International Journal of Qualitative Methods
Volume 20: 1–7

DOI: 10.1177/16094069211048383
journals.sagepub.com/home/ijq
SAGE

ASK a Midwife: A Qualitative Study Protocol

Nancy I. Stone[1], Gill Thomson[2], and Dorothea Tegethoff[3]

Abstract

Midwife-led institutions, also called free-standing birth centres, offer birth assistance to women at low risk for complications. Free-standing birth centres, because they are the institutions that provide low intervention birth assistance, also present the possibility to conduct research on the skills and knowledge that are necessary to provide safe care for women who are at low risk for complications desiring an out-of-hospital birth. The aim of this study is to reveal the skills and knowledge necessary to provide care at low intervention births in free-standing birth centres in Germany for midwives post-certification. The theoretical and methodological standpoint of this study is hermeneutic phenomenology. In-depth qualitative methods will be used that are particularly sensitive to the research participants and their social context and allow for complexity, detail and context. The research sites are free-standing birth centres in Germany. Three strands of data will be collected. Each birth centre has its own quality management handbook. From this handbook, the chapter concerning the induction of new midwives will be analysed. Small focus groups will be held in ten birth centres throughout Germany; and data will be collected from 10 to 20 midwives during their induction period at the birth centre. The data collection methods will be open-ended interviews, data capture, journaling and non-participant observation with the new midwives. In-depth data analysis will reveal midwives' experiences of skill acquisition in free-standing birth centres. The findings will be used to produce key recommendations for training midwives to work in birth centres.

Keywords

Midwife, Skill acquisition, Free-standing birth centre, Hermeneutic phenomenology, physiological birth

Background

Free-standing birth centres offer birth assistance to women at low risk for complications. Studies have shown that, for women who are at low risk for complications at birth, giving birth at a birth centre was as safe as hospital birth for mother and baby (Birthplace in England Collaborative Group, 2011; David et al., 2006; Stapleton et al., 2013). There are approximately 115 free-standing birth centres in Germany (QUAG, 2021). Possibilities for technological interventions at birth centres are not available. While there is the possibility for fetal heart monitoring, there is no diagnostic ultrasound available. In addition to this, it is not possible to administer epidural anaesthesia or to conduct an assisted vaginal birth (vacuum extraction) or a caesarean section. If these options become necessary, the labouring woman is transferred to a maternity unit in a hospital. Free-standing birth centres, because they provide low intervention birth assistance, also present the possibility to conduct research on the skills and knowledge that are necessary to provide care for women at low risk for complications in these institutions.

In Germany, practical midwifery education takes place predominantly in hospital maternity units, where the students are exposed to high intervention birth assistance (HebStPrV, 2020). 98% of women give birth in a hospital maternity unit, where the intervention rates are high (>93%) (Schwarz, 2008) and the caesarean section rates range from 24.0 to 37.2%

[1]Department of Midwifery Sciences, Protestant University of Applied Sciences, Berlin, Germany
[2]School of Community Health and Midwifery, Maternal and Infant Nutrition and Nurture Research Units (MAINN), University of Central Lancashire, Preston, United Kingdom
[3]Protestant University of Applied Sciences, Berlin, Germany

Corresponding Author:
Nancy I. Stone, Department of Midwifery Sciences, Protestant University of Applied Sciences, Teltower Damm 118-122, Berlin 14167, Germany.
Email: nancy.stone.phd@gmail.com

(Destatis, 2018). As a result of this, midwifery students learn about physiological low intervention birth in their theoretical studies (a spontaneous vaginal birth without induction or augmentation); however, the opportunity to experience this and learn necessary skills in their practical training is still infrequent. A significant decrease in caesarean section rates and the overuse of unnecessary medical procedures for childbearing women can only be made when midwives have the necessary skills to support normal, physiological birth.

In the currently valid version of the Study and Examination Regulations for Midwives, it is stated that 'the graduate must be able to manage a physiological birth in the vertex position (head down) …'(HebStPrV, 2020, p. 39). The level of competency necessary to offer care at hospital births is assured through rigourous study and examinations; however, the significance of this goes beyond assuring that midwives are well trained and have attained the level of competency necessary to assist (as opposed to intervene) at birth. Women have the right to birth without the use of non-medically indicated interventions. In addition to this, in Germany, according to §24f of the Social Code Book V, women have the right to choose the place where they give birth (Sozialgesetzbuch, 2019). The rights of women to choose where they give birth, as well as to choose how they give birth (in this case without interventions) are also protected by patient rights granting autonomy (Bundesgesetzblatt Jahrgang, 2013). Patient autonomy, however, is only truly achievable if choices are available. These choices can only become available when midwives achieve a high level of skill acquisition in offering low intervention birth assistance.

Study Aim

The aim of this study is to reveal the knowledge and skills necessary for midwives post-certification to provide safe care at low intervention births in free-standing birth centres in Germany. The findings of this study will use secondary evidence and empirical accounts to develop an evidence base for the training of midwives in free-standing birth centres. The results of this study can also be used to positively effect midwifery training in general.

Research Questions

The phenomena under study are the skills and knowledge acquired by midwives post-qualification to care for women within a birth centre setting. The main research questions are:

1. What are the experiences of midwives when they begin to work independently in a free-standing birth centre to support women to achieve a physiological birth?
2. What are the different formal and informal training procedures and methods that birth centres in Germany use to prepare new midwife colleagues to work independently to support and facilitate physiological birth?
3. What is the practical knowledge that is necessary to work at free-standing birth centres? Which skills are developed?

Literature Search and Originality of the Study

A literature search was conducted in the following databases concerning acquisition of skills and knowledge of newly examined midwives in free-standing birth centres: PubMed, BASE and EBSCOhost academic search complete. The search was limited to literature in English, German and French and to publications between 1980 and 2021, since birth centres did not exist before the 1980s. In addition to this, the following databases were also searched for dissertations and grey literature: Database of Abstracts of Reviews of Effects, Google Scholar and EThOS (British Library of Theses).

The search confirmed that there have been no studies conducted to date that describe skill and knowledge acquisition of midwives in a free-standing birth centre, although it did reveal one UK doctoral dissertation that described what supported and hindered skill acquisition of nurses doing their practical training to become midwives in a hospital (Chamberlain, 1993). In addition to this, articles were discovered that showed that newly qualified midwives, as well as midwives with hospital obstetric experience, needed an induction or training period in the birth centre to increase their knowledge and skills before commencing work in a birth centre. In a previous study conducted in a birth centre in Germany, the midwives required a period of apprenticeship-like training for new midwives, since it was believed that they needed skills specific to the birth centre to independently care for labouring women (Stone, 2012). In a study conducted in Norway, midwives commencing work in a birth centre after having worked in a hospital maternity unit had to 'de-learn the medical approach to birth' and experienced the change as 'culture shock' (Skogheim & Hanssen, 2015, p. 233). Norris and Murphy, in their study of student midwives' practical learning in an alongside maternity unit, remarked that the knowledge necessary for high risk births is advanced and appropriate for the hospital setting, 'whilst the low risk midwives use different, less tangible skills, but also advanced, to avoid intervention and enhance the physiological process' (Norris & Murphy, 2020, p. 4). Hence, while the necessity for an induction period has been found necessary, there are no studies to date which have described the skills and knowledge

that need to be acquired when newly qualified midwives commence work in a birth centre.

Explanation and Justification of Method

The epistemological approach of this study is social constructionism. In social constructionism, the world we live in is constructed through thoughts, actions and interactions (Berger & Luckmann, 1966). Social constructionist methodologies encourage a deeper look at 'who' is perceiving and experiencing 'what' in the context of 'where', since knowledge and understanding are context-specific. Within this interpretivist approach, the researcher can connect with the research participants and enter into intimate dialogue. This facilitates access into the lived experiences and lived understandings of research participants to reveal what has been hidden and forgotten (Crowther & Thomson, 2020). Entering into the dynamic of lived experiences and knowledge construction thus leads to deeper understandings (Hiller, 2016).

The theoretical and methodological standpoint of this study is hermeneutic phenomenology. In phenomenological research, the researcher is encouraged 'to sustain an intuitive grasp of what is there by "opening his eyes", "keeping them open", "looking and listening", "not getting blinded"' (Heron, 1992, p. 164 in Crotty, 1998, p. 80). In-depth qualitative methods are used that are particularly sensitive to the research participants and their social context and allow for complexity, detail and context that cannot be quantified. In a phenomenological study, the goal is not to look for cause and effect, or to generate theory, but to describe and understand phenomena in-depth and to identify key qualities. Furthermore, while it is not the goal of a phenomenological study to make generalizations, it can provide rich, contextual accounts that others can recognize and can inform evidence-based practice (Van Manen, 2014). Van Manen wrote: 'If we are concerned with "evidence-based practice", then we have to distinguish between (a) specific practical situations where "best action" can be supported by empirical (hopefully generalizable evidence that seems most relevant and applicable under the circumstances and (b) practical situations where thoughtful sensitivity, tactfulness, and meaningful understanding play a critical role. In the latter situation, phenomenological understanding and insight into a certain phenomenon may lead to more appropriate action' (2014, p. Loc 8631). Hermeneutic phenomenology was chosen for this reason, since acquiring the skills and knowledge to care for labouring and birthing women outside of a hospital requires sensitivity and heightened discernment, qualities which cannot be quantified.

Research Sites

The research sites are free-standing birth centres in Germany. Stratified purposeful sampling will be utilized to choose the birth centres where focus groups will be held (Palinkas et al., 2015). They will have diverse characteristics and be chosen according to:

- Size of the birth centre (determined by the number of births per year and the number of midwives working at the birth centre);
- Distance from the nearest hospital in the case of a transfer from the birth centre during labour or postpartum;
- Location of the birth centre (the size of the city or town in which the birth centre is located);
- Type of internal structure (team care for women or individual care: one midwife: one woman throughout pregnancy, labour and birth).

According to Lincoln and Guba, purposive sampling exposes the researcher to an extensive range of realities and reinforces the possibility that the results include a wide scope of experiences (Lincoln & Guba, 1985).

Sample Size

- Ten focus groups (3–4 midwives in each)
- 10–20 midwives-in-training (digital capture-messaging through a service with end-to-end encryption and journaling without observation)
- 5–10 midwives-in-training (digital capture and journaling with non-participant observation)

Inclusion and Exclusion Factors for Research Participants

For the focus groups, the midwives must have >3 years' experience as the lead midwife at births in a birth centre in Germany and have undertaken their midwifery studies in Germany. For the midwives-in-training, they must be in their first 3 months of working at the birth centre, must have undertaken their midwifery studies in Germany and must not have previously worked post-certification in a hospital maternity unit. Midwives who did not complete their midwifery studies in Germany will be excluded from the study. Midwives commencing work at a birth centre who have prior post-qualification experience in hospital maternity units will also be excluded.

Data Collection and Analysis

In this study, the lived experience of midwives as they acquire the skills and knowledge to manage and support physiological birth will be foregrounded. To provide a context for this, two further data sources will be utilized (Table 1). These include documents from the birth centres concerning the training of newly qualified midwives and focus groups with experienced birth centre midwives. Further data collection methods include open-ended interviews, digital capture, journaling and rapid

Table 1. Study Collection Methods.

Data Source	Number of Participants	Data Collection Methods	Analysis
Birth centre quality management handbook chapter for training new midwives	Voluntary submission of the handbook chapter. The birth centres in Germany publicly listed will receive a request. (N = 86)	Voluntary submission after being contacted through a mailing	Document analysis
Focus groups	One focus group to be held in 10 birth centres with 3–4 experienced midwives per focus group (n = 30–40 midwives total)	Focus group interviews	Hermeneutics
Midwives in induction period	10–20 newly qualified midwives	Open-ended interviews; digital capture (messaging through a service with end-to-end encryption); journaling	Hermeneutic phenomenology
Midwives in induction period	5–10 of the above newly qualified midwives	In addition to the above, non-participant observation (rapid ethnography) of the midwives during their training	Hermeneutic phenomenology

ethnography. The study design uses triangulation of data sources to increase rigour and trustworthiness and illuminate different aspects of the phenomena under study. Triangulation allows for various perspectives of the same phenomena and assures that the data honour the complexity of the phenomena (Lincoln & Guba, 1985). Adams and Michael Van Manen write: 'A human science phenomenological study needs rich experiential material to be successful. Experiential material may encompass descriptive accounts gathered from others, concrete observations by the researcher, as well as other empirical data that stir the researcher to reflect on a particular experience' (Adams & van Manen, 2017, p. 784).

In the initial phase of the study, free-standing birth centres in Germany will be contacted and asked to share the section of their quality management handbook concerning the induction of new midwives. Each birth centre in Germany, in order to receive reimbursement for operating costs from the statutory and private health insurance carriers, must have a handbook with this information. Birth centres in Germany (N = 86) will be sent study information and asked to provide this chapter of their official handbook for analysis. Because the birth centres are responsible for writing and maintaining their own quality management handbook, each birth centre has a written approach to training that is thought to be appropriate for their particular birth centre. There is no standardized catalogue or standardized training method for birth centres in Germany.

In the second part of the study, focus groups will be conducted in 10 birth centres with midwives who have three or more years of experience at births in birth centres. In these interviews, midwives in the same birth centre team will share their experiences training new midwives at the birth centre and their experiences deciding when a midwife is ready to work autonomously. These birth centres will be revisited throughout the study period 2-3 times to share results and to ensure that the researcher understood the participants. Re-visiting the birth centres and sharing the results of the project as it progresses will ensure that the research remains practice-driven. This also allows the participants to validate the results.

In the third part of the study, 10–20 newly certified midwives who are in their first 3 months at a birth centre will be accompanied for a period of 6–9 months. Open-ended interviews will be conducted with them, as well as data collection through journaling and data capture. 5–10 of these midwives will be observed through non-participant observation (rapid ethnography) 3-4 times over a period of 4 days.

The data collected during the different parts of the study will be analysed with approaches appropriate to the data (Petticrew & Roberts, 2003). The documents detailing the induction of new midwives in the birth centres will be analysed using document analysis. Document analysis will be utilized to analyse and synthesize the descriptions in the birth centres' quality management handbooks for the induction of new colleagues. This will provide information on the planned period of induction, the processes that are focused on during induction (i.e., antenatal care, birth assistance, administrative work at the birth centre), and the pathway and criteria to decide when the new midwife will be allowed to work independently.

The data from the focus groups will be explored using hermeneutic phenomenology. Focus groups at the research sites will provide the opportunity for research participants (experienced midwives) to tell stories about their experiences of skill and knowledge acquisition of midwives commencing work at the birth centre. The aim of the focus group is to encourage interaction and an exchange of ideas and experiences (Kvale & Brinkmann, 2009). In a friendly, collegial atmosphere, it is expected that the research participants will stimulate each other to exchange stories, providing the researcher with peer-inspired narratives. In phenomenological research, storytelling is fundamental to achieving an understanding of the language of the participants (Benner, 1994). The focus groups will be small so that each participant has ample time to share their experiences training new midwives.

Because midwives in birth centres work as a team—there are always two midwives present at the moment the woman gives birth—the focus groups can bring to light training at the birth centre as a process of co-constitution. As such, the focus group interviews will provide a text for analysis that expresses the group voice. Benner writes that 'The whole group interview session becomes a discourse in practical reasoning because one story organized around particular concerns raises either confirming or disconfirming stories' (Benner, 1994, p. 109).

The open-ended interviews with the midwives in their induction period will be carried out ideally in the birth centres in which the research participants work. For the midwife-research participants, the birth centre is a natural environment, a place that is familiar to them where they have experienced the phenomena under study. The midwives in their induction period will be offered the opportunity to participate in digital capture and journaling for 6–9 months of their training and participate in an interview at the beginning of their participation in the study and in a final interview after they have completed their training. Those who have agreed to an open-ended interview will be offered the opportunity to be observed during their training (rapid ethnography), as well as to participate in digital capture and journaling.

Rapid ethnography, which includes participant observation, will allow the lead researcher to observe training in real time in the lifeworld of the midwives. Rapid ethnography, also called rapid assessment, is a method of data collection utilized to collect data on a specific, framed topic (i.e., issue, disease, intervention) and is particularly appropriate when the researcher is familiar with the research setting (Harris et al., 1997). Rapid ethnography will take place only in agreement with the midwife-in-training and the midwives who are training her/him. Contributing to triangulation, observations will allow the researcher to perceive the environment that training takes place in (Emerson et al. 2001). In addition to this, it is not meant as a means to examine truth, but to understand context and observe practices. Fieldnotes and digital notes will be taken at the birth centre in password-protected devices.

All of the data collected from the individual midwives during their induction period will be explored through Heideggerian hermeneutic phenomenology. The lived experiences of the individual research participants concerning particular phenomena will be sought out to reveal the skills and knowledge necessary to work autonomously at the birth centre. Smythe writes that 'the hermeneutic interpretive phenomenological process (is) always in motion, never linear, always going back-and-forth-and-around' (2011, p. 35). Every single sentence and section of each interview will be read and re-read to expose meanings of the phenomena. This stage of analysis will be highly iterative to identify key qualities within the data set. All the data strands will be brought together to enable a deeper understanding of the phenomena.

The data from each part of the study will be viewed as parts of a whole, representations of different realities of the same phenomena explored with openness to answer the research question. The goal is to 'go beyond systems of categorization' (Crowther & Thomson, 2020, p. 1) and make the interpretive leap with the help of the philosophical notions of Heideggerian and Gadamerian phenomenology into the lifeworld of newly qualified midwives training in birth centres. Crowther & Thomson write: 'Every understanding is thus an understanding surfacing in myriad conversations' (Crowther & Thomson, 2020, p. 2). The objective of data analysis is thus not to produce theory or a fixed interpretation, but to describe the lived experiences of the midwives.

Rigour

As opposed to Husserlian transcendental phenomenology, where the researcher brackets his/her experiences and 'becomes aloof', in hermeneutic phenomenology, the chosen methodology for this study, the researcher enters into the context of the study (Koch, 1996, p. 178). Throughout the research process, the researcher, through listening to the stories of the research participants and making observations, informs the interpretation of the data through her values and beliefs, thus becoming a co-constructor of the research findings (Smythe, 2011). As new data is collected and considered, the lens of the researcher will change. There are several ways to mitigate bias in a hermeneutic phenomenological study. Because the researcher participates in data production, the meanings that the researcher brings to the study need to be brought to the surface. In doing this, the researcher can explore her/his own lived experience of the phenomena and, through reflection, come to an understanding of the predispositions that she/he may bring to data collection and analysis (Carpenter, 2011). It is essential for the researcher to approach data collection and analysis with an openness to the discovery of notions, ideas and experiences that may be different from her/his own (Smythe, 2011).

This project began with an interview of the lead researcher to reveal her preunderstandings of the phenomena under study. The lead researcher is a midwife who worked in a birth centre and experienced a training period there in spite of 8 years' experience delivering babies in hospitals. Her preunderstanding is that the institution in which a birth takes place requires an expertise specific to that institution. This brings to bear on the starting point of the research, namely, that a midwife trained in a hospital must be newly trained to work at a birth centre.

In addition to this, the lead researcher is maintaining an audit trail and a reflexive diary to make the course of the research transparent and possible for others to retrace and comprehend. Further, the interpretations will be shared and discussed within the supervision team, composed of two methodological experts, and with the cooperating partners (see below). These will provide opportunities to garner deeper insights into the phenomena, to highlight and explore any potential prejudices and biases, and obtain consensual validation over final interpretations. Lastly, the longitudinal nature

of this study allows for member checking across sites and comparisons of the descriptions of the learning and training processes in the different birth centres.

Ethics

Ethics Approval for this study was obtained by the Ethics Commission at the Protestant University of Applied Sciences Berlin in July 2021 (project number EK 2021-01) and the Ethics, Integrity and Governance Unit at the University of Central Lancashire (unique reference number HEALTH 0222 CA). The study does not include any procedure which involves danger, harm, distress or discomfort to the participants or to the researcher(s). If a midwife should become distressed at any time during an interview as a result of talking about a memory of a birth that they attended, the lead researcher will take time to listen and, if necessary, refer them to a counsellor. The study does not involve any activity or information pertaining to illegal activities or materials or the disclosure thereof, nor will any interventions be conducted. Because the lead researcher is an experienced midwife, she will have liability insurance when she is conducting observations in birth centres.

Data protection will be implemented according to German data protection legislation. The data protection protocol for the Acquisition of skills and knowledge (by midwives to support low intervention childbirth at birth centres) a Midwife Study has been reviewed by the data protection officer at the Protestant University of Applied Sciences Berlin, as well as the Ethics, Integrity and Governance Unit at the University of Central Lancashire. The interviews will be recorded on a hand-held digital recording device and erased from the device after they are downloaded on the lead researcher's password protected laptop. The names of the interview subjects will not be mentioned on the audio recording, and a pseudonym will be given at the time of transcription so that the interview subject is not identifiable. The data capture audio journaling of the midwives-in-training will be recorded on their smart phones and sent *via* Signal, an open source, secure and private instant messaging platform. The data capture will be free of all names. If the midwife-in-training chooses to keep a written journal, the journal will be free of all names, and stored in a locked storage cabinet.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Funding is being provided for this study by the German Ministry of Education and Research (Funding number 01GY2007) and can be found with the following link: https://www.gesundheitsforschung-bmbf.de/de/ask-a-midwife-erwerb-von-kompetenzen-und-fertigkeiten-von-hebammen-zur-unterstutzung-von-13526.php.

Cooperating partners

The German Network of Birth Centres, Q.U.A.G. (Quality of Out-of-Hospital Births), the German Society of Midwifery Science and Mother Hood.

Registration

The registration number for the study is DRKS-ID: DRKS00025383 and can be found with the following link: https://www.drks.de/drks_web/navigate.do?navigationId=trial.HTML&TRIAL_ID=DRKS00025383

ORCID iD

Nancy I. Stone https://orcid.org/0000-0002-2404-7845

References

Adams, C., & van Manen, M. A. (2017). Teaching phenomenological research and writing. *Qualitative Health Research*, *27*(6), 780-791. https://doi.org/10.1177/1049732317698960.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), *Interpretive phenomenology. Embodiment, caring, and ethics in health and illness* (pp. 99-128). Thousand Oaks, CA: Sage.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge* (Kindle ed.). London, United Kingdom: Penguin Books.

Birthplace in England Collaborative Group, Brocklehurst, P., Hardy, P., Hollowell, J., Linsell, L., Macfarlane, A., McCourt, C., Marlow, N., Miller, A., Newburn, M., Petrou, S., Puddicombe, D., Redshaw, M., Rowe, R., Sandall, J., Silverton, L., & Stewart, M. (2011). Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study. *BMJ*, *343*, d7400. https://doi.org/10.1136/bmj.d7400.

Bundesgesetzblatt Jahrgang (2013). Gesetz zur Verbesserung der Rechte von Patientinnen und Patienten. Teil 1, Nr. 9. https://www.bundesaerztekammer.de/recht/gesetze-und-verordnungen/patientenrechtegesetz/.

Carpenter, D. R. (2011). Phenomenological method. In *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed., pp. 72-96). Philadelphia: Wolters Kluwer, Lippincott Williams & Wilkins.

Chamberlain, M. (1993). *Factors affecting the acquisition of skills in midwifery students*. [Unpublished PhD Dissertation, University of London]. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.321864.

Crotty, M (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage Publications.

Crowther, S., & Thomson, G. (2020). From description to interpretive leap: Using philosophical notions to unpack and surface meaning in hermeneutic phenomenology research. *International Journal of Qualitative Methods*, *19*, 160940692096926. https://doi.org/10.1177/1609406920969264.

David, M., Pachaly, J., Wiemer, A., & Gross, M. (2006). Außerklinische Geburtshilfe in Deutschland—Perinataldaten, großer", mittlerer" und, kleiner" Geburtshäuser im Vergleich. *Zeitschrift für Geburtshilfe und Neonatologie*, *210*(5), 166-172. https://doi.org/10.1055/s-2006-951740.

Destatis (2018). 30,5% der Krankenhausentbindungen per Kaiserschnitt im Jahr 2017. [Press release]. Retrieved from https://www.destatis.de/DE/Presse/Pressemitteilungen/2018/09/PD18_349_231.html.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2001). Participant observation and fieldnotes. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of ethnography* (pp. 352-368). Thousand Oaks, CA: Sage Publications.

Harris, K., Jerome, N., & Fawcett, S. (1997). Rapid assessment procedures: A review and critique. *Human Organization*, *56*(3), 375-378.

HebStPrV. (2020). Studien-und Prüfungsverordnung für Hebammen (HebStPrV) vom 8. Januar 2020 BGBl I. S. 39. https://www.gesetze-im-internet.de/hebstprv/BJNR003900020.html.

Heron, J. (1992). The Psyche and its Worlds. In *Feeling and Personhood: Psychology in Another Key*. London: Sage.

Hiller, J. (2016). Epistemological foundations of objectivist and interpretivist research. In B. Wheeler, & K. Murphy (Eds.), *Music therapy research* (pp. 236-268). New Braunfels, TX: Barcelona publishers.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing*, *24*(1), 174-184.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Thousand Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA; Sage.

Norris, S., & Murphy, F. (2020). A community of practice in a midwifery led unit. How the culture and environment shape the learning experience of student midwives. *Midwifery*, *86*(2), 102685. https://doi.org/10.1016/j.midw.2020.102685.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533-544. https://doi.org/10.1007/s10488-013-0528-y.

Petticrew, M., & Roberts, H. (2003). Evidence, hierarchies, and typologies: Horses for courses. *Journal of Epidemiology & Community Health*, *57*(7), 527-529.

QUAG (2021). Historie QUAG. Retrieved from https://www.quag.de/quag/historie.htm.

Schwarz, C. (2008). *Entwicklung der geburtshilflichen Versorgung am Beispiel geburtshilflicher interventionsraten 1984-1999 in Niedersachsen*. [Doctoral Dissertation, Technische Universität Berlin]. http://dx.doi.org/10.14279/depositonce-1992.

Skogheim, G., & Hanssen, T. A. (2015). Midwives' experiences of labour care in midwifery units. A qualitative interview study in a Norwegian setting. *Sexual & Reproductive Healthcare*, *6*(4), 230-235. https://doi.org/10.1016/j.srhc.2015.05.001.

Smythe, E. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childbirth: Phenomenological approaches* (pp. 35-54). Oxfordshire, United Kingdom: Routledge.

Sozialgesetzbuch, V. (2019). *§24f SGB V Entbingung*. Retrieved from https://www.sozialgesetzbuch-sgb.de/sgbv/24f.html.

Stapleton, S. R., Osborne, C., & Illuzzi, J. (2013). Outcomes of care in birth centers: Demonstration of a durable model. *Journal of Midwifery & Women's Health*, *58*(1), 3-14. https://doi.org/10.1111/jmwh.12003.

Stone, N. I. (2012). Making physiological birth possible: Birth at a free-standing birth centre in Berlin. *Midwifery*, *28*(5), 568-575. https://doi.org/10.1016/j.midw.2012.04.005.

Van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Oxfordshire, United Kingdom: Taylor & Francis.