trained to provide support to make it possible for women to breast feed (by looking after other children, for example) the child health nurses were concerned that Mothercarers may transgress this boundary to actually offer advice on breast feeding. These concerns were expressed most strongly by the lactation consultants in the group. Their years of training and experience made them concerned that more harm than good might result should Mothercarers give advice.

Conclusion and Implications for Future Programs

The provision of home based postnatal support by a new category of trained paid care worker was an important initiative given the significant reductions in the length of time women spend in hospital following childbirth. The innovative Australian program to train young unemployed women as paid carers described in this paper has provided some salutary lessons for future program development. The initiative had clear benefits

for the postnatal women and their families who take up the service (Zadoroznyj 2007). However, the youth and relatively low level of training were perceived as problematic by many potential and experienced users of the service who would have preferred postnatal support workers to be drawn from a wider range of ages and with a more sustained and higher level of training.

The Mothercarers themselves, unlike many of the other stakeholders interviewed, did not see their youth as a disadvantage. Rather, they saw their youth as particularly advantageous in relating to 'young mums' of whom there is a high prevalence in the area.

The program of training young unemployed women described in this paper has also clearly had a major positive impact on the employment and the employability of these women, and on their life skills and confidence. For a number of those who trained but did not continue as Mothercarers, the program has functioned as an Intermediate Labour Market (Ziguras and Kleidon 2005) which has allowed participants to utilise wider skills that have facilitated entry into other training and employment pathways. Given this, it is imperative that training programs of this type are formally recognised by the welfare system and by the vocational training and further education systems to ensure their credibility and the transferability of skills.

However, Mothercarers and all other stakeholders were of the view that significant improvements could be made to the training program itself. First, it would seem that the greater involvement of midwives and health care professionals in the training program could enhance its practical utility and its credibility with both professionals and potential clients. This concurs with experience from other countries which indicates the importance of involving midwives in 'defining the support workers' role and their ... training program..' (Morrell et al 2000: 593). The reach of medicalisation remains strong in the area of childbirth despite de-institutionalisation, and postnatal women would clearly feel more confident in, and possibly more likely to use a postnatal carer whom they perceived to be well trained. In terms of specific improvements, a greater depth of content and faster pace would have advantages for all stakeholder groups. Work based training through placements need to be better defined in terms of relevance for the job, training objectives and competencies to be achieved.

The introduction of any new worker in a health care system has the potential to encroach on the professional boundaries around work and particular tasks and responsibilities. A new occupation of care workers (especially if young and minimally trained) has implications for the workload of domiciliary midwives in the first instance and this needs to be addressed through involving the midwives themselves and making organisational adjustments accordingly. From a managerial perspective there needs to be recognition of the additional responsibilities taken on by the domiciliary midwives particularly in the implementation phase and there also need to be clear mechanisms for performance appraisal that involves these midwives.

Ultimately, postnatal care workers will provide valuable support to professionals and to birthing women and their families. Yet who is trained, how, and under what circumstances their work is organised will determine the long term success or otherwise of such initiatives.

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Endnotes

¹ Alphanumeric interview numbers are researcher reference tools only