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NEW ZEALAND

Maternity Consumer Survey 2014

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Maternity Consumer Survey 2014

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Thank you

The Ministry of Health would like to thank all of the women who generously gave their time to participate in the 2014 Maternity Consumer Survey. Your views and comments were greatly appreciated and provide valuable insight into women's personal experiences of the New Zealand maternity system.

Executive Summary

This report presents the results of the 2014 Maternity Consumer Survey which was completed between November 2014 and February 2015.

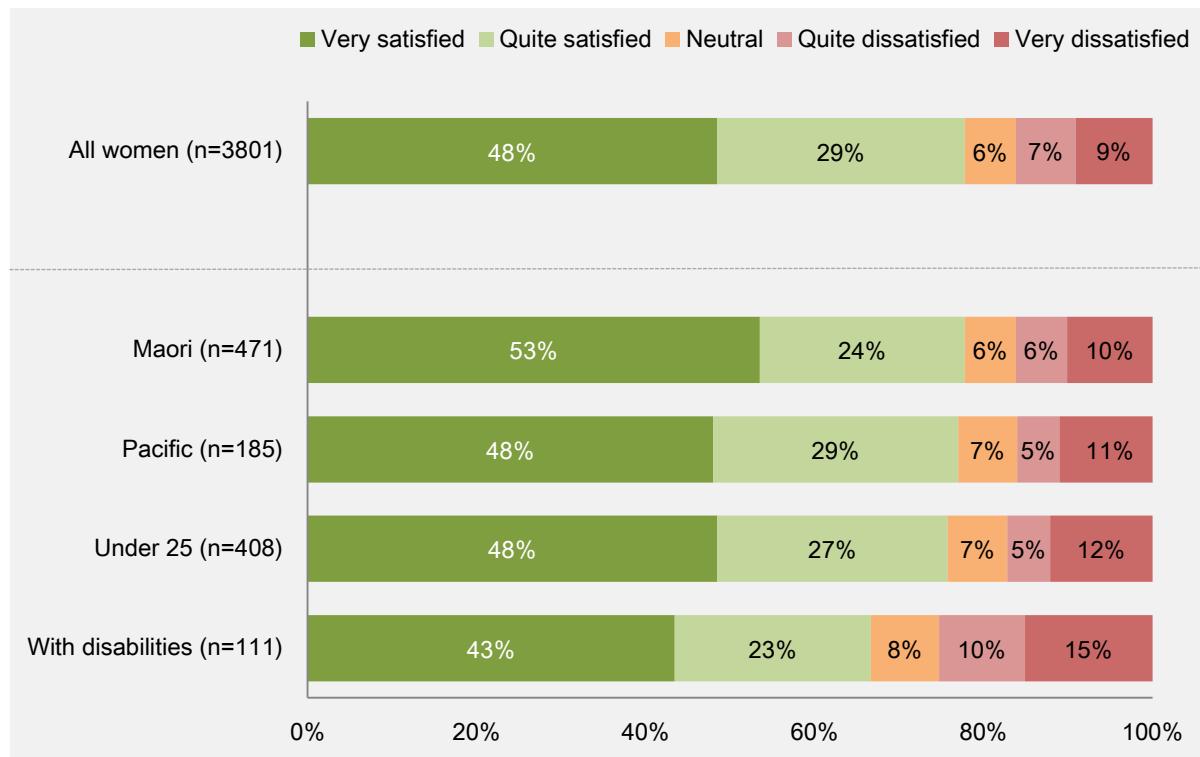
The survey results are based on the responses of almost 4,000 women who had a live birth between December 2013 and February 2014. The survey covered women's experiences and satisfaction with all aspects of their maternity care, from when they first discovered they were pregnant, through to the weeks following their baby's birth.

Overview of key results

Three-quarters of all women surveyed (77 percent) were satisfied or very satisfied with the overall level of maternity care they received.

Māori women, Pacific women and young women (defined as women under 25 years of age) reported similar levels of satisfaction to that of all women surveyed (Figure 1). Women with disabilities¹ reported being less satisfied with the overall maternity care they received, compared with all women surveyed (66 percent, compared with 77 percent of all women).

Figure 1: Overall satisfaction with maternity care



¹ 'Women with disabilities' refers to women who indicated that they had "a long term disability" which is based on their own interpretation as to what qualified as a 'disability'.

The survey also assessed the experiences of women with regard to the maternity care they received at each key stage of their pregnancy, from the antenatal care they received whilst they were pregnant, the care they received during the labour and birth of their baby, through to the postnatal care they received in the first few weeks following their baby's birth.

Table 1 shows the extent to which women reported being satisfied or very satisfied with the care they received overall, as well as at each of the stages.

Table 1: Satisfaction results for each of the key areas of maternity care

	All women n=3,801 %	Māori women n=471 %	Pacific women n=185 %	Young women n=408 %	Women with disabilities n=111 %
Overall care % of women satisfied or very satisfied overall with the maternity care received	77	77	77	75	66
Antenatal care % of women satisfied or very satisfied with the care received from their LMC or midwife while they were pregnant	90	88	89	87	88
Labour and birth % of women satisfied or very satisfied with the care received from their LMC or midwife during the labour and birth	87	85	90	83	84
% of women satisfied or very satisfied with the care received from the hospital or birthing unit staff during the labour and birth	85	83	88	80	77
Postnatal care % of women satisfied or very satisfied with the care received from the hospital or birthing unit staff after the birth of their baby	80	83	81	80	70
% of women satisfied or very satisfied with the care received from their midwife during the first few weeks after baby's birth	89	89	92	88	89

The base numbers shown are unweighted counts.

The most positively rated aspects of the antenatal care women received while they were pregnant, included:

- ⦿ How well informed women felt about the care they were entitled to (91 percent were satisfied or very satisfied).
- ⦿ That the people involved in their antenatal care listened to them (90 percent were satisfied or very satisfied)
- ⦿ How easy it was to get the care they needed while pregnant (90 percent were satisfied or very satisfied).

The lowest satisfaction rating was given in relation to knowing who would care for them if their midwife or LMC was not available (81 percent were satisfied or very satisfied with this).

When asked about the maternity care they received during labour and the birth, women rated the following aspects most positively:

- ⦿ The way in which the women's background, culture, beliefs and values were respected (92 percent were satisfied or very satisfied).
- ⦿ How confident women were in the skills of the people caring for them (90 percent were satisfied or very satisfied).

The lowest satisfaction rating in terms of their labour and birth experience related to the support that was available immediately following the birth (81 percent were satisfied or very satisfied).

In terms of postnatal care, the most positively rated aspects of care following baby's birth related to:

- ⦿ Baby's physical checks that were carried out by the midwife in the weeks following baby's birth (93 percent were satisfied or very satisfied).
- ⦿ The way in which women's backgrounds, cultures, beliefs and values were respected (93 percent were satisfied or very satisfied).

The lowest satisfaction ratings in terms of postnatal care related to:

- ⦿ The amount of rest women were able to get in hospital or the birthing unit following their baby's birth (64 percent were satisfied or very satisfied).
- ⦿ The hospital food (65 percent were satisfied or very satisfied).

Regression analysis was conducted on the survey data to help identify the specific factors that are likely to have the most significant impact. These are the aspects of care that are of most importance to women and therefore have the greatest influence on their overall satisfaction ratings.

The specific aspects of care identified as priorities for improvement are:

- That carers inform women who will care for them if they are not available. Improving this will help improve women's satisfaction with antenatal care.
- That LMC's, hospital and birthing unit staff provide more support to women immediately following birth.
- Ranked in order of priority, focusing on the following aspects of care will help improve satisfaction with postnatal care:
 - The level of care and attention provided by hospital or birthing unit staff following the baby's birth.
 - The help and support provided by hospital or birthing unit staff during their stay.
 - Increased flexibility with regard to visitors and support people during the woman's hospital or birthing unit stay.
 - The amount of privacy provided to women in hospital or a birthing unit following baby's birth.
 - Ensuring women get enough rest during their hospital or birthing unit stay.
 - Improving the hospital or birthing unit food.

Background, purpose and approach

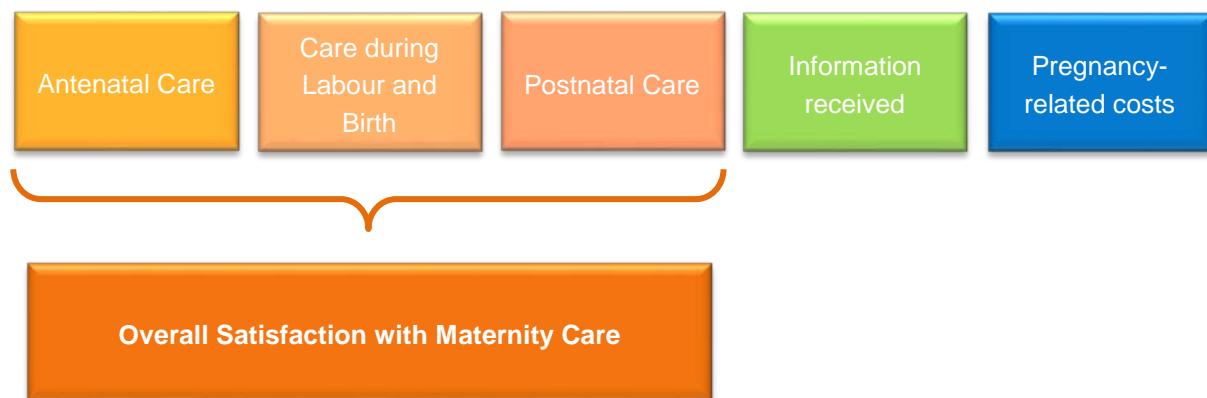
The Maternity Consumer Survey explores women's experiences and satisfaction with various aspects of their maternity care, from the point at which they first discovered they were pregnant through to the first few weeks after the baby's birth. This report presents the results to the fifth Maternity Consumer Survey, which was completed between 9 October 2014 and 8 March 2015 for women who gave birth between December 2013 and February 2014.

The Ministry of Health commissioned the first of the Maternity Consumer Surveys in 1999. Subsequent surveys were completed in 2002, 2007 and 2011.

The Maternity Consumer Survey provides the maternity sector with direct feedback from women who have recently given birth, about their maternity experience and the care they received throughout their pregnancy and the weeks that followed. This information is used by the Ministry and the maternity sector to assess the impact and effectiveness of recent initiatives and policies and to help inform future planning and improvement activities.

As well as measuring women's overall satisfaction with the maternity care they received, women's maternity experience was examined in relation to three stages. This enabled the examination of each stage of care in more detail and the identification of specific aspects or priorities for improvement, in order to support positive outcomes for mothers, their babies and their families and whānau. In addition to these three stages of care, the survey also explored the range and perceived quality of information they received and identified which pregnancy-related services women paid for.

Figure 2: Areas of maternity care examined in the 2014 Maternity Consumer Survey



Approach

The 2014 Maternity Consumer Survey was completed between 9 October 2014 and 8 March 2015 by women who had live births between December 2013 and February 2014.

The 2011 survey materials (the questionnaire and survey invitation letter) were reviewed by internal stakeholders within the Ministry of Health and external stakeholders who provide maternity services. As a result of this review, changes were made to the order and wording of the questions to make the survey easier to understand, easier to follow and to make the survey more appropriate and relevant for Māori and Pacific women.

Due to the changes made to the survey, the current results are not directly comparable to the results from the earlier surveys.

The survey was cognitively pre-tested with a group of eight women who represented a range of different ethnicities and ages. As a result of the pre-testing, further changes were made to the wording of some of the questions.

A pilot survey was conducted in October 2014 with n=300 women in order to assess how well the survey worked, and to see what the likely participation rate would be, particularly for the groups of women who in previous surveys had been less likely to respond (Māori and Pacific women and women under 25 years of age). Each of the 300 women were posted a paper copy of the questionnaire and an invitation letter outlining the purpose of the survey and letting them know that, if they preferred, they could complete the survey online. A reminder postcard was sent two weeks later to Māori, Pacific and younger women who had not yet responded and follow-up telephone calls were made two weeks later. No changes were made to the survey as a result of the pilot, so the pilot results were added to the results of the main survey for analysis purposes.

The main survey began in November 2014, following the same process as the pilot survey:

1. Women were posted an invitation letter, a paper copy of the questionnaire and a reply-paid envelope. The invitation letter gave women the option to complete the survey online and a Freephone number to call if they had any questions.
2. Māori, Pacific and younger mothers were sent a reminder postcard two weeks after the initial posting.
3. Where telephone numbers were available, follow-up telephone calls were completed in January 2015 with Māori, Pacific and younger women.

The timing of the survey coincided with the Christmas holiday period, negatively impacting the response rate, which was lower than expected. To help boost the level of participation, in January 2015 a further reminder postcard was sent to all women who had not yet responded.

A total of 13,634 women were invited to take part in the Maternity Consumer Survey. Of the 3,801 women who completed the survey, most completed the paper version (76.7 percent), one-in-five completed the survey online (22.5 percent), and a small number (30 women) completed the survey over the telephone. Taking into account the number of survey packs that were ‘returned to sender’, the response rate for this survey was 29.4 percent.

The maximum margin of error based on the total sample of 3,801 is ± 1.5 percent, at the 95 percent confidence level. This means that if we found 50 percent of women were satisfied with the maternity care they received, we are 95 percent sure that we would get the same result (plus or minus 1.5 percent) had we interviewed all 13,634 mothers. Larger margins of error apply to sub-samples (Table 2).

Table 2: Response rates and margins of error

	Response rate %	Number of completed surveys*	Margin of error %
		Count	
All women who took part in the survey	29.2	3801	± 1.5
Māori women	18.4	471	± 4.7
Pacific women	14.5	185	± 8.0
European women	39.5	2988	± 2.2
Asian women	24.0	478	± 5.1
Middle Eastern/Latin American/African women	21.0	68	± 15.4
Women under 25 years	14.9	408	± 5.5
Women 25 years and over	33.1	3393	± 1.9

*Please note that women were able to provide multiple responses when asked to indicate their ethnicity and therefore the number of completed surveys by ethnicity will not sum to 3801.

A more detailed description of the methodology, response rates and analysis techniques used for this research is provided in Appendix A.

Report notes

Results in this report focus primarily on responses of ‘all women’ (i.e. the total sample). However, statistically significant differences are provided in each section in relation to the Ministry’s four priority groups: Māori, Pacific and young women and women who indicated having a long term disability.

Where reference is made to women of ‘other’ ethnicities, this primarily includes New Zealand European women, but generally refers to women who did not identify as being of Māori or Pacific ethnicities.

Where reference is made to ‘younger’ women, this refers to women aged under 25 years of age.

Where reference is made to ‘women with disabilities’ this refers to women who indicated that they had “a long term disability” and is based on their own interpretation as to what qualified as a ‘disability’.

Antenatal care

There is no right or wrong way to access maternity services, and different women can get care from different people at different times. Knowing how women access health services during their pregnancy, and finding out how well those services worked for them, helps the Ministry of Health to make it easier for pregnant women to get the services they need in the future.

This section looks at the antenatal care received by women during their pregnancy, from when they first suspected they were pregnant to just before they went into labour.

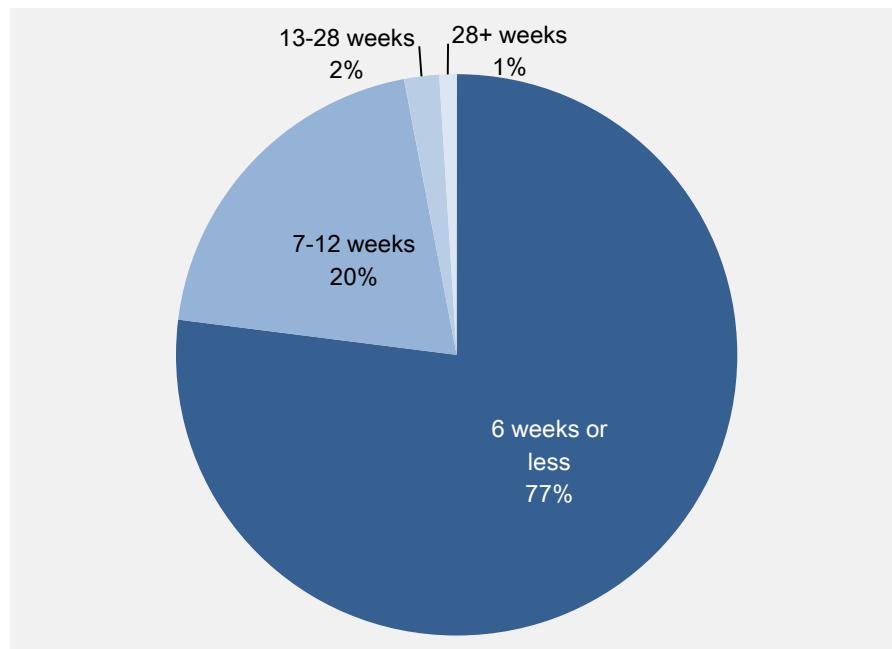
When women first suspected they were pregnant

All women were asked how many weeks pregnant/hapū they were when they first thought they might be pregnant/hapū.

As shown in Figure 3, 77 percent of women first suspected they were pregnant/hapū within the first 6 weeks of their pregnancy. Another 20 percent were 7-12 weeks pregnant, while three percent did not suspect they were pregnant/hapū until after their first trimester.

Figure 3: How early women suspected they might be pregnant

Q4. How many weeks pregnant/hapū were you when you first thought you might be pregnant/hapū?



Base (n=3762).

Sub-sample based on all women who provided a response for this question and excludes women who said 'Don't know/Can't remember'. Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to when they first suspected they were pregnant

Māori women

- Māori women were less likely to have first suspected they were hapū within the first 6 weeks of their pregnancy (65 percent, compared with 84 percent of women of ‘other’ ethnicities).

Pacific women

- Pacific women were less likely to have first suspected they were pregnant within the first 6 weeks of their pregnancy (53 percent, compared with 84 percent of women of ‘other’ ethnicities).

Younger women

- Younger women (those aged under 25 years) were less likely to have first suspected they were pregnant within the first 6 weeks of their pregnancy (64 percent, compared with 80 percent of women aged 25 and over).

Women with disabilities

- Women with disabilities were less likely to have first suspected they were pregnant within the first 6 weeks of their pregnancy (66 percent, compared with 77 percent of women without disabilities).

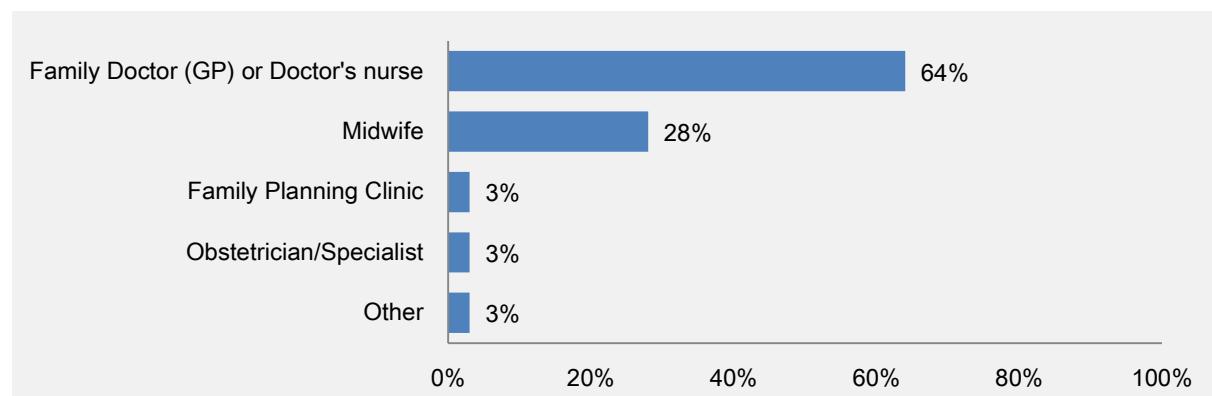
Initial contact with a health care provider

Women were asked which health care provider they contacted when they first thought they were pregnant, and how many weeks pregnant they were at the time.

As shown in Figure 4, almost two-thirds of all women (64 percent) reported that when they first suspected they were pregnant, the first health provider they contacted was their family doctor (GP). Twenty-eight percent initially contacted a midwife, three percent contacted a Family Planning Clinic and another three percent contacted an obstetrician/specialist.

Figure 4: First health care provider contacted

Q5. Which one of the following health care providers did you first contact when you first thought you might be pregnant/hapū?



Base (n=3759).

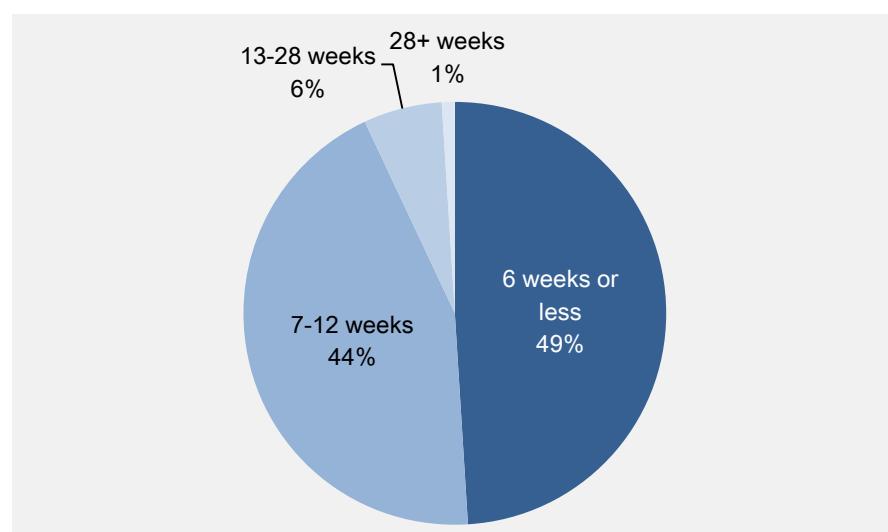
Sub-sample based on all women who provided a response for this question.

Total may not sum to 100 percent due to rounding.

One-half of all women (49 percent) saw a health care provider within the first 6 weeks of their pregnancy. Forty-four percent saw their first health care provider at 7-12 weeks, while seven percent did not see a health care provider until after their first trimester (Figure 5).

Figure 5: When women first saw a health care provider

Q6. How many weeks pregnant/hapū were you when you first saw this health care provider?



Base (n=3718).

Sub-sample based on all women who provided a response for this question and excludes women who said 'Don't know/Can't remember'.

Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to their initial contact with a health provider

Māori women

- ⦿ When they first thought they might be pregnant, Māori women were more likely than Pacific women to contact a midwife (29 percent, compared with 16 percent of Pacific women).
- ⦿ Māori women were less likely to see a health care provider in the first six weeks of their pregnancy (45 percent, compared with 52 percent of women of 'other' ethnicities).
- ⦿ Ten percent of Māori women saw a health care provider for the first time when they were 13-28 weeks pregnant (this is significantly higher than the three percent of women of 'other' ethnicities who saw a health care provider for the first time when they were 13-28 weeks pregnant).

Pacific women

- ⦿ Pacific women were more likely to contact their family doctor/GP when they first thought they might be pregnant (76 percent, compared with 62 percent of Māori women and 63 percent of women of 'other' ethnicities), and less likely to contact a midwife (16 percent, compared with 29 percent of Māori women and 29 percent of women of 'other' ethnicities).
- ⦿ Pacific women were less likely to see a health care provider in the first six weeks of their pregnancy (39 percent, compared with 52 percent of women of 'other' ethnicities) and more likely to see a health care provider for the first time when they were 13-28 weeks pregnant (16 percent, compared with three percent of women of 'other' ethnicities).

Younger women

- ⦿ Younger women were more likely than those aged 25 years and over to contact a Family Planning Clinic when they first suspected they might be pregnant (seven percent, compared with one percent).
- ⦿ Compared to older women, younger women were more likely to see a health care provider for the first time when they were 13-28 weeks pregnant (nine percent, compared with five percent of older women).

Women with disabilities

- ⦿ Women with disabilities were more likely to first see a health care provider when they were 7-12 weeks pregnant (55 percent, compared with 43 percent of women without disabilities).

Choice of antenatal care provider

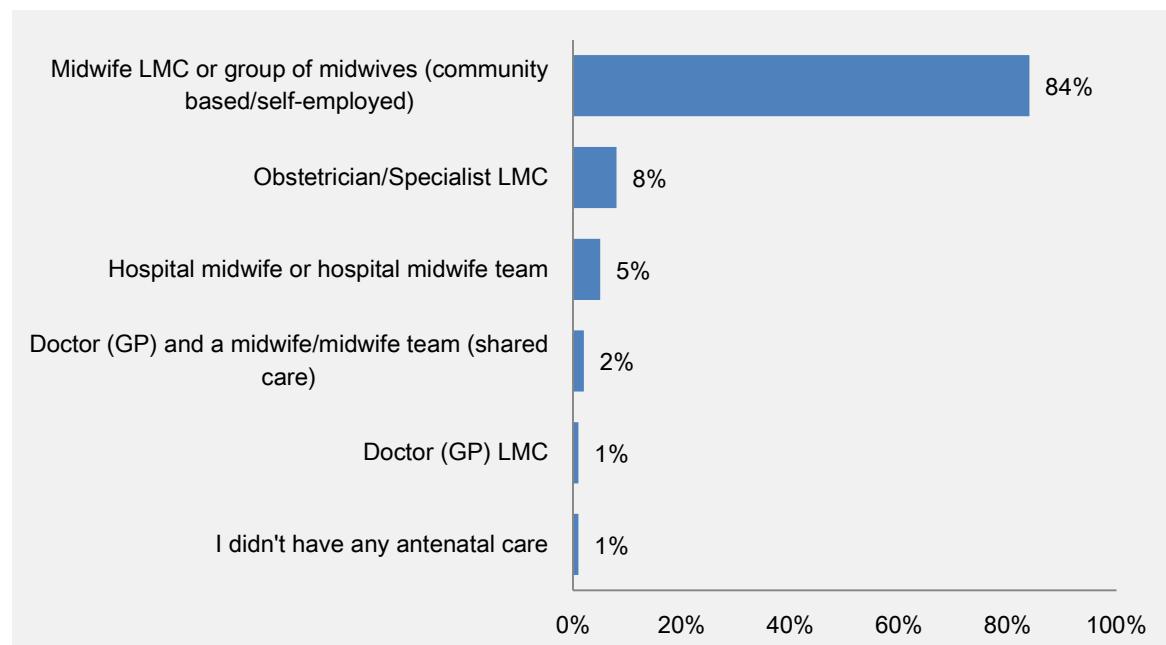
Maternity care is a partnership between a woman and her maternity care provider. A maternity care provider looks after the mother and baby's physical health and supports the mother's emotional and mental health and helps them to feel confident about pregnancy and birth. A provider is expected to involve whānau/family or other support people in this partnership if that is what a woman wants.

Women can choose a Lead Maternity Carer (LMC) to be responsible for co-ordinating their maternity care, or they may get their antenatal care from the hospital.

Women were asked to identify which health care professional(s) provided most of their antenatal care. The majority (84 percent of women) reported having received most of their antenatal care from a midwife LMC or a group of midwives.

Figure 6: Antenatal care provider

Q7. Who did you get 'antenatal care' from for most of your pregnancy?



Base (n=3764).

Sub-sample based on all women who provided a response for this question and excludes women who said 'Don't know'.

Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to their choice of antenatal care provider

Māori women

- Māori women were less likely to have received most of their antenatal care from an obstetrician/specialist LMC (three percent, compared with 10 percent of women of ‘other’ ethnicities).

Pacific women

- Pacific women were less likely to have been under the care of an obstetrician/specialist LMC for most of their pregnancy (three percent, compared with 10 percent of women of ‘other’ ethnicities).

Younger women

- Younger women were more likely than those aged 25 years or more to report having received most of their antenatal care from a midwife LMC/group of midwives (89 percent, compared with 82 percent of women aged 25 years or more) and less likely to have had an obstetrician/specialist LMC (two percent, compared with nine percent of older women).

Women with disabilities

There were no significant differences between women with and without disabilities.

Selecting a Lead Maternity Carer (LMC)

An LMC is someone who provides maternity care and support to women throughout their pregnancy, labour and birth, and for the first 4-6 weeks of their baby's life. Most LMC's are midwives, although some GPs and obstetricians also carry out the role. An LMC may provide all of a woman's maternity care or may share it with other health providers.

Factors influencing choice of LMC

Women who reported having received most of their antenatal care from an LMC were asked to describe what influenced their decision when choosing their LMC (Figure 6).

Key influencing factors included: the LMC being knowledgeable and professional (40 percent of women identified this as a key factor in their choice of LMC), warm and caring (36 percent), close to where they lived (21 percent) and being respectful of the mother's background, culture, beliefs and values (19 percent).

Her level of experience was 15+ years in different areas (hospital, private, home-based) and she was a registered nurse, she believed in homeopathic remedies and was in a central location.

My chosen LMC never hassled me about my eating. She answered any questions I had and spoke to me in a way I could understand the medical terminology. She was the best support and experience I had. Offered home visits.

We "clicked" the first time we met; we share the same faith, and I felt I could trust her to look after me and baby.

She was Māori, knew my cultural background, just knows Māori as people and treated my whānau like how she would treat her own. Belonged to a Māori community of other LMC's also. I had her as my first midwife and thoroughly enjoyed all of her awhi, manaakitanga, whānaungatanga etc.

Thirty-nine percent of women chose their LMC based on recommendations of whānau/family or friends, while 27 percent went with the LMC who had looked after them in a previous pregnancy.

My friend recommended her and she was very respectful and supportive of whatever/however you wanted to do things. She was older and had been a midwife a long time. Since this was my first baby, her experience was important to me.

My stepmother used to be a midwife and recommended my midwife to me, however I did also research her on the internet before meeting her in person.

LMC was part of a group of midwives I had used for [my] previous pregnancy (original LMC used for previous pregnancy had since retired, but I trusted the professionalism and care of the group).

Sixteen percent simply chose from a list of LMC's that was given to them by a health professional and another seven percent felt they had no choice in the matter.

I chose the first LMC that was available, the first two I contacted were unavailable. I think this was one of the most stressful decisions as the list that was given to me by my GP was the same list that was given to everyone else so they were all full. So I had to do my own research. I think choosing an LMC could be much easier.

Was given a list and rung round till I found an available midwife.

We worked through a list of providers looking for one that met our needs and was professional and very experienced. However as we were due soon after the Christmas holidays, there were very few choices available by the time we made up our minds.

I didn't actually choose the midwife I got. I rang to meet up with her for a chat and she just got the maternity book out so I thought that's who I had to have.

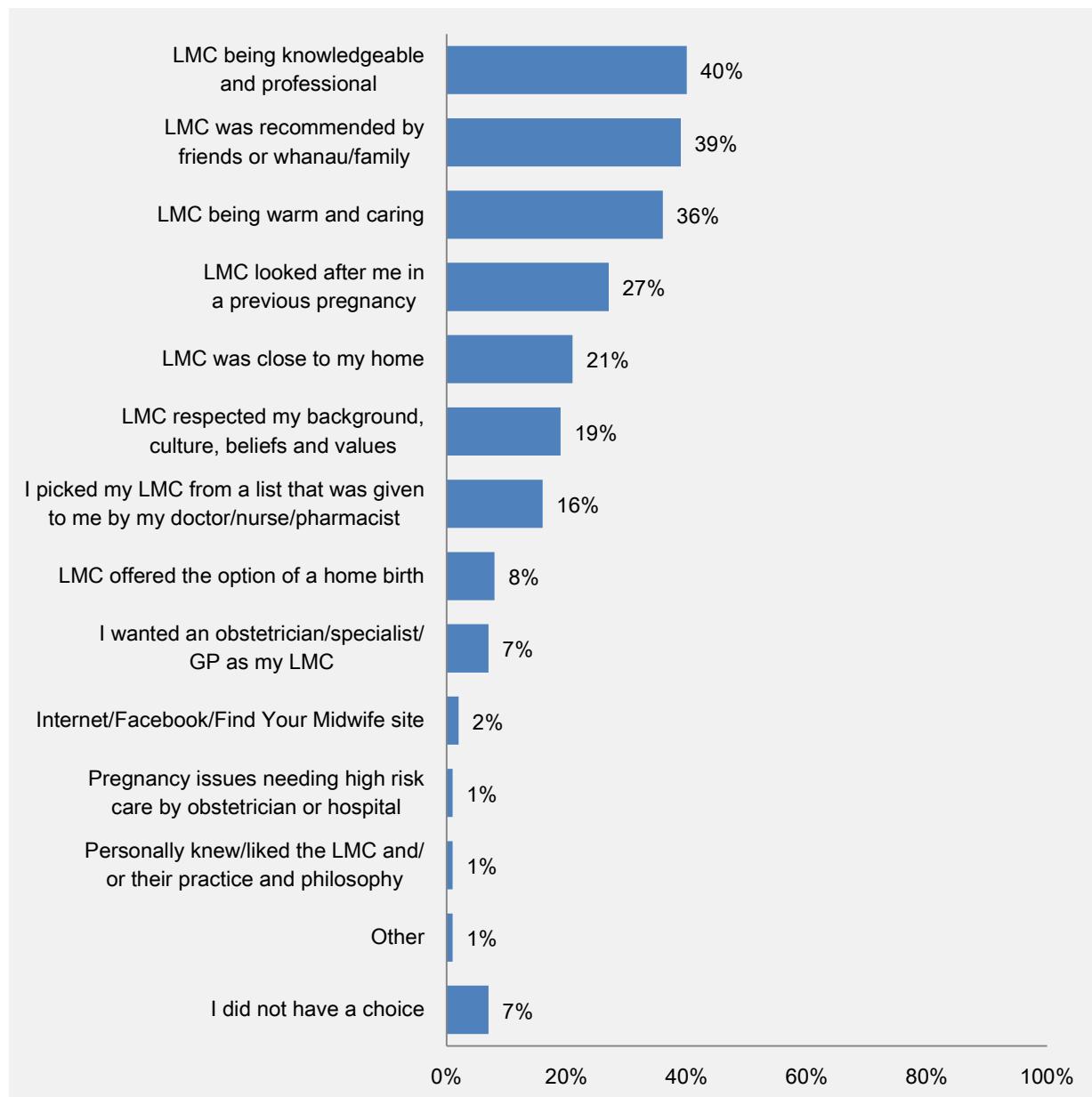
Called all midwives in area and she was the only one that could take me on as just had a cancellation.

She was the person who contacted me after phoning a group of midwives and asking for 'anyone', as my first phone message to a 'specific' midwife was not returned. Basically I got my midwife by 'default'.

It was very difficult to find an available LMC, so I had to go with the first one who was free.

Figure 7: Reasons for choosing an LMC

Q9. Which of the following influenced your decision when choosing who was going to be your Lead Maternity Carer (LMC)?



Base (n=3524).

Sub-sample based on women who said they received most of their antenatal care from an LMC – excludes those who did not provide a response for this question.

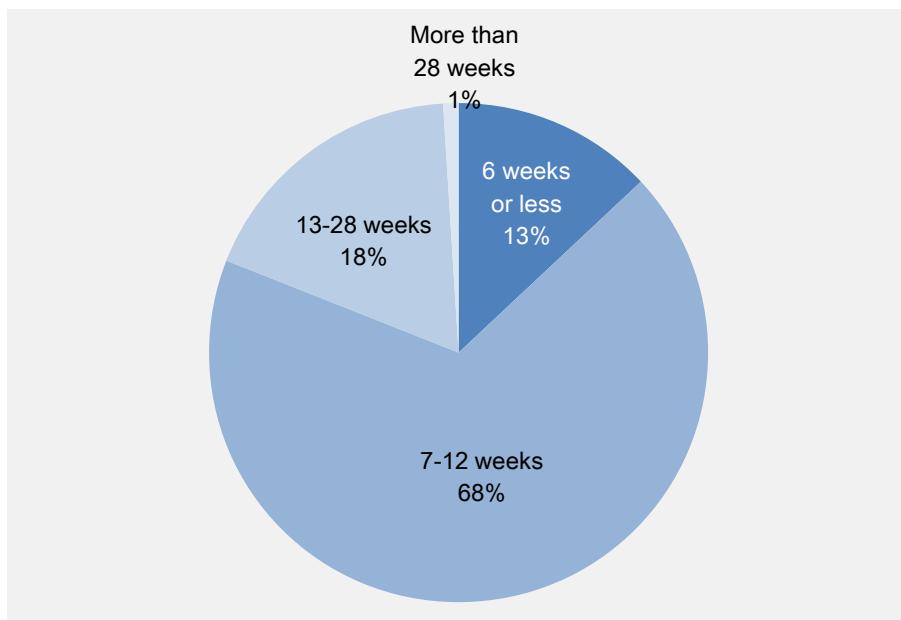
Total will not sum to 100% because women could provide multiple responses to this question.

Women who had an LMC for most of their antenatal care were also asked how many weeks pregnant they were when they first saw their LMC.

As illustrated in Figure 8, 13 percent of these women reported that they first saw their LMC within the first six weeks of their pregnancy, 68 percent saw their LMC for the first time when they were 7-12 weeks pregnant, while 19 percent did not see their LMC until after their first trimester.

Figure 8: When women first saw their LMC

Q10. How many weeks pregnant/hapū were you when you first saw your Lead Maternity Carer?



Base (n=3462).

Sub-sample based on women who said they received most of their antenatal care from an LMC – excludes women who said 'Don't know' or did not provide a response for this question.

Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to their choice and initial contact with their LMC

Māori women

- Māori women were more likely to choose an LMC who respected their background, culture, beliefs and values (23 percent, compared with 17 percent of women of ‘other’ ethnicities).
- One-in-four Māori women (26 percent) saw their LMC for the first time when they were 13-28 weeks pregnant (compared with 18 percent of women of ‘other’ ethnicities).

Pacific women

- Pacific women were more likely to have chosen their LMC from a list that was given to them by their doctor, nurse or pharmacist (23 percent, compared with 14 percent of women of ‘other’ ethnicities).
- One-in-three Pacific women (36 percent) did not see their LMC until they were 13-28 weeks pregnant (compared with 18 percent of women of ‘other’ ethnicities).

Younger women

- Reflecting their young age and the fact that this was more likely to be their first pregnancy, women under 25 years of age were less likely than older women to have chosen their LMC because they had cared for them in a previous pregnancy (17 percent, compared with 30 percent of those aged 25 years or more).
- One-in-four younger women (27 percent) did not see their LMC until they were 13-28 weeks pregnant (compared with 15 percent of older women).

Women with disabilities

There were no significant differences between women with and without disabilities.

Reasons for not having an LMC

Women who did not have an LMC were asked to describe their reasons for this (Figure 9).

Thirty-nine percent reported they did not have an LMC because they wanted to use the hospital team, while 16 percent indicated that their pregnancy was high risk or had complications so having an LMC was not considered an option. One-in-five (20 percent) did not know they needed an LMC or did not know how to get one, while 13 percent said there were a shortage of LMC's in their area.

The hospital midwife was my LMC. We only have one community based one in our area and I preferred to use the DHB.

High risk pregnancy due to medical conditions and previous high risk/problems with my first three pregnancies, and also all three previous has been C-section births.

I didn't know who to go to or what to do. My GP referred me to the hospital midwife team and they called me.

I didn't know that any were available.

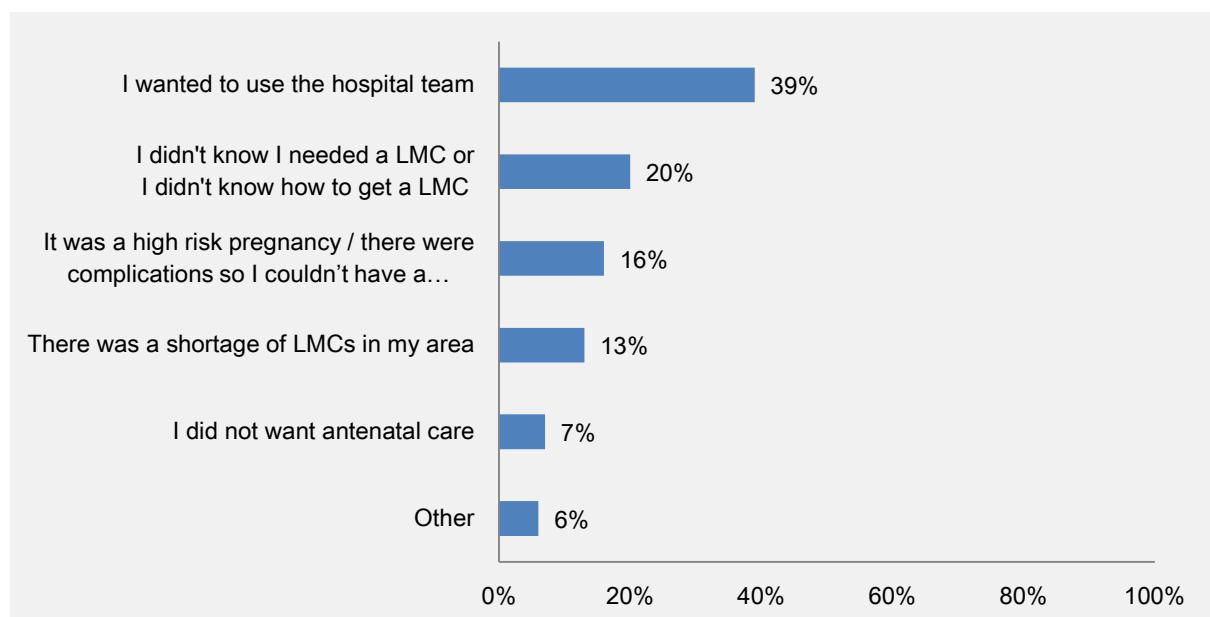
All LMC's I approached already had full workloads.

Since I was due in early January, there was a shortage of LMC's in my area. Most were on Christmas/New Year break.

There were no significant differences in reasons for not having a community-based LMC, for Māori, Pacific or younger women or women with disabilities.

Figure 9: Reasons for not having a community-based LMC

Q8. Which was the main reason you did not have a community-based Lead Maternity Carer?



Base (n=196).

Sub-sample based on women who did not have a community-based LMC – excludes those who did not provide a response for this question.
Total may not sum to 100 percent due to rounding.

Satisfaction with antenatal care received

All women were asked to rate various aspects of the antenatal care they received on a scale of 1 to 5, where 1 = very dissatisfied and 5 = very satisfied.

As shown in Figure 10, satisfaction with the antenatal care received was high, with 90 percent of women indicating that they were satisfied or very satisfied with the overall level of care received from their LMC or midwife during their pregnancy. Of this, 74 percent were 'very satisfied'.

My midwife was outstanding. She is attentive, caring, thorough and respectful. She made my pregnancy easy and worry free. I highly recommend her!

As an older first time mum, I found that my midwife listened very well to my questions, what I said and what I wanted. I do not believe I could have received any better care.

Antenatal care was excellent.

Reflecting the high level of satisfaction overall, at least two-thirds of women were also 'very satisfied' with the following aspects of care, most of which related to accessibility:

- Being well informed of the care they were entitled to while pregnant (73 percent were very satisfied).
- Appointment times and places were convenient (69 percent).
- The people involved in their care listened to them (69 percent).
- How easy it was to get the care they needed (68 percent).
- The people involved in their care were responsive to their needs (67 percent).
- The people involved in their care spent enough time with them (66 percent).

Less positive results were recorded in relation to women knowing who would care for them if their LMC or midwife was not available. Eight percent of women were dissatisfied or very dissatisfied and 11 percent provided a neutral rating to this statement.

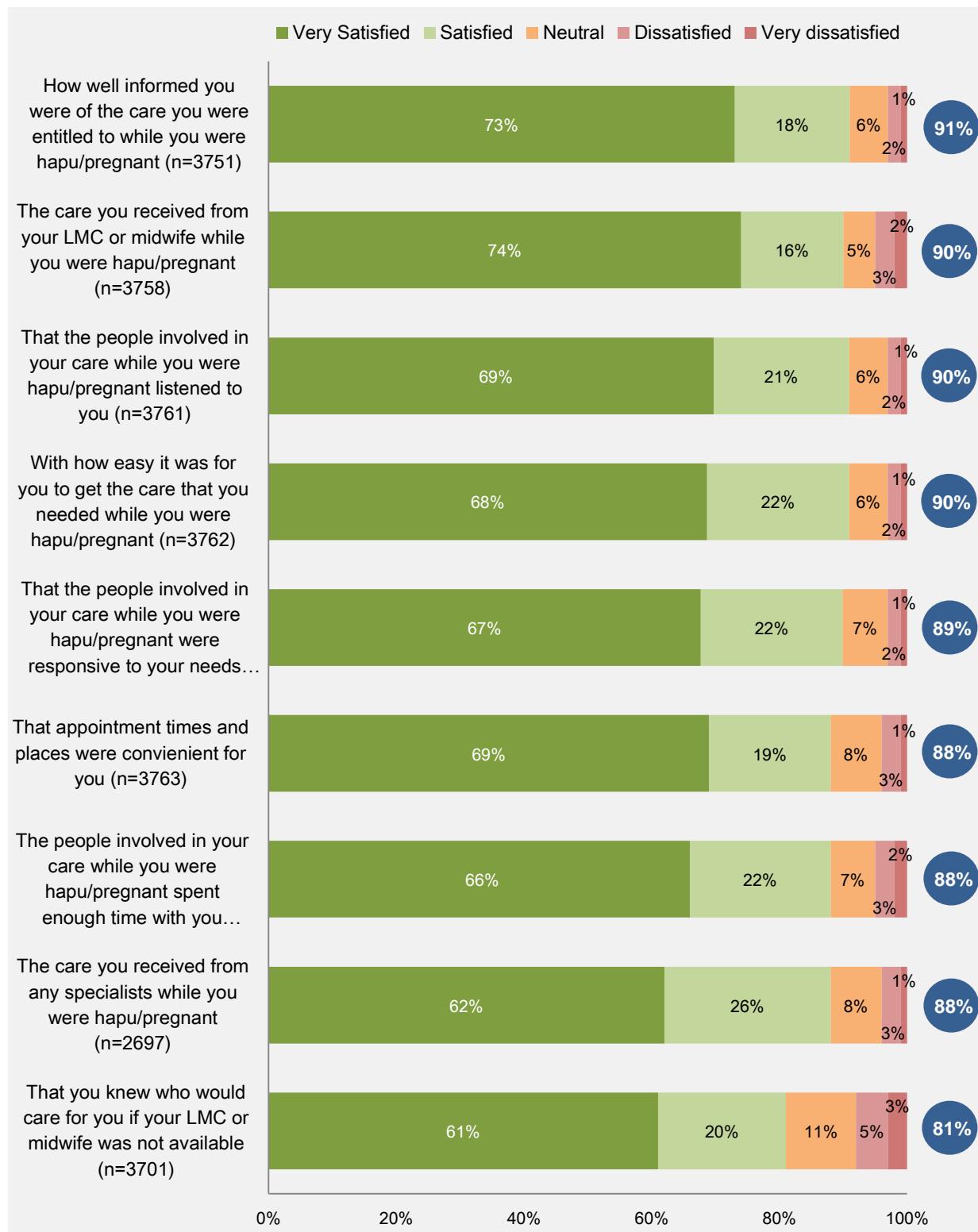
The only complaint in my situation was the backup midwife procedure. My midwife was on leave when I had my baby, and although she had given me some details of her backup, when I contacted her she informed me she was not her backup anymore, so turning up to hospital not knowing who would assist me in my delivery was not very reassuring and a little frustrating. In the end we had a wonderful midwife for our delivery, but I think the backup system needs to be updated.

I just assumed the hospital would help me.

Because it was Christmas we didn't have a backup midwife.

Figure 10: Satisfaction with the antenatal care received

Q11. Thinking about the antenatal care that you received while you were pregnant/hapū, so before pēpi/baby was born, how satisfied were you with the following?



Please note: Sub-samples are based on women who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.



Percent of women who were satisfied + very satisfied.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to satisfaction with the antenatal care they received

Māori and Pacific women

There were no significant differences in satisfaction with the different aspects of antenatal care for Māori or Pacific women.

Younger women

- Younger women were more likely to be very satisfied that their antenatal appointment times and places were convenient (74 percent, compared with 68 percent of older women).

Women with disabilities

There were no significant differences between women with and without disabilities.

Antenatal classes

Antenatal classes give pregnant women, their partners, support people and whānau/families the opportunity to learn more about what will happen to them and the care they are likely to receive during labour and the birth, to understand what happens after their baby is born and to meet other parents-to-be.

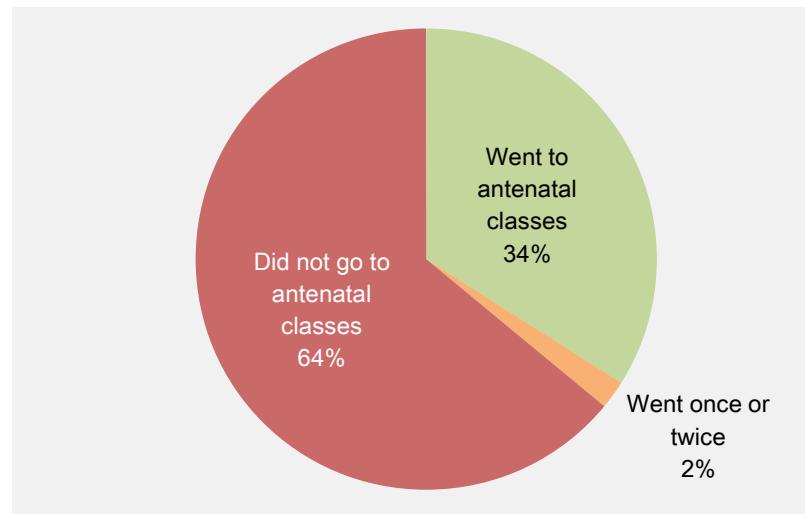
All women were asked if they attended antenatal classes. Women who went to antenatal classes were then asked further questions to determine their satisfaction with the classes they went to.

One-third of all women (34 percent) went to antenatal classes for their most recent birth, another two percent went once or twice but didn't finish, and 64 percent did not attend any antenatal classes at all (Figure 11).

Participation in antenatal classes varied depending on whether or not this was the mothers' first pregnancy. Two-thirds of first-time mothers (64 percent) went to antenatal classes, compared with only seven percent of women for whom this was not their first birth.

Figure 11: Attended antenatal classes

Q12. Did you go to antenatal classes?



Base (n=3793).

Sub-sample based on those who provided a response for this question.

Total may not sum to 100 percent due to rounding.

Satisfaction with antenatal classes attended

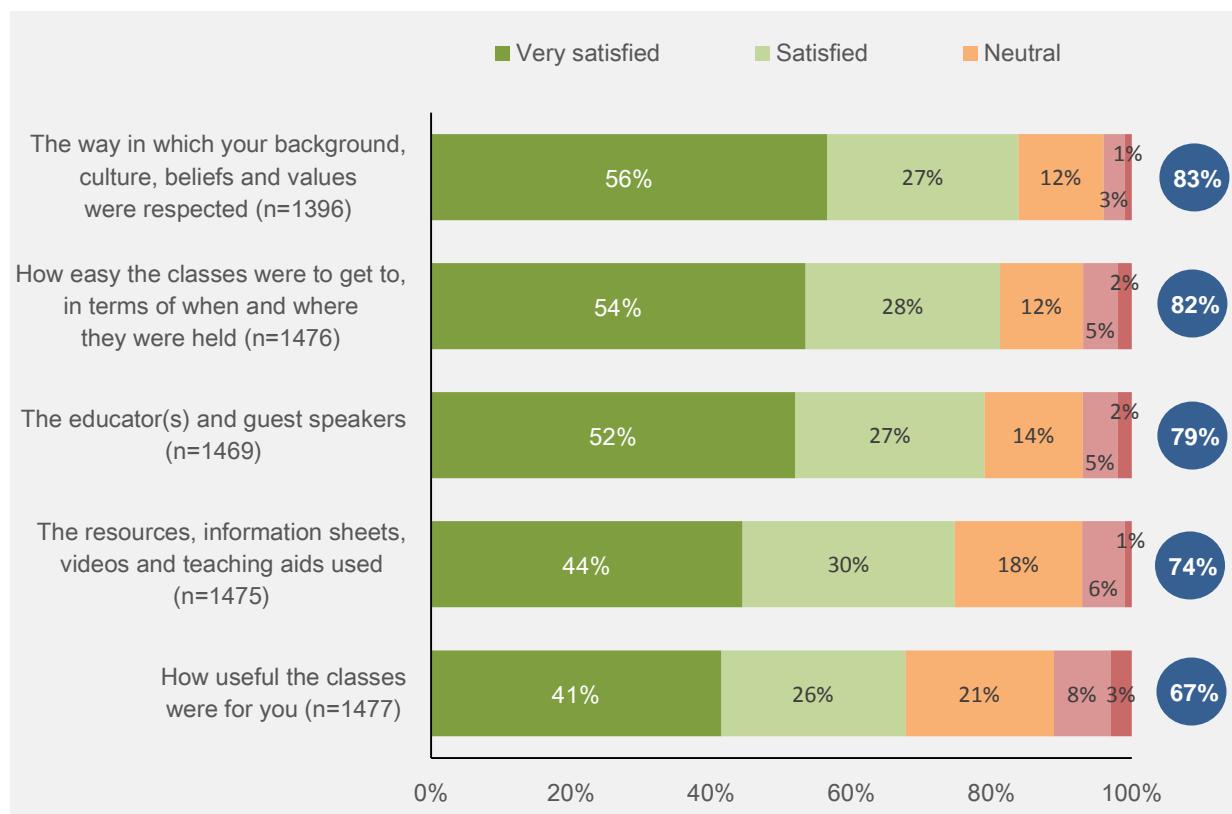
Women who went to antenatal classes (even if they only went once or twice) were asked to rate their satisfaction with particular aspects of these classes on a scale of 1 to 5, where 1 = very dissatisfied and 5 = very satisfied.

At least 60 percent of women who went to antenatal classes were satisfied or very satisfied with each individual aspect. Women were most satisfied with the way in which their background, culture, beliefs and values were respected (83 percent reported being satisfied or very satisfied with this).

Women were less satisfied with how useful the antenatal classes were (67 percent were satisfied or very satisfied with the usefulness of these classes, 11 percent were dissatisfied or very dissatisfied and 21 percent gave a neutral rating).

Figure 12: Satisfaction with the antenatal care received

Q13. Thinking about the antenatal classes you went to, how satisfied were you with ... ?



Please note: Sub-samples are based on women who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.

 Percent of women who were satisfied + very satisfied.

Examples of comments women provided in regards to antenatal classes are as follows:

Thanks to the antenatal classes and my midwife, myself and my partner were confident about the birth. I'm really satisfied about the process and even now I'm really satisfied about the healthcare provided to my son.

[Provider] delivered great antenatal classes - I wish I had known earlier about them as we were on a waiting list as they fill up so early, but we got in and have made great friends through it.

Antenatal classes helped with information on the birthing process but didn't cover enough practical information for after the birth.

I was very grateful for antenatal class that I learned a lot more from than my LMC.

The antenatal classes were great for information on birth, but need more information on caring for the baby.

The antenatal classes were good but needed more practical hands on experiences.

Antenatal classes were average, I thought. Was too much time spent on the birth, when practical parenting sessions would have been more useful e.g. how to settle your baby, setting up for success on the sleep front, how to manage bottle-feeding, skincare etc.

I think a class of ten woman and partners is too many; you don't want to ask many questions and we didn't get an opportunity to talk and get to know each other.

At antenatal classes, I asked about formula feeding and was told "I'm not allowed to tell you about that". Shame, because I couldn't breastfeed and could have done with some information.

There is little information given to you at antenatal classes or elsewhere that provides you with a positive outlook on the birthing process. Simple information would have helped me and all members of my antenatal classes e.g. positioning, length, contractions, how to deal with pain, relaxing, breathing, pelvic floor [and] how to push.

Antenatal classes focus on the birth and immediate care afterwards, but I had no idea of what raising a baby actually involved. More preparation information on this would have helped avoid postnatal depression.

My antenatal class was useless, I was misinformed and not helped at all from it; free courses at [Place] Hospital.

The antenatal classes which most people attend through [Provider] are terrible. They are full of incorrect, unsafe, biased information and set women up for postnatal depression. I believe the best way to teach antenatal classes would be to have midwives, obstetricians, GPs, physiotherapists etc. come to speak, rather than a childbirth educator with an agenda. The classes need to start much earlier in pregnancy.

I feel New Zealand antenatal classes don't really prepare you for birth, there is so much more to learn about the physical aspects of birth than just "stages of labour" and pain relief options.

Reasons for not attending antenatal classes

The 64 percent of women who did not attend antenatal classes were asked if there were any particular reasons why they decided not to go. As illustrated in Figure 13, the most common reason provided as to

why these women did not attend antenatal classes was because this was not their first baby (73 percent).

The next most common reasons were because they did not want to go (12 percent), they had other commitments (10 percent) or they did not know enough about the classes (seven percent).

None available (that I knew of) but I had asked and they didn't do the classes here in [Place].

One lot of classes, I called five times and they did not get back to me. The other set of classes were for two or three days for all day and I could not commit to that much time all at once.

The free classes were inconvenient times and booked out very early.

I specifically wanted to go to a Māori-run antenatal class that encompassed Māori values and practices during pregnancy. There was one available in [Place] which only ran during the day (I worked full time) and my midwife found out that it was the same kind of antenatal classes that were offered at the community centre near my house that had the classes at night. Classes were also fully booked by the time I applied. My midwife was amazing helping to try and find a class that fitted my needs but unfortunately there was nothing. I was also disappointed that the classes at the marae were aimed at women who were home during the day (i.e. unemployed). Throughout NZ I discovered plenty of antenatal classes that would have suited me but just not in [Place].

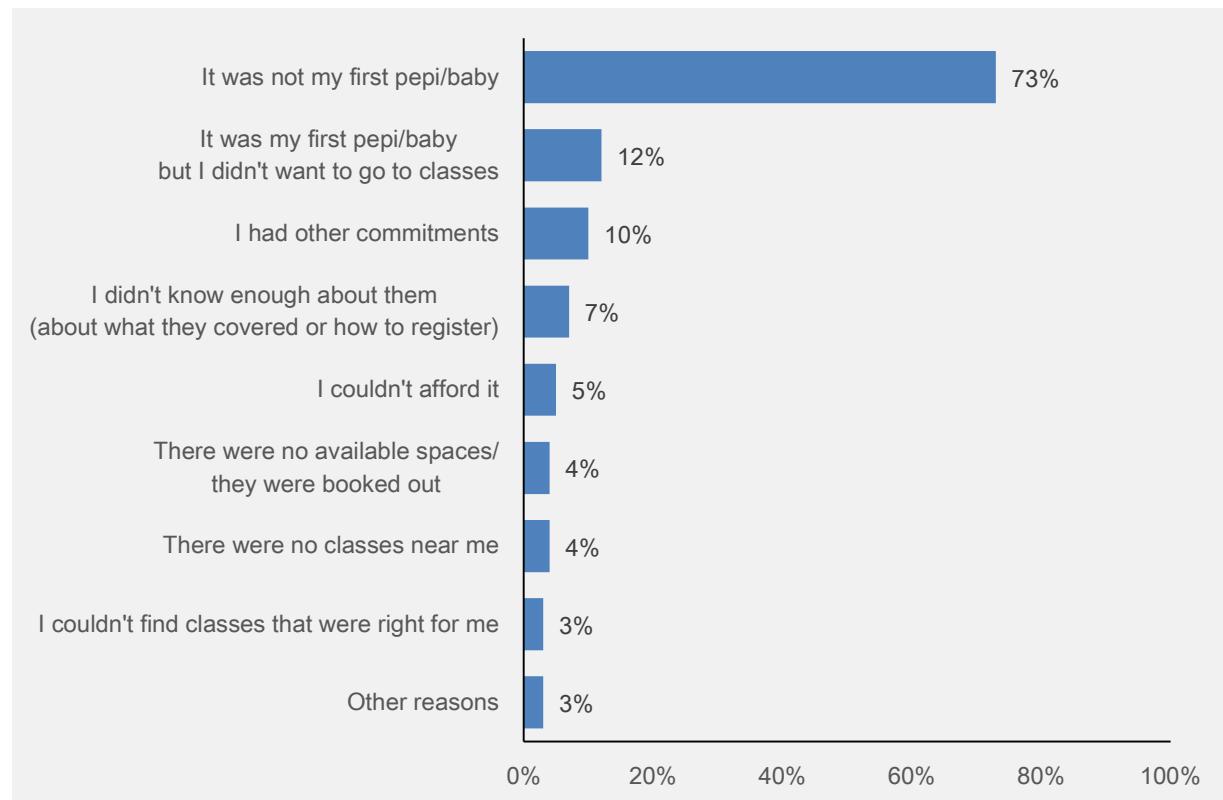
They weren't offered to me. Possibly due to being second time. But eight year age gap - lots has changed.

Too shy and didn't want to go alone. No partner.

Never got told about them until it was too late. Would have gone otherwise.

Figure 13: Reasons for not going to antenatal classes

Q14. Are there any particular reasons you did not go to antenatal classes?



Base (n=2284).

Sub-sample based on women who did not go to antenatal classes – excludes those who did not provide a response for this question.
Total will not sum to 100% because women could provide multiple responses to this question.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to antenatal classes

Māori women

- ☒ Māori women were less likely to attend antenatal classes (25 percent, compared with 43 percent of women of ‘other’ ethnicities).
- ☒ Māori women were more likely than women of ‘other’ ethnicities to say that they did not go to antenatal classes because they:
 - ☒ Did not want to go, even though it was their first baby (14 percent, compared with nine percent).
 - ☒ Had other commitments (14 percent, compared with six percent).
 - ☒ Couldn’t afford it (seven percent, compared with three percent).
- ☒ Māori women who did go to antenatal classes were more likely than women of ‘other’ ethnicities to be very satisfied with:
 - ☒ The way in which their background, culture, beliefs and values were respected (64 percent, compared with 54 percent).
 - ☒ The educator(s) and guest speakers (61 percent, compared with 49 percent).
 - ☒ The resources, information sheets, videos and teaching aids used (56 percent, compared with 41 percent).
 - ☒ How useful the classes were for them (53 percent, compared with 38 percent).

Pacific women

- ☒ Pacific women were less likely to attend antenatal classes (16 percent, compared with 43 percent of women of ‘other’ ethnicities).
- ☒ Pacific women were more likely than women of ‘other’ ethnicities to say that they did not go to antenatal classes because they:
 - ☒ Did not want to go, even though it was their first baby (19 percent, compared with nine percent).
 - ☒ Had other commitments (17 percent, compared with six percent).
 - ☒ Couldn’t afford it (nine percent, compared with three percent).
- ☒ Pacific women who did go to antenatal classes were more likely than women of ‘other’ ethnicities to be very satisfied with:
 - ☒ How easy the classes were to get to, in terms of when and where they were held (71 percent, compared with 52 percent).
 - ☒ The resources, information sheets, videos and teaching aids used (62 percent, compared with 41 percent).

- ↳ How useful the classes were for them (60 percent, compared with 38 percent).

Younger women

- ↳ Women under 25 years of age were less likely than older women to go to antenatal classes (26 percent, compared with 36 percent).
- ↳ Younger women were more likely than those aged 25 years or more to say that they did not go to antenatal classes because:
 - ↳ They didn't want to (27 percent, compared with seven percent).
 - ↳ They had other commitments (16 percent, compared with eight percent).
 - ↳ They couldn't afford it (11 percent, compared with three percent).
 - ↳ There weren't any classes near where they lived (10 percent, compared with three percent).
 - ↳ The classes were booked out (nine percent, compared with three percent).
- ↳ Younger women who went to antenatal classes were more likely to be very satisfied with how useful the classes were (49 percent, compared with 40 percent of older women).

Women with disabilities

- ↳ Women with disabilities were more likely to say that they could not find antenatal classes that were right for them (13 percent, compared with three percent of women without disabilities).

The labour and birth

Labour and birth is an exciting and sometimes scary time. The care women receive during their labour and birth should help them feel reassured and safe. Women have the right to be listened to, to be told what's happening to them and their pēpi/baby, and to make their own decisions. Care providers should talk with women about their needs and respect their wishes.

The results in this section will help the Ministry of Health to ensure that women have the best possible experience of labour and birth in the future.

Where the birth took place

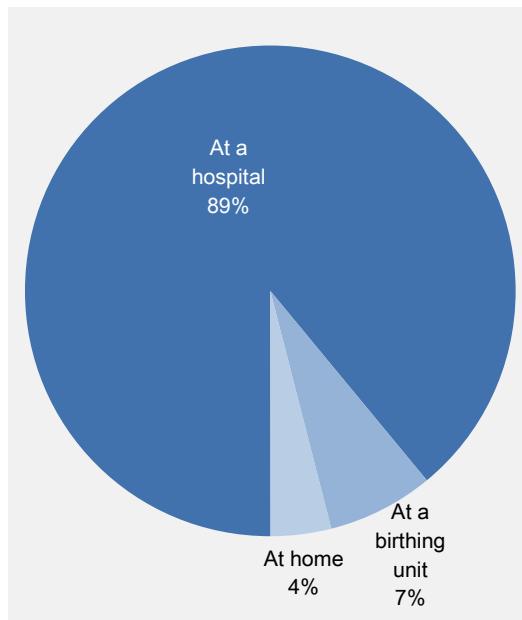
Most of the women interviewed (89 percent) gave birth in a hospital (Figure 14). First-time mothers were more likely to give birth in a hospital than women who were pregnant with their second or subsequent child (93 percent, compared with 86 percent).

A small proportion of women gave birth in a birthing unit (seven percent) or at home (four percent).

Women mostly gave birth where they had planned to (89 percent). Only one percent of women had an unplanned home birth or an unplanned birth in a birthing unit (one percent). Ten percent of women had an unplanned hospital birth (Figure 15).

Figure 14: Where women gave birth

Q15. Where did you give birth?



Base (n=3788).

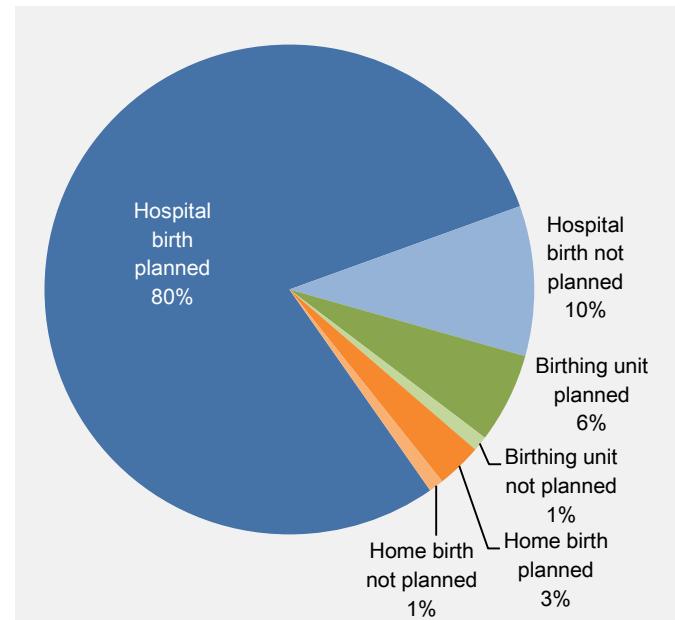
Sub-sample based on mothers who provided a response for this question.

Total may not sum to 100 percent due to rounding.

Figure 15: Location of births in relation to plans

Q15. Where did you give birth?

Q16. Was this where you planned to give birth?



Base (n=3744).

Sub-sample based on mothers who provided a response for both questions.

Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the location of the birth

Māori women

- ⦿ Māori women were more likely to have had an unplanned hospital birth (13 percent, compared with nine percent of women of ‘other’ ethnicities).

Pacific women

In terms of the location of the birth, there were no significant differences when the results for Pacific women were compared to the results of Māori women and women of ‘other’ ethnicities.

Younger women

- ⦿ Younger women were more likely to have had an unplanned hospital birth (14 percent, compared with eight percent of older women).

Women with disabilities

There were no significant differences between women with and without disabilities.

Satisfaction with care received during labour and birth

All women were asked to rate their satisfaction with aspects of the care they received during their labour and birth on a scale of 1 to 5, where 1 = very dissatisfied and 5 = very satisfied (Figure 16).

The overall care received from their LMC during the labour and birth was highly rated with 87 percent of women reporting that they were satisfied or very satisfied (74 percent were very satisfied).

Midwife was awesome, explained everything clearly and birthing was nice and steady. She let me know on the progress I was doing, how far away baby was to coming etc. I was lucky to have the best care and a good labour.

My midwife was in charge of my labour and birth; he did a fantastic job getting the ball rolling. To be honest I felt very relieved he was there to organise/sort out a delivery suite, then C-section (getting approval from specialists), being in theatre, and meeting the person who did the epidural. He kept me informed with everything. If I didn't have him I would have been stressed out.

The overall care received from the hospital or birthing unit staff during the labour and birth was also rated highly with 85 percent of women reporting that they were satisfied or very satisfied.

I am so proud of all the staff from the start of my labour till the end! They all made it so much easier for me; without their professionalism, it [wouldn't have been as] easy but I'm so grateful to all. [Hospital birth]

[Birthing unit] was the best place to give birth.

Satisfaction with individual aspects of the care women received during the labour and birth was also high, with at least 80 percent stating they were satisfied or very satisfied with each aspect.

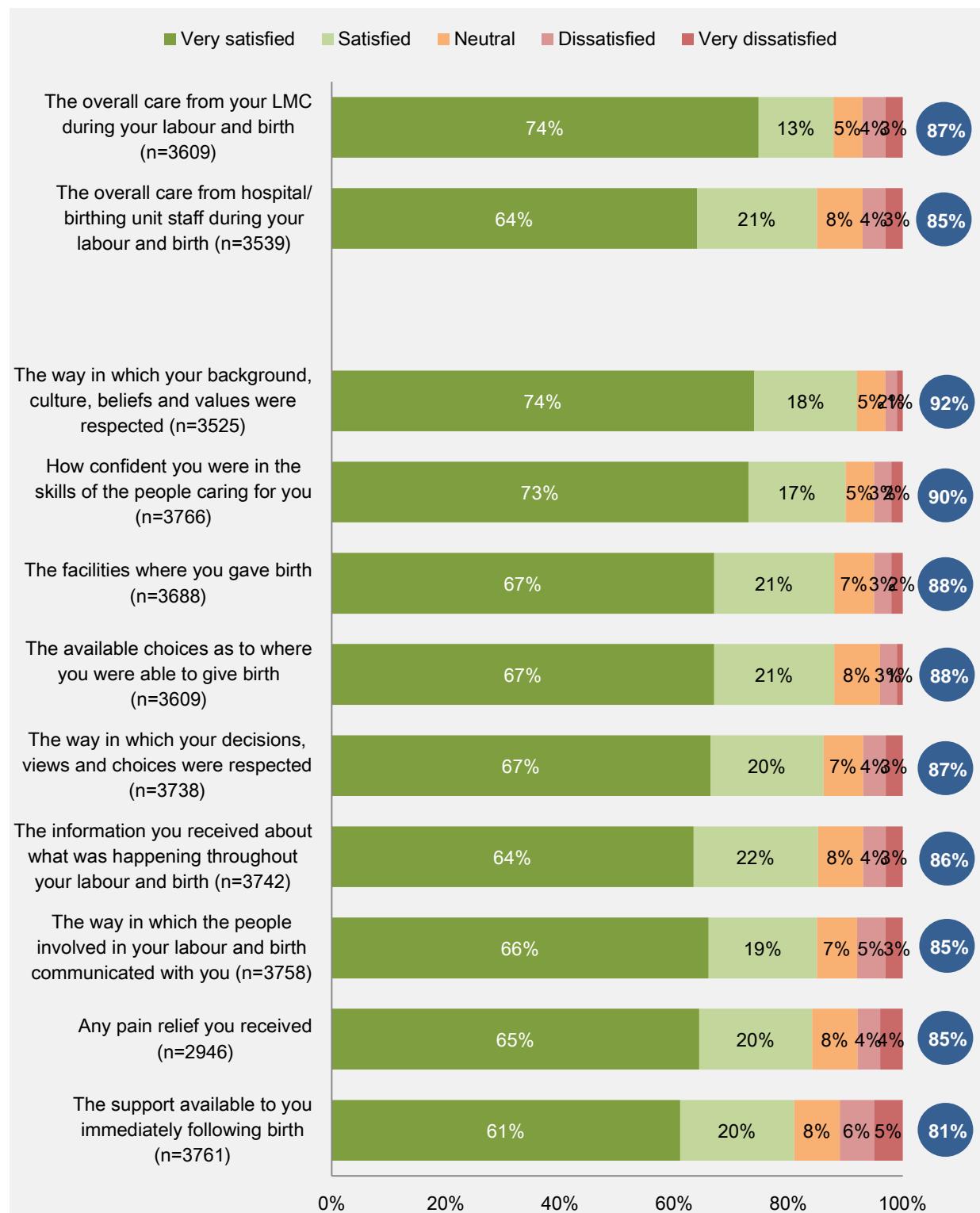
The most positively rated aspect was in relation to the way in which the women's backgrounds, cultures, beliefs and values were respected during the labour and birth (92 percent were satisfied or very satisfied). At least two-thirds of women were 'very satisfied' with the following aspects of the care they received during their labour and birth:

- Being confident in the skills of the people caring for them (73 percent were very satisfied).
- The facilities where they gave birth (67 percent).
- The choices available for the location of the birth (67 percent).
- The way in which their decisions, views and choices were respected (67 percent).
- How people involved in their care communicated with them (66 percent).

At 61 percent, women were least likely to report being very satisfied with the level of support that was available to them immediately following the birth.

Figure 16: Satisfaction with care received during labour and birth

Q17. Thinking about the care you received during labour and the birth of your pēpi/baby, how satisfied were you with...?



Please note: Sub-samples based on women who provided a response for each statement – excludes those who answered 'not applicable'.

Totals may not sum to 100 percent due to rounding.

%

Percent of women who were satisfied + very satisfied.

Differences in satisfaction with care received between women who gave birth at home or in a birthing unit and women who gave birth in a hospital

Women who gave birth at home or in a birthing unit were more likely than women who gave birth in a hospital to report being satisfied or very satisfied with the overall care they received from practitioners during their labour and birth (94 percent, compared with 87 percent of women who gave birth in a hospital).

They were also more likely to report being very satisfied with the following aspects of care they received during their labour and birth:

- The way in which their background, culture, beliefs and values were respected (86 percent, compared with 72 percent of women who gave birth in a hospital).
- Being confident in the skills of the people caring for them (83 percent, compared with 72 percent).
- The facilities where they gave birth (82 percent, compared with 66 percent).
- The choices available for the location of the birth (80 percent, compared with 65 percent).
- The way in which their decisions, views and choices were respected (83 percent, compared with 65 percent).
- How people involved in their care communicated with them (77 percent, compared with 65 percent).
- The support that was available immediately following their birth (77 percent, compared with 59 percent).
- The information they received about what was happening throughout their labour and birth (73 percent, compared with 62 percent).

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the care received during labour and the birth

Māori women

- Māori women were more likely to be very satisfied with the support that was available to them immediately following the birth (66 percent were very satisfied, compared with 58 percent of women of ‘other’ ethnicities).
- Māori women were more likely to be dissatisfied or very dissatisfied with the overall care they received from their LMC during labour and birth (10 percent, compared with six percent of women of ‘other’ ethnicities), the overall care they received from hospital or birthing staff during labour and birth (10 percent, compared with six percent of women of ‘other’ ethnicities and five percent of Pacific women) and the following individual aspects of care:
 - The way in which the people involved in their labour and birth communicated with them (11 percent, compared with seven percent of women of ‘other’ ethnicities and six percent of Pacific women).
 - The information they received about what was happening throughout the labour and birth (10 percent, compared with five percent of women of ‘other’ ethnicities and five percent of Pacific women).
 - The pain relief they received (10 percent, compared with seven percent of women of ‘other’ ethnicities and four percent of Pacific women).
 - The way in which their decisions, views and choices were respected (nine percent, compared with five percent of women of ‘other’ ethnicities).
 - How confident they were in the skills of the people caring for them (nine percent, compared with five percent of women of ‘other’ ethnicities and three percent of Pacific women).

Pacific women

There were no significant differences with regard to the care received during labour and the birth for Pacific women, in comparison to women of ‘other ethnicities’ and Māori women.

Younger women

- Younger women were more likely than those aged 25 years or more to report being dissatisfied or very dissatisfied with the overall care they received from their LMC during their labour and birth (12 percent, compared with six percent) and very dissatisfied with the support that was available to them immediately following birth (eight percent, compared with four percent).

Women with disabilities

- ⦿ Women with disabilities were more likely to be dissatisfied or very dissatisfied with:
 - ⦿ The support available to them immediately following birth (28 percent, compared with nine percent of women without disabilities).
 - ⦿ The information they received about what was happening throughout their labour and birth (13 percent, compared with seven percent of women without disabilities).
 - ⦿ Their confidence in the skills of the people caring for them (10 percent, compared with five percent of women without disabilities).

Postnatal care

The postnatal period (i.e. the period after the birth) is the time for a mother to recover from the birth and get to know their baby.

The results in this section explore the postnatal care women received while in hospital or a birthing unit, as well as the care they received in the 4-6 weeks following the baby's birth.

The hospital or birthing unit stay

Staying in hospital after giving birth can be a time for recovery and bonding with pēpi/baby, and for learning important new skills like breastfeeding. Women don't have to stay in hospital after they give birth, but if they do, it's important that they are respected and get the help and support they need.

The results presented in this section will help the Ministry of Health to improve the way in which new mothers are cared for in hospital or at a birthing unit immediately after birth.

Length of stay

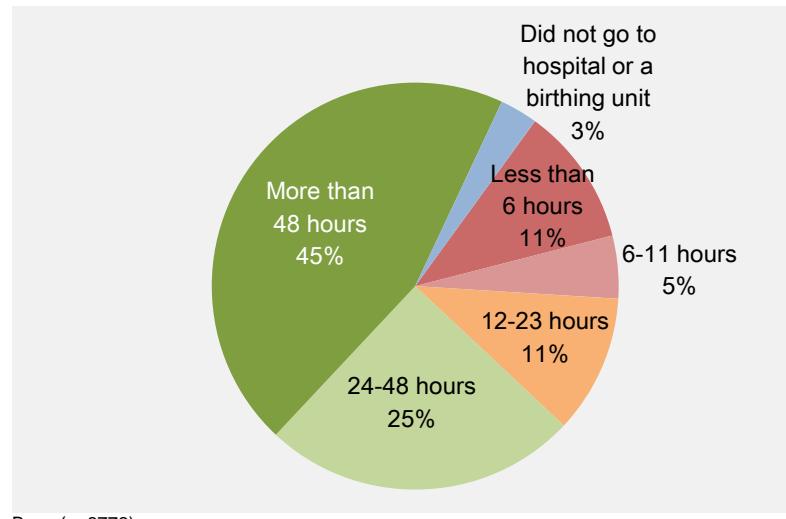
All women were asked how long they stayed in hospital or a birthing unit after they gave birth (Figure 17).

Seventy percent of women reported having stayed in hospital or in a birthing unit for at least 24 hours after they gave birth, with almost one-half (45 percent) remaining in hospital or a birthing unit for more than 48 hours.

First-time mothers were more likely to report having stayed in hospital or a birthing unit for more than 48 hours following the birth of their child (55 percent, compared with 37 percent of other mothers).

Figure 17: Length of stay in a hospital/birthing unit after the birth

Q18. How long did you stay in a hospital or birthing unit after you gave birth?



Sub-sample based on women who provided a response for this question.
Total may not sum to 100 percent due to rounding.

When they left the hospital or birthing unit, most women (83 percent) felt they were 'ready to leave'.

I stayed in hospital for five days. I got good help from nurses.

I spent equal time at [Hospital 1] (two days) and [Hospital 2] (two days). I felt ready to transfer to [Hospital 2] and then I felt ready to go home.

As ready as a new mother can feel I guess.

However, seven percent reported having left the hospital or birthing unit before they were ready because they didn't like it there, while another six percent said they left before they were ready because they had been discharged or sent home early (Figure 18).

Partners/husband were not allowed to stay overnight and I did not want him to go, so I went home.

[Place] Hospital was oversubscribed and I felt forced to leave within the hour I gave birth, transferred to [Place]. I did not feel ready to leave the place or hospital I originally gave birth in. Felt I should have had at least one day.

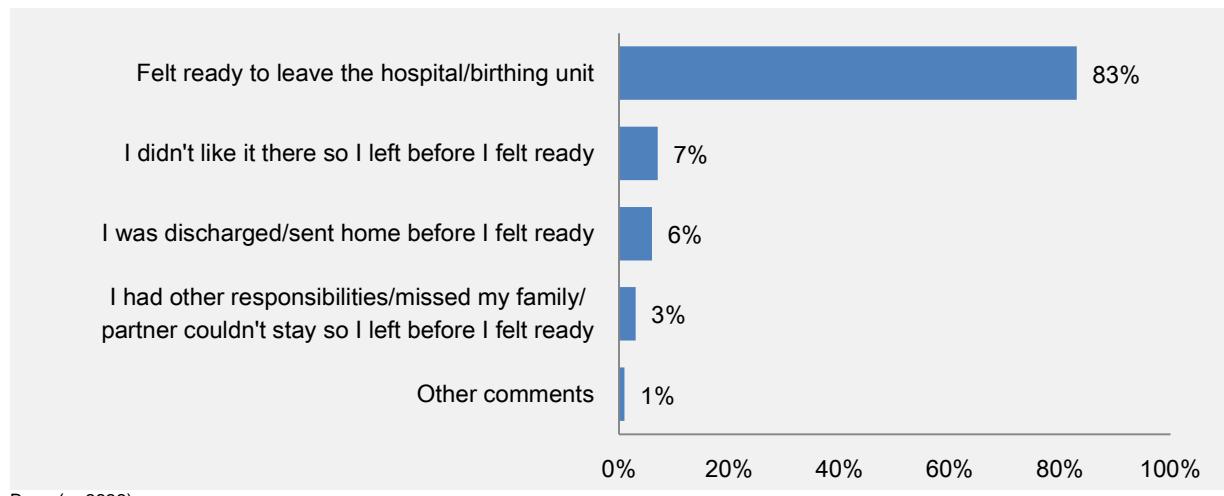
I didn't like the way I was being treated so I left early.

I was not ready to leave as baby wasn't gaining weight. Doctor said we could leave when she started gaining weight but we were discharged before this.

I was made to feel guilty about staying on because the department was "getting very busy" so I left before I felt confident with breastfeeding. I ended up getting mastitis as my baby had allergies so wouldn't latch properly and I was readmitted less than a week later for 4 more nights in hospital on IV antibiotics!

Figure 18: Feeling ready to leave the hospital or birthing unit

Q19. If you had your pēpi/baby in a hospital or birthing unit, or stayed in one after you gave birth, when you left, did you feel ready to leave?



Sub-sample based on women stayed in a hospital or birthing unit after they gave birth – excludes women who answered 'not applicable' and those who did not provide a response for this question.
Total may not sum to 100 percent due to rounding.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the length of stay in hospital or the birthing unit

Māori women

- Māori women were more likely to have left the hospital or birthing unit within 6 hours of giving birth (14 percent, compared with 10 percent of women of 'other' ethnicities) and less likely to report having stayed in hospital or the birthing unit for more than 48 hours after giving birth (39 percent, compared with 49 percent of women of 'other' ethnicities).

Pacific women

- Pacific women were less likely to report having stayed in hospital or the birthing unit for more than 48 hours after giving birth (37 percent, compared with 49 percent of women of 'other' ethnicities).

Younger women

- Younger women were less likely than older women to have stayed in a hospital or birthing unit for more than 48 hours after they gave birth (41 percent, compared with 48 percent of older women).

Women with disabilities

- Sixty-nine percent of women with disabilities said that when they left the hospital or birthing unit after giving birth, they felt ready to leave. This result is significantly lower than that of women without disabilities (83 percent of whom were ready to leave when they did).

Satisfaction with postnatal care at hospital or birthing unit

Women who had stayed in a hospital or birthing unit after giving birth were asked to rate their satisfaction with different aspects of the postnatal care they received while they were there. This was based on a 5 point scale where 1 = very dissatisfied and 5 = very satisfied.

Eighty percent of women were satisfied or very satisfied with the overall care they received at the hospital or birthing unit after they gave birth, with one-half stating that they were very satisfied (52 percent).

[Town/City] hospital were AMAZING! I was in hospital for eight days and they were really supportive and helpful during this time.

I ended up with a C-section so stayed in hospital for four nights and had a lot of help with breastfeeding which helped me a lot.

[Town/City] hospital do an awesome job, all the staff were lovely and friendly and willing to help out where needed, night staff were absolutely lovely. Wouldn't birth anywhere else.

At least one-half of women were very satisfied with the following aspects of postnatal care they received while in the hospital or birthing unit:

- The cleanliness of the hospital or birthing unit (65 percent were very satisfied).
- Visitors or support people being around whenever the mother wanted them to be (58 percent).
- The amount of privacy they had (57 percent).
- The help and support available during their stay (52 percent).
- The care and attention received from staff (51 percent).

However, less than half were very satisfied with the following aspects of their hospital or birthing unit stay:

- The food (40 percent were very satisfied).
- The amount of rest they were able to get (41 percent were very satisfied).

If my partner (husband) was able to stay with me the first couple of nights, I would have been a lot less anxious and probably would have been able to sleep and rest a lot more.

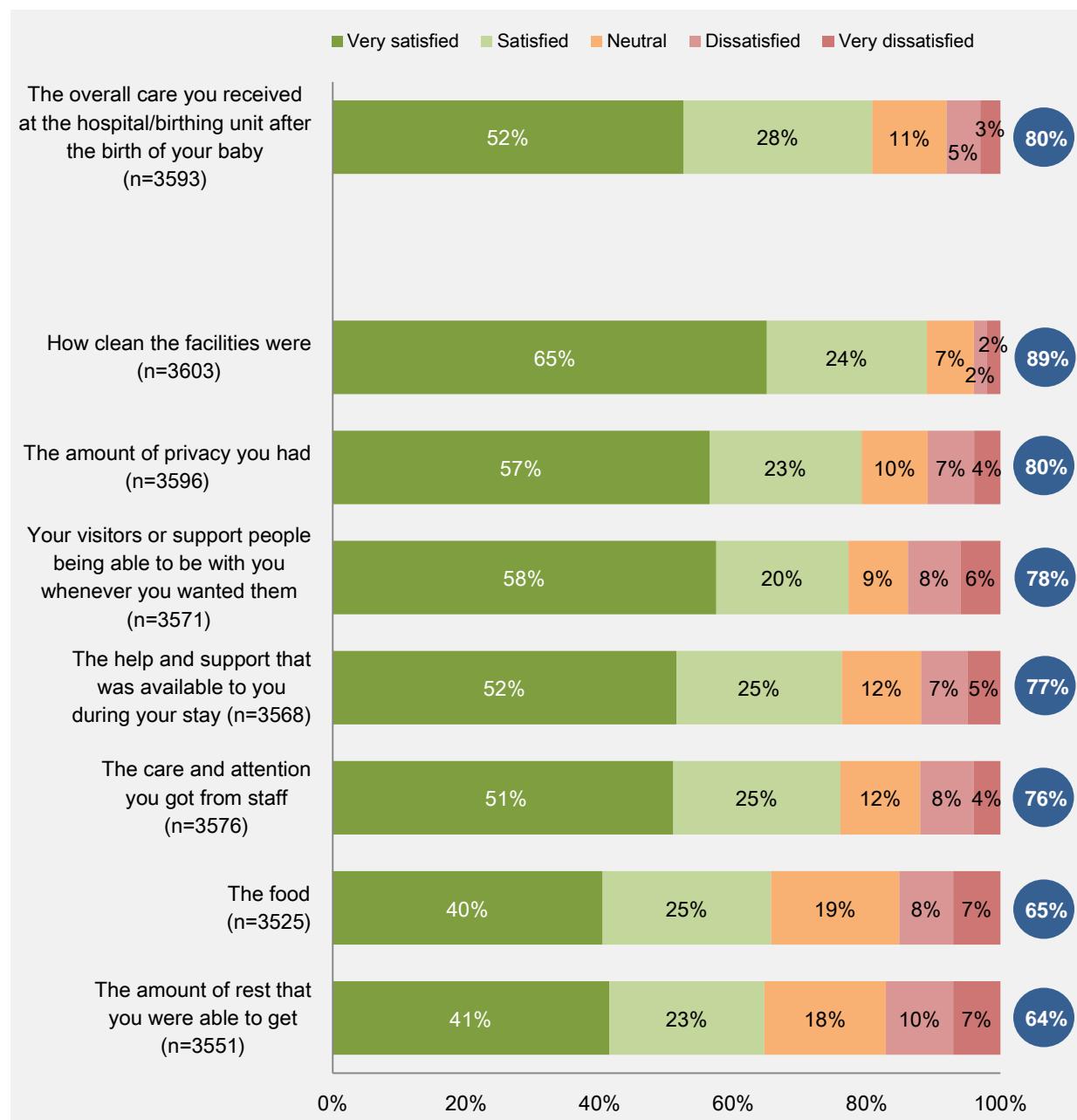
[The food was] horrible and not healthy or nutritious.

Quality of [food] I got was fine but there was no way enough of it! I was told I had to make my own breakfast in the family room! How can someone who is recovering from birth and trying to attend a newborn baby get up and make their own breakfast! I had someone (a hospital volunteer) make my breakfast on the first morning and then the second morning I

didn't get any at all! I was starving the entire time I was there and I had to ask my family to bring me food.

Figure 19: Satisfaction with postnatal care received at the hospital or birthing unit

Q20. Thinking about the postnatal care you received during your time in hospital or the birthing unit, how satisfied were you with...?



Please note: Sub-samples based on who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.

Percent of women who were satisfied + very satisfied.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the postnatal care they received while in hospital or a birthing unit

Māori women

- Māori women were more likely than women of ‘other’ ethnicities to be very satisfied with the overall care they received at the hospital or birthing unit after the birth of their baby (58 percent, compared with 49 percent), as well as the following individual aspects of care:
 - The amount of privacy they had (61 percent, compared with 55 percent).
 - The care and attention they received from the hospital or birthing unit staff (60 percent, compared with 47 percent).
 - The help and support available to them during their stay (59 percent, compared with 49 percent).
 - The amount of rest they were able to get (48 percent, compared with 38 percent).

Pacific women

- Pacific women were more likely than women of ‘other’ ethnicities to be very satisfied with the overall care they received at the hospital or birthing unit after the birth of their baby (59 percent, compared with 49 percent), as well as the following individual aspects of care:
 - The care and attention received from staff (56 percent, compared with 47 percent).
 - The food provided by the hospital or birthing unit (49 percent, compared with 39 percent).
 - The amount of rest they were able to get (49 percent, compared with 38 percent).

Younger women

- Younger women were more likely than those aged 25 or older to be very dissatisfied with the following aspects of postnatal care they received at a hospital or birthing unit:
 - The food (10 percent, compared with seven percent).
 - The amount of time their visitors or support people were allowed to be with them (nine percent, compared with five percent).
 - The help and support that was available to them during their stay (eight percent, compared with four percent).

Women with disabilities

- Women with disabilities were more likely to be dissatisfied or very dissatisfied with the overall care they received at the hospital or birthing unit after they birth of their baby (17 percent, compared with eight percent of women without disabilities), as well as the following individual aspects of care:
 - The care and attention they received from staff (20 percent, compared with 11 percent of women without disabilities).

- The help and support available to them during their stay (27 percent, compared with 11 percent of women without disabilities).

Postnatal care at home

Being at home with a newborn can be hard work. Midwives are there to support women and their whānau/families in the first 4-6 weeks after baby is born. Women are entitled to at least five home visits unless they ask not to have them. Midwives and other health professionals should talk with women about their needs and be available if there are any problems during this time.

The results in this section will help the Ministry of Health to improve the postnatal care women and their babies receive at home in the first 4-6 weeks after birth.

Home visits from a midwife

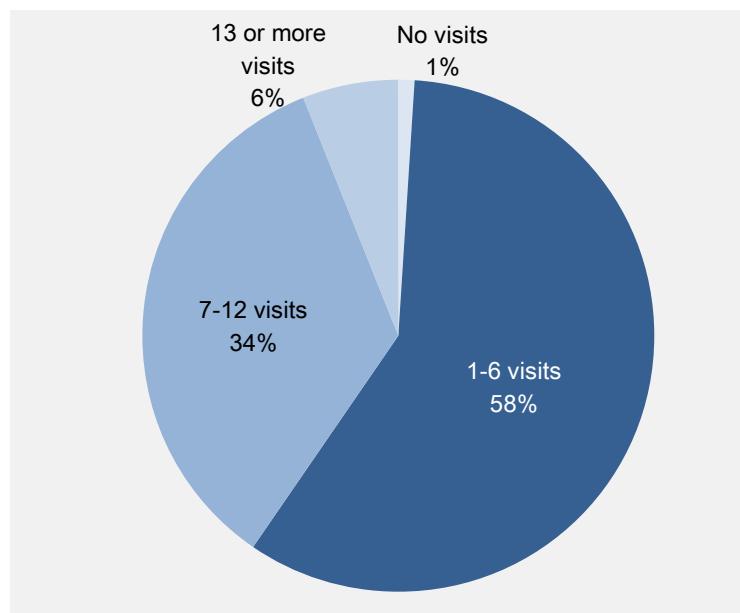
All women were asked how many home visits their midwife made following the birth of their child (Figure 20) and if they felt the amount of visits they received was right for them (Figure 21).

More than one-half of all women (58 percent) reported having received up to six visits at home from their midwife in the 4-6 weeks following the baby's birth. Another third (34 percent) reported having received 7-12 visits, while six percent were visited 13 times or more.

Only one percent of women received no home visits at all.

Figure 20: Number of home visits received from midwives

Q21. After the birth of your baby, how many home visits did your midwife make?



Base (n=3763).
Sub-sample based on women who provided a response for this question.
Total may not sum to 100 percent due to rounding.

Most of the women who received 1-6 home visits from their midwife felt this was the 'right amount' of visits (83 percent). Those who received more than six visits were even more likely to agree that they received the 'right amount' of visits (96 percent of those who received 7-12 visits and 95 percent of those who received 13 or more visits).

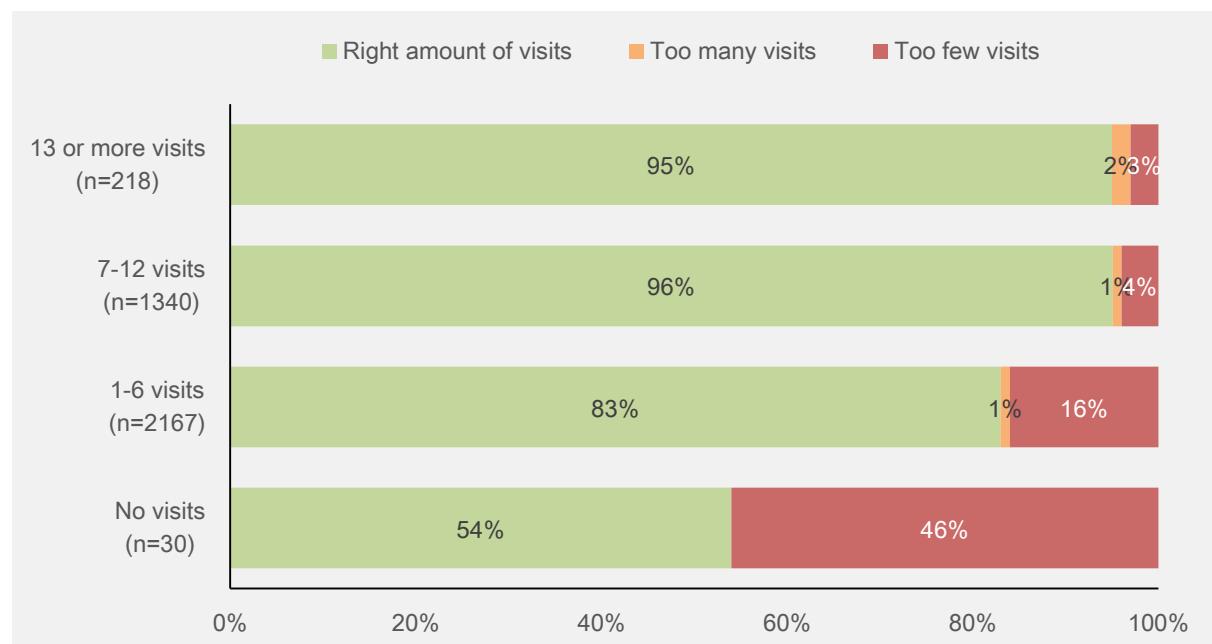
One percent ($n=30$ women) reported having not received any home visits from their midwife in the 4-6 weeks following the baby's birth. Approximately one-half of these women (54 percent) were happy to have not received any visits, while 46 percent described it as 'too few'.

There were no significant differences in terms of the number of home visits received and whether or not the number was considered to be the right amount, for Māori, Pacific or younger women or women with disabilities.

Figure 21: Whether or not women received the right amount of home visits

Q21. After the birth of your baby, how many home visits did your midwife make?

Q22. Was this the right amount of visits for you?



Satisfaction with postnatal care received at home

All women were asked to rate how satisfied they were with particular aspects of the postnatal care they received at home in the weeks following the baby's birth. Satisfaction was measured using a scale from 1 to 5 where 1 = very dissatisfied and 5 = very satisfied.

Overall, 89 percent of women were satisfied or very satisfied with the care they received from their midwife during the first few weeks at home with their baby.

[Name] was an exceptional midwife and a wonderful, caring, loving person. She will always be a part of our family.

I was very, very lucky to have an amazing midwife who went the extra mile and her care was exceptional.

My midwife was amazing and I will definitely be trying to have her or anyone else from her team [next time]. It was sad to end the relationship after my six post weeks.

I was very fortunate to have an extremely experienced and amazing midwife. She made every step of my pregnancy right through to birth and postnatal care an absolute stress-free time.

My midwife was amazing in every aspect of my pregnancy and care for my daughter after she was born.

Individual aspects of the postnatal care received at home were also positively rated, with at least 70 percent of women describing themselves as being 'very satisfied' with:

- The physical checks carried out on their baby (76 percent were very satisfied).
- The way in which their background, culture, beliefs and values were respected (75 percent).
- The way in which their decisions, views and choices were respected (72 percent).
- The advice they received from their midwife about caring for their baby (72 percent).
- Their midwife listening to them (72 percent).
- The advice from their midwife about caring for themselves (71 percent).
- The way their midwife responded to their needs (71 percent).

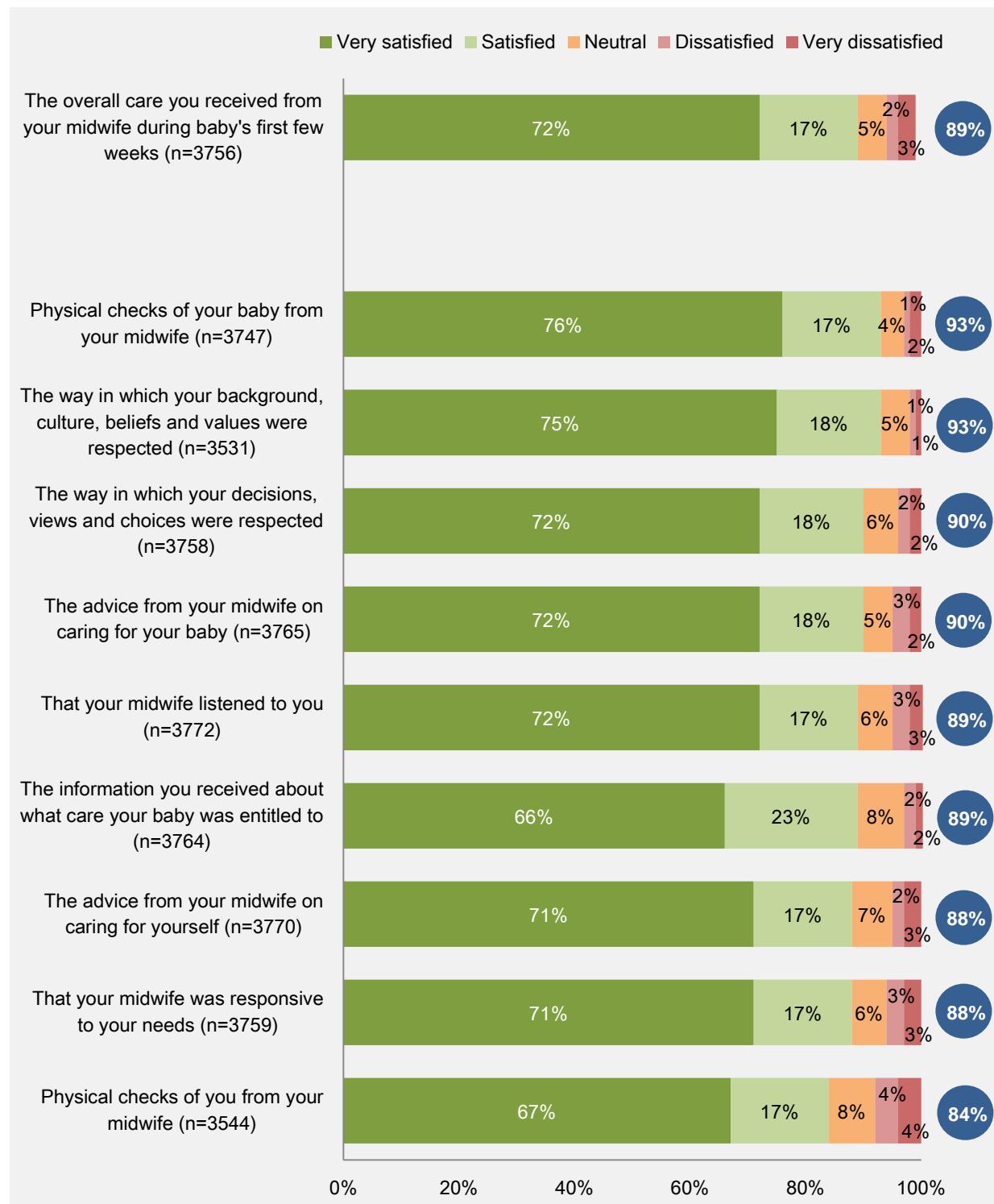
Women were least likely to be very satisfied with the physical checks completed on themselves (67 percent were satisfied or very satisfied).

[I had an] infection which apparently she should've noticed as it was bad.

No checks when there should have been in order to detect infection.

Figure 22: Satisfaction with postnatal care received at home

Q23. Thinking about the postnatal care you received at home, how satisfied were you with...?



Please note: Sub-samples based on who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.

Percent of women who were satisfied + very satisfied.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the postnatal care they received at home

Māori women

- ⦿ Māori women were more likely than women of ‘other’ ethnicities to be very satisfied with the overall care they received from their midwife during their baby’s first few weeks (76 percent, compared with 70 percent), as well as the following individual aspects of care:
 - ⦿ That their midwife listened to them (76 percent, compared with 70 percent).
 - ⦿ The advice from their midwife on caring for their baby (76 percent, compared with 70 percent).
 - ⦿ That their midwife was responsive to their needs (75 percent, compared with 69 percent).
 - ⦿ The advice from their midwife on caring for themselves (75 percent, compared with 69 percent).
 - ⦿ The physical checks they received from their midwives (72 percent, compared with 64 percent).
 - ⦿ The information they received about what care their baby was entitled to (69 percent, compared with 64 percent).

Pacific women

- ⦿ Pacific women were more likely than women of ‘other’ ethnicities to be very satisfied with:
 - ⦿ The advice from their midwife on caring for their baby (77 percent, compared with 70 percent).
 - ⦿ The physical checks they received from their midwife (73 percent, compared with 64 percent).

Younger women

There were no notable differences in satisfaction with the postnatal care received at home, between younger women and those aged 25 years and over.

Women with disabilities

- ⦿ Women with disabilities were more likely to have had 13 or more home visits from their midwife (15 percent, compared with six percent of women without disabilities).

Satisfaction with the accessibility of other service providers

Women were asked to rate their satisfaction with how accessible other service providers were after the birth of their baby. This included their GP, Well Child provider and any specialists they saw (Figure 23).

Overall, the proportion of women who were satisfied or very satisfied with how easy it was to get in contact with other service providers was high.

At least one-half of women were very satisfied with how easy it was to contact or see:

- Their GP (58 percent).
- Their Plunket or Tamariki Ora provider (55 percent).
- Any specialists they needed to (52 percent).

Women who were satisfied or very satisfied with how easy it was to access other service providers did not comment specifically about this. Instead they provided comments about the service they received:

Fantastic staff. Paediatricians in hospital, ditto breastfeeding services. So lucky to have such amazing follow up 'specialist' services.

I paid to see a private lactation consultant who was fantastic!

[Well Child Provider] were the best in taking care of me and my baby and made sure I didn't have any questions unanswered.

[Well Child Provider] and GP have been excellent. Great extra care from [Well Child Provider] with my concerns.

Examples of comments from women who were less satisfied with how easy it was to access other service providers are as follows:

I went to a private lactation consultant as I did not feel the hospital and free clinics were accessible and quality was not there.

Two hour drive away. Would have been nice to have lactation consultant here in town.

Lactation consultant only in [Town/City] once a week which was a challenge.

Changed GP's due to an overcrowded and inattentive GP.

Couldn't get an appointment [with GP] when baby was a matter of weeks old and unwell.

[Well Child Provider] not great, had appointments and the nurse did not show up.

[Well Child Provider] I had to ring them and remind [them] to get in contact with me. Went to GP at one point, was then told GP was unavailable.

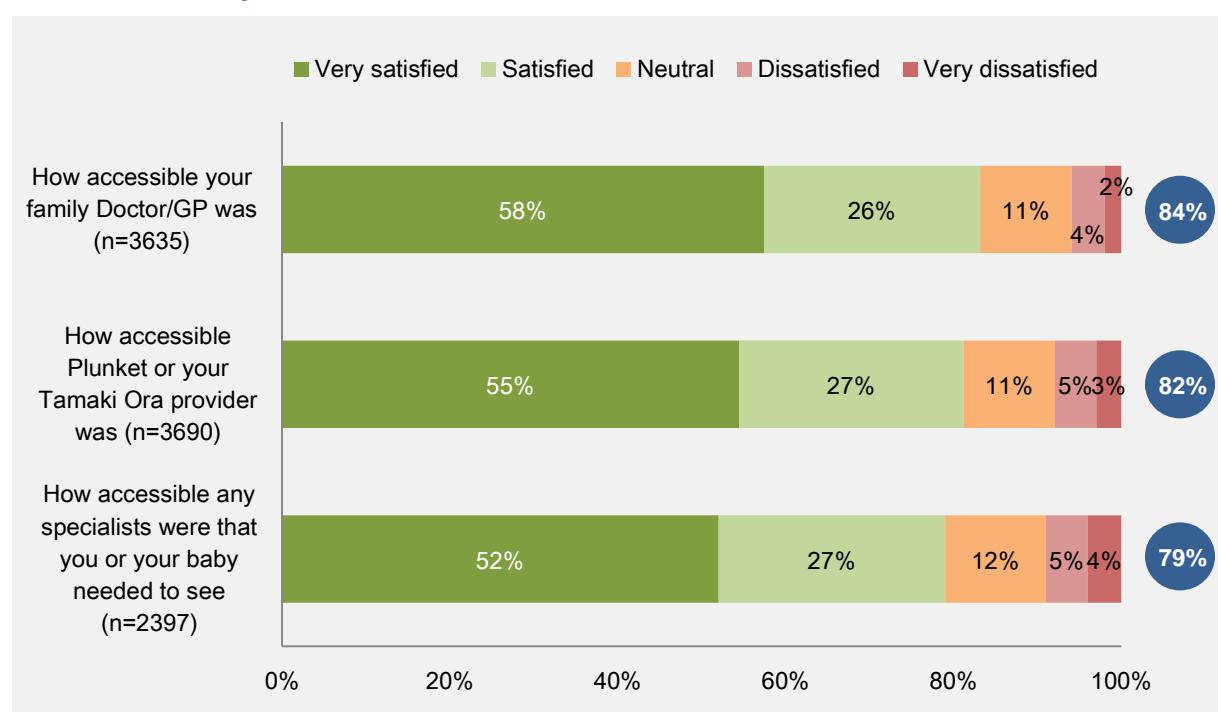
We had major trouble getting access to the paediatricians for assessment on allergies, silent reflux and troubled breast milk supply. In the end I had to seek information from companies like Nutricia, and online. The [Family Centre] are a HUGE support and helped me when the [DHB] didn't seem to be able to fit us in. As far as those big wheels were concerned, I was just to starve my baby and have him scream all the time.

The reason why I have given very dissatisfied is because of the challenges associated with seeing a GP and getting consistent care for my son from a GP. It's impossible to get an appointment to see a doctor, let alone your own doctor. Therefore treatment is inconsistent and we spend more time sharing background because doctors don't have accurate notes. Getting in to see an ear specialist is an even harder challenge. All of this has impacted my son's development and wellbeing.

Just one comment I'd like to make is that it took so long time to get an appointment with the paediatrician for my baby when our GP referred her. It would be great if access to the specialist can get easier.

Figure 23: Satisfaction with accessibility of other service providers

Q24. Thinking now about any contact you may have had with other services following pēpi/baby's birth, how satisfied were you with each of the following...?



Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the accessibility of other service providers

Māori women

- Māori women were less likely to be satisfied or very satisfied with how accessible Plunket or their Tamariki Ora provider was (76 percent, compared with 84 percent of Pacific women and 84 percent of women of ‘other’ ethnicities).

Pacific women

- Pacific women were more likely than Māori women to be satisfied or very satisfied with how accessible Plunket or their Tamariki Ora provider was (84 percent, compared with 76 percent of Māori women).

Younger women

- Younger women were less likely to be satisfied or very satisfied with how accessible Plunket or their Tamariki Ora provider was (75 percent, compared with 84 percent of older women).

Women with disabilities

- There were no significant differences between women with and without disabilities in terms of how accessible other service providers were.

Information and costs

The results in this section are divided into two sub-sections relating to sources of information and paying for pregnancy-related services.

Information sources

There is a lot of information around for women about maternity services, pregnancy, birth and caring for baby. It can be hard for women to find what they need, when they need it and the sheer volume of information in itself can be overwhelming.

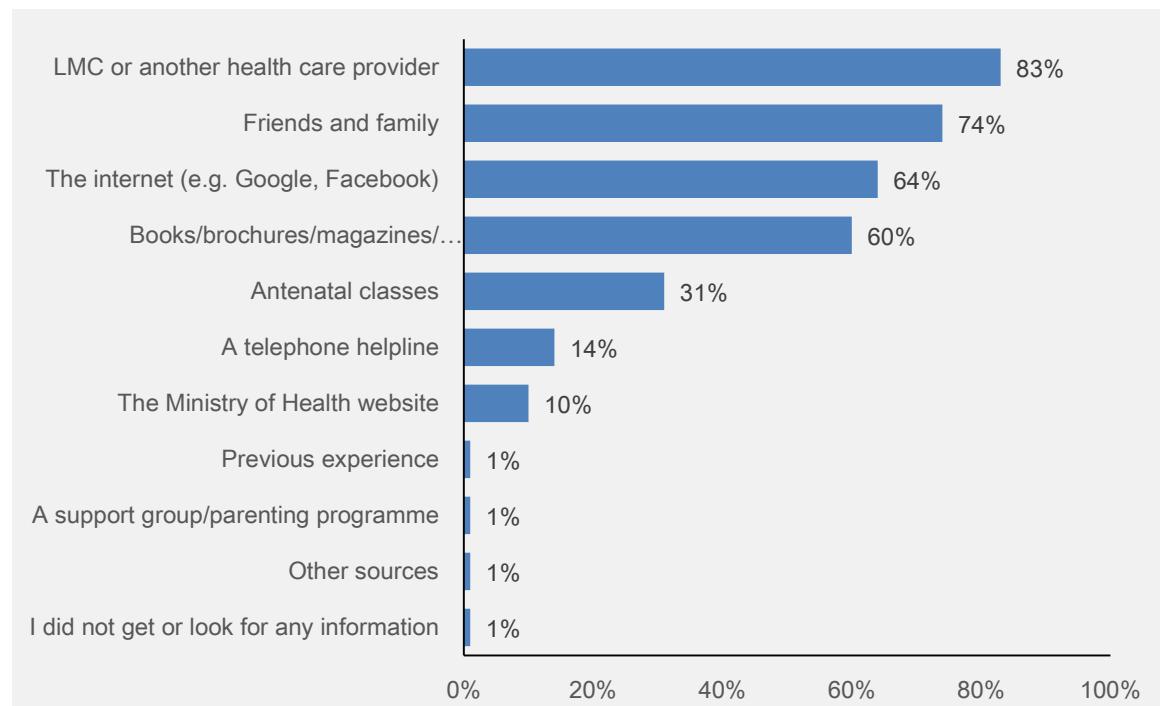
The results in this sub-section will help the Ministry of Health to work out better ways to get useful information to pregnant/hapū women and new families.

All women were asked to identify where they had sourced their information about maternity services, pregnancy, birth and caring for newborns (Figure 24).

As illustrated below, most of this information came from LMC's or other health care providers (83 percent), friends and family (74 percent), the internet (64 percent) and books, brochures, magazines or information packs (60 percent).

Figure 24: Sources of information

Q25. Thinking more generally now, there is a lot of information around for women about maternity services, pregnancy, birth and caring for newborns. Where did you get your information from?



Base (n=3776).

Sub-sample based on women who provided a response to this question.

Total will not sum to 100 percent because women could provide multiple responses to this question.

Satisfaction with the quality of information received

Women were asked to rate their satisfaction with the quality of information they received on a variety of topics, from knowing what to do when you first find out you are pregnant, through to parenting skills and immunisations. Each of these topics were rated on a 5 point scale where 1 = very dissatisfied and 5 = very satisfied.

While at least 70 percent of women were satisfied or very satisfied with each of the information topics, they were most satisfied with the information they had received about safe sleep (64 percent were very satisfied with the quality of information they received about this), and least satisfied with the information they received about how maternity services work (47 percent were very satisfied) and antenatal classes (45 percent were very satisfied).

Below are some examples of the general comments and suggestions received relating to the provision of information:

The information about labour was very good. I felt well-informed and it was good that we were able to make decisions in a birthing-plan.

My #1 most helpful source of information for both first and second child was La Leche League. LMC was great, no complaints, but LLL provides a support network with loads of community resources and just plain good advice. I am a researcher by nature so looked for my information everywhere, but honestly found the most helpful to be the LLL groups, with the added bonus of incredible friendships made along the way and outstanding community involvement!

I was pleased with the neutral stance my LMC had on conventional treatments vs natural, and also vaccination. She provided information for both sides and allowed me to make my own informed decisions.

I had no information given to me after a positive pregnancy test, I had to try [to] find things by going online. I texted and emailed a few midwives and none responded.

Real lack of information around next steps of finding a LMC after you find out you're pregnant. More direction from GP's is needed.

There is no good info to compare and find the right midwife. No performance info. Choosing a midwife is random arbitrary luck/or bad luck. There is more info online for choosing a plumber (i.e. no cowboy's website etc.). It's a [expletive] stupid system.

How to choose a midwife? A list is nowhere near enough. Would have been useful to also see profiles to help me determine who would be a good fit.

Provide more information about home birthing as a choice for birth.

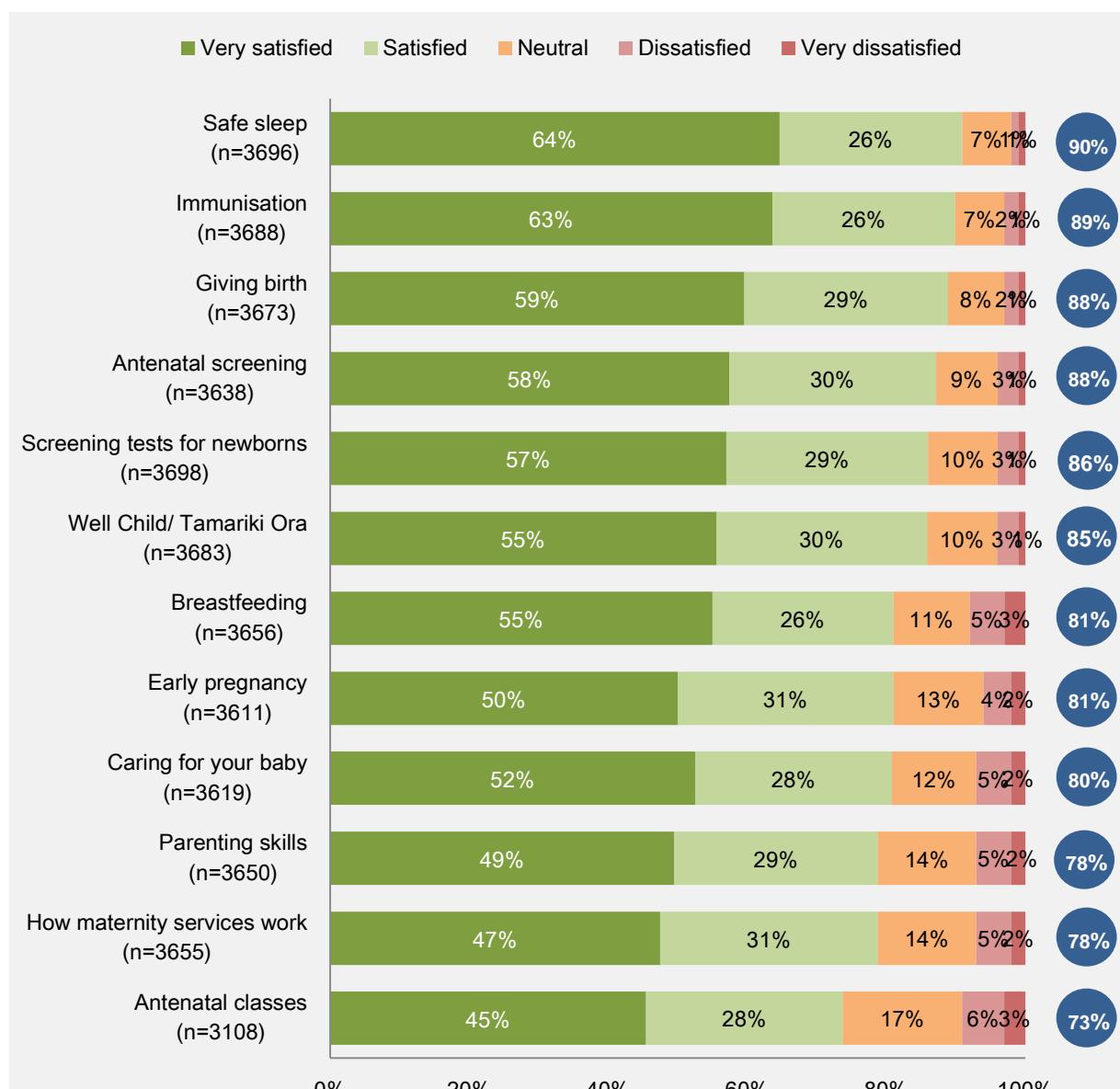
More information [needed] on [Well Child Provider]. Pamphlets on FREE places for a variety of things.

More information and classes/workshops about caring for your baby after it is born is vital. That is a very stressful time and unless you have a good support system, even with several visits from an LMC, it can leave you feeling helpless and hopeless e.g. soothing, infant sleep, what to do, when to feed, what clothes do they wear. Simple things, but for some first-time mums they are unknown.

More information or help on how to soothe your baby, how to wean your baby, when to feed baby solids and how much he should be eating etc. I feel like I had to just figure all this out for myself which made it very hard at times. [Well Child] nurse not readily available.

Figure 25: Satisfaction with the quality of information received on a number of topics

Q26. How satisfied were you with the quality of information you received in terms of ... ?



Please note: Sub-samples based on women who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.



Percent of women who were satisfied + very satisfied.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to the quality of information received

Māori women

- Compared to women of 'other' ethnicities, Māori women were more likely to have turned to whānau and friends for information and advice about maternity services, pregnancy and childcare (78 percent, compared with 73 percent).
- Although Māori women less likely than women of 'other' ethnicities to have sourced information through the internet (59 percent, compared with 69 percent of 'other' mothers) or through antenatal classes (23 percent, compared with 37 percent of 'other' mothers), they were significantly more likely to do so than Pacific mothers (59 percent of Māori mothers sourced information through the internet, compared with 48 percent of Pacific mothers and 23 percent of Māori women sourced information through antenatal classes, compared with 13 percent of Pacific mothers).
- With regard to quality of information, Māori women were more likely than women of 'other' ethnicities to be very satisfied with the information they received about:
 - Immunisation (68 percent, compared with 61 percent).
 - Safe sleep (68 percent, compared with 62 percent).
 - Giving birth (63 percent, compared with 57 percent).
 - Breastfeeding (61 percent, compared with 51 percent of all women).
 - Plunket and Tamariki Ora services (59 percent, compared with 53 percent).
 - Caring for their baby (58 percent, compare with 49 percent of all women).
 - Parenting skills (58 percent, compared with 45 percent of all women).

Pacific women

- Pacific women were less likely to have sourced their information from the internet (48 percent, compared with 59 percent of Māori women and 69 percent of women of 'other' ethnicities) or antenatal classes (13 percent, compared with 23 percent of Māori women and 37 percent of women of 'other' ethnicities). However, Pacific women were more likely than Māori women to have sourced their information from the Ministry of Health website (13 percent, compared with five percent of Māori women).
- With regard to quality of information, Pacific women were more likely than women of 'other' ethnicities to report being very satisfied with the information they received about:
 - Immunisation (71 percent, compared with 61 percent).
 - Breastfeeding (66 percent, compared with 51 percent).
 - Giving birth (65 percent, compared with 57 percent).
 - Screening tests for newborns (64 percent, compared with 55 percent).
 - Plunket and Tamariki Ora services (64 percent, compared with 53 percent).
 - Caring for their baby (64 percent, compare with 49 percent).

- Parenting skills (63 percent, compared with 45 percent).
- How maternity services work (55 percent, compared with 45 percent).

Younger women

- Younger women were more likely than those aged 25 years or more to source their information through friends and whānau/family (79 percent, compared with 71 percent) and less likely to source information from:
 - The internet (57 percent, compared with 65 percent of older women).
 - The Ministry of Health website (six percent, compared with 11 percent).
 - A telephone helpline (eight percent, compared with 15 percent).
 - Antenatal classes (23 percent, compared with 33 percent).
- Younger women were more likely than older women to be very satisfied with the quality of information they received about:
 - Caring for their baby (58 percent, compared with 51 percent).
 - Immunisation (68 percent, compared with 62 percent).

Women with disabilities

There were no significant differences between women with and without disabilities in terms of their sources of information or the quality of information they received.

Services paid for during the pregnancy

While most maternity care is free for New Zealand citizens and other eligible women, there may be a charge if women choose to use some private or specialist services. For example, there is often a charge for private obstetrician LMCs, antenatal classes if women chose to go to a class that is not funded by the government, and ultrasounds in some areas of New Zealand.

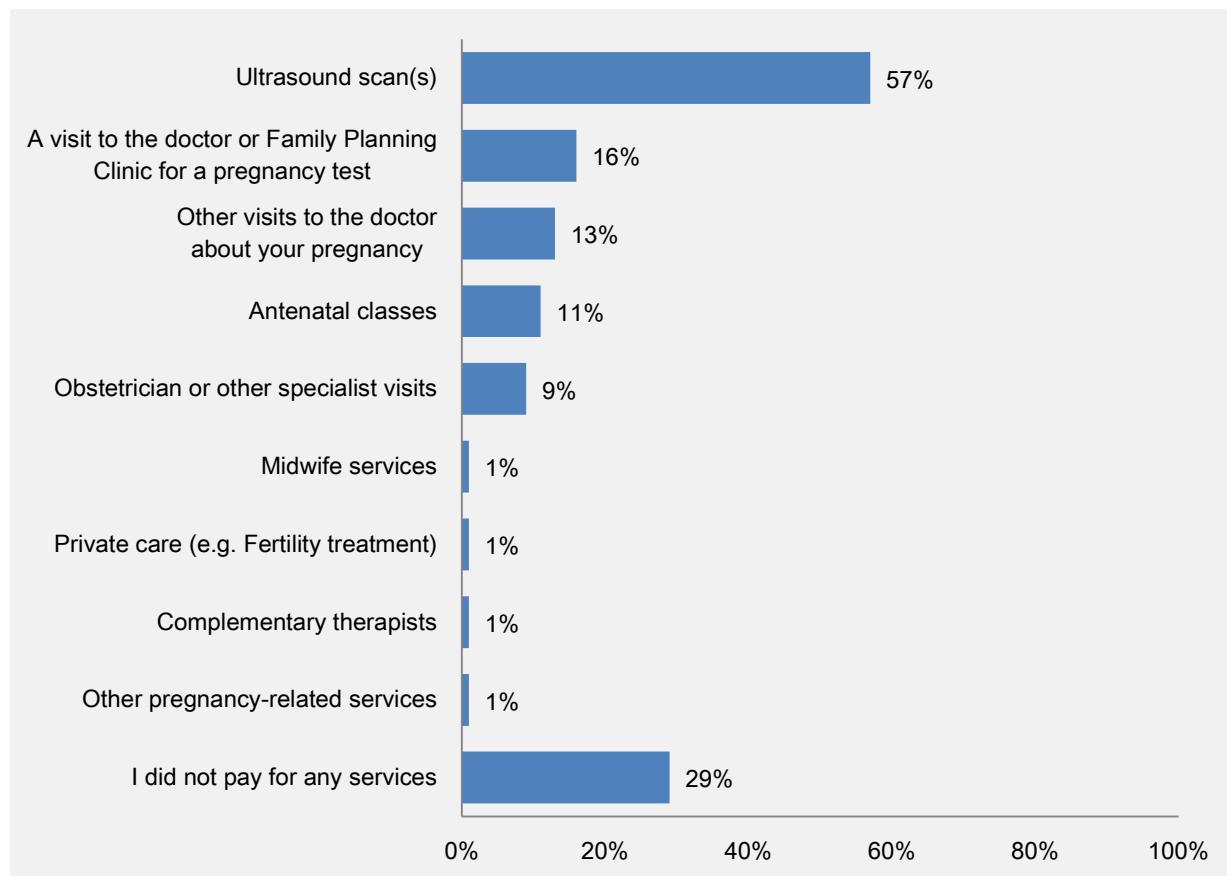
The results provided in this sub-section will help the Ministry of Health to identify the specific types of pregnancy-related services women are currently being charged for and whether or not there is an unmet need.

Seventy-one percent of all women reported that they had paid for at least one pregnancy-related service.

When asked to identify which specific pregnancy-related service they had paid for, the most common response was an ultrasound scan (57 percent of all women reported having paid for an ultrasound). Almost one-in-five women (16 percent) reported paying for a visit to their doctor or a Family Planning Clinic for a pregnancy test, 13 percent paid for other pregnancy-related visits to their doctor, 11 percent paid to attend antenatal classes and nine percent paid to see an obstetrician or another specialist (Figure 26).

Figure 26: Pregnancy-related services paid for

Q27. Did you pay for any of the following services in relation to your pregnancy?



Base (n=3705).

Sub-sample based on women who provided a response for this question.
Total will not sum to 100 percent because women could provide multiple responses to this question.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to payment of pregnancy-related services

Māori women

- Māori women were more likely to not have paid for any pregnancy-related services (36 percent, compared with 25 percent of women of 'other' ethnicities).

Pacific women

- Pacific women were more likely to not have paid for any services related to their pregnancy (45 percent, compared with 25 percent of women of 'other' ethnicities).

Younger women

- Younger women were more likely than those aged 25 years or more, to not have paid for any services related to their pregnancy (33 percent, compared with 28 percent).

Women with disabilities

There were no significant differences between women with and without disabilities in terms of paying for pregnancy-related services.

Overall satisfaction with maternity care

This section summarises women's overall satisfaction with the maternity care they received and looks at some of the factors that appear to have influenced their experience.

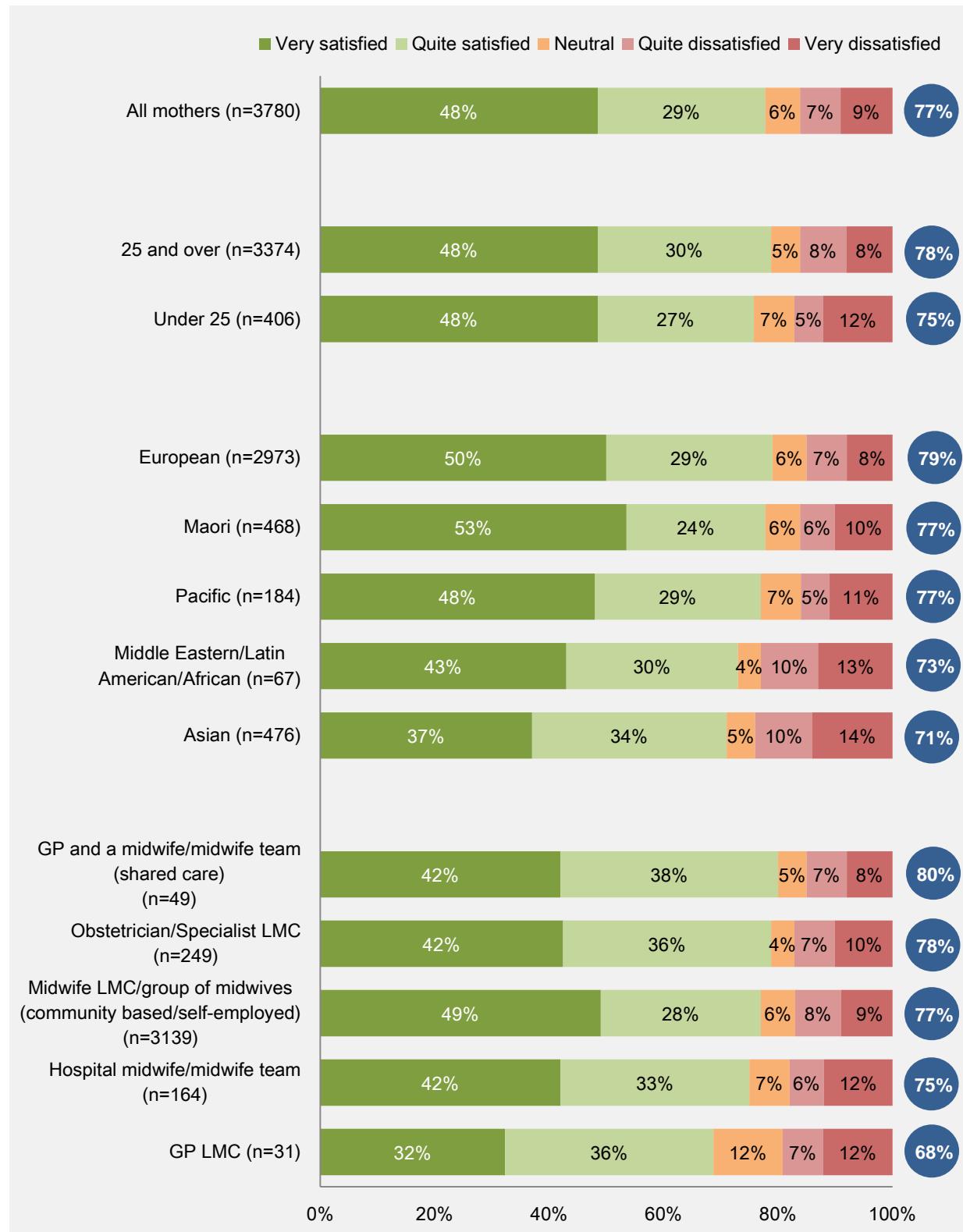
Overall satisfaction

Women were asked to provide an overall satisfaction rating, taking into account their experience of care during their pregnancy, labour and birth, postnatal care and care for themselves and their baby in the first few weeks at home. This was measured on a scale of 1 to 5 where 1 = very dissatisfied and 5 = very satisfied.

Three-quarters of women (77 percent) were satisfied or very satisfied with the overall level of maternity care they had received (48 percent of whom were 'very satisfied').

Figure 27: Overall satisfaction with maternity care

Q28. How satisfied were you with your overall experience of care during your pregnancy, labour and birth, postnatal care and care for you and your pēpi/baby in the first few weeks at home?



Please note: Sub-samples based on who provided a response for each statement – excludes those who answered 'not applicable'. Totals may not sum to 100 percent due to rounding.



Percent of women who were satisfied + very satisfied.

Statistically significant differences for **Māori**, Pacific and younger women and women with disabilities, with regard to overall satisfaction with the maternity care received

Māori women

- ⦿ Māori women were more likely to be very satisfied with their overall experience of maternity care (53 percent, compared with 46 percent of women of ‘other’ ethnicities).

Pacific women

There were no significant differences between Pacific women and Māori women or women of ‘other’ ethnicities in regards to overall satisfaction with the maternity care received.

Younger women

- ⦿ Younger women were more likely to be very dissatisfied with the overall maternity care they received (12 percent, compared with eight percent of women aged over 25 years).

Women with disabilities

There were no significant differences between women with and without disabilities in terms of overall satisfaction with maternity care received.

Areas for improvement

Understanding what drives satisfaction with maternity care, and identifying specific aspects of the experience that have the most influence on satisfaction, is complex. Whilst this survey allows the exploration of these factors to some degree, there are many other situational, physical and psychological factors that influence women's perceptions of their care that are largely beyond the control of maternity services. This especially applies to women's experience of the labour and birth. The mother's assessment of care at this point is heavily influenced by her perceptions as to how 'well' the labour went, how long it took, her experience of pain, and her health and wellbeing and that of the baby after birth.

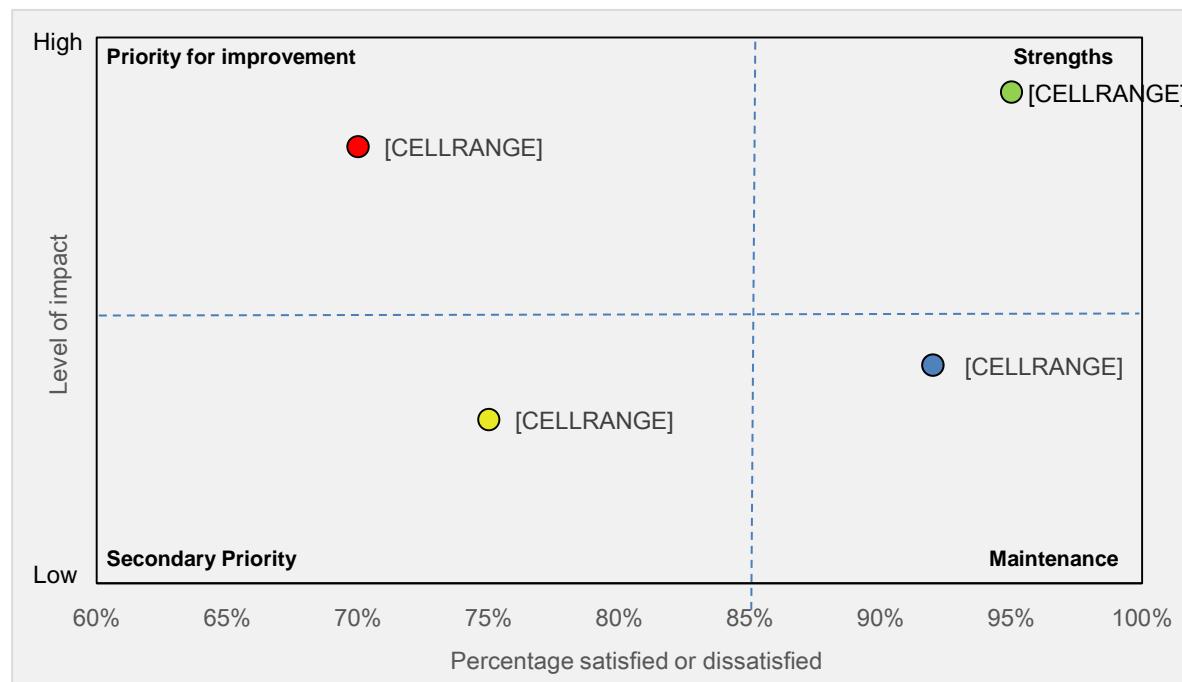
Whilst the survey results highlight some of the factors that the Ministry and maternity care providers can influence and improve on with regard to antenatal and postnatal care, it is difficult to pinpoint through scientific analysis, specific areas for improvement with regard to labour and birth. Therefore the results in this section of the report mainly focus on the care received before and after the birth.

Regression analysis

By applying regression analysis to the survey data we identified specific factors that influenced women's satisfaction with maternity care (particularly with regard to antenatal and postnatal care). These factors are presented in diagrams similar to the example shown below, which illustrate the relationship between the performance and impact of each of those factors.

The diagram shows not only how satisfied or very satisfied women are with specific factors (or aspects of the care they received), it also shows the extent to which each of those factors drives or influences overall satisfaction with maternity care.

Figure 28: Factors influencing satisfaction with maternity care (Example diagram)



How to interpret this information

Each regression diagram relates to a specific area of maternity care and is divided into four quadrants.

1. The top-right quadrant shows the factors identified as service ‘strengths’ in relation to that particular area of maternity care. ‘Factor 1’ with the green dot, is a factor that is performing well (at least 95 percent of women were satisfied or very satisfied with this factor), and has a big influence on overall satisfaction.

Ideally, all aspects of maternity care would sit in the ‘strengths’ quadrant.

2. The bottom-right quadrant shows the ‘maintenance’ factors. The factors that sit in this quadrant are aspects of care that are also performing well, but are less important to women. ‘Factor 2’ with the blue dot is one that over 90 percent of women were satisfied or very satisfied with, but it has less influence on overall satisfaction.

So whilst it is important that this factor continues to perform well, it is not likely to significantly change women’s overall perceptions of maternity care.

3. The top-left quadrant shows all factors identified as being ‘priority for improvement’. These are factors that have a big influence on women’s overall satisfaction with maternity care, but are currently not performing as well as some of the other factors. ‘Factor 3’ is something that is important to women, but is not performing as well as it should be.

Factors in this quadrant are the aspects of care that the Ministry and maternity providers should focus on, as improving performance in this area is likely to have the most positive impact on overall satisfaction.

4. The bottom-left quadrant identifies factors of ‘secondary priority’. These are factors that are not performing as well as others, but do not have a significant impact on overall satisfaction. ‘Factor 4’ with the yellow dot is not as important to women as the other factors are, but is also not performing well.

Focusing some attention on the factors in this quadrant would help in terms of bringing their performance more in line with the other more positively rated aspects of maternity care. Although it will have less of an impact on overall satisfaction, it will still have some degree of impact so should not be ignored.

It is also important to note that whilst regression analysis helps to identify which factors have an impact on satisfaction, it also provides an estimate as to how much of the overall satisfaction rating can be explained by those factors, by calculating an attribution rating. For example, it may tell us that the factors we have included in the analysis account for 70 percent of the overall satisfaction rating, in which case we can be confident that if we get all of those factors right in terms of service delivery that it is likely to have a positive impact on overall satisfaction.

However, if the attribution rating is low (i.e. less than 50 percent), this means that we are only seeing half the picture (or even less), because there are other (unknown) factors that are just as important (if not even more important) in influencing overall satisfaction.

Factors influencing women's satisfaction with the antenatal care they received from their LMC or midwife

Ninety percent of women who completed the Maternity Consumer Survey reported being satisfied or very satisfied with the care they received from their LMC or midwife while they were pregnant.

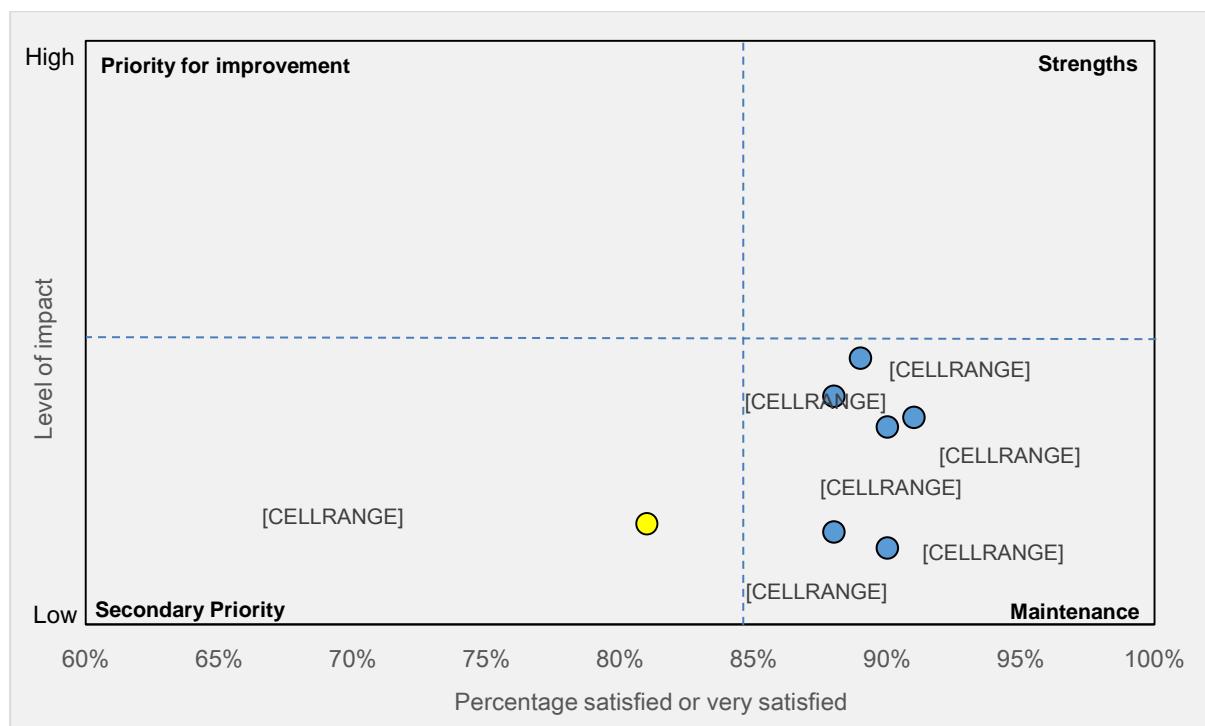
Of all the factors measured in relation to antenatal care from midwives and LMC's, the only factor that was found to have no impact at all on overall satisfaction with antenatal care, was the statement relating to appointment times and places being convenient.

The specific factors measured through the survey that were found to have influenced satisfaction are shown in the diagram below. The regression analysis showed that these factors accounted for 64 percent of women's satisfaction with the care they received from their LMC or midwife while pregnant.

Most factors were rated positively in terms of their current performance, with around 90 percent of women satisfied or very satisfied with six of the seven factors. While each of these factors are likely to have some influence or impact on overall satisfaction, none of them have a particularly strong impact and are therefore sitting in the 'maintenance' quadrant.

One factor was identified as currently performing less well than the other factors; that is women knowing who would care for them if their LMC/midwife was not available. By ensuring more LMC's and midwives keep women informed as to who would care for them if they were not available, this factor would move from the 'secondary priority' quadrant into the 'maintenance' quadrant.

Figure 29: Improving satisfaction with antenatal care from midwives and LMCs



Factors influencing women's satisfaction with the overall care they received during labour and birth

Overall, 87 percent of women were satisfied or very satisfied with the care they received from their LMC during their labour and birth, and 85 percent were satisfied or very satisfied with the care they received from the hospital or birthing unit staff during labour and birth.

The regression analysis showed that the factors relating to the labour and birth that were measured in the survey accounted for 49 percent and 46 percent of this satisfaction, respectively. This means that just over 50 percent of women's satisfaction with the care they received during the labour and birth was influenced by factors not covered in the survey.

Because of the low attribution rating the results presented in this section should be viewed with caution.

Satisfaction with the overall care received from LMC's during labour and birth

Only five specific factors measured through the survey were found to have influenced satisfaction with the overall care received from LMC's during labour and birth. These factors are shown in the diagram below.

The following factors were identified as not having any impact on overall satisfaction:

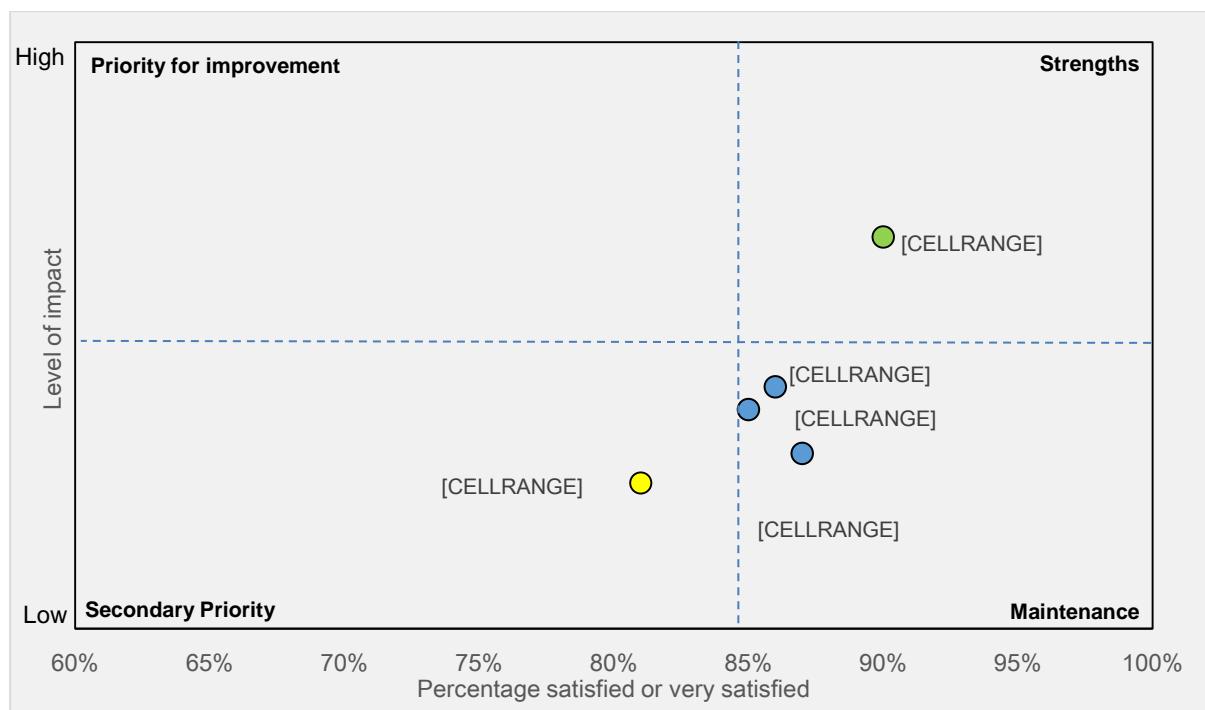
- The way in which their background, culture, beliefs and values were respected.
- The facilities where they gave birth.
- The available choices as to where they were able to give birth.
- Any pain relief they received.

The confidence women had in the skills of the people caring for them (i.e. LMC's) was identified as a 'strength'. This factor has a great impact on satisfaction and is currently performing well.

Three factors were rated positively in terms of their current performance, with at least 85 percent of women satisfied or very satisfied with each factor. While these factors are likely to have some influence or impact on overall satisfaction, none of them have a particularly strong impact and are therefore sitting in the 'maintenance' quadrant.

The one factor that was identified as currently performing less well is the support available to women immediately after birth. By ensuring women receive greater support from LMC's after they give birth, this factor would move from the 'secondary priority' quadrant into the 'maintenance' quadrant.

Figure 30: Improving satisfaction with care received from LMCs during labour and birth



Satisfaction with the overall care received from hospital or birthing unit staff during labour and birth

Specific factors which were measured through the survey, and found to have influenced satisfaction with the overall care received from hospital or birthing unit staff during labour and birth, are shown in the diagram below.

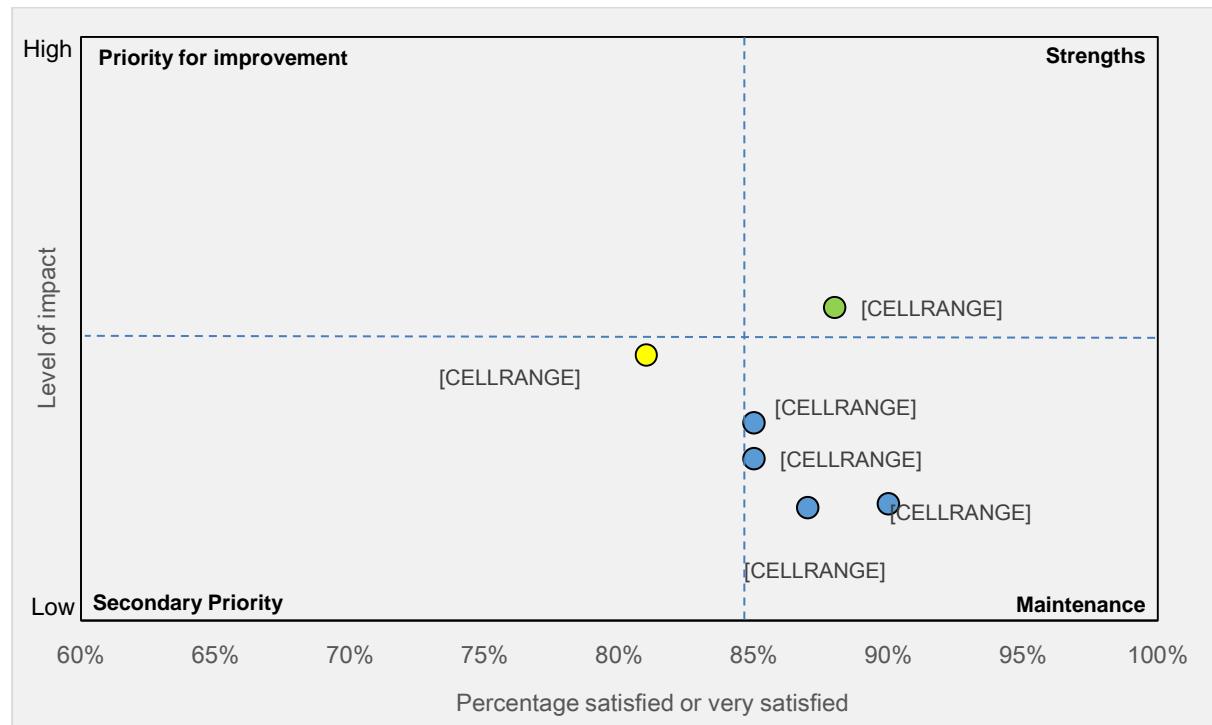
The following factors were identified as not having any impact on overall satisfaction:

- The way in which their background, culture, beliefs and values were respected.
- The available choices as to where they were able to give birth.
- The information received about what was happening during the labour and birth.

The facilities where women gave birth was identified as a 'strength' as this factor has a great impact on satisfaction and is currently performing well.

Again, improving the support available to women immediately following birth was identified as an area for improvement. Support received following the birth was identified as the second most important or influential factor relating to care received during labour and birth, but it was rated the lowest in terms of performance.

Figure 31: Improving satisfaction with care received from LMCs during labour and birth



Factors influencing women's satisfaction with the postnatal care they received at a hospital or birthing unit

The majority of women (90 percent) were satisfied or very satisfied with the postnatal care they received at a hospital or birthing unit after giving birth.

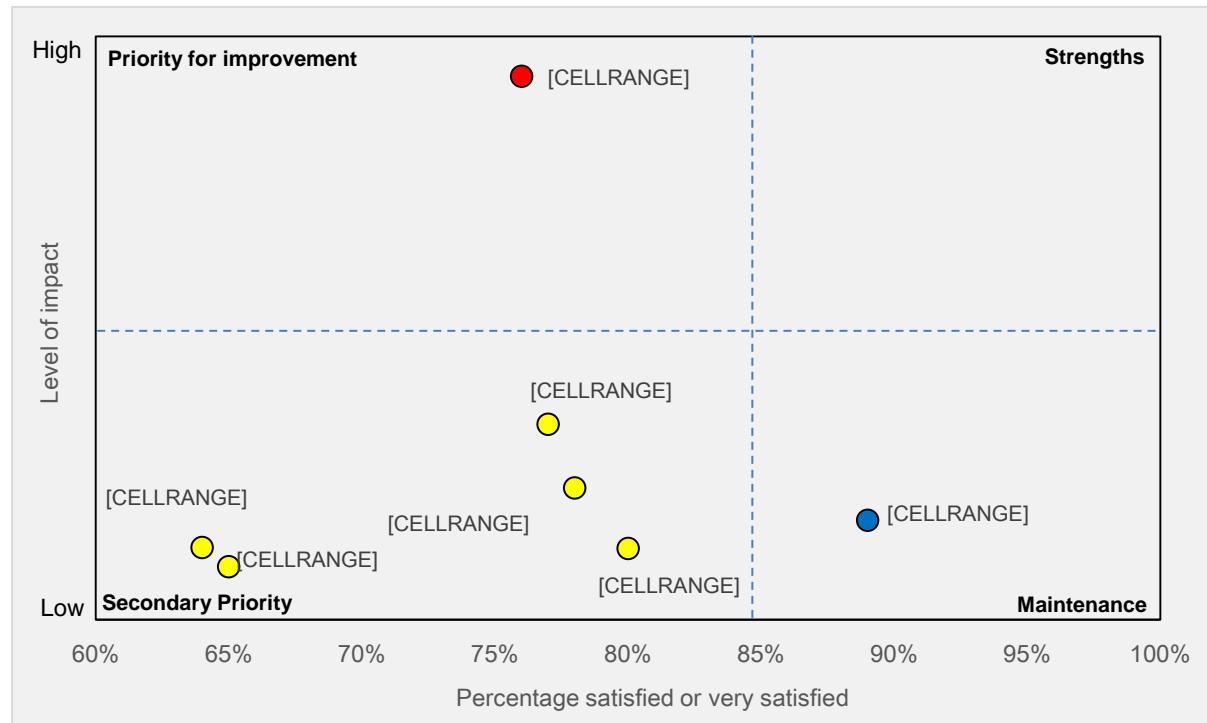
The specific factors measured through the survey that were found to have influenced this level of satisfaction are shown in Figure 32. The regression analysis showed that these factors accounted for 79 percent of overall satisfaction with the postnatal care received at the hospital or birthing unit.

Improving the level of care and attention received from hospital and birthing unit staff after giving birth was identified as a clear priority area for improvement. Care and attention received after the birth was identified as the most important or influential factor relating to this particular area of maternity care, yet it received the third lowest rating in terms of performance.

Other secondary areas for improvement, in descending order, include:

- Improving the amount of help and support available to women during their stay.
- Being more flexible in terms of access for visitors and support people.
- More privacy.
- Enabling women to get enough rest.
- Improving the food provided.

Figure 32: Improving postnatal care received from hospital or birthing unit staff



Factors influencing women's satisfaction with the postnatal care received from their midwife

Overall, 89 percent of women were satisfied or very satisfied with the care they received from their midwife during their first few weeks at home with their baby.

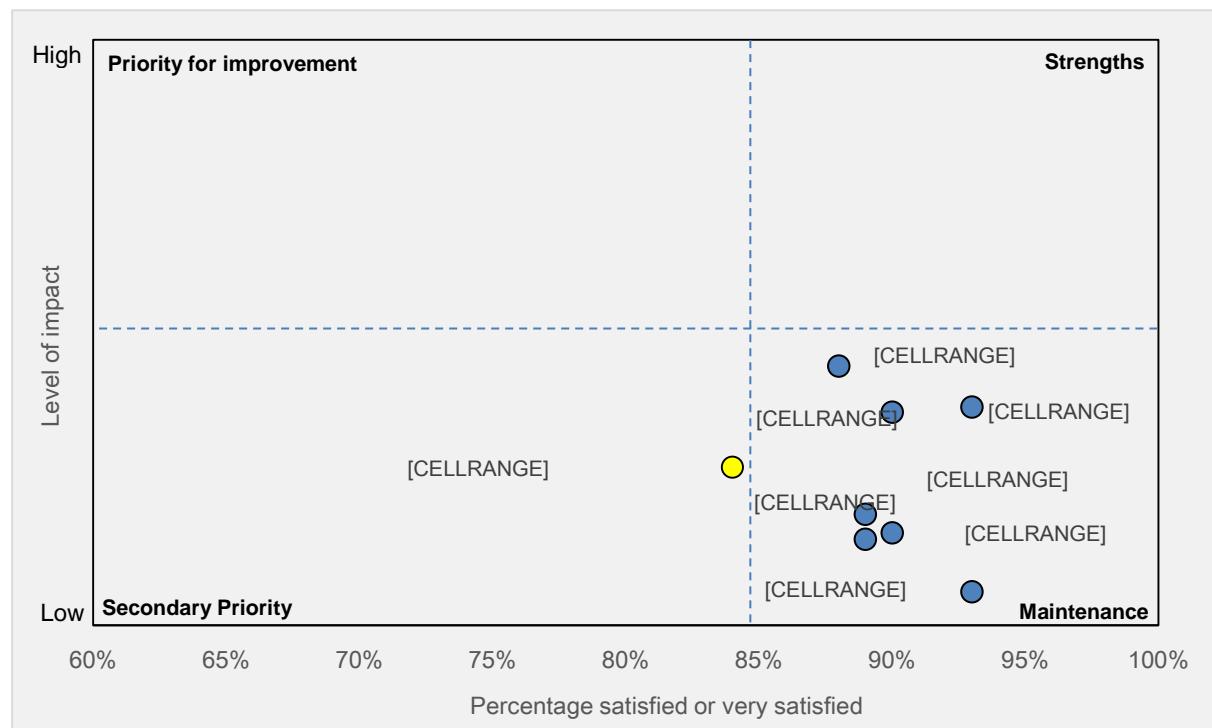
The specific factors measured through the survey that were found to have influenced this level of satisfaction are shown in Figure 33.

The regression analysis showed that these factors accounted for 86 percent of overall satisfaction with this particular area of maternity care.

As illustrated below, most of these factors are rated positively in terms of their current performance, with around 90 percent of women satisfied or very satisfied with seven of the eight factors. While each of these factors are likely to have some influence or impact on overall satisfaction, none of them will have a particularly strong impact and are therefore sitting in the 'maintenance' quadrant.

One factor was identified as performing less well than the other factors, with less than 85 percent of women satisfied or very satisfied with the physical checks they received from their midwife after the birth. This particular aspect of post-natal care is identified as a possible area for improvement.

Figure 33: Improving postnatal care received from midwife



Factors influencing women's overall satisfaction with the maternity care they received

Overall, 77 percent of women were satisfied or very satisfied with their overall experience of care during their pregnancy, labour and birth, the postnatal care while in hospital (or a birthing unit) and the care received at home in the first few weeks following the baby's birth.

However, because this overall satisfaction rating was influenced by so many different factors, different situations and different experiences, the regression analysis was only able to account for 20 percent of the overall satisfaction rating.

For this reason, we have not presented the results to the regression analysis in relation to overall satisfaction.

Feedback received from women about the care they received

At the end of the survey, all women were given the opportunity to provide any additional feedback or suggestions as to any aspects of their care that could be improved.

Most of the feedback provided at this point consisted of positive comments about the people who had been involved in their care.

Most frequently, women specifically mentioned the great care they received from their midwife (18 percent). The following examples illustrate positive comments women made about their midwife:

Very grateful for having my midwife guide and care for me, my puku and my whänau. Her whole manner, personality, general consideration was really welcoming and easy to confide in. I felt/feel she is very professional, confident, warm and a top notch midwife and I am honoured she has been the lady who helped me bring my three healthy, beautiful children into this world and is currently my midwife doing her best as I am hapü with my fourth.

I am very lucky that my midwife, [name] is such a wonderful and caring woman. She always made me feel thoroughly cared for throughout my pregnancy, labour and when our pēpi was born. If all midwives were like [name], women would feel looked after during a time they really need to be.

Our midwife made all the difference as she was very experienced and professional with a great back-up team. My experience having an elective C-section was very positive with the very caring and professional staff there. Follow up care with the [Well Child Provider] service has been excellent.

I was very fortunate to have an extremely experienced and amazing midwife. She made every step of my pregnancy right through to birth and postnatal care an absolute stress-free time. I hope that every first-time mum is able to have the same experience I did from a midwife they can trust and is there for them during what can be quite a stressful time where little is known about how maternity services operate in New Zealand, what you are entitled to, how to access these services etc. I also do believe that it is up to the individual to ask questions and seek advice should they require it to make the best choices for their situation.

I had an amazing birth experience, right from developing a good rapport with my midwife throughout pregnancy and developing a sense of trust that enabled me to birth at home and be looked after post-birth. The midwives were a cohesive unit that showed amazing dedication, passion and responsibility and I look forward to seeing them again for my next pregnancy.

My midwives were fantastic. I burst into tears as they drove off after their last visit as I was so sad to see them go.

I have had seven children and have been more than satisfied with the care I had been given. My midwife was the best in the west! She is awesome and is also our family LMC. She has delivered nine of our children and a set of twins. I never stayed in hospital any longer than I had to. But while I was there, the hospital care was awesome too! Thank you all!

I had a fantastic pregnancy and birth experience. I felt confident and extremely well supported throughout. I was very happy to allow a student midwife at my birth and the aftercare. She was fantastic! I would definitely do the same again next time. My midwife made me feel like I was in charge and that she was there to inform and support me completely, and she did.

Others complimented the maternity system as a whole and/or commented that they were very satisfied with the maternity care they received overall (12 percent). Examples of these comments are as follows:

New Zealanders are extremely lucky to have free maternity care and to the high level of service on offer. I look forward to having another baby, as I know I will be in safe hands.

Even though this was my second baby, I felt totally supported in every aspect of my pregnancy, birth and afterbirth care. If I needed reassurance at any stage, I received it and it was never assumed that I knew everything as I had done it before, which was fantastic, because I didn't! My husband also felt very included and valued, he also feels very satisfied with the overall experience.

Our maternity care here in New Zealand is incredible. I am so grateful that we are provided with this care as new mothers, at such an important and crucial time of our lives, it is amazing that it is all free and so accessible. Thank you, amazing.

I am overwhelmed by the work of my LMC and the doctors and nurses, and I am satisfied with all of that. Thanks.

I had an excellent pregnancy, labour and aftercare, mostly due to the people I liaised with who gave me so much information and confidence. I could not fault any part of the maternity care I received and hope I get to do it all again when or if the time comes.

I could not fault the care I received, both pre and postnatally. My midwife was very helpful, supportive and available to answer questions when I had concerns. The hospital care was caring and professional. I felt safe during my pregnancy and labour. The standard of care was brilliant.

I would like to comment A VERY HUGE THANK YOU. If it wasn't for any of the services and great help that MoH have provided, I don't think things would have been so great. Without the services that are provided for mums and their babies, a lot of us would be really struggling and stressed out, especially being a solo mum. Very much appreciated, and keep up the awesome work that you are providing.

I really had a wonderful experience, everyone was so positive and supportive. I can't wait to have another baby and go through the system again.

A wonderful healthcare service. Amazing midwives and hospital service, I feel incredibly lucky to have so much support and wonderful care available to us, without additional payment other than our taxes. My older son had health issues and surgery, all looked after by the public health system. I cannot speak highly enough of the service we have received. Thank you.

The New Zealand system works great for our family. We had a great midwife readily on hand and very much appreciate [that] we live in a country where our choices for birth are adhered to and costs are minimal.

Another eight percent complimented the hospital or birthing unit staff on the care they received. Following are examples of the types of comments provided:

I birthed and had aftercare at [Hospital] and I found the care brilliant. I called on the midwives constantly to check if I was feeding correctly and not once did I feel like I was being a pain! I definitely think this is the reason I am still breastfeeding a year on. My birth was not easy but I always felt in capable hands, not only from my LMC, but also the nurses, midwives and doctors at [Hospital], will birth future babies there for sure.

The hospital team was amazing. I loved it how the whole team introduced themselves and said what they did. It gave me confidence that they had our best interests at heart. Overall I was very happy with the care I received during and after my pregnancy.

This was my third baby and she was born into 'the toilet' after only 15 minute labour, therefore there was no midwife there but she arrived about ten minutes after the birth, along with the paramedics. She was just brilliant in what could have become a very traumatic time. I then spent two days in [Hospital] and would just like to say how brilliant the staff in there were. It was a very restful time and the care and attention was second to none. There was no pressure to leave, a completely different experience to giving birth in the United Kingdom.

The staff at [Hospital] were very helpful during my stay after the delivery. They [took] extra steps to ensure baby and me were in good condition to be discharged.

In hospital I had to be induced and ended up having an emergency C-section. It was quite stressful but the staff in the operating theatre and my midwife on the night were absolutely amazing. Then the care I received in the ward after delivery was absolutely outstanding. I actually didn't want to leave hospital. The nurses were like a big bunch of "mums" giving me advice, always checking on me and asking if I needed any help. Thanks, [Hospital], for the best birth ever!

Excellent facilities and staff at [Hospital]. Lovely food and great breastfeeding support. Thanks.

It was so good. I have better care in the hospital. What I needed, they helped me on this and also my midwife [at] the hospital was so kind and caring. They helped me when I needed help and when I gave birth to my baby, they also cared [for] me and my baby. I'm so happy for this much care I got from the hospital. Thanks so much for this and I wish this care will always [be] going on to [everyone]. Thanks.

[Hospital] do an awesome job, all the staff were lovely and friendly and willing to help out where needed, night staff were absolutely lovely. Wouldn't birth anywhere else.

The staff/team at [Birthing Unit] were absolutely brilliant - especially as a first time mum. They were like a one-stop shop - with ability to get hearing, heel prick tests etc. done. They were considerate to all needs and they gave me and my husband the confidence to be able to look after and care for our newborn. It was like a three day workshop for new parents while there - whilst also getting the care I needed to recuperate after birth. AMAZING! Would recommend this for all first time mums!

While most of the feedback received was positive, certain aspects of care were less positive for some women. Reflecting the results presented earlier in this report, one area of concern related to the care and attention provided by hospital or birthing unit staff after the birth and other issues related to their stay in a hospital or birthing unit (23 percent). Examples of comments in this regard are as follows:

I couldn't fault the care I received from my midwife and doctor. However, the aftercare at the hospital was appalling! No one came near me unless I pushed the buzzer and even then they sometimes didn't come. I received no support for breastfeeding and no one checked me at all! Thank goodness I had a great midwife visiting each day.

It's great mums are encouraged to do all the care for baby but seriously after labour you totally need a rest and someone to help care for baby and this is definitely not what you get in hospital. But if you could then I think it could be a massive benefit to many mums. If you're not tired you cope a lot better with the challenges ahead.

I was appalled at the quality of service that I got from the nurses on the maternity ward after I had my baby. On the second day I wasn't given my medication until midday and that was only because I had rung the bell and asked who was looking after me and could I have my medication. I wasn't shown how to nurse my child properly until a lovely night nurse saw me struggling with my baby. I had to go home and YouTube how to bathe a baby because no one turned up to show me or even bathe my baby, even after numerous requests from me. No one came to check up on us and ask if everything was ok, I could have walked out of there and they wouldn't have known. No one checked my baby out before we left the hospital, we ended up back at the hospital two days later because my child had lost too much weight. As a first-time mother I couldn't believe how I was treated, if it wasn't for my partner and family I would have been very stressed.

Postnatal care at the hospital was shocking. Hospital completely understaffed, food absolutely shocking! Conflicting advice from all midwives regarding breastfeeding. Completely understaffed at night time, when you most need one-on-one care, had to wait over 40 minutes for someone to come after I pressed the buzzer. Not enough lactation consultants at all, again for first-time mums there should be one-on-one care from lactation consultants not just ten minutes every second day!

I think it would be very nice to have help once baby is born. I did not sleep for the whole time I was in hospital. Nurses never took my baby, so I could rest. This is why I had to leave earlier from hospital.

I think it is unfair when you have just had a baby, you are scared and overwhelmed, and your partner/husband is not allowed to stay the night at the hospital with you, especially for the first baby. This was the case with my first baby so I went straight home because I didn't want to be alone with unfamiliar people and it is a chance for you to bond as a family.

I had excellent care from my LMC. But at the birthing unit, after the birth, they forgot me. They put me in a ward by myself and I missed the next two meals, I had laboured through the night, delivered at 7am, but was not given anything to drink/eat till my husband came back at 4pm. Very hungry and disorientated.

My stay at [Birthing Unit] was fantastic. However, my baby was born at [Hospital] and I was there for the first 36 hours. I was in a double room despite having had a C-section, the night staff were less than helpful and one midwife made my husband feel very uncomfortable about the way he changed our son's nappy.

A further 12 percent were dissatisfied with other aspects of postnatal care they received, particularly the care received from Well Child providers and the support they received in regards to breastfeeding. The following comments provide examples of women who were dissatisfied with the postnatal care they received:

I have a lot of family and friends who have tried to be in contact with [Well Child provider], they have been very, very poor with their duties as a [Well Child provider]. My own experience, I even tried contacting them many times, I spoke with someone and left my details then I left voicemails of all my details, contact numbers, progress of my baby and questions I had, and still no one came to visit or see baby, so I asked my midwife if she could check my baby and she forwarded my details to [Healthcare provider], and as I suspected, my baby was very sick and ended up in hospital with bronchiolitis. I blame [Well Child provider] for that because they didn't come to see my baby for seven weeks after my midwife passed us onto aftercare. I did ring up to complain but nothing was done about it. So very, very disappointed with [Well Child provider]'s care.

[Well Child provider] was not welcoming, in fact they made it very apparent that our baby was low priority as we live in a nice neighbourhood and it was my third baby. In his first year, we have only had three visits with [Well Child provider]. The midwife and doctor offered far better support and care.

[Well Child provider] need to get their act together though - made three appointments with me and didn't show, got my son's name wrong EVERY time and were very judgemental on how I did things! I don't normally like to put people off things due to my experiences but I would never ever recommend [Well Child provider] to anyone, an absolute disgrace!

I had a great pregnancy but I feel I was not educated on breastfeeding enough and my postnatal care in hospital led to a bad experience with breastfeeding (very sore, cracked nipples, thrush for weeks). Also there was no lactation consultant at the time (December 2013) which did not help.

I had problems breastfeeding and gave up after two weeks, I didn't receive the right information from anyone until it was too late. My daughter was tongue tied which I think should be added to

the checklist after birth, as this caused issues and wasn't noticed for a week. I was also bedridden in hospital and couldn't care for her properly, better beds for baby needed so able to get her out and in.

I did not receive enough hands-on help with feeding. It took nearly two days before I had a nurse show me what to do and provide me with a breast pump. My milk supply only came in after I went home and I didn't have help. I tried to book into the [Well Child provider] family clinic, but the wait was over a week.

Perhaps more information about breastfeeding, how to increase supply? I eventually had to stop breastfeeding as my baby needed way more than I could supply. Especially in the case that my baby was premature and wouldn't latch on. NICU nurse tried their very best to help but a lactation consultant was not available the week we were in the hospital after birth.

Nine percent of women mentioned that they would have liked more information and consistent advice on a range of topics. Examples of comments provided in relation to needing more information are as follows:

I feel that pregnant mothers should be more aware about what happens after the baby is born. Everything revolves around labour and when baby is coming. No one informed me what breastfeeding would be like, no one bothered to explain about the painful mastitis and what all comes with it. No information was given from beforehand. A weekly visit from a midwife isn't good enough when you are suffering in pain. Even leaflets explaining about the difficulties that can be faced during breastfeeding would suffice and a helpline that one can call 24/7.

I wish I had been given more information on looking after myself in the early stages of pregnancy with having twins, as that resulted in early labour and having no choices. I feel more information about taking it easy could have changed the outcome.

I feel the information given out about immunisation is very one-sided and it is filled to make people fearful about childhood diseases. It's not the midwives, it's the way all the pamphlets are written. There should be facts about not immunising so people have an informed decision.

There was a huge lack of support and information provided on how to look after your baby, settle your baby etc. My baby cried constantly for three-five weeks, I almost had a breakdown as I was told this is what babies did.

More information on [Well Child Provider] services and the services after giving birth, and more information where you can go to have your baby like birthing units and where maternity houses are.

I found it very hard to find information on available midwives so enrolled with the first one I found in the phone book.

Better information for selecting midwife. All I got was a list of names and numbers. A website or brochure with information on each midwife and their birthing beliefs would be really helpful.

More centralised information on how to find a midwife, that is up-to-date, I ended up doing a google search as the information I was given by the GP wasn't fully up-to-date and the list of midwives I was given were already full and I was contacting them at 13 weeks. Was a very stressful situation as I was worried about not finding a midwife.

Learning to care for your baby - lots of info on birth at antenatal classes but actually learning practical parenting and settling information would be so much more helpful!

There is little information given to you at antenatal classes or elsewhere that provides you with a positive outlook on the birthing process. Simple information would have helped me and all members of my antenatal classes e.g. positioning, length, contractions, how to deal with pain, relaxing, breathing, pelvic floor [and] how to push.

Antenatal classes to have un-biased "correct" information about choices of birth/drugs etc. and breastfeeding. Incorrect information provided to me led to difficult decisions for birth and a huge amount of guilt around breastfeeding with a premature baby etc.

One of the biggest issues I found (and I've spoken to many friends who agree) is the amount of differing information that you receive in hospital from midwives post-birth. Don't get me wrong, they do a fantastic job but each one has a different idea about things like breastfeeding so it can make it quite confusing. For example, my milk hadn't come in (premature baby) and each midwife had a different way of trying to extract milk. One would tell you one thing, you'd try that and then a shift change would take place and the next one would come along and change what you were doing as they thought their way was better. Can be quite confusing for a sleep-deprived new mum.

Better communication between doctors and nurses. It was a long stay at the hospital for me due to induction. Different shifts of doctors and nurses involved. [I] was told one thing by one person and different on the same by another person. (A little upset at the end of induction).

My only concern during my time in hospital immediately after my son was born, was an overload of information and opinions from different midwives. I found that they contradicted each other greatly, and I often felt very confused about whose advice to follow. At the time I found this to be very upsetting.

Another area of concern for eight percent of women was the care provided their midwife. Following are examples of comments from women who were dissatisfied with the care they received from their midwife:

Wish I had a better midwife, who listened, cared and helped me out after trying to get breast pump etc. A few times appointments were moved, not written down or had no idea I was coming due to different midwives.

My midwife gave me no instructions on how to actually "push" or deliver my baby and was pushing for four hours because we later found out she was stuck. She didn't seek help, I needed to get through [and] no direction on the process. I feel very alone in the process. She seemed like she didn't really care and assumed everybody should just know what to do. Another midwife at the hospital stopped in to intervene and finally my baby was delivered.

I was not satisfied with my midwife at all. She said not to give me any information and it was really hard to contact them when I needed her. When I left the hospital, she did not know.

I felt rushed by my midwife throughout my pregnancy with our appointments. My midwife didn't even come and see me after the birth (I had C-section, so had hospital midwife) but no contact from her. I was very disappointed. Also, within the four weeks after, she wanted me to drive to her place for my appointment, which I felt was unprofessional, all because it was easier for her.

Midwife may have had too big a caseload. She was a lovely person, but she was not responsive to my needs especially with breastfeeding (my baby was tongue tied and I had severely cracked nipples). I was not informed as to what to do when I went into labour or asked about a birth plan. I was in false labour and she laughed at me over the phone when I called her (this was the first time I had ever called her to ask anything). She was always late for home visits and at one stage referred to my baby girl as a boy. She lost my maternity notes then blamed this on me, and to this day (my baby was born on [date]) I still don't have them. My Whānau Ora nurse had to ask [for the Well Child book] after my repeated attempts. I only got this six months post-birth of baby.

Midwives can be more empathetic with people. My midwife was not chosen by me but was rather a last resort and she was inconvenient to travel to for me. She wasn't friendly. Very cold. It felt as though because I had a child before I should automatically know what I should be doing. I did not feel comfortable with her and while I was giving birth she didn't talk to me with the exception of telling me to push. She broke my waters and pulled baby out with forceps all without telling me. And after I had baby she was barely there for me. I saw her a couple of times when it was convenient for her and I couldn't wait to see [Well Child provider]. I ended up not wanting to continue on with her care and will not recommend her to anyone. Other than her, every other service or people I encountered were amazing and the free services were a blessing.

I felt like my midwife had no idea what she was doing. She made so many mistakes during my labour, causing my daughter to go into ICBU until after she was born, so not a good experience for me but it was just because of my midwife. I told her I thought my daughter was breech my whole pregnancy but she wouldn't listen to me, resulting in an emergency C-section.

I was very dissatisfied with my midwife during my pregnancy, labour and birth. This is because she didn't provide [an] unbiased approach to care for my child and myself during my pregnancy. I did not find that she respected my culture or beliefs. She did not explain every aspect during the labour or birth e.g. what the breaking of my waters would be similar to, she did not advise that they were waiting to cut the umbilical cord before I could turn around to see my baby. She took a long time to stitch me up - what was supposed to take 30 minutes took up to an hour.

My midwife seemed more concerned about her life than my pregnancy. At all appointments, she was always rushed and answering texts and calls. She wasn't there for my C-section and the midwife who was there didn't place the baby skin-to-skin. During the last two weeks of my pregnancy, because I was having [a] C-section, she planned it around her needs and not mine. On her six weeks visit to baby, she just didn't show and never made contact again.

My only complaint really is that my midwife pushed her agenda regarding no pain relief, she delayed an epidural I had requested. I have had two natural, painful labours and wanted pain relief this time. Sometimes I think the midwives get cocky and forget it is OUR labour, not theirs.

Appendix A - Questionnaire

Appendix B - Methodology

This section provides a detailed description of the development and implementation of the 2014 Maternity Consumer Survey.

Survey design

The Maternity Consumer Survey was first carried out in 1999 and then in 2002, 2007 and 2011.

As part of the survey design phase, the Ministry of Health conducted a review of the 2011 survey content to make sure:

- The questions were relevant to women completing the survey, to maternity services providers and to the Ministry.
- The questions were worded in a way that was easy to understand.
- The length of the survey was not too long and therefore off-putting.
- The layout of the questionnaire was clear and easy to follow.

This review included extensive consultation with key stakeholders within the Ministry and a number of external stakeholders involved in providing maternity services. In summary, the review found that the 2011 survey:

- Was hard to follow in terms of flow
- Had too many questions
- The layout and instructions for some sections was daunting or confusing
- Looked at satisfaction by provider rather than focusing on the system
- Did not reflect the New Zealand Maternity Standards
- Did not include women who did not have an LMC.

As a result of this review, some of the survey questions were re-ordered and question wording revised. Specific changes were also made to make the survey more appropriate and inclusive of Māori and Pacific women.

Cognitive pre-testing

The revised survey for 2014 was cognitively pre-tested, as was the invitation letter. This involved face-to-face interviews with eight women representing a range of ages and ethnicities, who had recently had a baby. The purpose of the pre-testing was to get first-hand feedback on how they found the questionnaire, to see how they interpreted each question, whether they found any of the questions confusing or off-putting, to get their feedback on the length of the questionnaire and to identify any potential barriers or issues with the survey. They also provided feedback on the wording of the invitation letter.

As a result of the cognitive pre-testing, minor wording changes were made to both the survey and the invitation letter.

Pilot survey recruitment and methodology

After the pre-testing, the survey was piloted. The purpose of the pilot (or ‘test-run’) was to:

- Assess the likely overall participation rate and particularly the response rate for Māori and Pacific women, and women less than 25 years of age.
- Assess the paper versus online response.
- Monitor the nature of the queries made to the Freephone number.
- Assess the likely success of obtaining telephone numbers for Māori, Pacific and young mothers, based on the postal addresses provided by the Ministry of Health.
- Review the data collected as a further confirmation that the survey was working as intended and questions/instructions are being understood.

This survey received ethics approval from the Southern Health and Disability Ethics Committee (reference: E14/STH/96).

Following ethics approval, the pilot proceeded as follows:

1. The Ministry of Health provided Research New Zealand with an electronic file containing the names and addresses of women who had given birth between December 2013 and February 2014, from their National Maternity Collection (MAT) database. Research New Zealand then randomly selected a sample of 300 women, made up of 75 Māori women, 75 Pacific women, 75 women who were aged under 25 years, and 75 women who were aged 25 years and older (and were not identified as being Māori or Pacific).
2. These 300 mothers were posted an invitation letter, a paper copy of the survey and a reply-paid envelope to the address they had provided when they gave birth.

The invitation letter outlined the purpose of the survey, how they were selected, what participation involved, that they didn’t have to take part if they didn’t want to and that anything they said would be kept strictly confidential. This letter also provided women with the option of completing the survey online, by providing them with a personalised password and login. A Freephone number for those wanting more information about the survey was also provided.

The invitation letter was printed on Ministry of Health letterhead.

3. Two weeks later a reminder postcard was sent to Māori and Pacific women and women under 25 years of age to encourage them to respond. This was because for each of the previous Maternity Consumer Surveys, these groups of women had been less likely to take part.

4. Two weeks after the reminder postcards were sent, Māori, Pacific and younger women for whom we had telephone numbers were prompted with a follow-up call. As the Ministry does not collect telephone numbers, tele-matching was conducted which involved matching the mother's surnames and addresses to public white pages listings.

Key findings from the pilot survey included:

- ⦿ The overall participation rate was 21 percent (12 percent for Māori women, 18 percent for Pacific women, 21 percent for women under 25 years and 34 percent for women over 25 years).
- ⦿ Women preferred to complete the survey on paper (76 percent), although the online option, new for 2014, was also used (12 percent).
- ⦿ Only 16 percent of the Māori, Pacific and young mothers' names and addresses were able to be matched to listed telephone numbers.
- ⦿ Calls made to the Freephone number were mainly about women wanting to know more about the survey, asking if they were eligible to complete the survey and women wanting to make a complaint about the maternity services they received.
- ⦿ Women who completed the survey seemed to have understood the questions and responded as intended.

As a result of the pilot, changes were made to the wording of the invitation letter.

Main survey recruitment and methodology

All women who had given birth to live born babies between December 2013 and February 2014 (with the exception of those who were involved in the pilot survey) were invited to take part in the main survey.

The main survey followed the same overall process as the pilot survey:

1. Women were posted an invitation letter, a paper copy of the survey and a reply-paid envelope. The invitation letter also gave them the option of completing the survey online and provided a Freephone number for them to call if they had any queries.
2. Māori, Pacific and younger mothers were sent a reminder postcard two weeks after the initial posting.
3. Follow-up telephone calls were completed with Māori, Pacific and younger women for whom we had telephone numbers for (after tele-matching).
4. Due to the timing of sending out the survey and then the reminder postcard (just before Christmas) the response rate was not as high as intended. Therefore, in January 2015 a reminder postcard was sent to all women who had not yet responded, regardless of their age or ethnicity.

Analysis

As the survey could be completed on paper, online and by telephone, the responses needed to be processed before they could be analysed. This involved the following:

- v As completed paper-based surveys were received, they were edited in preparation for data entry. Editing is the process that is used to correct (in a standard and agreed manner between Research New Zealand and the Ministry of Health) incorrectly answered questions and to code open-ended questions and ‘other specify’ comments (using a developed coding frame). All coding lists were developed in consultation with the Ministry of Health.
- v When the online version of the survey was closed-off and the telephone interviewing completed, the online and telephone survey data was also checked and comments from open-ended questions were coded and cleaned (‘cleaning’ refers to the correcting of spelling and punctuation errors).

Once processing was complete, the data from the paper, online and telephone surveys were merged into one combined dataset and the results were analysed by:

- v All women
- v Ethnicity – the Ministry of Health was particularly interested in the results for Māori and Pacific women. It is important to note in this regard, that the results presented in this report for Māori and Pacific women, reflect their self-reported ethnicity as collected through the survey questionnaire.

For reporting purposes, a ‘total response’ approach (as recommended by Statistics New Zealand) was used. This means that if a woman identified as being of both Māori and Pacific ethnicity then she is included in both categories. Prioritised ethnicity, an alternative approach often used within the health sector, is one where a decision is made (using a prioritisation schedule) as to which one of her self-reported ethnicities will be used for analysis purposes.

- v Age – the Ministry of Health was particularly interested in the results for women under 25 years.
- v Disability – the Ministry of Health was particularly interested in the results for women who indicated that they had “a long term disability”. This was based on their own interpretation as to what qualified as a ‘disability’.

Regression analysis was also completed in order to determine the main ‘drivers’ or influencing factors of women’s satisfaction with the maternity services they experienced.

The analysis involved a three step process:

1. Correlation

The results were analysed within each area of maternity care to see if satisfaction ratings for individual aspects of care were correlated with one another. For example, the analysis looked to see if women who were satisfied that ‘the people involved in their care listened to them’, were also satisfied that ‘the people involved in their care were responsive to their needs’. Because there was a high level of correlation between individual aspects of care within each area of maternity care, we proceeded to the next stage, which involved factor analysis.

2. Factor analysis

Factor analysis involved determining which ‘factors’ (i.e. aspects of care) could be grouped together because women rated them similarly. Unfortunately, because women provided similar ratings to almost all of the individual aspects of care, grouped ‘factors’ were not able to be created. For example, when factor analysis was conducted for satisfaction with postnatal care, all of the individual aspects of care (‘your midwife listened to you’, ‘your midwife was responsive to your needs’, ‘your decisions views and choices were respected’, etc.) were grouped into one factor. Therefore, regression analysis – which identifies the main drivers or influencing factors of women’s satisfaction – was conducted with the original individual aspects of care rather than with grouped ‘factors’.

3. Regression analysis

Regression analysis was completed to try and uncover what was driving women’s satisfaction with maternity services overall and in relation to each area of maternity care.

The outcome of this analysis is a regression coefficient which we have reported as a percentage.

The higher this percentage is, the more influence or impact that aspect of care has on satisfaction. For example, Table 6 shows that satisfaction with the postnatal care received at hospital or a birthing unit was largely influenced by the care and attention they received from staff. This means that if women received optimal care and attention from staff after they gave birth, they were more likely to be satisfied or very satisfied with the overall care they received at a hospital or birthing unit, and if they received poor care and attention, they were more likely to be dissatisfied or very dissatisfied with the overall care they received at a hospital or birthing unit. In contrast, the food provided at the hospital or birthing unit influenced their overall satisfaction to a much smaller extent (four percent). This means that the bearing ‘the food’ had on overall satisfaction was not as great as the care and attention they received from staff.

The tables on the following page show the results of the regression analysis in relation to antenatal and postnatal care.

Table 3: Results of regression analysis for the antenatal care received from LMC/midwife

Individual aspects that influenced satisfaction	Regression coefficient %
That the people involved in your care were responsive to your needs	16
That the people involved in your care spent enough time with you	14
How well informed you were of the care you were entitled to	12
That the people involved in your care listened to you	12
That you knew who would care for you if your LMC or midwife was not available	6
The care you received from any specialists	5
How easy it was for you to access the care that you needed while you were pregnant	5

Table 4: Results of regression analysis for care received from midwife or LMC during labour and birth

Individual aspects that influenced satisfaction	Regression coefficient %
How confident you were in the skills of the people caring for you	33
The information you received about what was happening throughout your labour and birth	21
The way in which the people involved in your labour and birth communicated with you	19
The way in which your decisions, views and choices were respected	15
The support available to you immediately following birth	12

Table 5: Results of regression analysis care received at hospital or birthing unit during labour and birth

Individual aspects that influenced satisfaction	Regression coefficient %
The facilities where you gave birth	27
The support available to you immediately following birth	23
The way in which the people involved in your labour and birth communicated with you	17
Any pain relief you received	14
How confident you were in the skills of the people caring for you	10
The way in which your decisions, views and choices were respected	10

Table 6: Results of regression analysis for postnatal care received at hospital or birthing unit

Individual aspects that influenced satisfaction	Regression coefficient %
The care and attention you got from staff	45
The help and support that was available to you during your stay	16
Your visitors or support people being able to be with you whenever you wanted them	11
How clean the facilities were	8
The amount of rest that you were able to get	6
The amount of privacy you had	6
The food	4

Table 7: Results of regression analysis for the postnatal care received from midwife during baby's first few weeks

Individual aspects that influenced satisfaction	Regression coefficient %
That your midwife was responsive to your needs	18
Physical checks of your pēpi/baby from your midwife	15
The advice from your midwife on caring for your pēpi/baby	15
Physical checks of you from your midwife	11
That your midwife listened to you	8
The way in which your decisions, views and choices were respected	7
The advice from your midwife on caring for yourself	6
The way in which your decisions, views and choices were respected	2

Because the regression results were inconclusive with regard to overall satisfaction, they are not presented. For the results to be conclusive, the regression needs to show that the factors fed into the analysis programme account for most of the overall satisfaction rating for that particular area of care.

For example, 90 percent of women were satisfied or very satisfied with the postnatal care they received from hospital staff. The regression analysis showed that 79 percent of that satisfaction rating could be explained by the factors that were measured in the survey relating to postnatal care.

However, only 20 percent of overall satisfaction was able to be explained by the questions included in this survey. This should be considered and tested in future survey design.

Response rates

In total, 13,634 women were invited to take part in the 2014 Maternity Consumer Survey. By the time the survey was closed off, 3,801 of those women had completed the survey. Most completed and returned the paper version of the survey (76.7 percent), one-in-five completed the survey online (22.5 percent), while 30 women (just under one percent) completed the survey by telephone (Table 8).

Table 8: Number of completed surveys by channel

	2014 Count	2014 %
Paper	2914	76.7
Online	857	22.5
Telephone	30	0.8
Total	3801	100

Of the 13,634 survey questionnaires that were posted out, 678 were ‘returned to sender’ likely due to the fact that the women were no longer living where they were when they gave birth.

Taking into account the surveys that were returned to sender, the overall response rate for the 2014 survey was 29.4 percent (Table 9). However, the actual number of questionnaires completed was higher because the original sample size was bigger than in previous years.

Table 9: Overall response rates by year

	Number of completed surveys	Response rate
	Count	%
2007	2936	37.5
2011	3235	40.9
2014	3801	29.4

The response rates by ethnicity, age and DHB region are shown in Table 10.

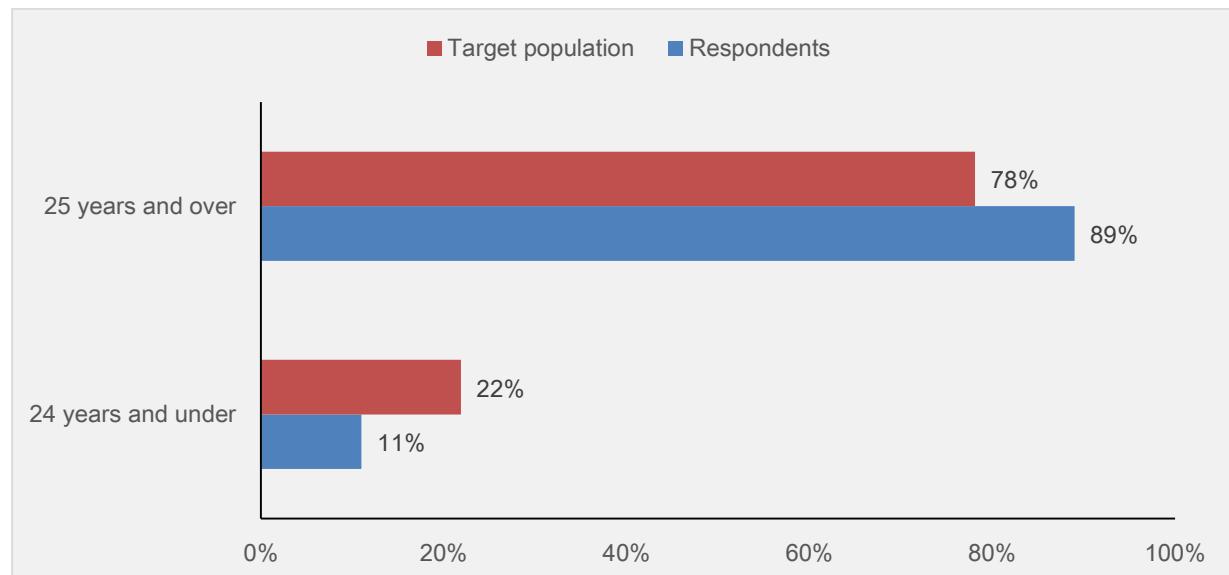
Table 10: Response rates by ethnicity, age and DHB region

	Number of completed surveys Count	Response rates for 2014 %
Ethnicity		
European	2988	39.5
Mäori	471	18.4
Pacific	185	14.5
Asian	478	24.0
Middle Eastern/Latin American/African	68	21.0
Age		
Under 25	408	14.9
25 and over	3393	33.1
DHB region		
Auckland	391	27.8
Bay of Plenty	179	28.5
Canterbury	475	35.7
Capital and Coast	321	36.2
Counties Manakau	351	19.3
Hawkes' Bay	98	19.1
Hutt	138	31.3
Lakes	77	24.0
Midcentral	134	29.2
Nelson Marlborough	111	35.2
Northland	101	22.2
South Canterbury	36	25.7
Southern	300	38.6
Tairawhiti	37	23.6
Taranaki	117	35.3
Waikato	294	26.3
Wairarapa	38	31.1
Waitemata	513	29.0
West Coast	29	44.8
Whanganui	48	29.8
Other	12	57.1
Overall	3801	29.4

Sample characteristics

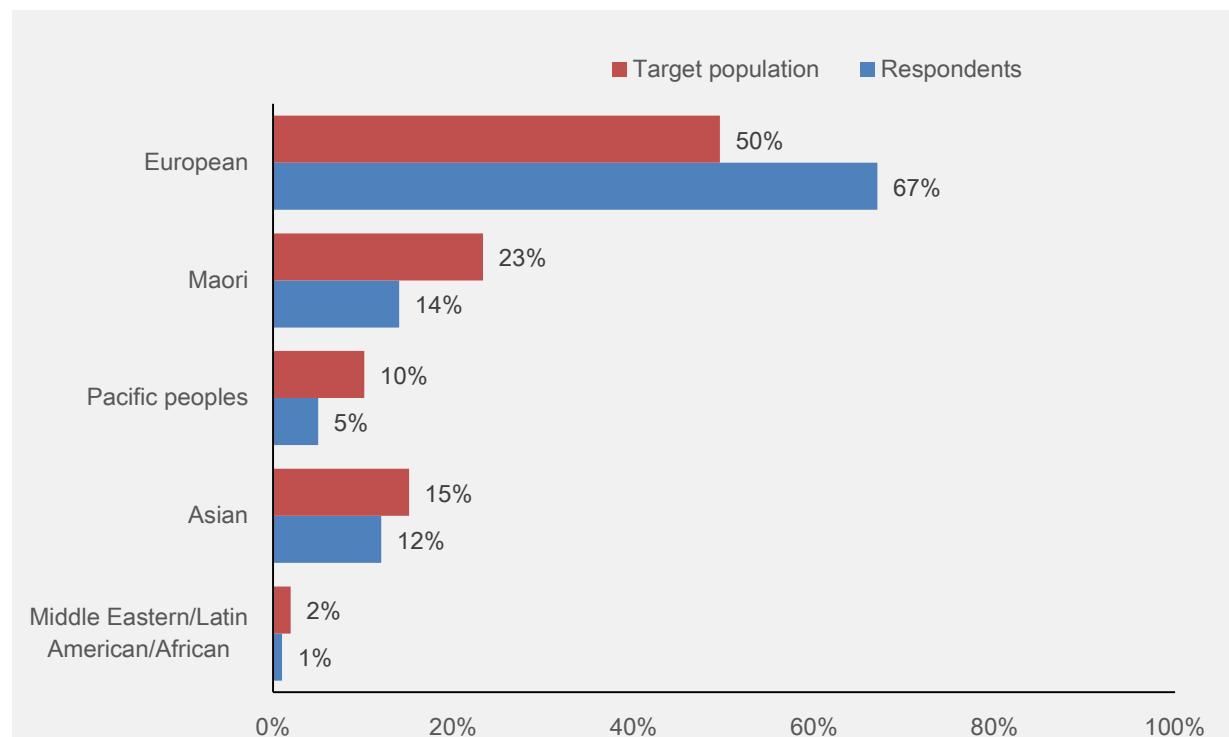
The two figures below, and the table on the following page, compare the demographic characteristics of the 3,801 women who completed the survey (the survey ‘sample’) against the characteristics of the target population (all women who gave birth between December 2013 and February 2014).

Figure 34: Age



Base: All women who participated in the survey (n=3801).

Figure 35: Ethnicity



Base: All women who participated in the survey (n=3801).

In order to make a comparison between the target population and the sample ethnicity results, ethnicity is based on the data held by the Ministry of Health.

Table 11: DHB where birth occurred

Base =	Target population		Survey sample	
	13634	%	3801	%
Auckland	11		10	
Bay of Plenty	5		5	
Canterbury	10		12	
Capital and Coast	7		8	
Counties Manakau	13		9	
Hawkes' Bay	4		3	
Hutt	3		4	
Lakes	3		2	
Midcentral	4		4	
Nelson Marlborough	2		3	
Northland	4		3	
South Canterbury	1		1	
Southern	6		8	
Tairawhiti	1		1	
Taranaki	3		3	
Waikato	8		8	
Wairarapa	1		1	
Waitemata	13		14	
West Coast	1		1	
Whanganui	1		1	
No known DHB	0		0	
Total	100		100	

Total may not sum to 100% due to rounding.

Weighting

As shown in the graphs on the previous page, Māori, Pacific and younger women were under-represented in the survey sample. To balance out these differences, the data has been weighted at the analysis stage. Weighting the data ensures the total sample results more accurately reflect the results we would have achieved had we surveyed every woman who gave birth between December 2013 and February 2104.

All results presented in the body of this report are based on the weighted data. The only exception to this are the tables presented in the methodology section relating to response rates and sample characteristics.

Accuracy

Results based on the weighted sample of women who completed a survey (n=3,801) are subject to a maximum margin of error of plus or minus 1.5 percent (at the 95 percent confidence level). This means that had we found that 50 percent of women who took part in this research were satisfied with their overall experience of maternity services, we could be 95 percent sure of getting the same result if everyone who was invited to take part did so, give or take 1.5 percent.

In all cases, larger margins of error apply to sub-samples. For example, results based on the sub-sample of (n=2,284) women who did not attend antenatal classes is subject to a maximum margin of error of plus or minus 2.3 percent and the results based on the sub-sample of (n=196) women who did

not have a community-based LMC are subject to a maximum margin of error of plus or minus 7.9 percent.

Methodological recommendations for future surveys

The regression analysis highlighted a number of issues with the survey design. These are listed below:

- The survey did not cover all of the factors accounting for satisfaction within each of the three areas of maternity care, most notably, the factors relating to care received during labour and birth. The best way of uncovering what those factors are, is through qualitative research with mothers. This would involve semi-structured discussions or focus groups with women who have recently given birth to determine whether there are any other factors that should be included in the survey.
- Because most women are satisfied or very satisfied with the maternity care they received, the Ministry could consider changing the rating scale used in the survey from a rather blunt, 5-point scale to one that provides a more granular level of detail (i.e. a scale of 0-10).
- To apply the regression analysis more effectively, each specific area of care needs an overall satisfaction question that is separate from the factors of care. The regression analysis can then be applied more effectively to other specific areas (e.g. overall satisfaction with antenatal care, overall satisfaction with the care received during labour and the birth and overall satisfaction with information received).
- The regression analysis could also be used to help determine which factors are of least importance to women, in terms of their overall satisfaction with maternity care. These factors could then be removed from the survey to help reduce the length of the survey, or at least make it appear to be shorter.

In terms of implementation and improving response rates, we suggest the Ministry consider the following suggestions:

- Continue to offer the option of completing the survey online (as well as in paper form).
- Implement the survey over the winter months when women with young children are more likely to be at home due to the cold weather and if at all possible, avoid the Christmas holiday period.
- Encourage key stakeholders (particularly those who work with the ‘harder to reach groups’ such as Māori, Pacific and young mothers) to promote and encourage participation in the survey.