Maternity Services

Consumer Satisfaction Survey

Report

Auckland

10 January 2008
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1. Executive Summary

The Primary Maternity Services Notice (pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000) was first implemented nationally in 1996. A number of changes have occurred since then including minor amendments in 1998, a major review in 2001, and price adjustments in 2005.

A new Notice was issued by the Ministry on 1 July 2007. The new Notice has introduced further changes in service specifications and quality requirements in the provision of primary maternity care.

The Ministry of Health carried out consumer satisfaction surveys in 1999 and 2002 following changes to primary maternity services.

The present report outlines the result of the 2007 survey of 2,936 women using Maternity Services. The objectives of the survey were to measure satisfaction among women using Maternity Services during March and April 2007 and where possible to compare the levels of satisfaction (or percentage of those satisfied) to those recorded in the 2002 survey.

Although the format and content of the questionnaire used in the present survey was essentially similar to the format and content in the previous (2002) survey, there were some differences in terms of format and sequence of questions, more use of open-ended questions, and some new questions to cover core issues in maternity care that had become relevant during the last five years.

The procedure used in the 2007 survey were also slightly different in that demographic data held by the Ministry was combined with survey responses which allowed a comparison between the population and respondents, showing an overrepresentation of older and European women. Respondents were also offered the facility to complete the survey on-line.

The results show an increase in the percentage of women who knew that they had to register with an LMC (registrations with self-employed midwives increased from 54% to 71%), who were given a copy of the care plan to keep, were told about the back-up care if their LMC couldn’t make herself available and those who were able to meet this back-up LMC during their pregnancy. There is also an increase in the number of post-natal home visits made by the LMCs and the percentage of women who knew which Well Child Providers were going to provide the Well Child visits.

Compared to 2002, a greater percentage of women have difficulty in finding a suitable LMC. Shortage of LMCs in that particular area or because the existing midwives are just too busy are the main reasons women gave for this. Also, while they had an opportunity to meet the back-up LMC, there was a slight decrease in the percentage of women who said they were able to contact her easily.

There was a significant increase in the percentage of women returning home within 12 hours of the birth of their baby (from 8% in 2002 to 14% in the current survey). Across the board, irrespective of when they left hospital, 13% of women reported not feeling ready to leave hospital. When asked why they felt not ready to leave, the women mentioned needing more rest, feeling unwell, breast feeding issues, facility issues, baby needing special care, medical reasons, as well as feeling pressured to leave.
2. Methodology

2.1 Objectives of the survey

The objectives of the survey are to measure satisfaction among women using Maternity Services during March and April 2007 and comparing the levels of satisfaction (or percentage of those satisfied) to those recorded in the two previous surveys.

In addition, the following objectives specific to the Ministry of Health need to be achieved: It was intended that the results of the survey would:

- Provide the Ministry with a comprehensive analysis of women’s perceptions of maternity services;
- Enable the Ministry to assess the current framework for primary services;
- Provide information to inform future planning.

2.2 Description of the questionnaire:

Although the format and content of the questionnaire used in the present survey was essentially similar to the format and content in the previous (2002) survey, there were some differences in terms of format and sequence of questions, more use of open-ended questions, and some new questions cover core issues in maternity care that had become relevant during the last five years.

Questions relating to awareness about the need to choose an LMC, the difficulty some women may have experienced in selecting one, what professional they registered with, the discussion of the care plan, the need for back-up maternity care, urgent visits, when they returned home from hospital, issues surrounding feeding the baby, post-natal visits, talks about arrangements for a Well-Child provider, costs incurred, were all kept.

This meant that, including the demographic items which were obtained by other means, about half of the questions in the proposed questionnaire were exactly the same as the ones asked in 2002.

However, some questions in the 2002 survey were deleted because it was felt that they did not provide any information that would help LMCs, the Ministry or other stakeholders in decision about future services.

Some of the questions in section 2 of the original survey were kept but in a slightly different format: instead of asking respondents to agree or disagree with statements, we asked them to select from a range of (fewer) options.

---

1 Examples of deleted questions are those that tried to elicit agreement or disagreement with statements such as: “I had confidence in all the health professionals who were providing care for me and my baby”, “I had confidence in at least one of the health professionals who were providing care for me and my baby”, “I felt there was disagreement between the health professionals involved in my care”, “I felt it was fine to ask questions whenever I wanted to”, “The care I received after my baby was born suited my needs”
The reason for using the different format is that asking respondents to agree or disagree with a very large number of statements (there were 25 in total in 2002) tends to encourage the well-documented phenomenon of “response set”, which is the tendency of a person to respond to questions in a particular way independently of the content of the questions\(^2\). In contrast, providing a small number of labelled options gives more time for reflection and a more considered response as a result.

The new 2007 questionnaire also uses rating scales and other closed-ended response options, as well as a few more open-ended questions for participants to voice independent views.

As suggested by the College of GPs, women who are dissatisfied with an aspect of their treatment are now asked to indicate in several places in the questionnaire what could be done to improve matters.

While the number of questions in the current survey was similar to the previous questionnaire which consisted of 55 questions, the number of open-ended questions increased significantly from five to eight. This allowed many women to express themselves in their own words.

Several totally new questions were included which focussed on issues such as:

- The Ministry’s Pregnancy booklet
- The usefulness or otherwise of ante-natal classes
- Information on antenatal tests (blood tests, scans)
- Information on immunisation and the mother’s decision to immunise her baby
- The six-week GP check.

Finally, the sequence of the questions was altered slightly to follow the logical sequence of (1) pre-natal issues – (2) issues surrounding the actual birth – (3) post-natal issues.

2.3 Sample

To be consistent with previous years, the sample consists of all women who have been recorded on the MNIS as having given birth to live babies during a two month period (that is, during April and May 2007).

As there are approximately 48,000 women who give birth to live babies annually (i.e. 8,000 over a two month period), and the expected response rate based on the previously achieved response rate is close to 40%, the sample was thus expected to consist of approximately 3,000 to 3,200 women.

The appropriateness of the sample is confirmed by determining the achieved confidence interval. Table 1 shows that a population of 8,000 women, a sample size of 3,000 respondents and a confidence level of 95% result in a confidence interval of ±1.41%. However, this is based on the assumption of the worst case scenario in the distribution of responses i.e. 50% positive and 50% negative. The confidence interval reduces as the distribution becomes less balanced.

\(^2\) In the 2002 survey all but 2 of the 25 questions went in the same direction.
Table 1 Confidence interval achieved for a population of 8,000 and a sample size of 3,000

<table>
<thead>
<tr>
<th>Confidence level</th>
<th>50%-50%</th>
<th>75%-25%</th>
<th>95%-5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence interval</td>
<td>±1.41%</td>
<td>±1.23%</td>
<td>±0.62%</td>
</tr>
<tr>
<td></td>
<td>±1.86%</td>
<td>±1.61%</td>
<td>±0.81%</td>
</tr>
<tr>
<td></td>
<td>±0.62%</td>
<td>±0.62%</td>
<td>±0.81%</td>
</tr>
</tbody>
</table>

Thus, the sample size of about 3,000 women was considered to be appropriate for the present study.

However, it must be noted that the confidence interval for subgroups such as women in specific age brackets or specific ethnic groups which have lower response rates is somewhat larger. For instance, if the population of 800 Pacific women results in a sample size of 200 (i.e. a response rate of only 25%) it would produce, at 95% confidence level, a confidence interval of ±6.01%. This reduces to ±5.21% for the 75%-25% distribution and ±2.60% for the 95%-5% distribution.

2.4 Procedure

In order to provide a more appropriate baseline against which to measure changes as a result of the new Notice, the Ministry decided to select the survey sample from women who gave birth during the April-May 2007 period instead of the planned July-August 2007 period.

Because of the ability to combine demographic and semi-demographic data from the HealthPAC database relating to age and ethnicity of the mother, type of birth, first/subsequent, home-birth, etc. with responses to the questions in the questionnaire, the current survey was made potentially more accurate than the previous one.

Details of the procedure adopted in the current survey are as follows:

- Each woman was assigned a *totally random* nine-digit number (that is associated with demographic information such as age and ethnicity) which was placed on the questionnaire. The accompanying letter explained the reason why each questionnaire is numbered (see Appendix 7.1).
- All women who gave birth in this two-month period received a one-page letter which told them that they had been selected for this survey and that they were asked to complete the enclosed questionnaire and return it in the enclosed reply-paid envelope to HSCR.
- An *0800 helpline* was set up to answer queries and to allow women to answer the same questions in a telephone-interview context.
- The facility to complete the survey *on-line* on [www.MaternitySurvey.org.nz](http://www.MaternitySurvey.org.nz) was offered.
- Women who wanted to see results of the survey would be able to do so after completion of the analyses on that same website address.
2.5 **Confidentiality of information**

To ensure that the confidentiality of the information returned to HSCR in the form of responses to the questionnaire questions was not compromised, returned questionnaires identifiable only by their random number were grouped in batches and kept separate from any files that connected the random number with personal identifiable information.

2.6 **Data processing**

2.6.1 **Data entry**

The majority of questions were closed questions and required the data entry personnel to just enter the appropriate number in a previously prepared Excel data file. Responses to open-ended questions were typed in by data entry personnel *verbatim*.

2.6.2 **Data entry error check**

As is standard practice with any survey HSCR carries out, a 10% data entry check was carried out to ensure there are as few as possible errors in recording of survey responses. The obtained overall data entry error rate was 1.35%.

2.6.3 **Availability**

A cleaned electronic dataset (anonymous) has been made available in a spreadsheet to the Ministry for any further analysis.

2.6.4 **Integration with qualitative information**

Most important to a thorough understanding of the rich tapestry of information that is provided by the survey participants is the integration of the quantitative results with the qualitative comments made.

Qualitative data analysis combined content and discourse analysis of the responses to open-ended questions, using a method which Pam Oliver & Associates developed to synthesise information obtained through mixed-method data collection into a coherent and integrated whole.

Qualitative findings have been integrated alongside quantitative data in the report, to further clarify the interpretation and understanding of the quantitative data.

2.6.5 **Statistical analysis of results**

To check that the results of the survey were representative of the population of women giving birth to live babies during March and April 2007, a number of chi-square analyses were carried out on the various population parameters (e.g. age, ethnicity).

Also the percentage ± of the confidence interval which is applicable to the result was calculated.

Where possible, and where applicable, a comparison with the results obtained in the previous survey was made – again indicating in the same manner whether or not the results are statistically significant.

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3 This method is used extensively by some DHBs and approved by the Ministry of Health in the Patient Survey Guidelines produced by a government led working party in (see Survey Guidelines, 2000)
2.7 Description of target Population

In September 2007 the Ministry of Health provided HSCR with a dataset that consisted of all women who had been recorded as having given birth to live babies during April and May 2007\(^4\). Three tables were linked:

- The first table contained information obtained from HealthPAC with the section 88 data;
- The second table had hospitalisation data which provided information on the facility, DHB and also procedures/inductions etc for in-hospital births. (This didn’t include private hospital information as this is generally manually entered at NZHIS and therefore there is a time delay.)
- The third table contained the name, address and ethnicity of the women from the NHI.

The three tables collectively gave HSCR information on the age and ethnicity of the mother; delivery type (normal, Caesarean, forceps, vacuum); a birth code description (first or subsequent); condition of the baby (well born or referred to neonatal care facility); homebirth (yes/no); Length of stay; name and place of facility. After “cleaning” the data of any remaining duplicates the total number of women in the database came to 8079.

In previous surveys, not much was known about the characteristics of the women included in the survey: the questionnaire was merely sent to all women who gave birth during a two month period and only upon the return of the questionnaires could data such as age, ethnicity, type of delivery, place of birth, etc. be determined.

The method followed in the present survey differs markedly from this in that information about the women was obtained before the questionnaire was sent out. Moreover, by attaching a random number (not the NHI) to each questionnaire, and recording that number when the questionnaire was returned, it became possible to compare respondents with non-respondents, thus revealing any statistically significant differences between the two groups.

\(^4\) There were around 900 records sent through from HealthPAC after the NHI numbers were validated that were not included in the data as the majority of them only had an NHI number and no name, date of birth etc., so therefore could not be validated. A number of duplicate records and twin/triplet births which resulted in 2/3 mothers records were reduced to one record per mother.
2.7.1 Age

The average age of the population of women who gave birth during April and May 2007 was 28.9, with a median of 29 years old and a standard deviation of 6.2 years. The youngest mother was 14 and the oldest mother was 48 (see Figure 1).

Figure 1 Distribution of age of mother

2.7.2 Ethnicity

Of the 8079 women for whom ethnicity was recorded, there are 4,685 European (representing 58%), 1,582 Māori (20%), 842 Pacific (of which 400 Samoan, 171 Tongan, 128 Cook Island Māori, 48 Fijian, 40 Niuean, 9 Tokelauan), 774 Asian (of which 257 Chinese, 243 Indian) and 195 “Other” ethnicities (see Table 2).

Table 2 Ethnic group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>4685</td>
</tr>
<tr>
<td>Māori</td>
<td>1582</td>
</tr>
<tr>
<td>Pacific</td>
<td>842</td>
</tr>
<tr>
<td>Asian</td>
<td>774</td>
</tr>
<tr>
<td>Other</td>
<td>195</td>
</tr>
</tbody>
</table>

Further details are provided in the results section where population characteristics are compared with percentage returned questionnaires.
3. Response rate and description of respondents

On Monday 8 October 2007 a questionnaire was mailed to all 8,079 women recorded on the Maternal & Newborn Information System as having given birth to a live baby (or babies) in March and April of that year. A total of 252 questionnaires (3.1%) were returned unopened giving a total of 7,827 survey recipients.

3.1 Response rate

By the 15\textsuperscript{th} of November 2,836 questionnaires had been completed and returned to HSCR, while an additional 100 were completed on the internet. This amounts to 2,936 completed questionnaires and a response rate of 37.5%.

The 2002 survey was based on 2,909 completed questionnaires and a response rate of 39.6%.

3.2 Description of respondents

3.2.1 Age of respondents

The average age of the population of women who responded was 30.6 with a median of 31 years old and a standard deviation was 5.5 years. The youngest mother was 16 and the oldest mother was 48.

Table 3 shows that there is an under-representation of younger mothers and a corresponding over-representation of older mothers. The difference in the two distributions is statistically significant ($\chi^2(1,5) = 184.43; p<.0000$).

Table 3 Age of mother

<table>
<thead>
<tr>
<th>Age</th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>629</td>
<td>112</td>
<td>17.8%</td>
</tr>
<tr>
<td>20-24</td>
<td>1432</td>
<td>315</td>
<td>22.0%</td>
</tr>
<tr>
<td>25-29</td>
<td>1940</td>
<td>740</td>
<td>38.1%</td>
</tr>
<tr>
<td>30-34</td>
<td>2284</td>
<td>1041</td>
<td>45.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>1278</td>
<td>598</td>
<td>46.8%</td>
</tr>
<tr>
<td>40+</td>
<td>264</td>
<td>130</td>
<td>49.2%</td>
</tr>
<tr>
<td></td>
<td>7827</td>
<td>2936</td>
<td>37.5%</td>
</tr>
</tbody>
</table>
3.2.2 Ethnicity

Of the 2936 respondents, there are 2,224 European (representing 76%), 306 Māori (10%), 113 Pacific (of which 48 Samoan, 24 Tongan, 18 Cook Island Māori, 13 Fijian, 5 Niuean), 234 Asian (of which 99 Chinese, 61 Indian) and 58 “Other” ethnicities (see Table 4).

Table 4 Ethnicity

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>4545</td>
<td>2224</td>
<td>75.7%</td>
</tr>
<tr>
<td>Māori</td>
<td>1520</td>
<td>306</td>
<td>10.4%</td>
</tr>
<tr>
<td>Pacific</td>
<td>821</td>
<td>113</td>
<td>3.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>756</td>
<td>234</td>
<td>8.0%</td>
</tr>
<tr>
<td>Other</td>
<td>184</td>
<td>58</td>
<td>2.0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>7827</td>
<td>2936</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

In the 2002 survey, the response rate of European was very similar at 48%, for Māori it was calculated to be 28%, for Pacific 6% and for Asian 25%.

These response rates have resulted in an over-representation of European women and a corresponding under-representation of Māori and Pacific women.

So it is clear that although the special effort made to increase the response rate of Pacific women by translating the questionnaire in Samoan and Tongan resulted in doubling the response rate of the 2002 survey, it has only marginally improved their representation in this 2007 survey.

3.2.3 First/subsequent birth

In the population of 8079 women giving birth during the April-May 2007 period, 56% gave birth to a second baby, for 44% it was the first time (see Table 5).

Table 5 First and subsequent birth

<table>
<thead>
<tr>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>First birth</td>
<td>3411</td>
<td>1397</td>
</tr>
<tr>
<td>Subsequent Birth</td>
<td>4416</td>
<td>1539</td>
</tr>
<tr>
<td>Total</td>
<td>7827</td>
<td>2936</td>
</tr>
</tbody>
</table>
3.2.4 Homebirths

381 or 5% of the women in the population had homebirths, as did the 143 women who responded to the request to participate in the survey (see Table 6).

Table 6 Homebirths

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home birth</td>
<td>361</td>
<td>154</td>
<td>42.7%</td>
</tr>
<tr>
<td>Birth at hospital</td>
<td>7466</td>
<td>2782</td>
<td>37.3%</td>
</tr>
<tr>
<td>Total</td>
<td>7827</td>
<td>2936</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

3.2.5 Length of stay

The number of days that the women stayed in hospital was also assessed.

Table 7 Length of stay

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1313</td>
<td>469</td>
<td>35.7%</td>
</tr>
<tr>
<td>1</td>
<td>1862</td>
<td>611</td>
<td>32.8%</td>
</tr>
<tr>
<td>2</td>
<td>1319</td>
<td>471</td>
<td>35.7%</td>
</tr>
<tr>
<td>3</td>
<td>921</td>
<td>370</td>
<td>40.2%</td>
</tr>
<tr>
<td>4</td>
<td>747</td>
<td>326</td>
<td>43.6%</td>
</tr>
<tr>
<td>5</td>
<td>444</td>
<td>202</td>
<td>45.5%</td>
</tr>
<tr>
<td>6</td>
<td>171</td>
<td>77</td>
<td>45.0%</td>
</tr>
<tr>
<td>7</td>
<td>93</td>
<td>36</td>
<td>38.7%</td>
</tr>
<tr>
<td>&gt;7</td>
<td>149</td>
<td>63</td>
<td>42.3%</td>
</tr>
<tr>
<td>blank</td>
<td>808</td>
<td>311</td>
<td>10.6%</td>
</tr>
<tr>
<td>Total</td>
<td>7827</td>
<td>2936</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

The results show that women who stayed longer in hospital were more likely to respond to the survey ($X^2(1,8) = 23.34; p<.0015$).
### 3.2.6 Delivery type

Almost three quarters (73%) of all births during April and May 2007 were normal deliveries, one in six (16%) were caesarean while 7% were vacuum and 3% forceps deliveries (see Table 8).

**Table 8 Delivery type**

<table>
<thead>
<tr>
<th>Delivery Type</th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>5503</td>
<td>1931</td>
<td>73.0%</td>
</tr>
<tr>
<td>Caesarean Section</td>
<td>1255</td>
<td>555</td>
<td>68.0%</td>
</tr>
<tr>
<td>Vacuum</td>
<td>556</td>
<td>246</td>
<td>7.4%</td>
</tr>
<tr>
<td>Forceps</td>
<td>221</td>
<td>106</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>7535</td>
<td>2838</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

First births were more likely to involve caesarean section, vacuum or forceps while subsequent births were much more likely to be normal vaginal deliveries ($X^2 (1,3) = 656.65; p<.0000; see Table 9).

**Table 9 Delivery type by first/subsequent birth**

<table>
<thead>
<tr>
<th>Delivery Type</th>
<th>First Birth</th>
<th>Subsequent Birth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>60%</td>
<td>84%</td>
<td>73%</td>
</tr>
<tr>
<td>Caesarean Section</td>
<td>22%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Vacuum</td>
<td>13%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Forceps</td>
<td>5%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

5 Type of birth data was not provided on 292 women
3.2.7 Facility

Table 10 shows that, for this sample, particular types of delivery were associated with specific hospitals: for example, normal deliveries were most common in Papakura Obstetric; Caesarean sections were most likely in Auckland and North Shore; Dunedin had a relatively higher percentage of women undergoing forceps delivery; North Shore had relatively more vacuum deliveries.

Table 10 Facility and type of delivery

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>Total</th>
<th>Normal</th>
<th>Caesarean</th>
<th>Forceps</th>
<th>Vacuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland City Hospital</td>
<td>1072</td>
<td>58%</td>
<td>27%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Middlemore</td>
<td>638</td>
<td>79%</td>
<td>12%</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Christchurch Womens</td>
<td>569</td>
<td>59%</td>
<td>25%</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>North Shore</td>
<td>504</td>
<td>58%</td>
<td>27%</td>
<td>2%</td>
<td>14%</td>
</tr>
<tr>
<td>Waitakere</td>
<td>408</td>
<td>76%</td>
<td>15%</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Wellington</td>
<td>345</td>
<td>62%</td>
<td>24%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Waikato</td>
<td>320</td>
<td>62%</td>
<td>22%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Tauranga</td>
<td>267</td>
<td>71%</td>
<td>18%</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>Hastings Memorial</td>
<td>261</td>
<td>80%</td>
<td>14%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Botany Downs Maternity Hospital</td>
<td>247</td>
<td>81%</td>
<td>11%</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Palmerston North</td>
<td>241</td>
<td>76%</td>
<td>16%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Dunedin</td>
<td>218</td>
<td>66%</td>
<td>16%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Hutt</td>
<td>211</td>
<td>81%</td>
<td>12%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Whangarei Area Hospital</td>
<td>206</td>
<td>80%</td>
<td>12%</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Southland</td>
<td>174</td>
<td>74%</td>
<td>13%</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Rotorua</td>
<td>165</td>
<td>77%</td>
<td>15%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Nelson</td>
<td>149</td>
<td>75%</td>
<td>16%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Papakura Obstetric</td>
<td>143</td>
<td>83%</td>
<td>8%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Taranaki Base</td>
<td>108</td>
<td>81%</td>
<td>15%</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>

3.2.8 Urban/Rural division

The response rate from urban and rural areas were very similar and as a result there is adequate representation of both (see Table 11)

Table 11 Urban and rural respondents

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>6358</td>
<td>90.6%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Rural</td>
<td>661</td>
<td>9.4%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Total</td>
<td>7019</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
4. Results of the Survey (Quantitative)

4.1 Pregnancy and preparation for birth

4.1.1 First point of contact

Question 1: When you found you were pregnant, where did you first go for care?

Across the board, 55% of respondents indicated that their first point of contact was their GP while an additional 33% indicated they consulted a midwife. Another 5% approached a specialist obstetrician while 2% consulted a FPC or a Practice Nurse. Other approaches were made to hospitals, A&E clinics and fertility clinics. A number of respondents said they were overseas when they found out they were pregnant.

Younger women tended to be more likely to consult their GP while older women were more likely to ask a specialist obstetrician for advice and care ($X^2(1,4) = p<.0000$; see Figure 2).

Figure 2 First point of contact
When we compare the responses of those women who gave birth for the first time with those who had given birth to a subsequent child, we find that the point of first contact for first-time mothers much more likely to be the GP, whereas for the latter group it is more likely to be the (perhaps already known) midwife ($\chi^2(1,3) = 656.65; \ p < .0000$; see Figure 3)

Figure 3 Point of contact first/subsequent birth

The qualitative data showed that, while many women (51 respondents) appreciated and specifically wanted midwife-led care, others (38 respondents) explicitly preferred a doctor to be their LMC. Typically women’s responses noted that these preferences were based on confidence.

4.1.2 Knowledge of maternity system

Knowledge of the maternity system was assessed in question 2: At that time, did you know that you needed to choose and register with a lead maternity carer (LMC)?

In 1999, 65% of respondents answered “yes”, while in 2002 some 77% answered in the affirmative. In the current survey 80% said they knew this (see Figure 4). The increase from 2002 to 2007 is statistically significant ($\chi^2(1,2) = 5.49; \ p < .02$)

Figure 4 Knowledge about registration
In the 2002 survey it was found that the percentage of women who knew that they had to register with an LMC was lowest in the outliers: i.e. both younger and older women tended to respond less frequently in the affirmative. This was again evident in the current survey ($X^2(1,1) = 10.84; p<.001$; see Figure 5). However, the ethnicity of the respondent was not a factor in this distribution.

**Figure 5 Knowledge of registration as a function of age**

**4.1.3 First registration**

Having informed the women that registration meant signing a registration form to confirm that they had chosen this particular health professional to be responsible for coordinating all of her maternity care, question 3 asked: Who did you first register with as your LMC?

Almost three quarters of respondents (71%) indicated they first registered with a self-employed midwife with a further 15% choosing a hospital midwife. Almost 10% of women opted for an obstetrician and 5% decided on a GP (see Figure 6). The increase in registrations with self-employed midwives from 54% in 2002 to 71% in the current survey is statistically significant ($X^2(1,3) = 271.72; p<.0000$). A few respondents were not sure whether their midwife was independent or hospital employed while some chose shared care.

**Figure 6 First registration**
When this registration process is cross-tabulated with the age of the respondent, we find that younger women are more likely to first register with hospital midwives and older women are more likely to register with specialist obstetricians (see Figure 7).

It is also clear that European women are much more likely to register with a self-employed midwife as their LMC while Pacific women are more likely to register with their local GP ($X^2(1,2) = 102.16; p<.0000$; see Figure 8).

Similarly, rural women are more likely to register with their local GP or a hospital midwife, whereas urban women are much more likely to register with a specialist obstetrician or an independent midwife ($X^2(1,2) = 33.35; p<.0000$).
4.1.4 Access to a Lead Maternity Carer (LMC)

Ease of access was ascertained with question 4a: “Was it difficult for you to find an LMC to provide care for you?”. Responses indicate that close to one in five women (or 19%) found it difficult to find an LMC to provide care for them. This is a significant change from the 11% who reported having difficulty with this in 2002. ($X^2(1,2) = 63.58; p<.0000$, see Figure 9)

Figure 9 Difficulty in finding an LMC

When we investigate what specific subgroup of women found it difficult to find an LMC we determined that it was not a function of age or ethnicity. However, we learned that, compared to women living in urban centres, rural women are less likely to have difficulty in finding an LMC ($X^2(1,2) = 6.00; p<.0143$).

Although the number of respondents in the overview below is in some cases on the low side, it appears that the women who gave birth in Christchurch, Ashburton, Lincoln and Wellington are more likely to have experienced difficulty finding a suitable LMC\(^6\) (see Table 12)

Table 12 Centres in which women experienced relatively greater difficulty finding an LMC

<table>
<thead>
<tr>
<th></th>
<th>Total respondents</th>
<th>It was difficult</th>
<th>It was not difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2913</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td>Christchurch</td>
<td>256</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>Ashburton</td>
<td>19</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>Lincoln</td>
<td>13</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>Wellington</td>
<td>191</td>
<td>28%</td>
<td>72%</td>
</tr>
<tr>
<td>Kaitaia</td>
<td>15</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td>Rotorua</td>
<td>39</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Napier</td>
<td>43</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Cambridge</td>
<td>20</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Upper Hutt</td>
<td>12</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Lower Hutt</td>
<td>39</td>
<td>21%</td>
<td>79%</td>
</tr>
</tbody>
</table>

\(^6\) Note: in 2002, Wellington and Hutt were mentioned as centres where relatively greater difficulty was encountered
But why was it difficult to find an LMC? The responses to the same question posed in the 2002 survey made it possible to formulate five response options which facilitated the quantification of the various problems encountered in accessing care.

Responses to question 4b which asked: “If you answered yes, please explain why;” showed that the main problem appeared to be that midwives are too busy, or that there is a shortage of midwives in that area (see Figure 10). About a quarter of respondents ticked both (1) shortage and (2) all too busy.

Figure 10 Why was it difficult to find an LMC?

These findings were supported by the qualitative data, where 53 women commented specifically on difficulties in finding a midwife due to factors such as shortages in their regions, local midwives all being already fully subscribed, not having confidence in the midwives that were available (sometimes because they were new graduates), and a lack of information about where to look for a midwife.

When these categories were linked to specific maternity hospitals, it became clear that the problem of access to LMCs in Wellington and Hutt is mainly due to a shortage while in the other centres there are LMCs but they are all “too busy” (see Figure 11)

Figure 11 Difficulty of finding an LMC by centre
The next question, question 5, asked: If you could not find an LMC, who provided your antenatal care?

263 women or 9% of the respondents replied that they could not find an LMC. Instead, they received care either from a hospital team, or a GP who was not an LMC or from somewhere else such as a pre-pregnancy clinic or a high risk unit at hospital.

Results showed that 122, of these 263 women were provided with antenatal care by a hospital team, a further 82 visited a GP who was not an LMC and 59 ticked the “Other” response option (see Figure 12). However, virtually all respondents who selected the “Other” category also indicated, in response to question 3, that they had registered with a midwife (self-employed or hospital-employed), so there may have been some misunderstanding here.

46 women, representing 1.6% of all those who responded, indicated that they did not receive any antenatal care.

Figure 12 Who provided your antenatal care?

| If you could not find an LMC, who provided your antenatal care? |
|-----------------|-----------------|-----------------|
| Hospital team   | A GP who was not an LMC | Other |
| 50%             | 45%             | 35%             |
| 40%             | 30%             | 20%             |
| 35%             | 25%             | 15%             |
| 30%             | 20%             | 10%             |
| 25%             | 15%             | 5%              |
| 20%             | 10%             | 0%              |

If you could not find an LMC, who provided your antenatal care?

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4.1.5 Overall satisfaction with antenatal care

Next, respondents were asked, in question 6a, to indicate how satisfied they were with their antenatal care. The response options given were: “I felt well looked after”; “It was satisfactory” and “I didn’t feel well looked after”.

Results indicate that, across the board, more than three quarters of the 2,811 women (or 78%) felt “well looked after”, while another 18% said it was “satisfactory”. However, 107 women, representing 4%, “didn’t feel well looked after”.

When we compare the responses to this question with the profession of their LMC (question 3) we find that 1,570 women felt “well looked after” by their self-employed midwife, 287 women felt well looked after by their hospital midwife, 239 women felt well looked after by their specialist obstetrician and a further 100 women felt well looked after by their GP (see Figure 13).

As a percentage of the total number of women registered with each professional group, respondents were relatively more satisfied if they had registered with a specialist obstetrician and relatively less satisfied if they had registered with a hospital-employed midwife ($X^2(1,2) = 18.05; p<.0001$).

104 of the 107 women who said they didn’t feel well looked after provided an explanation. While some of the comments contained more than one grievance, 90 could be classified as belonging mainly in one of the following categories: poor attitude (20%), lack of availability (19%), lack of good, relevant or timely information (17%), hurried, postponed or cancelled visits (13%), lack of overall care (10%) and poor knowledge or expertise (8%). These issues were also reflected in the responses to the open-ended questions, where 146 women perceived their LMC’s service to be inadequate in some way.

7 However, this does not take into account the correlation that can be shown to exist between satisfaction and age of mother.
Some examples of the perceived lack of LMCs showing a poor attitude were:

‘Felt impersonal like I was just another number!’
‘Felt like I was just a number in a production line, saw her 2 months later and she didn't even remember me!’
‘I found the service from my midwife very impersonal. The visits felt rushed. I was told not to call her unless it was an emergency, if I had any questions I had to text her.’
‘I was humiliated by my Midwife was very rude at and after my delivery.’
‘Midwife did not seem to really care.’
‘My first midwife was not a good fit, she was quite rude in manner and did not make me feel comfortable. In contrast my second midwife was absolutely wonderful, she was super clear and reassuring.’
‘My LMC made me feel uncomfortable to ask her questions.’
‘Race, age and social economic discrimination - treated as a foolish adolescent.’

Some examples of the perceived unavailability of LMCs were:

‘Couldn't get hold of LMC when needed to.’
‘Didn't have enough time with her to establish good rapport.’
‘GP (LMC) went on holiday after referring me to a specialist. Hospital lost all paperwork twice. Ended up having to use a midwife 3 weeks before delivery.’
‘I felt my LMC was too busy for me and often lost test results and couldn’t make appointments.’
‘LMC was great but is very far away - Kaitaia to Auckland.’
‘Only one midwife available in the area and very unhappy with her care. Transferred to different LMC for birth and post-natal.’
‘Unable to get hold of LMC after hours or out of appointment times when problems occurred.’
‘Visits were always rushed. Midwife became part of a group of midwives so it became potluck who I saw on each visit and who would attend for the birth. Also midwives were too busy and never answered mobiles and returned calls hours later so I had to go to the doctors instead.’

And lack of information:

‘Because I didn't receive enough info or care.’
‘At the time I was giving birth I didn't know the midwife home number and she was not present at the birth.’ (Translated from Samoan)
‘Could have received more info about child birth in NZ being new to motherhood as well as to the NZ system. More free services could have been given as options.’
‘I wasn’t informed enough on antenatal care eg: different midwives before baby’s birth + developmental stages.’

‘Information only given when I questioned or asked. Not forthcoming with info.’

‘Never followed up on my questions, worries always felt rushed.’

‘No real communication, just papers handed for me to read.’

Examples of hurried, postponed or cancelled visits included:

‘Always cancelled appointments at last minute - bloods tests were late.’

‘Because my midwife would cancel appointments and not tell me or arrange an alternative midwife to see me more than once.’

‘Midwife always late for appointments. Often a no-show. Blamed other births or tired from births. Obviously over-committed.’

‘Missed appointments regularly had to chase LMC for scan results paperwork, not kept up to date.’

‘My LMC missed several appointments & didn’t always arrange for back-up midwife to see me, or let me know she was going to be away.’

‘She always cancelled appointments and would make me wait another whole week till she would see me.’

Examples of lack of overall care were:

‘Midwife available under health board contract was poor.’

‘My doctor of Remuera was not very good. I refused him to come to the birth and chose the hospital team.’

‘The midwife didn't listen carefully and I was infected, need to go to hospital.’

‘When they attached me to the machine I was neglected for at least 4 hours.’

Examples of poor knowledge or expertise were:

‘I didn't feel my midwife was thorough enough or organised.’

‘I told my midwife I experienced numbness down my right side. She did nothing, I ended up staying a night in hospital.’

‘She misplaced my urine sample result twice and at the same time I had a urine infection.’

‘She was very inexperienced and too busy to provide satisfactory care.’

In addition, 44 women identified other aspects of their ante-natal care that they thought was inadequate, including the lack of preparation for the early stages of parenting.
4.1.6 Information about antenatal tests

The previous 2002 survey asked the women to agree or disagree with the statement: “It was easy to ask my LMC questions about my pregnancy”. (92% agreed)

The present survey was more specific and women were asked in question 7: Did your LMC give you enough information to make an informed choice about antenatal tests? (blood tests, scans, etc.)

Results showed that 95% of women replied that their LMC gave them sufficient information to make an informed choice about antenatal tests.

Further investigation revealed that the percentage of women who responded that they had received sufficient information about antenatal tests was not influenced by either their age or type of LMC with whom they had registered. However, it did come to light that Māori women in particular were more likely than European women to say that they did not receive enough information to make an informed choice ($X^2(1,1) = 17.21; p<.0000$; see Figure 14)

Figure 14 Information about antenatal tests

4.1.7 Receiving a copy of the Pregnancy Booklet

The next question asked them: Did you receive a copy of the Ministry of Health’s consumer information (Your Pregnancy booklet)?

Results showed that, across the board, 93% of women replied that they had received a copy of the Ministry of Health’s consumer information (Your pregnancy booklet)

Although it appears that women who have chosen a GP as their LMC are more likely to report not receiving this booklet, the apparent difference is statistically not significant.
4.1.8 Information about immunisation

A total of 2,522 of the 2,815 respondents (or 89%) reported receiving information to make an informed choice about immunisation. However 290 women, or one in ten (10%) said that they had not received this information.

Further analysis showed that the distribution between those who had received this information and those that had not received this information was not a factor of age, ethnicity, the type of LMC selected, the urban/rural variable, or where in New Zealand they had given birth to their baby.

To the next question, i.e. Question 9b: “If you answered yes, what information did you receive?” 58% responded they had received National Immunisation Register information and 46% said they had received National Immunisation Schedule for babies information.

As many had received both, the combined percentage of those receiving either one is 79%. In other words, one out of five women did not receive either.

An additional 8% replied with “Other” with which they referred to: advice from the GP or midwife, a website, other brochures or pamphlets, Well Child book, IAS newsletter, Immunisation Advisory Centre, Immunisation Awareness Society, from antenatal classes, and talking to family, friends and other people.

In response to the open-ended questions, 86 women commented on receiving insufficient information in relation to maternity care in general, with a lack of information about immunisation being a common concern. In particular women wanted more balanced information to make an informed choice.

Most important was what action the mother took with regard to her baby’s immunisation. To ascertain this, question 9c asked: “What did you decide to do?”

Results indicated that 95% of respondents said that they decided to immunise their baby, 4% made the decision not to immunise her baby while less than 1% answered with “Don’t know” / “undecided”. One mother replied with “yes, but not meningococcal”, another with “yes, but not meningitis”
4.1.9 Antenatal classes

The previous 2002 survey asked the women to agree or disagree with the statement: “I received the right amount of information from antenatal classes”. The present survey first inquired whether the respondent in fact attended any antenatal classes:

Question 10a: Did you attend any antenatal classes? (Yes/No)

Among all respondents, 43% reported attending antenatal classes, 57% said they had not. Considering only first-time deliveries, this percentage increased to 78% (Only 12% of women who had given birth before attended antenatal classes).

Considering the LMC with which the respondent registered, it was found that those women who had registered with an obstetrician were more likely than those who registered with either a GP or a hospital midwife to attend antenatal classes.

While older women are less likely to attend antenatal classes because of previous births, and rural women may be less likely to attend because of access or distance, a more significant variable that had a bearing on whether or not to attend antenatal classes was the ethnicity of the mother: both Māori and Pacific women were significantly less likely to attend antenatal classes ($\chi^2(1, 2) = 76.22; p<.0000$, see Figure 15).

Figure 15 Did you attend any antenatal classes?

Having stated that they had attended antenatal classes, they were then asked about their usefulness in question 10b: How useful were these classes?

The results indicated that 91% of 1267 respondents felt that these classes had been either “very useful” (44%) or “useful” (47%). Only 9% considered the classes to be “not useful”. Amongst the 44 open-ended responses noting inadequacies in the classes, many women commented that they would have liked these classes to include more preparation for the first weeks of parenting. A number of women also suggested post-natal classes in those first weeks to assist women with basic tasks such as bathing the baby and coping emotionally.
More importantly, the survey also wanted to know what, specifically, was good about antenatal classes. The question was posed: What were the best things about the classes? And the options to choose from were: information, social network, inclusion of partner. Also, respondents could give their own reasons under “other”.

Analysis showed that, although many chose to tick more than one box, 67% of 1267 respondents opted for “information”, 57% selected “social network” and 45% ticked “inclusion of partner”. Some 45 respondents, representing 4%, added their own “best things”. They reported they were interested in finding out more about the birthing process and about the types of medicines used in the birthing process, what to expect in the post-natal period, they were impressed by the person teaching the class, enjoyed the on-site tour of maternity ward and delivery suites, and were grateful for the increase in confidence the classes gave them. Having said that, one woman complained about “having been shown a home birth video when all of the class were opting for hospital birth. All of us were negatively impacted by that video”.

However, if the respondent said they had not attended antenatal classes, they were asked in question 10d. to indicate why they had not attended them. The three response options provided were: “They were held too far away”, “The hours didn’t suit me” and “There were no places available”.

However, 87% of 1666 respondents made use of the “Other (please specify)” option to record their reason. Excluding the 1,061 women who had given birth before and who gave this reason as the explanation for not attending, Figure 16 shows the number of women responding to the three options provided plus the responses to this “Other, please specify” provision.

Figure 16 Why did you not attend antenatal classes?

![Chart showing reasons for not attending antenatal classes]

8 The reason why numbers are used instead of percentages is that many respondents chose to select more than one option.
### 4.1.10 Care Plan

The next three questions asked about the care plan. The first two were couched in the same terms as the question asked in 2002: Question 11a: Was a care plan discussed with you during your pregnancy?

The results showed that 84% of respondents answered “yes”. In 2002, the percentage of respondents agreeing was 86%. The difference between the change is statistically not significant ($\chi^2(1,2) = 3.53; p<.0604$; see Figure 17).

When asked, in question 11b: “If yes, were you given a copy of this care plan to keep?”, 66% said yes, compared with 63% five years earlier. This increase is statistically significant ($\chi^2(1,2) = 3.53; p<.0604$; see Figure 17).
But the next question was new; it wanted to know to what extend the care plan was adhered to and offered the following response options: Yes, Mostly, No and “My circumstances changed so unable to follow the birth plan”.

Of the 2550 women who answered this question, 51% responded with “yes” while an additional 29% answered “mostly”. 16% responded that circumstances had changed so they had been unable to follow the birth plan. However, 108 women, or 4% said that the plan was not adhered to (see Figure 19)

Concerns about birth plans not being followed, and about a lack of respect in general for women’s preferences, requests, choices and decisions, were raised by 127 women in their open-ended responses. Some examples were:

‘LMC didn't want me to deliver standing - should have complete flexibility in birth position.’

‘Doctors need to listen to the woman more. We know when not feeling that great.’

‘My midwife was terrible. She was overworked, impatient, arrogant, ignored our wishes and never listened.’

‘Truthfully asked for more pain relief but denied, they said too far along. Would have liked wishes respected.’

In contrast, 247 women identified respect for their decisions and having control over their birth process as the most ‘best’ aspect of their maternity care, indicating how important this is to women.

Figure 19 Was the plan followed during your pregnancy, birth and afterwards?

![Graph showing the percentage of women who adhered to their birth plan](image-url)
4.1.11 Back-up care

As a comparison between the results of this survey and that completed in 2002 was regarded as important, the next four questions dealing with back up arrangements were asked in exactly the same way as in the previous survey: First question 12a: “Were you told who would provide back-up care if your LMC couldn’t be there at any stage?”, and the next question 12b: If you answered yes, were you able to meet your LMC’s back-up people during your pregnancy?

Figure 20 Were you told who would provide back-up care?

![Bar chart showing the percentage of affirmative responses to the question of being told who would provide back-up care, comparing 2002 and 2007. The affirmative responses increased from 85% to 90% in 2002 and from 64% to 69% in 2007.](chart1.jpg)

Results demonstrated that the affirmative responses increased for the first question from 85% to 90% and for the second question from 64% to 69% (This was statistically very significant: $\chi^2(1,2) = 33.35$ and $\chi^2(1,2) = 19.74$, both $p<.0000$; see Figure 20 and Figure 21).

Figure 21 Were you able to meet the back-up?

![Bar chart showing the percentage of affirmative responses to the question of being able to meet the back-up, comparing 2002 and 2007. The affirmative responses increased from 40% to 50% in 2002 and from 20% to 30% in 2007.](chart2.jpg)
However, 39 women commented in question 33 that their LMC did not attend their delivery and had not given them notice that that would happen. When this occurred it caused significant distress to many women. Two further questions involving the back-up care were asked in question 12c: “During your pregnancy, did you ever need to see your LMC urgently, when you did not have a scheduled visit with your LMC?” and question 12d: “If yes, were you able to contact your LMC easily (or the back-up to the LMC)?”

The answers to the first question are shown in Figure 22. Four out of ten women (41%) needed to see their LMC urgently. However, the decrease from 44% to 41% in positive responses is statistically not significant ($X^2(1,2) = 3.02; p<.0821$)

Figure 22 Did you ever have to see your LMC urgently?

The answers to the second question are shown in Figure 23: It shows that 94% of women needing to see their LMC urgently were able to contact her easily. This time, the slight decrease in the percentage positive responses, from 96% to 94%, is statistically significant ($X^2(1,2) = 8.32; p<.0039$)

Figure 23 Were you able to contact your LMC easily?
The lack of availability of LMCs when needed was also raised as a major concern by many women in response to question 33 (response category #6).

4.2 The birth of the baby

4.2.1 Suitability of place of birth

Although data was already available from the initial dataset provided by the Ministry of Health on the name of the facility, 143 or 5% of all women who responded confirmed that they gave birth to their baby at home. (Responses relating to homebirths are provided in section 4.4 on page 59).

A further 2679 respondents provided more detailed information on the hospital or birthing unit in which they gave birth to their baby, showing that 36% of all births in New Zealand during the April-May 2007 period took place in Auckland, 11% in Christchurch and 6% in Hamilton (Note: the designation of a hospital as being “large” or “small” was decided upon by the respondent; see Table 13).

Table 13 Place of birth

<table>
<thead>
<tr>
<th>Place</th>
<th>Small hospitals</th>
<th>Large hospitals</th>
<th>All hospitals</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>48</td>
<td>924</td>
<td>972</td>
<td>36%</td>
</tr>
<tr>
<td>Christchurch</td>
<td>22</td>
<td>283</td>
<td>305</td>
<td>11%</td>
</tr>
<tr>
<td>Hamilton</td>
<td>47</td>
<td>121</td>
<td>168</td>
<td>6%</td>
</tr>
<tr>
<td>Wellington</td>
<td>2</td>
<td>145</td>
<td>147</td>
<td>5%</td>
</tr>
<tr>
<td>Tauranga</td>
<td>9</td>
<td>103</td>
<td>112</td>
<td>4%</td>
</tr>
<tr>
<td>Dunedin</td>
<td>1</td>
<td>92</td>
<td>93</td>
<td>3%</td>
</tr>
<tr>
<td>Palmerston North</td>
<td>4</td>
<td>84</td>
<td>88</td>
<td>3%</td>
</tr>
<tr>
<td>Hastings</td>
<td>10</td>
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</tr>
<tr>
<td>Lower Hutt</td>
<td>1</td>
<td>72</td>
<td>73</td>
<td>3%</td>
</tr>
<tr>
<td>Invercargill</td>
<td>2</td>
<td>70</td>
<td>72</td>
<td>3%</td>
</tr>
<tr>
<td>Whangarei</td>
<td>2</td>
<td>70</td>
<td>72</td>
<td>3%</td>
</tr>
<tr>
<td>Nelson</td>
<td>3</td>
<td>59</td>
<td>62</td>
<td>2%</td>
</tr>
<tr>
<td>Rotorua</td>
<td>1</td>
<td>45</td>
<td>46</td>
<td>2%</td>
</tr>
<tr>
<td>Timaru</td>
<td>9</td>
<td>22</td>
<td>31</td>
<td>1%</td>
</tr>
<tr>
<td>New Plymouth</td>
<td>0</td>
<td>29</td>
<td>29</td>
<td>1%</td>
</tr>
<tr>
<td>Blenheim</td>
<td>11</td>
<td>17</td>
<td>28</td>
<td>1%</td>
</tr>
<tr>
<td>Masterton</td>
<td>6</td>
<td>19</td>
<td>25</td>
<td>1%</td>
</tr>
<tr>
<td>Whakatane</td>
<td>9</td>
<td>12</td>
<td>21</td>
<td>1%</td>
</tr>
<tr>
<td>Gisborne</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>1%</td>
</tr>
<tr>
<td>Wanganui</td>
<td>1</td>
<td>17</td>
<td>18</td>
<td>1%</td>
</tr>
<tr>
<td>Pupekohe</td>
<td>13</td>
<td>1</td>
<td>14</td>
<td>1%</td>
</tr>
<tr>
<td>Kawakawa</td>
<td>8</td>
<td>5</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Papakura</td>
<td>10</td>
<td>3</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Paraparaumu</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>0%</td>
</tr>
<tr>
<td>Taupo</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>0%</td>
</tr>
</tbody>
</table>
When asked in question 13a: “Were you able to give birth in the facility of your choice?”, 86% of women replied affirmatively. However, 403 or 14% of women replied that they had not been able to give birth where they had wanted or intended. If the respondent answered “no” they were asked to provide a reason for this in question 13b: “If you answered no, why was this?”

The distribution of responses, summarised in 7 categories, is shown in Figure 24:

![Figure 24 Were you able to give birth in the facility of your choice?](image)

41% of respondents gave a medical reason; e.g. previous medical history, complications, prem or overdue baby, needed inducing or epidural, baby not in correct position, emergency transfer to larger hospital:

Some examples included:

‘Due to gestational diabetes had to go to Auckland.’
‘Pre existing medical condition - deemed I was only able to birth in hospital environment.’
‘Previous complications so had to deliver at National Womens.’
‘Because of my blood pressure.’
‘Duration of labour needed antibiotics.’
‘Geriatric Gravida, previous complications.’
‘Because of complications from first baby delivered.’
‘Because there were complications so I had to go to Chch Womens.’
‘Facility did not offer care for Strep B IVE (positive) mothers.’
‘Antibiotic allergies. Advised to give birth in main hospital.’
‘Birthing pool is what I wanted but had to have inducing drugs.’
‘Merconium when my waters broke so midwife advised we got to Chch Womens instead of maternity unit.’
‘I was admitted to hospital with Pre eclampsia 4 days before the birth and was induced.’

‘I have bad medical history so I had to give birth at ChCh Womens so I was not able to birth anywhere else if I wanted to.’

‘Because post partum haemorrhage first time.’

‘I wanted an epidural so couldn’t deliver in Botany.’

‘Had Placenta Previa.’

‘Got rushed to hospital, baby’s cord was around his neck.’

Another 14% of respondents referred to the need to have a C-section, either because they had previously had a C-section for their previous child or because of a medical condition or as an emergency.

Some examples were:

‘2 weeks overdue - needed to be induced and an emergency c-section for delivery.’
‘As we had to have c-section.’
‘Was scheduled for an elective Caesar at Auckland Hospital.’
‘Emergency caesarean, already in hospital.’
‘Our first child was c-section so we had no choice for our second.’
‘Facilities not up to doing c-sections.’
‘It was an emergency c-section due to high blood pressure.’
‘Was booked for caesarean.’
‘Had to travel to Whangarei as had c-section previously.’

Another 13% of respondents said that the reason why they were not able to give birth where they had wanted to was because the appropriate facilities either were not available in their area or there was no space in the facility of their choice.

Examples included:

‘Hospital was too full and overworked.’
‘Renovations and unit booked out.’
‘Booked up, fully occupied no beds.’
‘Wanted a water birth but no pool available.’
‘Opted for a pool birth, but as it happened earlier all the pools (2) were taken.’
‘Maternity unit full. Also LMC at hospital with an induction of someone else.’
‘I was living in wrong area.’
‘No private facility on North Shore.’
‘Birthing hospital was full.’
‘Only one facility available (hospital).’
‘No specialist care in Queenstown.’
‘Only because of a large number of births that morning so the pool birthing room was in use.’
‘Would have preferred a 'birthing suite' & possibly a water birth. My local hospital (Tauranga) did not have these.’
‘No too many choices available in Blenheim!’
‘Special care baby unit at North Shore Hospital was full when I went into premature labour.’
‘River Ridge was fully booked.’
‘No private maternity hospital in Wellington.’
‘Rooms were occupied.’

Another 13% of respondents said that because the baby came earlier than expected, they had to go to the nearest hospital.

Some examples were:

‘Transferred to AKL for a premature birth.’
‘Water broke too early and had to go to the hospital.’
‘Born early and quickly.’
‘Because he was born prematurely.’
‘Was 4 and a half weeks early.’
‘I rang my midwife and told her that I might be in labour but she thought I wasn't so she told me to go to the Maternity Unit. She was based at for a check up. When I got there it was too late I was ready to push.’
‘Labour progressed too quickly, so has to take closest to home option. Baby arrived 8 minutes after arriving at hospital. Never would have made it into town in peak hour traffic.’
‘Went into full labour in the WHK Annex car park and had baby in the back of my car.’
‘Planned for home birth but LMC was in maternity unit with another lady which meant I had to go there. Had baby in truck on way to hospital.’
‘Because I had a fast labour and weren't able to get to the birthing unit in time, so had her at home instead.’
‘Baby arrived very quickly.’
A further 13% of women replied that they didn’t think they had a choice or were not given a choice because of pre-existing arrangements or as instructed by their LMC.

Some examples were:

‘My LMC midwife insisted on Auckland Hospital <and> would not sign the birthcare reg form.’

‘My midwife only delivers at Auckland Hospital so I didn't have a choice.’

‘LMC said she used National Womens.’

‘Midwife delivered only in one hospital.’

‘My midwife told me to go to the other birthing unit which is closer to my house.’

‘Had to give birth at Christchurch Women's Unit unable to transfer to Burwood.’

‘Was told I had to birth in a hospital rather than birthing unit.’

‘We felt we had no choice but to give birth at Chch Womens.’

‘Middlemore hospital was the only option.’

‘Was not asked or told about the choice of facilities.’

‘Obstetrician works at North Shore.’

‘Midwife was not registered with 'birthcare'.’

‘I didn't know that I was able to choose.’

‘My midwife did not do homebirths.’

‘My midwife was already at another birth at a different facility so I met her there.’

‘It was the choice of the LMC I did not know my rights she refused to go to another hospital.’

‘Well I didn't know I could choose a facility in a public hospital.’

‘I requested the birth centre but was dissuaded by the 1st midwife as a room nearby was ready & I don't think midwife wanted to move far.’

Finally, 14 women, representing 4% of the respondents, answered that they either wanted to give birth at home but couldn’t or planned to give birth in a hospital but unexpectedly gave birth at home.

Some examples:

‘Due to inducing, home birth no longer became an option.’

‘Wanted home birth ended up being induced in hospital.’

‘Chose a home birth but delivered in hospital because induced.’

‘Unplanned home birth on my own.’

‘Unplanned home water birth.’

‘The backup LMC advised that I was close to giving birth at 10cm dilated so I agreed to birth at home. I laboured for a further 3 hours so could have travelled to my place of choice being River Ridge birthing centre in Hamilton.’
‘I had my baby at home due to changing circumstances. But my LMC made sure everything was OK.’

4.2.2 Communication between LMC and Specialist Obstetrician

When, in the previous 2002 survey, women were asked to agree or disagree with the statement: “There was good communication between my LMC and the specialist obstetrician”, 52% strongly agreed and an additional 25% agreed while 12% either disagreed or disagreed strongly (each 6%).

In this survey, question 15 asked: “If you needed assistance by a Specialist Obstetrician during labour or birth, how do you rate the communication between your LMC and this Specialist Obstetrician?”

Of the 53% of women who required specialist assistance, 66% rated this communication as “excellent”, 28% rated it as “satisfactory” but 6% rated it as “very poor” (Figure 25).

Figure 25 How do you rate the communication between LMC and Obstetrician?

![Chart showing communication ratings](chart.png)

Poor communication amongst professionals was commented on spontaneously by a large number of women as problematic for them (question 33, response categories #1 and 16). Miscommunications and arguments amongst professionals, frequently in front of the woman and often during labour and delivery, caused some women major distress and resulted in them losing confidence in the professionals and feeling unsafe.
4.2.3 Pain relief

In the 2002 survey, respondents were asked to agree or disagree with the statement: “My wishes regarding pain relief were respected” (89% agreed, 5% disagreed while 5% neither agreed nor disagreed).

In the current survey we simply asked: “Were your wishes regarding pain relief respected? In reply, of the 2,746 women answering this question, 76% responded with “Yes” while 5% responded “No” and 19% said that they had not needed pain relief.

It was also evident in the responses to the open-ended questions (see page 81) that respect for their pain relief decisions and obtaining pain relief when they wanted it were important factors for women. Two percent of women responding to question 23 identified problems in obtaining pain relief during delivery, and access to pain relief post-natally was also problematic for many women.

In another question in the 2002 survey, women were asked to agree or disagree with the statement: “I needed more pain relief than I was given” (19% agreed, 69% disagreed and 12% neither agreed nor disagreed)

In this survey we asked: “Did you need more pain relief than you were given? The results showed that 13% responded with “Yes”, 60% responded with “No” and 27% said that they had not needed pain relief. Some women voiced concerns in question 33 that they were given pain relief against their specific instructions not to have it, leaving them feeling unsafe and powerless.
4.2.4 Overall appraisal of care by LMC

A general question about the LMC asked: “How well did you feel your LMC looked after you during your labour and birth?” The response options given were: (1) I felt well looked after by my LMC; (2) Satisfactory and (3) I didn’t feel well looked after.

Figure 26 shows that more than eight out of ten women (82%) felt well looked after by their LMC while an additional 12% felt it was “satisfactory”. However, 163 of the 2,845 women answering this question, representing 6%, replied that they didn’t feel well looked after.

In addition, 76 women described concerns in response to the open-ended questions around poor experiences during labour and delivery, typically involving what they perceived as a lack of care and/or professional incompetence.

When the women who answered “I didn’t feel well looked after”, were asked: “what could be improved”?, they mentioned increasing LMC’s availability both before and after birth, more all-round care, better communication, more positive attitude, higher degree of expertise and various other aspects of care (see Figure 27).

Figure 27 What could be improved?
Some examples of the perceived lack of availability were:

‘My midwife was day off, the backup one was at dinner and the emergency midwife was looking after 7 beepers. I got to the hospital and 2 other ladies were pushing and only 2 midwives there. My partner was ready to deliver for me.’

‘Because she didn’t visit me apart from twice.’

‘Was told 1 week before birth that she was going to be away for a week & 1/2 & told to hold on till she got back.’

‘My LMC on day off her partner on leave and other LMC didn’t make it on time so hospital midwife I had never met ended up delivering my baby.’

‘My LMC left half-way during my labour which I thought shouldn't happen.’

‘My midwife kept leaving the room I don't know why she was.’

‘She should have visited me on 24 h after the baby was born. She left during c-section and did not come back until 2nd day.’

‘My LMC wasn’t there until 30 mins after the birth and the hospital midwife delivered my baby then left me causing my baby to get cold and sugar levels dropping, so had to be admitted to SCBU.’

‘Was in hospital for a week she visited once.’

‘My LMC hospital midwife didn’t be with me during my labour (her day off).’

‘My midwife couldn't make it. Backup midwife, I’d never met. She acted like she didn't want to be there. Very unprofessional. Have made a formal complaint with health and disabilities and midwife assoc.’

‘Don't have so many clients to attend to - then you would have time to get to know your clients. As opposed to just being a number.’

‘My LMC left me and went home as I was taking too long. The hospital midwives were great. I was really disappointed with my LMC.’

‘After birthing in my car my midwife was birthing another client and I was left with the baby for an hour until a backup student midwife took over my care who I had never met.’

‘My LMC could have been there & should have come up to PN with me to make sure everything went OK.’

Some examples of perceived lack of overall care were:

‘Midwife held out giving pain relief and sat around reading and texting other clients instead of explaining what was going on.’

‘She shall have listened more and cared more. Should have spent more time with me.’

‘She was organising her day during labour in my room which was uncomfortable.’

‘I had concerns around the delivery only regarding the lack of services if there were complications with the birth I would have to be taken to Whangarei Hospital (flown / ambulance) as I had previous delivery complications in my last birth.’
‘I did feel well looked after but there were not much care for my baby after delivery. So many thing went wrong; he had a cut on his back which I had to find the next-day (after the delivery) from blood stain on his shirt. The cut was deep enough to leave mark.’

‘His temperature was not checked by staff and when they did after 2 days he needed urgent care by specialist.’

‘I was told by my LMC that I would not push for more than 1 hour as I have had a c-section before. Then she made me push for 2 hours while I was in complete agony and I ended up having to scream at her to get the specialist who took me straight in for another c-section.’

‘I felt that she didn't give me much attention during my first x 2 trimesters and hence. I felt I didn't really enjoy having her before and after my birth.’

‘Midwife was too pre occupied writing in book I was often alone.’

Some examples of lack of communication were:

‘Our LMC was not rostered on the weekend our baby was delivered. We felt there was poor communication between the LMC and her backup. We would not have chosen the backup as our LMC as we found her unable to handle the difficult delivery and we had to transfer from Birthcare to Auckland Hospital.’

‘Lack of communication between back-up midwife & hospital waited hours before getting transfer to maternity unit.’

‘I don't think my wishes for pain relief were listened to by the midwife, so listening to and following through requests would be good.’

‘I felt I was treated different because I was younger and felt like I had to rush to give birth and got talked into having a caesarean. I also only seen my LMC once after giving birth and I was in hospital for four days. I think I needed someone to talk me through what was happening because I didn't know as this was my first child.’

‘I was given no direction - more communication needed, more reassurance. The hospital duty midwife was more help than my LMC during the birth.’

‘Communication as to what was going on - I was left for several hours not knowing what was happening. After baby's birth I felt the support for a first time mother was poor. Was never given days or times when we would be visited at home. I ended up with back up midwife who was not very helpful and upset family members.’

‘My midwife didn't listen to my birth history hence I didn’t get to the Hospital on time. LMC back up person told me not to go to hospital hence I didn't get there in time. Lack of communication between LMC’s.’

‘Very little communication about progress and options for the labour and pain relief.’
Some examples of a perceived lack of experience or expertise included:

‘Overworked midwife was tired and not focused and I felt she did not know what she was doing! She was hesitant, unconfident had trouble explaining my case to specialist and anaesthetist. There should be more support during the birth from hospital midwives and the midwife should not be able to deliver a baby on her own. Overall incompetence.’

‘Midwife did stretch and sweep of membranes which resulted in sudden onset of labour - baby went into distress, very worrying experience for both of us. Also, a trainee was sent to take blood sample from baby’s head while he was in birth canal - she took far too long to do this, and after 10 minutes still hadn't got the sample. This was a ridiculous situation - the baby was in distress and this would not of helped!’

‘My midwife was very ‘GREEN’.’

‘Experienced nurse should be available all the time. Trainee student should not work independently during the labour and birth.’

‘The midwife is too old to find my blood vessel and he had to do several times to do the injection correctly because his hand is shaking.’

‘I felt that my LMC was inexperienced when it came to the birth, she even asked my sister to write down some notes of what was happening at the time. At one stage I had asked her about the epidural and she snapped at me because she was stressed. In the future I do intend to have more children from this experience I will only deal with experienced LMC’s.’

‘Had a stand in midwife that wasn’t prepared for me and felt she panicked.’

‘I called my LMC when in labour (my 2nd child) and she kept telling me not in labour. When finally got to hospital I was 4-5 cm dilated. I went to hospital after calling obstetrician who told me she’d thought she’d heard from me earlier.’

‘LMC did not intervene + take control when things started to go wrong. Lack of co-operation between hospital & LMC.’
4.3 Hospital stay

Respondents were asked to answer the questions in this section on “hospital stay” only if they gave birth in a hospital or birthing unit.

4.3.1 Appropriate level of privacy

In the 2002 survey, women were asked to agree or disagree with the statement: “I had enough privacy during labour and birth” (89% agreed, 6% disagreed while another 6% neither agreed nor disagreed).

In this survey we asked question 18: “How much privacy did you have during your stay in hospital?” and asked them to choose between (1) enough privacy and (2) not enough privacy.

Results showed that 95% agreed that they had enough privacy, while 5% said they did not have enough privacy. The lack of privacy was a real concern for 154 women who responded to question 33. The issues raised were mostly around being unable to get sleep or rest when they were exhausted, emotional and vulnerable following their baby’s birth.

4.3.2 Treatment of support people/whānau

In the 2002 survey, women were asked to agree or disagree with the statement: “My support people/whānau were made to feel welcome” (93% agreed, 3% disagreed while another 4% neither agreed nor disagreed).

Refining that question a little the present survey asked how welcome their support people/whānau were made to feel. The results showed that 73% said “always”, 20% replied “most of the time” (adding to 93%) while 5% thought “some of the time” and 2% informed us that they were “not really” made to feel welcome.

Among the women who felt they had enough privacy, 79% said that their support people were made to feel welcome, while among those who felt they did not have enough privacy, only 31% said that their support people were made to feel welcome (see Figure 28)

Figure 28 Privacy and welcoming support people
Exclusion of partners and other family members was raised by 60 women in response to question 33 (category #18) as an issue for them. Some women were particularly very upset when partners were made to leave when the women were feeling distressed and needy, and several noted how counterproductive this was, resulting in their needing extra attention from staff to undertake support that their partners could have provided.

4.3.3 Availability of staff

In 2002, the question was asked “If you stayed in hospital after your baby was born, was there ever a time when you felt the hospital staff or your LMC were too busy to attend to your needs?” (Yes/No/Not applicable)

In this survey we asked questions that were specific to the delivery room staff and the nursing and medical wards in the wards: Question 20: “How would you rate the availability of delivery room staff?”

Results show that 75% of respondents felt that their availability was “fine”, and an additional 21% thought it was “satisfactory”. However, 81 women, or 3% of those responding, replied with “bad, they often weren’t there when I needed them”.

Similarly, in question 21 we asked: “How would you rate the availability of nursing and medical staff in the wards?” and provided the same response options as before.

This time, only 61% of respondents felt that their availability was “fine”, and an additional 31% thought it was “satisfactory”. However, 229 women, or 9% of those responding, replied with “bad, they often weren’t there when I needed them”.

While staff’s lack of availability was often excused by respondents to question 33 as being because “they were short-staffed”, other women described seeing staff sleeping on duty and watching television and ignoring their call pagers ringing. Many women described being left, for example, with blood-soaked sheets, “screaming” babies or unable to get to the toilet unassisted for considerable periods without staff responding to calls for help, and at least three women described emergency situations where babies might have died when staff failed to respond quickly to calls for help.
4.3.4 Overall satisfaction with giving birth in a hospital

To assess women’s overall satisfaction with having given birth in hospital, the following question was asked: “Overall, how satisfied are you about having given birth to your baby in hospital?”

As shown in Figure 29, 58% of respondents reported being “very satisfied” and an additional 32% said they were “satisfied”. However, 4% were “undecided” and 7% were either “dissatisfied” (5%) or “very dissatisfied” (2%)

![Figure 29 Overall satisfaction with having given birth in hospital](image)

Most importantly, women expressing dissatisfaction were given the opportunity to list areas for improvement in hospital services in question 22b: “If you answered “dissatisfied” or “very dissatisfied”, what could be improved?”

![Figure 30 What could be improved?](image)
Of the 185 comments which followed an assessment that the respondents were (very) dissatisfied, 148 could be classified in terms of eight categories; they are the need to improve overall care, aspects of hospital facility, staff attitude, the need for more staff, problems caused by early discharge, and the need to improve communication, the availability of beds and the level of staff expertise (see Figure 30).

Some examples of the need to improve overall care are:

‘Answering the buzzer and actually coming to help & not ignore me.’

‘Felt like there were lots of well intended people, however there was no overall plan for helping you through this period, and each person may make a different decision or recommendation for example, relating to pain relief or the need to express to bring milk in.’

‘Help by ward staff - it was our first baby & we were just left to it with no help - didn't see anyone until we called them 8 hrs after the birth as he hadn't fed.’

‘Service - I wasn't seen by anyone until I wanted to leave.’

‘Support during labour was fantastic. Care and support when transferred to maternity ward was abysmal - staff had to be found and were reluctant to help.’

‘The birth was excellent in the delivery suite but on the ward I felt very much left on my own with the exception of one midwife who was excellent the rest I never saw.’

‘The birthing care was great but the aftercare needed to have more continuity with the same nurses, if possible, to be assigned.’

‘The hospital midwives didn't help me at all! When I asked them to call my midwife it took an hour and the baby was already there ready to pop out!’

Some examples of poor facilities are:

‘Hospital room wasn't clean I wasn’t given a meal.’

‘It was filthy. Cleanliness must be improved.’

‘More single bed rooms so that you can rest. I don’t think the toilets and showers were cleaned regularly and were pretty disgusting. Night was just like day with lighting not being turned down (as it couldn’t) and staff chatting/laughing thru-out the night. Basically I wanted to go home as soon as I could to get some sleep.’

‘The state of the ward I was labouring in was disgusting dirty - not even any toilet paper!! Not enough staff on duty - very overcrowded.’

‘The bathroom was filthy and while in labour I couldn't bring myself to sit on the toilet.’

‘The room was cold and the temp was as high as it would go. I was left to sleep on the birthing bed but constantly told by the hospital midwife I would be moved.’

‘More privacy and more restful rooms, I did not sleep the whole five days in hospital. Very hard on a new Mum.’

‘More privacy, bigger space, partners able to stay overnight. Not sharing the same toilets/shower with 8 women.’
More privacy, more food, cleaner facilities (hospital is old and run down).

Some examples of the need to improve the poor attitude demonstrated by some staff are:

- After my birth nursing staff could have been more respectful.
- The midwives made me feel incompetent.
- Bedside manner of staff!! Communication.
- Been treated like a person and not just another figure in the books.
- Hospital staff seemed angry every time I asked for help so I never asked - that's why I wanted to leave the hospital early.
- Nurses were rude and far too pushy when it came to breast feeding.
- The nursing staff need some people skills. Nurses were rude to me.
- Nurses were not helpful or friendly. Midwife was rude to me.
- Overworked & insensitive nurses need to be sacked or given a holiday
- People need no be so rude to obese patients.
- Some of the midwives on duty were terrible: bad attitudes, not supportive of breastfeeding, made me feel guilty for asking for any help.

Some examples of the need for more staff are:

- More staff - they were all far too busy to provide adequate care.
- More staff - understaffing was the general issue.
- More staff needed! More helpful advise. At night not to feel so lonely!
- More staff on ward more assistance and help, partner able to stay with you as its hard for out of towners.
- Nurses just too busy it is a scary time more time 1 on 1, and more time in the hospital helpful.
- Staff numbers, it was so overcrowded that I did not receive the care I should have.
- Staffing! I was in the post-natal ward for THREE hours before a nurse even checked on me!!! VERY poor standards of care post-natally so I went home.
- There does not seem to be enough staff on the ward - nurses appear overworked and stressed.
- There is a shortage of staff.
- They need more staff support in post-natal.
- Get more nursing staff in the wards & more ward midwives. Real lack of staff in Wgtn - unsafe (safety to be improved & cleaning).
- Availability of doctors and through out rather than a morning visit.
Some examples of the problems caused by too early discharge from delivery suite to an offsite postnatal facility are:

‘Kicked out too fast - only in Chch Womens for 2 hours total! Then couldn't go to St Georges where I was booked in as was full.’

‘Not to be leaving the hospital within 4 hours after labour in the middle of winter.’

‘We were forced to transfer after 2 hrs of giving birth. Disgusting! This is unacceptable to new parents and places the new baby in a vulnerable position, no matter what managers say.’

‘Being kicked out of Chch Womens after being induced, it was horrible and I was still in shock and not up to have to move on so soon.’

‘They could let you stay more than 30 mins and let rest.’

‘Being kicked out of Auckland Hospital at 3am with a newborn was very distressing. Transferred to birthcare.’

‘CHC Women's was unsatisfactory was transferred at 2am and had only just regained feeling in my legs. New born baby out in the cold night!’

‘Had to leave Christchurch Womans at 4am at 0 degrees to go to Burwood was not happy that had to take a 4 hour old baby out at that time but part from that was good there.’

Some examples of the need to improve communication are:

‘Letting people know what was going on.’

‘Communication - often didn't know what was happening. Would get different instructions from each midwife re: breast feeding etc and most seemed too busy / impatient to help.’

‘Communication between LMC and first time midwife who delivered our baby. She had no supervision and complications arose.’

‘Communication between staff/staff, staff/family. Response times. Explanation on how/where things are. Space + lots more.’

‘The communication between staff - (i.e.: reading my notes ahead etc. before changeovers).’

Some examples of the need to increase the availability of beds are:

‘After a long tiring labour I was put in a room with 4 other mothers and their babies how are you or your new baby supposed to get any sleep or get to know each other in that environment?’

‘Hated 4-berth room in maternity suite - worst night of my life, horrendous.’

‘Not moving beds 3 times in 4 days.’

‘Too crowded and beds crap.’

‘Ward resources were far too scarce i.e.: rooms, beds staff.’
‘Had to stay in the delivery room after baby was born. I did not see any nurses at all. Discharged myself very disgusted!’

‘I got moved 3 times and ended up in a freezing day room 1 hour after giving birth.’

‘Privacy, single rooms, more + frequent care.’

‘Ward - too crowded no privacy/quiet time, disrupted sleep.’

Some examples of the need to improve staff expertise are:

‘3 attempts to put a line in - anaesthetist had to do it in the end. Delivery staff could not find my cervix or unable to put a catheter in.’

‘I believe that my midwife panicked when things got tough and a specialist should have been called in sooner.’

‘Midwife knowledge (equipment, breast feeding, how to tell the time so they ring the specialist at 3pm when I asked not 5.30pm!) More midwives needed definitely!’

‘The nurse forgot to hang my catheter down (left lying on bed with me all night - back flow of urine) & the next day still did not know anything about it!’

In addition, taking into account all of the above categories and other responses to question 33, at least 1130 responses identified aspects of hospital or other neonatal facility services that were seen as inadequate (categories #1, 3, 4, 7, 9, 10, 18, 22, 28). Inadequacies in hospital and neonatal facility services were the greatest concern of women who responded to question 33, and some experiences had left some women fearful of having another baby in hospital. Of particular concern was the high number of instances (n=48) where women reported that professionals had failed to diagnose or adequately treat significant medical problems (category #22).
4.3.5 Returning home

The same question that was asked in 2002 was asked here about readiness to return home along with the same response category: Question 23a: “How long after the birth did you return home?” and the response categories were: within 12 hours, between 12 and 24 hours, between 24 and 48 hours and more than 48 hours (please specify days).

Figure 31 shows that one in seven women (14%) returned home within 12 hours, another 13% between 12-24 hours, 28% between 24-48 hours and 44% after more than 48 hours in hospital. The increase in the percentage of women who were discharged within the first 12 hours after the birth of their baby (from 8% in 2002 to 14% in 2007) was statistically significant ($\chi^2(1,3) = 45.57; p<.0000$)

Considering only the last group of 1,051 women who reported staying in hospital more than 48 hours, we find that 39% stayed 3 or 4 days, 24% stayed 4 or 5 days, 23% stayed 5 or 6 days while 15% of women remained more than 6 days in hospital (see Figure 31).

Did women feel ready to leave hospital when they did? In 2002 respondents were asked to agree or disagree with the statement “I left hospital when I was ready to” (83% agreed, 11% disagreed while 6% neither agreed nor disagreed)

In the present survey we did not ask them to agree or disagree with a statement but asked them point blank in question 23b: “When you left hospital, did you feel ready to leave?”
The distribution of their responses made it clear that 85% felt ready to leave the hospital when they did (see Figure 32). However, 347 women, representing 13% of all respondents, did not feel ready to leave while 61 women, or 2%, couldn’t make up their mind.

The difference between 2002 and 2007 is statistically significant but inconclusive because agreeing or disagreeing with a positive statement is not the same as answering a direct question.

Figure 32 Did you feel ready to leave?

![Did you feel ready to leave?](chart)

However, phrasing the question in this manner allowed us to ask those who had responded with “no” the more important question of why they felt not ready to leave.

Over 300 of the 347 responses could be grouped into 7 categories: Figure 33 lists them as follows: needing more rest, breast feeding issues, feeling unwell (incl. being in shock, in pain, anxious, insure, etc.), feeling pressured to leave, baby needing special care (incl. prem babies), facility issues (incl. not enough space, noisy environment) and medical reasons (incl. caesarean aspects).

Figure 33 Why did you not feel ready to leave?

![Why did you not feel ready to leave?](chart)
Of course, these dimensions are not mutually exclusive: feeling pressured to leave is often clearly related to the lack of space provided by the hospital and medical aspects are related to how good or unwell the women feel upon discharge.

Some examples of the need to have more rest are:

- ‘Could have done with more rest.’
- ‘Didn’t have much rest time - was in ward with 3 others!’
- ‘Felt rushed needed more time to rest and recover.’
- ‘I felt I needed more time to rest.’
- ‘I needed more rest before going home.’
- ‘I shared a room with a baby (mother) that cried constantly. I had to leave to get some sleep.’
- ‘I was exhausted and not ready to go home straight after birth.’
- ‘I was tired, there was too much noise in my ward. Another patient next to me had 2 x toddlers with her all day and they made a lot of noise etc.’
- ‘I would have liked to stay a bit longer but the conditions of the maternity ward especially noise and size of room led me to want to leave earlier.’

Some examples of breastfeeding issues were:

- ‘Breast feeding not established with confidence.’
- ‘First time mum, still getting used to baby and breastfeeding.’
- ‘Hadn’t mastered breastfeeding were told not enough funding for another night.’
- ‘I had cracked bleeding nipples and I had not mastered breastfeeding.’
- ‘I had not established breastfeeding but it was too overcrowded in the hosp.’
- ‘I still had no milk for breast feeding.’
- ‘I was having a lot of trouble breast feeding and had no confidence. Baby was consequently bottle fed.’
- ‘I was having problems breastfeeding and felt that I needed more help and time before going home.’
- ‘I was having problems breastfeeding and wanted to get it right before I left but had to leave.’
- ‘I was not confident with breastfeeding when I left birthcare and had problems afterwards.’

Some example of being unwell were:

- ‘Being a first time mum I felt very unsure of myself.’
- ‘Felt unwell and sick.’
- ‘I was in pain and couldn’t move much.’
‘I was still dizzy it had only been 3 hrs since birth.’
‘I was still in a lot of pain when discharged my stay was up I was told.’
‘I was still in pain.’
‘I was still in shock from the birthing process.’
‘Severe vaginal pain and exhaustion.’
‘Still feel headache, could not walk properly.’

Some examples of feeling pressured to leave included:
‘Felt pressured to leave.’
‘I felt pushed out.’
‘Just felt pressure to leave as beds were full.’
‘No option, you are expelled. It is such a shock having first baby, support and breastfeeding help would have been good.’
‘Not quite ready for being home with the baby!’
‘One more night would have been better, feeling pressured to leave 24-48 hrs after is a bit stressful!’

Some examples of baby needing special care were:
‘Baby in SCBU.’
‘Baby was 4 weeks prem and only 5lbs, I felt maybe another day or 2 as he's had low blood sugar.’
‘Baby was in neonatal unit I didn’t want to leave without him.’
‘Because my baby was 6 weeks prem & I had to go home without him. It would have been good to stay a couple more days to be close to him.’
‘I had a sick baby.’
‘My baby spent 30 hours in NICU so was nervous about taking her home.’
‘My son had to stay in hospital for two weeks and I didn't like to leave him there alone.’
‘Very upset to leave baby in NICU (3rd prem baby).’

Some examples of facility/availability of beds issues are:
‘Apparently there were no rooms available.’
‘But too noisy + busy to sleep. 4 people to a room is too many.’
‘Had to leave because it was too noisy and got no sleep and beds like rocks.’
‘No beds available in Kaitaia for me, was told Whangarei ward was busy and understaffed and was better off going home.’
‘No room as limited no of beds and so had to go home.’
‘No room available to stay in post-natal.’
‘Not enough place to stay.’
‘Shortage of beds we had to stay 2 days in consultation room so didn't want other mothers to do the same.’
‘Would have liked to stay longer but was crowded/noisy and largely left alone so better at home with husband and support.’

Some examples of medical issues are:
‘Asked to leave less than 24hrs after emergency caesarean. Re-admitted with peritonitis less than 24hrs post discharge!!’
‘Bad infection (abscess) they had to drain 300ml.’
‘Because my beautiful baby girl had silent reflux so bad that she stopped breathing - many many episodes.’
‘Constipation, high blood pressure, infected c-section scar.’
‘Delivery complications - lost blood, surgery - very weak - but left because not enough help caring for baby in night and felt more exhausted.’
‘Had catheter & highly dependent on others.’
‘Had emergency c-section. Didn't feel comfortable walking around or getting up.’
‘Had haemorrhage very drained and exhausted - 2 toddlers at home.’
‘Had major 3rd degree tearing and pain level was still rising when I went home. Couldn't afford to stay longer.’
‘I had an infected haematoma which wasn't picked up on because of inexperienced relieving LMC which led to my return to hospital.
‘I had lost a lot of blood during the delivery and after and felt very shaky and unwell on my feet but was told it was due to the loss of blood and low iron.’

These issues were also reflected in women’s responses to question 33, where 142 women commented that their time in hospital (usually) or a neonatal facility had not been long enough (category #7)

Women often described how having to leave before they were ready had resulted (they believed) in them not being able to breastfeed effectively, experiencing untreated severe pain, feeling inadequate and unsafe to look after their new baby, and in some cases contributed to them developing a depression. A sufficient time in hospital was also identified in response to question 32 (category #15) as a key aspect of maternity care that women wanted to have provided.
4.4 Homebirths

Of the 381 women who had been recorded as having given birth at home, 148 women (or 39%) responded to the request to participate in the survey.

This group, which represents 5% of all women giving birth during the selected period were asked question 24a: “Overall, how satisfied are you about having given birth to your baby at home?”

93% responded that they were “very satisfied” and another 4% said they were “satisfied”. Only 3 women replied that they were “dissatisfied” (1) or “very dissatisfied” (2). Two women remained undecided (see Figure 34).

Figure 34 How satisfied are you with having given birth in hospital/at home?

How satisfied are you with having given birth to your baby in hospital/at home?

When the three women who answered “dissatisfied” or “very dissatisfied”, were asked “what could be improved?”, only two made comments, one “Having a supply of hot wheat bags? Have gas offered? Have the pool set up?”

The other woman remarked “Nothing. Maia just wanted to come out in about 10 minutes so no-one could have done anything.”

This high level of satisfaction with home birthing contrasts with the range and frequency of hospital birthing issues identified in the survey.
4.5 Post-natal care

4.5.1 Suitability of Post-natal care facility

Question 25 asked “Were you able to have post-natal care in the facility of your choice?”

Responses show that, across the board, more than nine out of ten women (92%) replied in the affirmative. Yet 241 women, representing 8% of all respondents, disagreed.

When we cross-tabulate this answer with the type of facility in which they gave birth to their baby, it becomes clear that, while there is no statistically significant difference between the perceived suitability of primary care, secondary care and home births, clearly (and for good reason) 15% of the 934 women who gave birth in a tertiary care facility did not do so out of choice (see Figure 35).

Figure 35 Were you able to have post-natal care in the facility of your choice?
4.5.2 Number of post-natal visits by LMC

“How many times did a midwife visit you at your home after your baby was born?”

This question, which was also asked in 2002, requested the women to indicate the number of post-natal home visits the LMC made. Results showed that 27% reported fewer than 5 visits, 41% reported between 5 and 6 visits, 16% recalled 7 to 8 visits, 10% between 9 and 10 visits and 6% said more than 10 visits.

Comparing this distribution to 2002 results we find that there has been a definite, statistically significant, increase in the number of reported post-natal home visits ($X^2(1,4) = 51.95$; $p<.0000$; see Figure 36).

Figure 36 How many times did your LMC visit you at home?

4.5.3 Satisfaction with post-natal visits by LMC

Asked, in question 26b, “Overall, how satisfied are you with the number of home visits by your LMC?”, we find that nine out of ten women or 90% are either “very satisfied” (66%) or “satisfied” (24%) with the number of home visits. 4% are not sure while 4% are “dissatisfied” and 2% are “very dissatisfied” (see Figure 37).

Figure 37 How satisfied are you with the number of home visits?
And when we cross-tabulate the satisfaction score with the number of home visits we find that women who had fewer than 5 visits are much less likely to respond with “very satisfied” than are those who received more than 5 visits (see Figure 38).

Figure 38 Satisfaction as a function of number of visits

Home visits by LMCs were identified by 120 women as one of the ‘best’ aspects of their ante-natal and post-natal care, and by 121 women as an aspect of maternity care that they particularly wanted to continue, showing the importance and value of home visits to women. Responses to the open-ended questions also showed that home visits following birth were experienced as especially valuable where women had had problematic deliveries, complications or illnesses following their baby’s birth.

4.5.4 Advice or assistance in feeding the baby

The 2002 survey asked respondents to agree or disagree with the statement: “I got helpful advice from the LMC about feeding my baby” (74% agreed, 14% disagreed and 12% neither agreed nor disagreed).

The same issue was asked more directly in question 27a: “Did you receive any advice or assistance from your LMC or another maternity care provider on how to feed your baby?”

The results show that 2,635 women, or 90% of those responding, answered in the affirmative while 287 or just under 10% reported not having received advice or assistance on how to feed their baby.

Subsequent to which, respondents were asked to indicate to rate this advice in question 27b: “If you received this advice or assistance, how do you rate this?”

In reply, 1,540 women or 59% of those responding thought the advice was “excellent”, and an additional 830 women representing 32% felt it was “good”. 8% rated the advice as “average” while only 1% rated it as “poor” and 1% rated it as “very poor”.

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In hindsight, this question might have been rephrased to ask about satisfaction with the advice *and support* that women received from their LMC *and from other professionals*. Responses to question 33 show that poor lactation support was a major problem for new mothers, with 177 identifying dissatisfactions, including inconsistent advice, criticism, rudeness and impatience from staff, and even rough handling by nurses and midwives (category #3).

Help with breastfeeding was critical to new mothers, and a lack of support frequently resulted in women feeling distressed, blaming themselves, and “feeling like a failure” at a point where they were already vulnerable. Perceived coercion from professionals to breastfeed was reported by many respondents. Several women also reported developing mastitis, bleeding nipples and infections as a result (as they saw it) of poor support and care by hospital staff. Several women asked for lactation specialists to be available to all women following birth.

4.5.5 *Feeding the baby*

In the 2002 survey, women were asked to indicate how they fed their baby in the first four weeks. (77% said they breast fed, 6% bottle fed and 16% both).

The same question was asked in the current survey. In response to question 27c, 74% of women said that they had breast fed their newly born, 5% said they had bottle fed their baby and 21% said that they had used both methods.

Comparing the results to those obtained in 2002 show that while there was no statistically significant change between the percentage of women breast feeding vs those bottle feeding, the increase in the percentage of women who decided to use both methods is statistically significant ($\chi^2(1,2) = 22.66; p<.0000$; see Figure 39)

**Figure 39 How did you feed your baby?**

![Graph showing feeding methods for 2002 and 2007]
4.5.6 Well Child visits

In 2002, in response to the question “At the time that you had your last maternity visit with your LMC, did you know who was going to be providing your Well Child visits?”, 88% responded in the affirmative.

In the current survey we asked “By the time your baby was a month old, did you know who was going to provide your Well Child visits?” and the results showed that now 94% of women replied in the affirmative. This improvement is statistically significant (X² (1,2) = 50.13; p<.0000)

4.5.7 The Six-week check

A new question introduced in the current survey was question 29 which asked: “Has your baby had, or is it booked in for, its six-week check from your GP?”

Responses indicate that 96% of respondents confirmed their baby had had the check and another 1% tell us that the baby is booked in for the check. Only 90 of the 2,917 women responding representing 3% say that their baby has not had the check nor has been booked in.

Responses to question 33 showed that inadequate post-natal services were a concern to 153 women. Respondents concerns were mainly around: a lack of home visits; a lack of follow-up by Plunket; and/or other problems with Plunket services; long waits for appointments with LMCs; other aspects of LMC services, usually to do with a lack of availability (category #5). Many respondents described feeling anxious and inadequate as a result of being unable to access sufficient or appropriate post-natal support.

4.5.8 Costs of maternity related services

As in the 2002 survey, respondents were again requested to provide detail on costs incurred for pregnancy tests, ultrasound scan(s), care received, respectively, from an obstetrician, a GP, a midwife, an anaesthetist, paediatrician, or from attending antenatal classes.

Question 30 read: “Were you charged for any of the following services for either you or your baby? (please say how much):”

Of the 2,936 respondents, 2136 or 72%, reported being charged for services that they considered were related to their pregnancy, childbirth and post-natal needs. This compares with 50% of women who reported this in the 2002 survey.
Most frequently they recorded expenses for an ultrasound scan (median $45), antenatal classes (median $120), care from an obstetrician (median $2,500) or from a GP (median $38) or a positive pregnancy test (median $20, see Table 14)

Table 14 Cost of maternity related services

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Mean</th>
<th>Median</th>
<th>Max</th>
<th>Min</th>
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<tbody>
<tr>
<td>Positive Pregnancy test</td>
<td>300</td>
<td>$28</td>
<td>$20</td>
<td>$175</td>
<td>$2</td>
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<td>$78</td>
<td>$45</td>
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<td>Care from an obstetrician</td>
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<td>$38</td>
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<td>$2</td>
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<td>$150</td>
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</tr>
</tbody>
</table>

Some of the “Other” expenses mentioned related to private rooms at a private facility, pregnancy blood tests, (e.g. screening for Downs Syndrome), lactation consultants, osteopaths, physiotherapists, and GP visits.

These findings were reflected in 82 women’s responses to question 33 (category #13). In addition to costs of services outlined in Table 14 above, some women were concerned at having had to pay for extra time in hospital when they were too ill to be discharged.
4.6 Summary

4.6.1 Pregnancy and preparation for birth

- The percentage of women who knew that they had to register with an LMC which had improved from 65% in 1999 to 77% in 2002 further increased to 80% in the current survey;
-Registrations with self-employed midwives increased from 54% in 2002 to 71% in 2007;
- However, the increase in the percentage of women who found it difficult to find an LMC also increased from 11% in 2002 to 19% in the current survey. This is particularly the case for women living in an urban environment and in specific centres such as Christchurch and Wellington. Reasons given were that midwives appear to be too busy, or that there is a shortage of midwives in that area. The 5% of women who replied that they could not find an LMC received care from a hospital team, or a GP who was not an LMC or from somewhere else such as a pre-pregnancy clinic or a high risk unit at hospital;
- Asked how satisfied they were with their antenatal care, 96% expressed satisfaction: 78% of women reported feeling “well looked after”, while another 18% said it was “satisfactory”. Only 4% of women “didn’t feel well looked after”. Reasons given were: poor attitude, lack of availability, lack of good, relevant or timely information, hurried, postponed or cancelled visits, lack of overall care and poor knowledge or expertise;
- Respondents were most satisfied with their antenatal care if they had registered with a specialist obstetrician and relatively less satisfied if they had registered with a hospital-employed midwife;
- 95% of women replied that their LMC gave them sufficient information to make an informed choice about antenatal tests. Māori women are more likely than European women to say that they did not receive enough information to make an informed choice;
- 93% of women replied that they had received a copy of the Ministry of Health’s consumer information (Your pregnancy booklet);
- 89% reported receiving information to make an informed choice about immunisation while 58% responded they had received National Immunisation Register information and 46% said they had received National Immunisation Schedule for babies information;
- 43% reported attending antenatal classes, 57% said they had not. Considering only first-time deliveries, this percentage increased to 78%;
- Women who had registered with an obstetrician were more likely than those who registered with either a GP or a hospital midwife to attend antenatal classes. While older women are less likely to attend antenatal classes because of previous births, and rural women may be less likely to attend because of access or distance, a more significant variable that had a bearing on whether or not to attend antenatal classes was the ethnicity of the mother: both Māori and
Pacific women were significantly less likely to attend antenatal classes;

- 91% of respondents felt that these classes had been either “very useful” (44%) or “useful” (47%). Only 9% considered the classes to be “not useful”;

- Asked what was good about antenatal classes, 67% of respondents opted for “information”, 57% selected “social network” and 45% ticked “inclusion of partner”;

- When those who did not attend antenatal classes were asked why they did not attend them, the most frequent responses pointed to unsuitable hours, not required and location/too far away/not available;

- Similar to the percentage who responded likewise in 2002, 84% of respondents reported that a care plan was discussed. However, there was an increase from 63% in 2002 to 66% in the current survey in responses to the question “Were you given a copy of this care plan to keep?”;

- 80% of respondents agreed that the care plan was adhered to, 16% responded that circumstances had changed so they had been unable to follow the birth plan and 4% said that the plan was not adhered to;

- The percentage of respondents who replied affirmatively to the question “Were you told who would provide back-up care if your LMC couldn’t be there at any stage?”, increased from 85% to 90% and the percentage of respondents who replied affirmatively to the question “Were you able to meet your LMC’s back-up people during your pregnancy?” increased from 64% to 69%;

- As in 2002, 41% of women said that during their pregnancy they needed to see their LMC urgently. Among those who did need to see their LMC when they did not have a scheduled visit, 94% were able to contact her easily. However, there was a slight decrease in the percentage of women who said they were able to contact her easily.

4.6.2 Birth of the baby

- 36% of all births in New Zealand during the April-May 2007 period took place in Auckland, 11% in Christchurch and 6% in Hamilton. 5% were homebirths;

- Asked “Were you able to give birth in the facility of your choice?”, 86% of women replied affirmatively. However, 14% of women replied that they had not been able to give birth where they had wanted or intended. Explanations included medical issues, C-sections, the fact that appropriate facilities either were not available in their area or there was no space in the facility of their choice, baby came earlier than expected, the belief that they didn’t think they had a choice or were not given a choice because of pre-existing arrangements or as instructed by their LMC, and some wanted to give birth at home but couldn’t or planned to give birth in a hospital but unexpectedly gave birth at home;

- Asked to rate the communication between the LMC and the Specialist Obstetrician, 66% rated it as “excellent”, 28% rated it as “satisfactory” but 6%
rated it as “very poor”;

- 76% of respondents replied that their wishes regarding pain relief were respected, 5% said that they weren’t and 19% said that they had not needed pain relief;
- 13% said they needed more pain relief than they were given”, 60% said they didn’t;
- More than eight out of ten women (82%) felt “well looked after” by their LMC during their labour and birth of their baby while an additional 12% felt it was “satisfactory”. However, 6% replied that they didn’t feel well looked after. When asked what could be improved, respondents mentioned increasing LMC’s availability both before and after birth, more all-round care, better communication, more positive attitude, higher degree of expertise and various other aspects of care.

### 4.6.3 Hospital stay

- 95% of women giving birth in hospital agreed that they had enough privacy, while 5% said they did not have enough privacy;
- 93% of women reported that their support people/whānau were made to feel welcome “always” or “most of the time”. However, 5% thought they were only made to feel welcome “some of the time” and 2% believed that they were “not really” made to feel welcome;
- Asked to rate the availability of delivery room staff, 96% of respondents felt that their availability was either “fine” or “satisfactory”. However, 3% replied with “bad, they often weren’t there when I needed them”. Similarly, 92% of respondents rated the availability of nursing and medical staff in the wards as either “fine” or “satisfactory” while 9% replied with “bad, they often weren’t there when I needed them”;
- Evaluating their overall satisfaction with their stay in hospital, 58% of respondents reported being “very satisfied” and an additional 32% said they were “satisfied”. However, 4% were “undecided” and 7% were either “dissatisfied” (5%) or “very dissatisfied” (2%). Asked what could be improved, respondents mentioned the need to improve overall care, aspects of hospital facility, staff attitude, the need for more staff, problems caused by early discharge, and the need to improve communication, the availability of beds and the level of staff expertise;
- One in seven women (14%) returned home within 12 hours, another 13% between 12-24 hours, 28% between 24-48 hours and 44% after more than 48 hours in hospital. Compared to the results of the 2002 survey (when only 8% were discharged within the first 12 hours after the birth of their baby) there was a significant increase in this early discharge;
- When asked “When you left hospital, did you feel ready to leave?”, 85% responded affirmatively and said that they felt ready to leave. However, 13% of respondents did not feel ready to leave while 61 women, or 2%, couldn’t make up their mind;
• When those who had responded with “no” were asked the more important question of why they felt not ready to leave, they mentioned needing more rest, breast feeding issues, feeling unwell, feeling pressured to leave, baby needing special care, facility issues and medical reasons.

4.6.4 Homebirths

• Of the 148 women who gave birth at home, 93% responded that they were “very satisfied” and another 4% said they were “satisfied” with their homebirth. Only 3 women replied that they were “dissatisfied” or “very dissatisfied”;

4.6.5 Post-natal

• Across the board, more than nine out of ten women (92%) replied in the affirmative when asked “Were you able to have post-natal care in the facility of your choice?” Yet 8% disagreed;

• Asked to give an indication of the number of times the midwife made post-natal home visits, 27% reported fewer than 5 visits, 41% reported between 5 and 6 visits, 16% recalled 7 to 8 visits, 10% between 9 and 10 visits and 6% said more than 10 visits. Comparing this distribution to 2002 results we find that there has been a definite increase in the number of post-natal home visits;

• Nine out of ten women or 90% are either “very satisfied” (66%) or “satisfied” (24%) with the number of home visits. 4% are not sure while 4% are “dissatisfied” and 2% are “very dissatisfied”. Women who had fewer than 5 visits are much less likely to respond with “very satisfied” than are those who received more than 5 visits;

• Asked to indicate whether they received any advice or assistance from their LMC or another maternity care provider on how to feed the baby, 90% answered “yes”. When asked to rate the advice 91% believed it to be either “excellent” or “good”. Another 8% rated the advice as “average” while 2% rated it as “poor” or “very poor”;

• 74% of women said that they had breast fed their newborn, 5% said they had bottle fed their baby and 21% said that they had used both methods. Comparing the results to those obtained in 2002 show that while there was no statistically significant change between the percentage of women breast feeding vs those bottle feeding, the increase in the percentage of women who decided to use both methods is significant;

• 94% of women knew by the time the baby was a month old who was going to provide the Well Child visits. This is a significant improvement over 2002 when only 88% of women knew this at the time that they had their last maternity visit with the LMC;

• When asked “Has your baby had, or is it booked in for, its six-week check from your GP?” 96% of respondents confirmed their baby had the check and
another 1% tell us that the baby is booked in for the check. But 3% of the respondents say that their baby has not had the check nor has been booked in;

- When requested to indicate whether they were charged for any services that they considered were related to their pregnancy, childbirth and post-natal needs, 72% believed that they had. This compares with 50% of women who reported this in the 2002 survey. Most frequently they recorded expenses for an ultrasound scan, antenatal classes, care from an obstetrician or from a GP or a positive pregnancy test. “Other” expenses mentioned related to private rooms at Birthcare, pregnancy blood tests, (e.g. screening for Downs Syndrome), lactation consultants, osteopaths, physiotherapists, and GP visits.
5. Results of the survey (Qualitative data)

5.1 Method

At the end of the quantitative questions, respondents were asked three open-ended questions:

Q 31 – ‘List what was best about the maternity care you received’
Q 32 – ‘List what you would like to stay the same’
Q 33 – ‘List what was not good about the maternity care you received. What would you like to happen differently?’

The majority of the 2336 women responding to these questions answered questions 31 and 33, while there were fewer responses to Q 32. Many answers were lengthy, especially those to Q 33.

5.2 Data analysis

Response categories were developed separately for each question through a content analysis of the first 170 responses received. All responses were then coded into those categories, as shown in Tables 1-3. Each response was analysed to extract information in as many categories as apparent within that response; that is, a single response might contain information relevant to several categories. In this way it has been possible to calculate what percentage of all respondents gave a response within each category.

5.3 Reporting

Data are reported in discrete categories for each question. Quotes are reported verbatim and have been selected to represent the most common comments for each category. (That is, a greater number of quotes indicates greater diversity of comments; where there are fewer quotes given, responses tended to be more homogeneous.)

5.4 Question 31 – ‘List what was best about the maternity care you received’

5.4.1 Patterns in responding

It was apparent that the responses to Question 31 not only described what was best about maternity care but also contained implicit or explicit perceptions of what mattered to women about their maternity care. Response frequencies are given in Table 1, in descending order of frequency of response (and by implication importance of that facet of service).

Some categories reflect responses that are not, strictly speaking, facets of maternity care as such. These factors have been included nonetheless as they were reported with sufficient frequency to warrant inclusion as a significant response category.
### Table 1: What was experienced as ‘best’ about the women’s maternity care?

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supportive professionals (helpful, caring, supportive, etc.)</td>
<td>528</td>
<td>23</td>
</tr>
<tr>
<td>2. Provision of comprehensive information and good advice</td>
<td>317</td>
<td>14</td>
</tr>
<tr>
<td>3. Midwife (specified) service excellent</td>
<td>287</td>
<td>12</td>
</tr>
<tr>
<td>4. Competent professionals</td>
<td>239</td>
<td>10</td>
</tr>
<tr>
<td>5. Friendly, warm, kind professionals</td>
<td>236</td>
<td>10</td>
</tr>
<tr>
<td>6. Feeling safe</td>
<td>203</td>
<td>9</td>
</tr>
<tr>
<td>7. Hospital/birthcare facility staff who were flexible and accommodating</td>
<td>202</td>
<td>9</td>
</tr>
<tr>
<td>8. Attention to the woman when she needed it</td>
<td>170</td>
<td>7</td>
</tr>
<tr>
<td>9. Respect for the woman’s choices, decisions and preferences</td>
<td>165</td>
<td>7</td>
</tr>
<tr>
<td>10. A positive neonatal facility experience (hospital; neo-natal facility)</td>
<td>148</td>
<td>6</td>
</tr>
<tr>
<td>11. Continuity of services – the same professional/s, facilities, etc.</td>
<td>136</td>
<td>6</td>
</tr>
<tr>
<td>12. Receiving reassurance from professionals</td>
<td>121</td>
<td>5</td>
</tr>
<tr>
<td>13. LMC home visits – pre- and post-natal</td>
<td>120</td>
<td>5</td>
</tr>
<tr>
<td>14. Post-natal services (e.g. Plunket, LMC visits)</td>
<td>87</td>
<td>4</td>
</tr>
<tr>
<td>15. Maintaining control over one’s birth plan and birthing process</td>
<td>82</td>
<td>4</td>
</tr>
<tr>
<td>16. Specialist care available at the time it was needed</td>
<td>71</td>
<td>3</td>
</tr>
<tr>
<td>17. A positive delivery experience</td>
<td>68</td>
<td>3</td>
</tr>
<tr>
<td>18. Good hospital facilities and services</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>19. Support with breastfeeding</td>
<td>64</td>
<td>3</td>
</tr>
<tr>
<td>20. Good relationships and communication amongst the professionals involved (e.g. in delivery; in post-natal services)</td>
<td>62</td>
<td>3</td>
</tr>
<tr>
<td>21. Ante-natal classes and specialist ante-natal services (e.g. specialist mental health, cancer, diabetes services)</td>
<td>61</td>
<td>3</td>
</tr>
<tr>
<td>22. Free maternity services (of all kinds)</td>
<td>60</td>
<td>3</td>
</tr>
<tr>
<td>23. Partner and family able to participate as wished</td>
<td>53</td>
<td>2</td>
</tr>
<tr>
<td>24. Midwife-led maternity care</td>
<td>51</td>
<td>2</td>
</tr>
<tr>
<td>25. An obstetrician as LMC (vs midwife)</td>
<td>38</td>
<td>1</td>
</tr>
<tr>
<td>26. Second and subsequent pregnancy and birth experiences better than one’s first</td>
<td>33</td>
<td>1</td>
</tr>
<tr>
<td>27. Privacy (having own room)</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>28. Having a healthy baby</td>
<td>15</td>
<td>.6</td>
</tr>
<tr>
<td>29. Close proximity to services</td>
<td>12</td>
<td>.5</td>
</tr>
<tr>
<td>30. Culturally sensitive services</td>
<td>12</td>
<td>.5</td>
</tr>
<tr>
<td>31. ‘Everything’ – where the woman saw the whole maternity care service as highly satisfactory</td>
<td>11</td>
<td>.3</td>
</tr>
<tr>
<td>32. The maternity care system in New Zealand, especially shared LMC/hospital care</td>
<td>9</td>
<td>.3</td>
</tr>
<tr>
<td>33. ‘Nothing’ – where the woman saw the whole maternity care service as inadequate</td>
<td>7</td>
<td>.2</td>
</tr>
</tbody>
</table>

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9 ‘n’ refers to number of respondents who commented in each category; ‘%’ refers to percentage of respondents who commented in each category.

10 We have used the term ‘neo-natal facility’ throughout to refer to facilities other than hospitals that provide post-delivery care for women.
5.4.3 What mattered most to women?

It is apparent that what mattered most to women was to have the following kinds of support, in approximately this order of importance. Quotes here are taken from responses to both Q 31 and Q 32.

- **Supportive care from competent professionals** who collaborated and communicated well with one another

  ‘Excellent during the birth - first time I have felt in control with team effort.’

  ‘My obstetrician was calming had excellent oversight of every aspect of my pregnancy and managed my birth with a very high level of professionalism.’

  ‘Experienced midwife, quick assessment when things not going well in delivery, quick response from specialists.’

  ‘Clear communication between midwife and specialist.’

  Many women commented that having their first baby made them feel particularly vulnerable and in need of supportive services.

- **A midwife whom they liked and respected**

  ‘[Midwife] made me feel safe and secure in her care. She was very professional and respectful whilst imparting her knowledge in a loving and caring manner. She was very attentive, meticulous, culturally sensitive and genuinely sincere.’

  ‘Absolutely fantastic because she was organised, professional, trusting, included my husband at all times, friendly, caring and overall a very lovely person.’

- **Provision of timely, comprehensive and useful information and advice at all stages of maternity care**

  ‘Because this was my first baby, my LMC always told me the things I have to know at every stage.’

  ‘Midwife was always there to help me for my questions + needs. Full information & guidelines provided.’

  ‘My hospital midwife gave me enough information to make an informed choice about antenatal tests and how to feed my baby after the birth.’

  ‘Our LMC… told it like it was and was very open with us the whole time.’

  ‘LMC - she had a lot of knowledge and books to borrow - never made me feel silly when asking questions.’

  ‘The information booklet from the Health Ministry as it provided a good guideline as to what to expect during the trimester.’

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11 ‘Professionals’ includes midwives, GPs, doctors, nursing staff, lactation consultants and any other qualified personnel involved in maternity services.
• Professionals who were warm, gave them reassurance and made them feel safe
  ‘I was very scared but the doctor was great at calming me down.’
  ‘Our LMC was a great person who gave us best support and help. Her warm, lovely, natural way really helped me.’
  ‘All the anaesthetists, theatre staff & recovery room staff (I had a forceps delivery) were so lovely & caring and the hospital midwives were very encouraging too in the challenging first days!’
  ‘My midwife was excellent and I felt extremely confident with her, this enabled me to have a relaxed pregnancy and birth.’

• Receiving respect for their preferences and having control over their pregnancy and birth experience
  ‘Being able to have baby at home.’
  ‘My desires for a natural birth were fully supported and I felt in control. Being my third child I had very clear expectations.’
  ‘Even though it was my 2nd baby my LMC ensured that all information was provided and my choices were always respected.’
  ‘Midwife gave me enough information to help me make the decision before and during the labour.’
  ‘My LMC who respected my wishes throughout a difficult and long labour and birth and really went ‘beyond the call of duty’ for me staying for the full 30 hours and checking the baby after she was born by emergency c-section.’
  ‘Talking through options of pain relief throughout birth, knowing I was not getting pushed into anything.’
  ‘Obstetrician respected my wishes to as far as possible towards having a natural delivery of my twins.’
  ‘Good midwife throughout pregnancy who stood up for me during labour.’
  ‘My midwife who also does home births.’

• The availability of competent professionals and services, including specialist services, at the time the woman needed them
  ‘Best was going through a specialist from the start.’
  ‘My GP had a lot of experience and I felt like I could trust her completely.’
  ‘I needed an obstetrician to deliver our baby. She and her team were fantastic, quick, professional, helpful and I had a vaginal birth with no complications.’
  ‘Midwife is 24 hr on call even I don’t call her but I feel comfortable that she will help me anytime.’
  ‘The delivery was a caesarean unplanned and handled quickly by the surgeons.’
'I had an OB, haematologist and M/W looking after me. I also got to meet with the surgeon well before my due date. Got plenty of scans to ease my mind which was great especially after so many miscarriages.'

- A hospital or neonatal facility experience where professionals were cognisant of their vulnerabilities, and supportive and accommodating of their needs.

  ‘Everyone was excellent, baby admitted to SCBU and we were informed all the time on what was happening and made us feel at ease.’

  ‘The day nurses were brilliant. When I had a couple of problems with one of my twins, they were very helpful.’

  ‘The hospital (Nelson) was like a 5 star hotel, the nurses were wonderful. I am very lucky to have had the best maternity care and hospital stay.’

  ‘Hospital care during birth and 4 weeks in neonatal was incredible. Fantastic people!’

  ‘The hospital care was fantastic. I felt well looked after so therefore recovered faster.’

  ‘Nurses in maternity are very approachable, friendly towards me and my visitors (very important).’

  ‘Able to stay in Maternity unit for up to 5 days. Which was fantastic and they would have provided facilities for my husband to stay if needed.’

5.4.4 What was also important?

Additional facets of their pregnancy, delivery and early mothering experience that mattered significantly to women included the following:

- Continuity of service, including access to the same professional/s and facilities throughout their pregnancy, delivery and post-delivery care

  ‘My LMC was my GP who has delivered all 3 of my children so I know him well and have total trust in his ability to do the best possible for me and my baby.’

  ‘Having the same midwife all the way through the pregnancy, birth and postnatal care. I felt safe and comfortable with her and confident in her skills.’

  ‘3rd time around so midwife knows us well and knows our needs/wants to make sure these are met.’

  ‘Being able to have the same LMC for all of my children & being able to transfer to same hospital after birth.’
• **LMC home visits – pre- and post-natal**
  ‘My LMC came to my home for all the appointments. Having a toddler too I really appreciated that.’
  ‘Friendly LMC who always available - came to my home after baby was born so I didn’t have to drive to town.’
  ‘Home visits from my midwife right before my due date and following the birth of my baby first two visits from my Plunket/Karitane nurse at home.’

• **A positive delivery experience**
  ‘Hospital midwives were great during labour.’
  ‘Professional assistance in hospital when we had to have emergency caesarean.’
  ‘Our daughter was born not breathing… and the paediatric team were fantastic.’
  ‘The staff at delivery suite - excellent pre birth and birth care.’
  ‘Good communication & care from obstetrician & midwife, good birthing facilities.’
  ‘Only having her [midwife] and husband in room [homebirth]. Whereas with first child in Canada in hospital at least 6 people including me in room, all staff shouting when to push, totally overwhelmed.’

• **Good post-natal services**
  ‘Plunket have been fantastic with baby who is not gaining well. They are still visiting weekly at 41/2 months.’
  ‘The support given for the first 6 weeks from my daughter’s birth.’

• **Support with breastfeeding**
  ‘Midwives at hospital were very supportive and understanding of my baby's needs as well as mine, particularly when I had difficulty with breast feeding.’
  ‘Worked with a lactation expert while in hospital who helped me get the hang of breastfeeding.’
  ‘Hospital lactation consultant very helpful when I had severe trouble breastfeeding.’

• **Good hospital facilities and services**
  ‘Had a room all to myself in hospital - clean with own toilet and shower.’
  ‘The people and privacy I had and the cleanliness.’
  ‘Ability to attend large hospital with all facilities including epidural and c-section.’
‘The facilities were immaculate, great to have ensuite when you feel as though you have been hit by a truck.’
‘Comfortable modern facilities.’

- **Ante-natal classes and specialist ante-natal services** (e.g. specialist mental health, cancer, diabetes services)

  ‘Very professional care. Went to every length to make sure I was ok and well, both GP and specialist obstetrician.’
  ‘My fertility specialist for helping us get pregnant and my midwife. She was excellent with everything...’
  ‘Antenatal class was worth it - great information about labour/ birth.’
  ‘Antenatal classes -very informative, great social network afterwards.’

- **Free maternity services** (of all kinds)

  ‘Free things e.g. most things/visits were free, this made going to appointments/checkups more appealing.’
  ‘Having a free personal midwife - very experienced & absolutely wonderful. ’
  ‘Free visits while pregnant are very important.’
  ‘Antenatal class for free - great service.’
  ‘The amount of free care that can be accessed is excellent.’

- **Family/husband included**

  ‘My midwife allowed my partner a hands on approach to the delivery of our son and included him in all our visits.’
  ‘We were treated like family & given the opportunities to do what we wanted. My husband and 2 year old were more than welcome & provided meals.’
  ‘The friendliness and the way they made my husband and family feel when they visited.’
  ‘Our local hospital made my husband welcome, organising meals for him, nothing was too much trouble for them.’
  ‘My midwife was very good she listened and respected my husband and my choices.’
  ‘My midwives always took the time to discuss everything with me and my husband.’
Many women also identified aspects of New Zealand’s maternity care system as being valued by them. These included:

- **Midwife-led maternity care**
  ‘We had a brilliant LMC. She was able to put us both at ease and help us prepare for the birth. After the birth she helped us settle into parenthood after being kicked out of hospital. If it wasn't for our LMC I would not like to think how we would have managed.’

- **An obstetrician as LMC (vs midwife)**
  ‘Excellent having an OB as my carer - very reassuring.’

- **Privacy**
  ‘As a second-time mother, I really appreciated having my own room at North Shore Hospital after the birth.’
  ‘The single room was great. I also liked having only my midwife and my husband present at the birth - it was very intimate.’

- **Close proximity to services**
  ‘Small unit - friendly staff - close to home.’

- **Culturally sensitive services**
  ‘Whānau oriented, Māori focused, culturally comfortable.’
  ‘Understanding and empathy for me and my whānau.’

- **The maternity care system in New Zealand, especially shared LMC/hospital care**
  ‘The system seems to work really well, and I like that the whole maternal fees are free.’
  ‘What an amazing service we have here in New Zealand.’

In contrast, a few women could find nothing positive about their maternity care.
5.5 Question 32 – ‘List what you would like to stay the same’

5.5.1 Patterns in responding

This question elicited overt expressions of preference and what mattered to women. As shown in Table 2, the majority of comments focused on:

- Retaining the current maternity services system – that is, independent midwifery; shared obstetrician/midwife care; a range of care choices for women; free services\(^{12}\)
- Free maternity care
- Continuity of services and professionals for women
- The availability of home visits
- Maintaining control over one’s birth plan and birthing process, and having personal preferences respected
- Having a positive neonatal experience.

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ‘Everything’</td>
<td>360</td>
<td>15</td>
</tr>
<tr>
<td>2 Supportive professionals (helpful, caring, supportive, etc.)</td>
<td>351</td>
<td>15</td>
</tr>
<tr>
<td>3 Continuity of services – the same professional/s, facilities, etc.</td>
<td>205</td>
<td>9</td>
</tr>
<tr>
<td>4 Free services – of all kinds</td>
<td>158</td>
<td>7</td>
</tr>
<tr>
<td>5 Home visits – pre- and post-natal</td>
<td>121</td>
<td>5</td>
</tr>
<tr>
<td>6 Maintaining control over one’s birth plan and birthing process, and</td>
<td>108</td>
<td>4</td>
</tr>
<tr>
<td>having personal preferences respected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 A positive neonatal facility experience</td>
<td>105</td>
<td>4</td>
</tr>
<tr>
<td>8 Maternity system to stay the same (that is, shared midwife/obstetrician care; independent midwifery; small birthing facilities)</td>
<td>76</td>
<td>3</td>
</tr>
<tr>
<td>9 Post-natal services (e.g. Plunket, LMC visits)</td>
<td>71</td>
<td>3</td>
</tr>
<tr>
<td>10 Provision of comprehensive information and good advice</td>
<td>63</td>
<td>3</td>
</tr>
<tr>
<td>11 Good relationships and communications amongst the professionals</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>involved (e.g. in delivery; in post-natal services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Having one’s own room</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td>13 Good hospital maternity facilities</td>
<td>39</td>
<td>2</td>
</tr>
<tr>
<td>14 Antenatal classes</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>15 Sufficient length of stay in hospital (versus having to leave before ready)</td>
<td>37</td>
<td>2</td>
</tr>
<tr>
<td>16 Hospital staff flexible and accommodating</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>17 Higher level of care available where complications or risk factors</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>18 Good support with breastfeeding</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>19 Partner and family able to participate as wished</td>
<td>24</td>
<td>1</td>
</tr>
</tbody>
</table>

Responses to Q 32 closely mirrored those to Q 31. New categories in Q 32 responses were:

\(^{12}\) Many of the ‘everything’ replies implied keeping the system unchanged.
• ‘Everything’ – typically these responses referred to retaining the current maternity system
  ‘I think the system is great.’
  ‘Loved the shared care of obstetrician and midwife.’
  ‘I think it was all good and the care was great so everything should just stay the same.’

• Sufficient length of stay in hospital (versus having to leave before ready)
  ‘... being able to stay longer than 2 days at the unit to recover when I have two other children at home.’

• Higher level of care available where complications or risk factors
  ‘The anesthetist team at the hospital was wonderful despite the fact that my epidural was a nightmare and very complicated.’
  [See following section].
5.6 Q 33 – ‘List what was not good about the maternity care you received. What would you like to happen differently?’

5.6.1 Patterns in responding

This question elicited not only complaints and concerns, but also frequent emotional outpourings of the impacts that perceived inadequate service had on new mothers. It was noteworthy that women giving considerable responses to Q 33 had often left Q 31 blank, and vice versa. Table 3 lists women’s main areas of concern.

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Inadequate support or services during neo-natal facility/hospital stay (issues other than breastfeeding and poor treatment by staff); e.g. short-staffed; lack of essential staff; poor communication amongst professionals; inadequate facilities; poor services)</td>
<td>313</td>
<td>12</td>
</tr>
<tr>
<td>2  ‘Nothing’ (i.e. services satisfactory)</td>
<td>217</td>
<td>9</td>
</tr>
<tr>
<td>3  Breastfeeding support lacking (e.g. inconsistent advice; rude; critical; rough treatment)</td>
<td>177</td>
<td>8</td>
</tr>
<tr>
<td>4  Privacy and space lacking in hospital or neo-natal facility (e.g. crowded; noisy; intrusive)</td>
<td>154</td>
<td>7</td>
</tr>
<tr>
<td>5  Post-natal services inadequate (e.g. no home visits; long waits for services; inadequate follow-up; pain control poor)</td>
<td>153</td>
<td>7</td>
</tr>
<tr>
<td>6  LMC service ‘substandard’ (e.g. incompetent; too busy; overworked; inattentive; rude; long waits for appointments)</td>
<td>146</td>
<td>6</td>
</tr>
<tr>
<td>7  Insufficient time in hospital or neo-natal facility</td>
<td>142</td>
<td>6</td>
</tr>
<tr>
<td>8  Respect lacking for the woman’s preferences/autonomy</td>
<td>127</td>
<td>5</td>
</tr>
<tr>
<td>9  Hospital staff treatment poor (e.g. incompetent; rude; unkind; judgmental; lack of compassion)</td>
<td>119</td>
<td>5</td>
</tr>
<tr>
<td>10 Inadequate basic hospital services (other than maternity services; e.g. inadequate food; lack of cleanliness; dirty linen; no hot water)</td>
<td>101</td>
<td>4</td>
</tr>
<tr>
<td>11 Information inadequate (e.g. re availability of services generally; immunization; post-natal depression)</td>
<td>86</td>
<td>4</td>
</tr>
<tr>
<td>12 Particular vulnerabilities (e.g. C-section, cancer, diabetes, mental health, no English language)</td>
<td>82</td>
<td>4</td>
</tr>
<tr>
<td>13 Costs (e.g. scans; GP visits; ultrasound)</td>
<td>82</td>
<td>4</td>
</tr>
<tr>
<td>14 Continuity poor (e.g. different midwives, nurses, doctors)</td>
<td>77</td>
<td>3</td>
</tr>
<tr>
<td>15 Delivery experience bad (e.g. professional incompetence; pain relief slow; staff not available; no bonding opportunity following the birth)</td>
<td>76</td>
<td>3</td>
</tr>
<tr>
<td>16 Inconsistency across professionals (other than breastfeeding support)</td>
<td>76</td>
<td>3</td>
</tr>
<tr>
<td>17 First birth experience anxious and needy</td>
<td>62</td>
<td>3</td>
</tr>
<tr>
<td>18 Partner/family not allowed to stay during delivery or during hospital stay</td>
<td>60</td>
<td>3</td>
</tr>
<tr>
<td>19 Specialist services not available when needed (e.g. anaesthetist; obstetrician)</td>
<td>58</td>
<td>2</td>
</tr>
<tr>
<td>20 Lack of attention to mothers of second or subsequent babies</td>
<td>56</td>
<td>2</td>
</tr>
<tr>
<td>21 Difficulty finding a suitable, competent midwife</td>
<td>53</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Perceived incompetence (e.g. failure to diagnose significant illness of woman or baby; incorrect treatments)</td>
<td>48</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>23</td>
<td>Ante-natal classes and services inadequate in some way</td>
<td>44</td>
</tr>
<tr>
<td>24</td>
<td>LMC didn’t attend the birth and didn’t pre-advise their unavailability</td>
<td>39</td>
</tr>
<tr>
<td>25</td>
<td>Pain intervention inadequate around delivery</td>
<td>36</td>
</tr>
<tr>
<td>26</td>
<td>Cultural issues (e.g. ignorance, rudeness, insensitivity)</td>
<td>20</td>
</tr>
<tr>
<td>27</td>
<td>Induction issues (choice removed; poor communication; services delayed)</td>
<td>21</td>
</tr>
<tr>
<td>28</td>
<td>Hospital/neo-natal facility discharge processes poor</td>
<td>17</td>
</tr>
<tr>
<td>29</td>
<td>Lack of services close to home</td>
<td>12</td>
</tr>
<tr>
<td>30</td>
<td>Personal factors (e.g. timing of pregnancy; size of baby)</td>
<td>5</td>
</tr>
<tr>
<td>Total comments</td>
<td>2659</td>
<td></td>
</tr>
</tbody>
</table>

5.6.3 **Key areas of concern**

The areas of concern raised most often were a direct reflection again of the aspects of the maternity experience where women felt most vulnerable. Concerns voiced most frequently (45% of all comments to this question) were in relation to women’s hospital or birthcare facility stay, as follows:

- **Inadequate support or services during neo-natal facility/hospital stay** (i.e. issues other than breastfeeding and poor treatment by staff; e.g. short-staffed; lack of essential staff; poor communication amongst professionals; inadequate facilities; poor services)

  ‘I didn’t get sheets changed and no one offered to show me how to wash my baby for the whole 5 days. By day 3 I hardly saw a nurse/midwife.’

  ‘Requested to see midwife at Botany but was refused. Was my 10th pregnancy and only 3rd live birth.’

  ‘Hospital post natal ward full, midwives overworked so can’t answer call bells.’

  ‘More care for mothers in vulnerable state. Not given any real care - just left to deal with it. Shoved around hospital rooms to make room for others.’

  ‘The nurse/midwives [should] have personal pagers so you do not hear the call alarm all night.’

  ‘I had terrible pain which turned out to be adhesions... but suffered a lot because doctor kept telling me to see midwife and midwife would tell me to see doc/hospital etc.’

  ‘Post-natally on hospital ward. Shocking care by midwives. Not readily available to help with BF and even helping me lift baby out of cot when I had just had operation and attached to IV lines and in pain! I even had to ask for my vital signs to be checked after operation. I am a nurse myself and know that this is essential to be done. I am writing a letter of complaint to the hospital. I left the hospital with cracked, bleeding nipples!’

  ‘The wards at Auckland Hospital are overcrowded and understaffed. Things like, I would be woken up to feed my baby in intensive care, by the time I got out of bed the person who woke me was gone, and I would have to find someone to let me...’
into intensive care to get to my baby who didn't need feeding, but was just too hot. Not great at 3am. Feel sorry for the staff, they just had too many patients.’

‘There weren't enough nurses to help me in the ward after I gave birth by caesarean. I was in pain and often ended up juggling a catheter bag and a screaming baby without any assistance.’

‘Disagreement between hospital staff and specialist obstetrician interrupted birth of baby. Very poor communication.’

‘Being left the whole night in hospital with a catheter in that wasn't emptied & no-one to help me pick up & help me feed my baby!’

Many of the responses noted that staff were overworked and facilities were overcrowded.

‘Chch Women’s Hospital was understaffed. I was transferred within 48 hrs to Burwood Hospital (despite having had c-section) for post-natal care. This was not ideal however the poor experience I had with the ward staff at Chch Women’s meant I was quite relieved to be out of that environment.’

• Breastfeeding support lacking during neo-natal facility/hospital stay (e.g. inconsistent advice; rude; critical; rough treatment)

‘All midwives advise different methods of breast feeding which makes it very confusing.’

‘The midwives at the hospital were also so rough that I ended up with bruised breasts from them attempting to 'help' me feed. Needless to say within 2 weeks my child was on formula.’

‘My baby cried and cried at the Maternity Hospital in the days after birth cos he was hungry and I had no breast milk and it took too long before the LMCs would consider formula. I thought it was unnecessary!’

‘The nurses at the birthing unit would come and go but none (except one) actually sat with me for a minute & ACTUALLY helped me with breastfeeding properly instead of just putting the baby on then walking out everytime.’

‘Maternity staff’s staunchly pro-breastfeeding stance left me feeling guilty.’

‘The overwhelming pressure to breastfeed - I definitely gave it the best I could as wanted to succeed - but other circumstances meant I couldn't b/feed after a month. I felt like a failure and had a lot of emotional hang-ups because of the 'breast is best' drummed in to us.’
• **Hospital staff treatment poor** (e.g. rude; unkind; judgmental; lack of compassion)

  ‘I had a son at National Women's 14/08/07 it was the worst experience of my life. The nurses in the ward were awful... I had an emergency c-section, I was very comfortable after the operation however hospital staff kept insisting pain relief; at one stage I refused and did not take yet this was recorded on my charts taken.’

  ‘I have another health condition due to bowel cancer when I checked in and after my child was born, hospital staff treated me like I was a major inconvenience in spite of the fact I required no additional assistance from them. They effectively argued between wards over who should have me and upset me quite badly. I think the hospital midwives should be more considerate and less judgmental particularly as I added nothing extra to their workload.’

  ‘I felt the healthcare assistants in my 2 days staying in hospital were very nosy and intrusive. I also felt the nurse was rude to me and tried to move to a double room one day after having surgery from post birth complications.’

  ‘Poor communication during induction and after birth. Every midwife had different advice and different ways of doing things and often made us feel we were doing everything wrong.’

  ‘Some midwives at hospital very opinionated. This was not my first child.’

  ‘Once the babies were born and taken to NICU I was not encouraged to come and feed them every 3 hours (rather discouraged).’

  ‘There was 1 particular nurse who was rather curt and unsympathetic saying she would take [baby] for 15 mins (very sarcastic).’

  ‘I spent 3 nights in Akld Hospital & I had an awful midwife look after me on the 1st night. I was in tears because of how she treated me. It was an awful experience as it was my first baby & I was very emotional & overwhelmed as it was. She also told my baby how naughty he was. He was only a few hours old!’

  ‘One nurse was not very nice, ripped off my plaster covering my caesarian - most painful experience of the whole birth – cow.’

• **Privacy and space lacking in hospital or neo-natal facility** (e.g. crowded; noisy; intrusive)

  ‘Hospital staff should ask mother permission to allow groups of 'students??' into birthing suite.’

  ‘The birth care facility needs to be improved in terms of enough space and privacy because other baby crying could affect my baby and vice versa.’

  ‘My room mate has a large extended family that visited all day and both baby's and my sleep was interrupted. This is the only reason I went home early as I couldn't relax or rest properly with so many people around all the time.’

  ‘Double room in ward - would have preferred single room as had lots of visitors and did not feel other mother had privacy.’

  ‘Maternity Unit needs to expand, women were labouring out in the hallway when I went in.’
• **Insufficient time in hospital or neo-natal facility**

  ‘Length of stay at Chch Women's Hospital, we were transferred only 2 hrs after birth.’

  ‘Mothers need at least a week in hospital or birthcare especially first time mums it is very scary coming home after 3 days with a new born.’

  ‘I also felt that I had to leave the hospital earlier than I did. I stayed longer then most due to emergency c-section but felt guilty!’

  ‘I did not like being discharged so quickly after giving birth. My son was in an incubator for the first day and then I could only hold him for short periods during the second day and then I was discharged.’

  ‘I feel that 1st time mothers should be able to stay up to 5 days. 48 hrs is not long enough even for 2nd-3rd time mothers. Your milk needs to have come in.’

• **Inadequate basic hospital services** (other than maternity services; e.g. inadequate food; lack of cleanliness; dirty linen; no hot water)

  ‘When I asked to have my blood soaked sheets changed I was told I had to wait until the following day. When I checked out at 5 pm the following day I still had the same sheets. I felt it was degrading. The staff were probably doing all they could but there wasn't enough of them.’

  ‘The hospital is so stretched both staff and facilities, not enough beds even cloths as I had to wear a soiled nightgown that did not even do up as they had no others available.’

  ‘The food!! Serving watery porridge cold and jelly? I found I was hungry afterwards - most likely due to a combination of not being able to eat some of it - and the portions not being too big for a breastfeeding mum!’

  ‘It sounds crazy, but I never felt like we had enough to eat in hospital! I'm not an obese food addict or anything but with 2 of my children they forgot about our meals after delivery. My #3 (2007) was born at 3am and I couldn't get anything to eat until 11.30am.’

  ‘My bathroom was not cleaned, the food was inedible & un-nutritious - for breastfeeding mother. My catheter etc was left in a plastic bag on the floor for 2 days.’

  ‘My bathroom floor had blood stains on the floor from the previous person.’
• Partner/family not allowed to stay during delivery or during hospital stay

‘Adverse reaction to antibiotics while in hospital (after birth) and partner not allowed to stay overnight to assist when I was confined to bed.’

‘I would have liked my husband to stay at the hospital with me as I had to be induced and it was very scary and the hospital staff would not let him stay.’

‘I need to stay in ward until very close to delivery and without my husband's support. Because that is not visit time. That is terrible during labour and without anyone to stay with you.’

‘If husband/relatives could stay overnight at the hospital for the first few days it will be wonderful for new mothers, especially those have c-section.’

‘Also my husband was not allowed to stay the night (he was kicked out at midnight after an emergency c-section 2 weeks before due date) this was very hard and showed a complete lack of compassion and understanding.’

‘My husband was not allowed to stay and had to drive home, another 1/2 hour. He fell asleep at the wheel. Extremely dangerous. (Please provide a chair for husbands to sleep in, in the room, especially rural and especially after long labours!!)’

‘I got very lonely staying in hospital at night by myself. I would have felt a lot more comfortable if a member of my family would have been allowed to stay with me.’

• Specialist services not available when needed (e.g. anaesthetist; obstetrician)

‘Had to wait over 2 hours for epidural as only one anaesthetist and lots of women giving birth.’

‘I couldn't see a doctor in a timely fashion at the hospital with questions before going home.’

‘During birth I needed an epidural for pain relief and the anaesthetist was not able to administer it in the initial time. They were five failed attempts and the six attempt was successful however it was not inserted correctly as I was not receiving optimum pain relief. During contractions the pain was increasing instead of decreasing. Afterwards I found out she was a locum. I would like to see senior anaesthetist assisting locums.’

• Perceived incompetence (e.g. failure to diagnose significant illness of woman or baby; emergencies poorly attended; incorrect treatments)

‘When in hospital (baby 1 day old) aspirated. Shouted for help from midwives. No assistance came immediately. Very difficult experience! Sometimes regret not making a formal complaint!’

‘I was given episiotomy without anaesthetic or pain relief (I think it was a medical error).’

‘I had a Caesar and got an infection which they did not pick up till it was really advanced, even though I kept saying something was wrong with the wound.’
'Before giving birth to my baby I had been bleeding a lot. Midwife said no that's fine don't worry. After I had given birth I lost heaps of blood, midwife thought it was fine but it wasn't. I was given no pain killers and I had told midwife to give me the pain killers, for I can still feel the pain. No reply was given and she continued without my wishes.'

‘My baby suffers from reflux and this was not picked up even though she had it from 2 days old.’

‘They discharged me, when I got home, midwife came and visited me next day and as soon as she walked into the room she said your baby is jaundiced, why was this not picked up when I was in hospital?’

‘Mastitis was not picked up early enough which led to a 10 day stay in hospital with baby and me. Very traumatic. 1. Tongue-tie not picked up. Even though I requested check. 2. Tongue-tie lead to cracked nipples. 3. Cracked nipples lead to mastitis. 4. All preventable.’

‘Membranes left in my womb not discovered for 2 weeks, it would have made it a lot easier for me if this had been picked up sooner.’

‘Staff sent myself and baby home when my baby wasn't feeding and also baby was stopping breathing on her own very well. My husband and I found our beautiful baby cold and limp and not breathing on many occasions for the first 10 days, lucky he is a police officer [and] he brought her back to life. We went back to hospital when they accidentally made us an appointment for NICU follow up. She is now on an apnea monitor until she is 1 year old because of the severity of her reflux. We are very lucky that my husband and I were insistent otherwise we would not have our baby girl with us now.’

‘The lack of listening by doctors at the hospital. I was given 5 doses of prostens that obviously wasn't working and put through 3 days of discomfort.’

• **Hospital/ neo-natal facility discharge processes poor**

‘Being discharged very late at night was not at all professional. Myself, my family were not at all impressed. One nurse became quite unreasonable with finding a Dr to sign a script for me. That held up the lateness also.’

‘On leaving birthing unit 3 hours after giving birth (my choice), no wheelchair offered (I could hardly walk), no help!’

‘Having to leave Auckland Hospital 2 hours after birth and having to drive to birthcare.’

‘I also think it is DISGUSTING that Auckland Hospital and Birthcare cannot come to an arrangement regarding transporting women, instead we are made to get into our own cars and be driven with a very very newborn baby through the Domain and transport ourselves upstairs to Birthcare.’

‘We didn't feel confident leaving the hospital for birthcare. We didn't know how to fit the car seat and no-one helped us. Also it was very cold. Patient transport would have been better than our own car.’
Another key area of vulnerability was the delivery experience. Particular concerns voiced were (9% of all comments to this question):

- **Delivery experience bad** (e.g. pain relief slow; staff not available; no bonding opportunity following the birth)
  
  ‘Felt there was great staff at Lincoln Hospital, but under-resourced at one point as very busy and when needed help no-one available there and needed to help during delivery at the hospital.’
  
  ‘Midwife emptied her 'inbox' on cell phone whilst I was in labour - often left us for extended periods.’
  
  ‘Birthing rooms at Auckland hospital were all full - so had to wait in hallway for room to become available while in labour.’
  
  ‘Was waiting a long time in the delivery suite after giving birth to twins. Whilst waiting for a room. During this time there was very little assistance or information given re time etc. Almost felt like we’d been forgotten about.’
  
  ‘Improve communication between midwife and obstetrician.’
  
  ‘I was under the care of hospital midwives and was sent home when clearly in labour and baby born within 2 hours only of being sent home just made it back to hospital. I felt I wasn't taken seriously about being in labour even through I monitored on the machine which showed the contractions.’

- **Pain intervention inadequate around delivery**
  
  ‘Very slow on giving pain relief. Too casual attitude, when it's very scary for the one who is giving birth.’
  
  ‘I was OK but other mothers only found out about midwife's preferences towards pain relief towards end of pregnancy. By then it was too late to change. Midwives/LMC should disclose at the beginning if they are opposed to epidurals etc.’
  
  ‘Waiting for pain relief when baby got stuck for 2 hrs was terrible. It was taking so long I was offered a caesarean instead! I also ended up having pethadine (which I did not want) because the wait was so long. I am now terrified of having another baby and this happening again.’

- **LMC didn’t attend the birth and didn’t pre-advise their unavailability**
  
  ‘Was not aware until 1-2 weeks before the birth that my LMC would not be attending the birth. Would be nice if midwives could attend births or have it known much earlier that they don’t.’

- **Induction issues** (choice removed; poor communication; services delayed)
  
  ‘I felt a bit rushed to have an induction.’
  
  ‘Had to go home twice when asked in for induction as busy.’
‘Little info from midwife re options once induced - would have liked to know what she seemed to be thinking but didn’t say!’

‘I felt there was a lot of pressure placed on midwives to push for induction.’

‘Availability of an appointment at Waikato Hospital for induction. It was absolutely disgusting the first available appointment was going to have me 2.5 weeks overdue.’

‘When I was going to be induced (2 weeks overdue) the protocols and appointments were cumbersome - design a simple system.’

**Aspects of post-natal services** (e.g. no home visits; long waits for services; inadequate follow-up; pain control poor) were identified as inadequate by 7% of respondents.

‘Inadequate length of time in hospital, poor pain control when I went home I couldn't even sit down and had to breast feed standing up or lying down.’

‘Offer classes in caring for newborns - ante natal classes were good but I think first time parents especially Mums would find post natal classes in caring for newborns valuable.’

‘Care after birth not good. Not enough home visits. Visits promised but then cancelled. Too much reliance on text messages.’

‘There is a complete lack of help afterwards. It was fine at the beginning because of my midwife but after she stopped seeing me all I had was my Plunket nurse who wasn't all that helpful. She turned me away when I asked if I could pop in and get my baby weighed (my baby had trouble gaining weight) because she said the government only pays for me to get so many visits.’

‘I found it hard to get decent help - it took 7 weeks before I could feed properly, but stuck with purely breast feeding. It would have been nice to get more help and support during that time.’

‘Had to chase Plunket up about visiting me, they had not received my records yet my LMC had sent them. As a check perhaps the LMC or midwife should follow this up assuring Plunket have made contact.’

‘I felt a little unhappy about was that my post natal care seemed a bit hit & miss. This may be because it was my 4th baby or maybe she was busy with other more urgent needs.’

‘[There should be] lactation consultant appointments for all mothers e.g. 4 weeks in to ensure feeding correctly, rather than after issues arise.’

‘I had no post care from 4-8 weeks even though my LMC had advised Plunket would be in touch at 6 weeks. I was glad that I had a great baby and was coping otherwise it would have been difficult having no outside support during these weeks.’

‘GP's Plunket and Midwife that visits first 6 weeks have been a real let down. Suffered PND and was not picked up by any of the above!!!’

Seven percent of respondents identified some aspect of their LMC experience that was significantly unsatisfactory. In addition to having difficulties finding a midwife,
common problems were what women saw as ‘substandard’ LMC service. The most common concerns are expressed in the following quotes:

‘Difficult to find a midwife who was not too busy.’

‘With my first child I found it very difficult finding a midwife all to busy - and was just given a list had nothing to judge them by.’

‘Difficultly finding a midwife (independent) who was available to be my LMC. I think I phoned approximately 6 or7 independent midwives and none were available.’

‘Well there should be less clients for independent m/wives. I felt she did not spend as much time with me as poss? and ensure to every mother that they are there 24/7 for them. I felt intimidated ringing her and she was always busy with other appointments also, it felt, was too far for her to travel.!! I had to go to her office every visit for my pre-natal visits, then having to wait did not make me feel any better.’

‘I think I choose wrong LMC. At 7 months of pregnancy I wanted to change but it was too late. I could not find an LMC. I got the private but I had to pay so I had to stick with her. She was rude, not willing to give information.’

‘Horrific waiting times at clinic. LMC midwife interrupting nuc scan results and telling me my baby was Down's syndrome.’

‘I often waited more than 1 hour for each appointment and on one occasion waited over 2 hours. I have 2 other preschoolers also and this was very difficult to organise with such long waiting times.’

‘My midwife made it obvious she was very busy and had probably too many women to look after so I felt I didn't want to disturb her or be a burden, when really I needed help with a few things.’

‘I didn’t have full confidence in my LMC - she was very 'wishy washy' and unsure of any advice I asked for. It was too late to change m/w as I couldn’t get anyone else - too busy / booked up - need more midwives.’

Need more accessible info about LMCs (i.e. individual midwives) to assist newly pregnant couples make an important decision, rather than just picking a name at random.

Other concerns voiced by respondents were:

- **Respect lacking for the woman’s preferences/autonomy**

  ‘LMC didn’t want me to deliver standing - should have complete flexibility in birth position.’

  ‘The duty doctor at the hospital didn't want to give me the gel because she didn't want an overnight delivery so she sent us home and re-booked me for a water break the next morning without any discussion fortunately when her shift ended the next morning and a new doctor started she was a bit more flexible and kind! And let is try the gel. It was terrifying the night before how little control or consultation we had.’
‘... so much pressure on you to breastfeed and you are made to feel extremely guilty if you choose to bottle feed.’

‘Anaesthetist didn't listen about where to put the drip etc.’

‘More objective instead of pushing a philosophy. I was told by the first midwife I approached that if I was already considering an epidural I should go somewhere else.’

‘Doctors need to listen to the woman more. We know when not feeling that great.’

‘My midwife was terrible. She was overworked, impatient, arrogant, ignored our wishes and never listened.’

‘Truthfully asked for more pain relief but denied, they said too far along. Would have liked wishes respected.’

- **Information inadequate** (e.g. re availability of services generally; immunization; post-natal depression)
  
  ‘Just more information about what's out there and available for new mothers.’
  
  ‘More info given to midwives about ante/post natal depression.’
  
  ‘More info on formula feeding - wasn't able to continue breast feeding and felt like I was doing my baby a huge disservice as everything geared to breast is best.’
  
  ‘Would have liked to go to Birthcare after baby born even though she was born at home - didn't know I could do this.’
  
  ‘I would have like to have received more info on the prevanar vaccination to make an informed decision.’
  
  ‘I would like to have been offered both sides of the immunisation debate. I support Immunisation but the info provided felt more like coercion then informed choice.’
  
  ‘I was not informed that introducing cows milk formula too early might affect my baby's immune system. My son was diagnosed with multiple food allergy at three months including cows milk.’
  
  ‘More info regarding maternal screen test (blood).’
  
  ‘I do think more information could be given or the option of blood screening giving your chances of Down’s Syndrome.’
  
  ‘More info for 1st time mums about caring for your body after the birth e.g.: squirting lots of water down below to keep it clean + infection free (I was told to just do it if it hurt when I pee'd and my stitches got infected).’
  
  ‘We would like to be better informed about antenatal + postnatal classes. Regarding how to eliminate the chances of antenatal and postnatal depression.’

- **Particular vulnerabilities** (e.g. C-section; cancer; diabetes; mental health; limited English language)
  
  ‘More flexibility on visits for diabetic patients.’
‘Maybe with a 3rd degree tear you could have the option to stay in hospital instead of Birthcare? I would have preferred this.’

‘I hope more midwife can speak Chinese, also in the hospital language barrier is a really big problem for us.’

**Costs (e.g. scans; GP visits; ultrasound)**

‘There should be no charges for stays at birthcare; one week should be free for a woman whether they gave birth there or not.’

‘I shouldn't have to pay for every ultrasound - just because Horizon was fully booked every time I needed an ultrasound done.’

‘... refund of doctor's visit to determine pregnancy it should be covered under maternity care.’

‘... a baby that was in NICU for 48 hours I had to pay for an extra 24 hours so that I had the confidence to be able to do this.’

‘I would like to see obstetric care made available and cheaper for all woman, instead of "free" meaning midwife care.’

‘If required to have growth scans don't think you should be charged.’

**Continuity poor (e.g. different midwives, nurses, doctors)**

‘Lack of continuity care while in hospital - a different doctor every shift asking same questions.’

‘Perhaps also having midwife a lot longer! Once Plunket get involved you really feel alone! I.e. Midwife has had nearly a year to get to know you. Then a stranger takes over when I and many other woman are still very fragile.’

**Inconsistency across professionals** (other than breastfeeding support)

‘Specialist to make a decision to induce me and then once transferred to another hospital to then have to wait another 14 hrs before it was finally done - why not done as 1st recommended.’

‘I had a pregnancy condition called 'obstetric cholestasis'. The only frustrating thing about being in hospital was that every consultant had a different view of treatment - so there didn't seem to be a consistent plan for me.’

‘Although all nice, each shift change bought differing systems and things I was told. Very confusing and upsetting for first time mums.’

‘Too many different m/w swapping care @ hospital giving conflicting advice.’

‘I developed gestational diabetes and was therefore required to see the hospital obstetricians. Each time I went it was a different person and I feel they incorrectly advised me. I had to be induced 2 weeks early.’
• First birth experience anxious and needy

‘Not to be so laid back with first time mums. There is a reason they have phoned you and don’t make them feel guilty about phoning for no reason, the mum thinks there is.’

‘It was my first baby and I think first time mothers need as much assistance as possible (due to the fact it was busy though). I only had one night with baby in room and felt when I got home I had no idea what the sounds etc she makes, when to feed?’

‘I was lucky to birth after midday so got 3 nights in hospital. If baby had arrived half an hour earlier I would have only had 2 nights - this is ridiculous especially for a first time mother.’

• Lack of attention to mothers of second or subsequent babies

‘I think that mothers who have had babies before should still be treated like 1st time mothers too, staff should still make sure that they are fine.’

‘I occasionally felt as thought I wasn't as important as the other first time mums. This was my second baby (I supposedly knew already) as some of my scheduled post-natal appointments were put off... I think I got more attention with my first baby (same midwife) and this upset me because there is a 3 year 8 month age gap so I had to re-learn a lot.’

‘As it was my second child I didn't have the continuity of midwife care at Birthcare - had 5 different midwives (Birthcare not LMC) over the 48hrs I was there. Much better for 1st child where I had the same midwife looking after me for the entire 3 day rota.’

‘Follow-up care from Queenstown midwife was very slack. As it was my second baby, was left to my own defences, even though I had difficulty feeding and little family support.’

‘I felt that because it was my 3rd child I was neglected in favour of 1st time mum’s - especially as they knew I had had probs breastfeeding in the past.’

• Ante-natal services and classes inadequate in some way

‘I went to the emergency room with bleeding early in my pregnancy. They kept me in a room for a while, then sent me home with a "50% chance" of losing the baby. After spending the next 20 hours very sad and scared, I had an ultrasound which showed the baby was fine and the subchorionic tear causing the bleeding would likely heal itself. I don’t understand why the E/R didn't send me upstairs for an ultrasound while I was there.’

‘Ante-natal - impractical, largely irrelevant (e.g. you made to be past your first trimester yet they spoke about the first 3 months eating) and too mainstream like the birth video was unrealistic.’

‘Antenatal classes not very helpful - too much focus on 'giving birth'. Much more time / info should be spent on how to look after new born!’
‘Now I’m 6 months down the track I see practical everyday baby care basics it would have been good to have had covered in my antenatal classes retrospect. (it focused too much on the birth & not the ‘what happens next!’).’

- **Cultural issues** (e.g. ignorance, rudeness, insensitivity)
  
  ‘Treatment of Indian mums & their whānau ... - cultural training & much much more money.’

  ‘Fund/support ‘Māori’ Health Providers better to help the population with the worse health statistics (Māori). Narrow the disparities between Māori and Non-Māori, but make sure it is actually happening and not just a report, recommendation or lip service!’

  ‘Other than have all my whānau come in at once the day I gave birth because they were leaving Whakatane. I thought was a bit silly to ask most of them to leave cos you’re only allowed 2 visitors at a time. I think they should be more lenient considering they were leaving to go back to their own lives and it was only for 30 minutes.’

- **Lack of services close to home**
  
  ‘I’m glad that my parents live close to the hospital so I could stay with them after being discharged because I live 40kms from Hamilton. I feel that there is not a lot of opportunity to bond [baby in incubator] when that happens.’

  ‘It would have been nice if my midwife lived closer (it was 1.15 hour drive) I couldn't find a midwife who does home births in my area.’

However a large number of women (9% of respondents) reported ‘nothing’ lacking in their maternity care experience.

  ‘Nothing - a very positive experience.’

  ‘Nothing - I was very happy with all care received.’
Aspects of maternity care identified in the open-ended questions but not covered in the quantitative questions

Responses to the open-ended questions revealed a number of areas of maternity care important to women but not covered in the quantitative questions. These included:

- Information about pregnancy and the birth process
- Information about how and where to find a midwife, and criteria for making a choice of midwife
- How to make a complaint about incompetent or other unsafe or inadequate care
- Information about neonatal facilities and their policies (e.g. around accommodating the presence of partners and families)
- The adequacy of basic (non-maternity) hospital services (e.g. cleanliness; availability of linen, hot water)
- The availability of specialists when needed (e.g. anaesthetists, obstetricians, surgeons)
- Availability of specialist services, pre- and post-natally (e.g. mental health, diabetes, oncology)
- Issues around induction
- Post-natal support generally, and in particular around breastfeeding and basic parenting skills (e.g. bathing, coping with a crying baby)
- Whether services were culturally sensitive.

It was also noteworthy that the warmth and friendliness of LMCs and other professionals mattered almost as much to women as receiving competent care. This reflects the vulnerability that women experience around pregnancy, birth and the early weeks of parenting.
6. Conclusion

The 2007 survey demonstrates some clear service changes since the 2002 survey, as well as highlighting some new information.

Improved service to women is evident from the increase in the proportion of women who know that they have to register with an LMC and who know the name of the Well Child Providers which will provide her with Well Child visits. Care plans are in greater use and the role of the back-up LMC is better understood. Information about the need for antenatal tests, immunisation and the Ministry’s “Your Pregnancy” booklet is well distributed. Nine out of ten women gave birth and received post-natal care where they wanted or intended to. A similar proportion expressed overall satisfaction with their hospital stay. Post-natal home visits made by the LMCs have also increased over the last five years and 96% of babies have had their six-week check from the GP.

However, compared to the findings of the 2002 survey, there has been a significant increase in the percentage of women who have difficulty in finding a suitable LMC. Reasons given were that midwives appear to be too busy, or that there is a shortage of midwives in that area. Asked to indicate when they left hospital, 14% of women returned home within 12 hours after the birth of their baby. This percentage is statistically larger than the 8% of women who said they returned home within 12 hours in the 2002 survey. While the great majority of women (85%) were content to be discharged when they were, 13% of women participating in this survey reported not being ready to leave hospital - irrespective of when they actually left hospital.

Although the format of the questionnaire used in the present survey departed in some minor way from the format used in the previous (2002) survey, resulting in a decrease in comparability, it was thought to be necessary in order to provide a more robust baseline from which to measure progress over the next few years.

Gerard Zwier
Pam Oliver
Michele Lennan
Kellie Spee
7. Appendices

7.1 Letter accompanying the questionnaire:

The text of the letter is as follows:

Dear <Name>

This survey is being sent to all women who gave birth in New Zealand in April or May 2007. We are interested to know what you think about the maternity care you received during your pregnancy, childbirth and until six weeks after the birth.

Please take the time to fill out the enclosed questionnaire. Your participation in this survey will help to advise the Ministry of Health about maternity services. The more women who participate in the survey, the more useful the results will be.

Your response will remain anonymous. Each form is numbered simply to enable maternity statistical data to be included in the survey results. The confidentiality of the information will be protected throughout the survey process.

The questionnaire will only take a few minutes to complete. When you have finished, place it in the attached freepost envelope (no stamp is required) and put it in the mail. If you really do not wish to participate in this survey, just return the blank questionnaire in the freepost envelope provided.

If you need help to complete the questionnaire, please call 0800 639 686 so that someone can help you.

If you wish to complete this questionnaire online, please visit www.MaternitySurvey.org.nz and enter the number that is on the questionnaire in the space provided.

Please return your response by 24 October 2007.

We hope you take this opportunity to have your say.

Thank you very much for your assistance.

Yours sincerely,

The letter was signed by Geraldine Woods, Deputy Director-General, Ministry of Health
7.2 List of Maternity facilities

(Secondary maternity catchment area indicated by thickened line)

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7.3 Glossary

“Authorised Practitioner” means an Anaesthetist, General Practitioner, Midwife, Obstetrician, Paediatrician or Radiologist who has completed the Ministry of Health’s application form for authorisation of practitioner and has received written authorisation from the Ministry of Health to provide Maternity Services. An Authorised Practitioner includes both practitioners working in their individual capacity and practitioners who are employed by or affiliated to an Organisation.

“Back-up to a Lead Maternity Carer” means an Authorised Practitioner who has a formal agreement with the Lead Maternity Carer to provide Maternity Services to women registered with the Lead Maternity Carer when the Lead Maternity Carer is not available to provide these services.

“Breastfeeding” is defined as exclusively, fully, or partially. “Exclusive Breastfeeding” means that, the infant has never, to the mother’s knowledge, had any water, formula or other liquid or solid food. Only breast-milk, from the breast or expressed, and prescribed medicines, defined as per the Medicines Act 1981, have been given to the baby from Birth. “Fully Breastfeeding” means the infant has taken breast-milk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the previous 48 hours. “Partial Breastfeeding” means the infant has taken some breast-milk and some infant formula or other solid food in the past 48 hours.

“Care Plan” means the process by which the Lead Maternity Carer and the woman develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to this woman.

“District Health Board” means an organisation established as a District Health Board by or under section 19 of the New Zealand Public Health and Disability Act 2000.

“First Birth” means that a woman has not previously experienced a Birth. “Birth” means a delivery of a baby (or babies for a multiple birth) after a minimum of 20 weeks 0 days gestation and/or with a birth weight over 400 grams.

“Homebirth” means a Birth that takes place in a person’s home and not in a Maternity Facility or Birthing Unit.

“Home Visit(s)” means a domiciliary consultation between the woman/baby and the Authorised Practitioner at the home where the woman/baby is domiciled (or at a Maternity Facility where the woman has been discharged as an Inpatient but the baby remains as an Inpatient).

“Lead Maternity Carer (LMC)” means an Authorised Practitioner who is a General Practitioner with a Diploma in Obstetrics (or equivalent, as determined by the New Zealand College of General Practitioners), a Midwife or an Obstetrician who has been selected by the woman to provide her Lead Maternity Care as described in clauses C3 & C4 of the Section 88 Maternity Notice.

“Pregnancy & Parenting Education” means an antenatal course provided to a group of women as described in the relevant service specification issued by the Ministry of Health.
“Primary Maternity Facility” means a facility that has no inpatient Secondary Maternity service and does not have 24-hour on-site availability of Specialist Obstetricians, Paediatricians and Anaesthetists.

“Secondary Maternity” means the provision of comprehensive specialist services, as described in the relevant service specification issued by the Ministry of Health. The service is provided during the antenatal, labour & birth and post-natal periods for women and babies who experience complications and who, in reference to the Referral Guidelines, have a clinical need for referral to specialist services for either consultation or transfer on a planned or emergency basis.

“Specialist” means an Authorised Practitioner who is an Anaesthetist, Obstetrician, Paediatrician or Radiologist.

“Specialist Neonate” means specialist care for neonates who are born with additional needs or develop additional needs prior to discharge, as described in the relevant service specification issued by the Ministry of Health.

“Subsequent Birth” means that a woman has previously experienced a Birth (excluding a Vaginal Birth after Caesarean Section).

“Well Child Provider” means a health care provider who provides health education and support for babies and children as described in the Well Child Tamariki Ora National Schedule.

6 Definitions are from the Section 88 Maternity Notice (2002), except for those in italics.