Maternity Consumer Survey 2011

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MINISTRY OF HEALTH
MANATŪ HAUORA

Foreword

I am pleased to present the results of the 2011 Maternity Consumer Survey. The Maternity Consumer Survey provides an opportunity for women to have their say on the maternity services they receive during pregnancy, birth and in the postnatal period. It helps the Government and the Ministry of Health to understand what is important to women, what is working well, and where improvements could be made.

Previous surveys were undertaken in 1999, 2002 and 2007. The 2011 survey introduces a more consistent question format that can be used in future surveys and allow surveys to be compared over time.

For the first time, the 2011 Maternity Consumer Survey also includes a separate survey of bereaved women who have lost a baby between 20 weeks pregnancy and four weeks of age. The inclusion of this survey is the result of feedback from consumers about the importance of giving a voice to women who have lost their babies.

I would like to thank Sands NZ, which provided valuable support to help prepare for this survey of bereaved women and ensure it was undertaken with care and sensitivity.

The results of the survey will provide important information for the local maternity quality and safety programmes being set up in each DHB as part of the Government's Maternity Quality Initiative.

I trust that maternity consumers and their organisations along with DHBs, maternity practitioners and other maternity service providers will read this report with interest. The results of the 2011 Maternity Consumer Survey will contribute to ongoing improvement in the maternity services received by women, their babies and their families.

Hon Tony Ryall
Minister of Health

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Introduction

The publication of the 2011 Maternity Consumer Survey draws together two reports produced by the contracted providers of two separate surveys:

- a survey of women who had live babies which was carried out by Nielsen NZ (the main survey)
- a survey of bereaved women who had lost a baby between 20 weeks of pregnancy and four weeks after birth, which was carried out by Research New Zealand.

The document is divided into two sections. The first covers the main survey and the second covers the survey of bereaved women. Each section contains the background, methods, results and analysis of the respective survey. These sections have been edited and formatted to conform to Ministry of Health communication standards but their content is from reports to the Ministry by the survey providers. The discussion, analysis and any recommendations represent the work of the providers and do not necessarily reflect Ministry policies.

The original questionnaires from both surveys are available on the Ministry of Health website at www.health.govt.nz. In the case of the main survey, this is the actual questionnaire form received by survey participants in the post. In the case of the survey of bereaved women (which was carried out by telephone), the questionnaire shows the question format used by telephone interviewers. Also available on the website are the introductory letters that invited recipients to participate in the respective surveys.

Maternity Consumer Satisfaction Survey

Executive summary

This report presents the findings from a survey of women who gave birth in July or August 2010. It measures women's satisfaction with the care received during their pregnancy, during the birth and in hospital after the birth, and up until six weeks after the birth.

A total of 3235 women completed the survey, representing a 41 percent response rate. Over three-quarters (78%) of women were satisfied with the overall maternity care they received. Satisfaction among young mothers, and Māori and Pacific women was in line with average satisfaction among all women. However, satisfaction among women with disabilities was significantly lower than for all women.

Table 1: Satisfaction with maternity care

Percent satisfied ('very satisfied' or 'quite satisfied')	Total (%)	Young mothers (%)	Māori women (%)	Pacific women (%)	Women with disabilities (%)
Overall care received	78	75	75	80	59
Quality of information readily available	85	83	83	86	74
Quality of antenatal classes	72	71	69	77	73
Care received from all health professionals before the birth	87	85	84	87	79
Way in which they were cared for during the birth	87	85	86	89	76
Care received during their hospital stay, following the birth	77	76	80	79	73
Care received at home following the birth	86	84	86	87	74
Overall care received from LMC	89	86	88	90	79

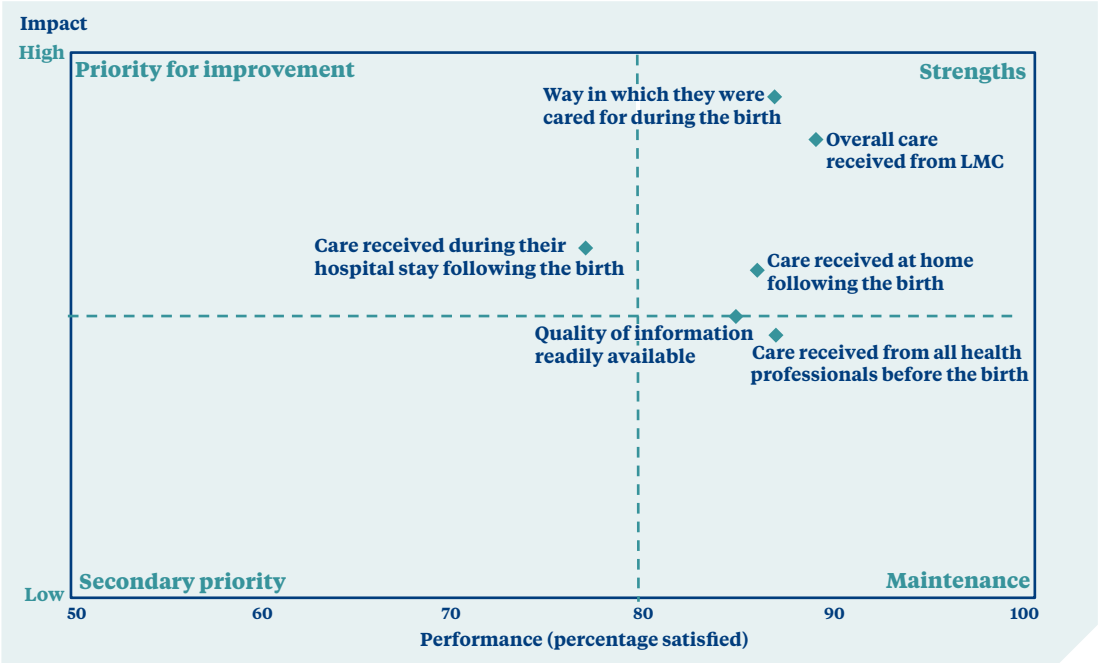
Looking at the different areas of maternity care, overall care received from lead maternity carers (LMCs) showed the highest level of satisfaction (89% 'very satisfied' or 'quite satisfied'), with the quality of antenatal classes receiving the lowest rating of satisfaction. Women with disabilities were less satisfied across all areas of care, with the exception of antenatal classes.

Regression analysis was carried out to identify which aspects of maternity care had the greatest impact on women's satisfaction with the overall care they received. The relationship between the 'performance' of each aspect of care (meaning the percentage of women satisfied) and the impact of that aspect on overall satisfaction is shown in Figure 1. This enables the identification of priority areas for improvement.

Care received during hospital stays following birth is identified as a priority for improvement. It had the third largest impact on women's satisfaction, yet satisfaction with this area of care was comparatively lower than other aspects of care.

Looking at specific aspects of care relating to women's hospital stays, staffing issues, such as getting enough care from hospital ward staff and availability of expertise, contributed more to the lower levels of satisfaction than the quality of care received.

Figure 1: Improving overall satisfaction



The following table summarises each area of maternity care surveyed. The individual aspects of care within each area are separated into those identified as strengths and those identified as priority areas for improvement.

Based on the responses of all women, the 'care during the birth' and 'care received from LMC' categories have no areas identified as priorities for improvement. However, women with disabilities were more likely to be dissatisfied with these areas of maternity care.

Table 2: Summary of each area of maternity care

Areas of maternity care	Aspects of care that are strengths	Aspects of care to focus on
Care during the pregnancy	Convenience of location where appointments took place Referrals made by LMC Responsiveness to health needs Time spent with LMC	Familiarity with people who would care for the mother should, for any reason, their LMC be unavailable
Information sources	Information on pregnancy in general Information on childbirth Information on management of pain	Information about selection of LMC
Care during the birth	Confidence in skills of people Having decisions respected Guidance on what to do Communication on what was happening/progress throughout Communication between all people involved	
Care during hospital stay, following the birth	Caring manner of hospital ward staff	Getting enough care from hospital ward staff Available expertise
Care at home, following the birth	Advice given to the mother on caring for themselves Physical checks of the baby	Physical checks of the mother
Care received from LMC	Arriving in sufficient time before the birth Being present throughout the birth There for enough time after the birth	

Background and objectives

Background

The Maternity Consumer Survey aims to assess women's perceptions of maternity services. It enables the Ministry of Health to measure progress on current policies and informs future planning. This is the fourth survey of satisfaction with maternity services amongst women who have had live births. Previous surveys were carried out in 1999, 2002 and 2007. This research involved women who gave birth in July and August 2010.

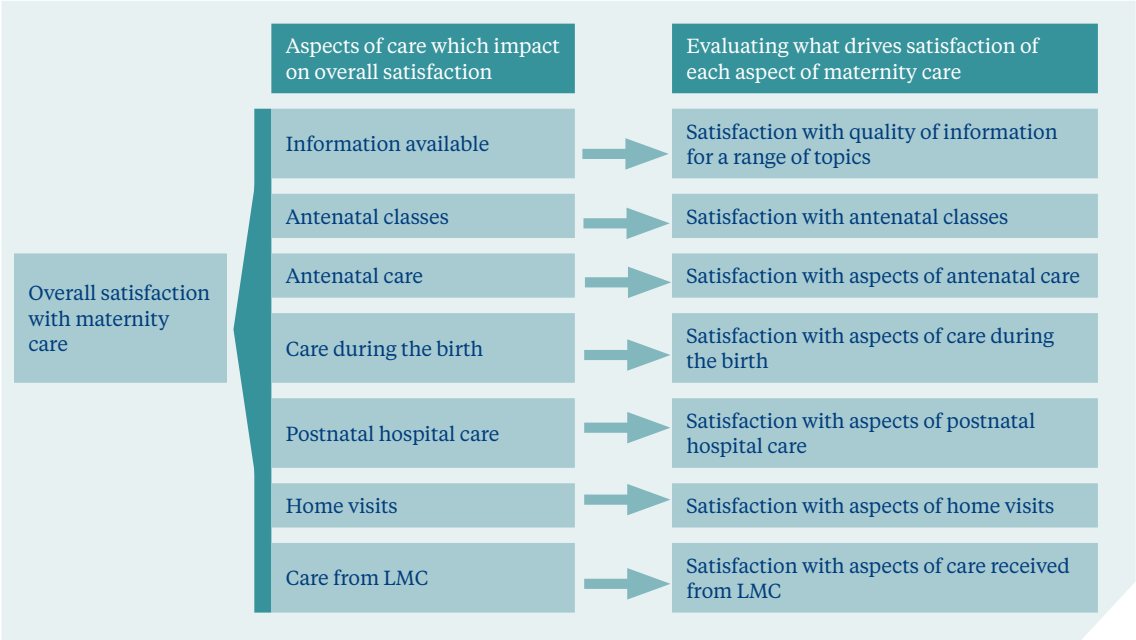
The design of the 2011 survey took into account the previous surveys.. It introduced a single, consistent question format to ensure that future surveys will be able to provide trend data for comparisons over time

Objectives

The survey split maternity care into areas and looked at satisfaction within each area. The relative impact each area had on women's overall satisfaction with maternity care was calculated, allowing priority areas for improvement to be identified.

The following diagram shows the different areas of maternity care covered in the survey.

Figure 2: Areas of maternity care



The research aimed to establish the relative impact of each area on overall satisfaction, and also drill down into the individual aspects of maternity care to understand what drives satisfaction with each individual aspect of maternity care.

The research highlights differences among the following groups of women:

- Māori and Pacific women
- young mothers
- women with disabilities.

Methodology

Pilot survey

Prior to the survey being carried out, a comprehensive pilot was undertaken, and consultation relating to the questionnaire took place with the following stakeholders:

- the Ministry of Health
- the New Zealand College of Obstetricians and Gynaecologists
- the New Zealand College of Midwives
- TAHA – Well Pacific Mother & Infant Service
- the Maternity Services Consumer Council.

All survey material was also pre-tested among eight women (including two Māori, two Pacific and four under 25 years of age). The main purpose of this was to identify any question wording that would cause confusion and whether there were any barriers to taking part in the research.

The pilot survey commenced in March 2011. The Ministry of Health provided Nielsen with details of women from the live births data for July and August 2010, and 300 European, Māori and Pacific women were randomly selected to participate in the pilot survey (100 from each ethnic group). All 300 women were sent the survey in the post (to the residential address they had provided at the time of the birth), along with a covering letter outlining the nature of the survey. A reply-paid envelope was provided so the survey could be returned and processed.

The survey was also available online, and women were provided with an 0800 number to call if they had any questions about the survey. The intention was to send a reminder postcard to all Māori and Pacific women after two weeks (as previous research had indicated a low response could be expected from these women). If they had still not completed the survey, a follow-up phone call would be made. As phone numbers are not recorded on the live births database, addresses were matched back to phone numbers.

Due to a printing error, a reminder postcard was unable to be sent to Māori and Pacific women. However, the follow-up phone calls were still carried out during the pilot.

The two key findings from the pilot survey were:

- only 22 percent of addresses were able to be matched to phone numbers
- the majority of women rated all aspects of maternity care as ‘very important’, when asked directly what aspects were important.

Because only a low number of phone numbers were matched to addresses, it was decided that for the main survey all women (rather than just Māori and Pacific women) would be included in the follow-up phone calls. It was also decided that the importance of each aspect of maternity care would be more accurately measured through regression analysis, identifying the correlation with women’s overall satisfaction rather than directly asking women to rate importance.

The introduction of regression analysis reduced the number of questions in the survey, as women were not asked to individually rate the importance of each aspect of maternity care.

The pilot survey also incorporated changes that were aimed at improving on the previous surveys that had been carried out. The surveys carried out in 1999, 2002 and 2007 included a range of ‘closed’ and ‘open-ended’ questions, which did not necessarily provide an accurate measure of satisfaction (for example women who experienced poor maternity care may have been more likely to voice this in ‘open-ended’ questions compared with those who experienced excellent maternity care).

The 'closed' questions in previous surveys also featured inconsistent scales, which impacted on analysers' ability to conduct statistical analysis (such as regression analysis). As a result the majority of the questions were changed in 2011 so that response options were consistent throughout the survey (predominantly a five-point scale). In addition, the pre-testing and consultation carried out prior to the pilot identified question wording from previous surveys that could be improved or revised, making it easier for women to complete the survey.

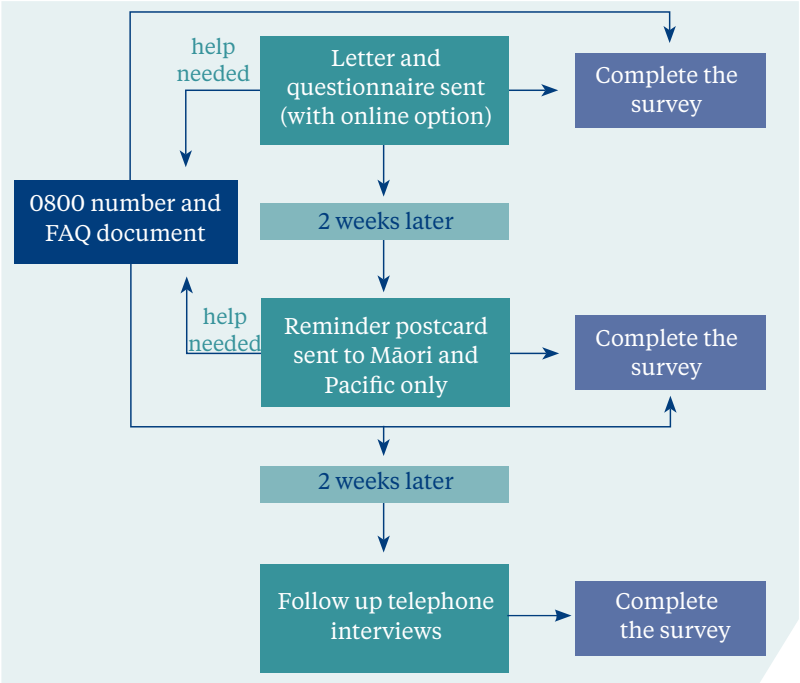
These changes meant the 2011 survey results were not strictly comparable with previous surveys. No direct comparisons with previous surveys have been made throughout this report.

Comprehensive consultation and pre-testing of the survey in 2011 has ensured that the survey is in a format that will provide valuable information to the Ministry of Health both now and in the future.

Main survey

The approach for the main survey was very similar to that of the pilot survey.

Figure 3: Survey approach



During the main survey, a reminder postcard was sent (after two weeks) to all Māori and Pacific women in an attempt to maximise the response from these women. Previous research had indicated the response from these two ethnic groups would be lower than average.

Target population

According to the live births data 8593 women gave birth during July and August 2010. This was the target population for the research.

Three-quarters of women who gave birth during July and August 2010 were under the age of 35.

Nearly two-thirds of women who gave birth during July and August 2010 were European. Around two in 10 were Māori.

Figure 4: Age

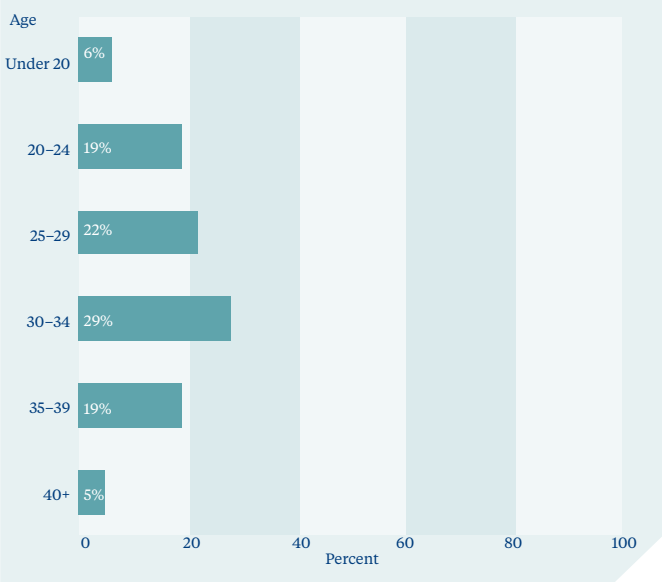
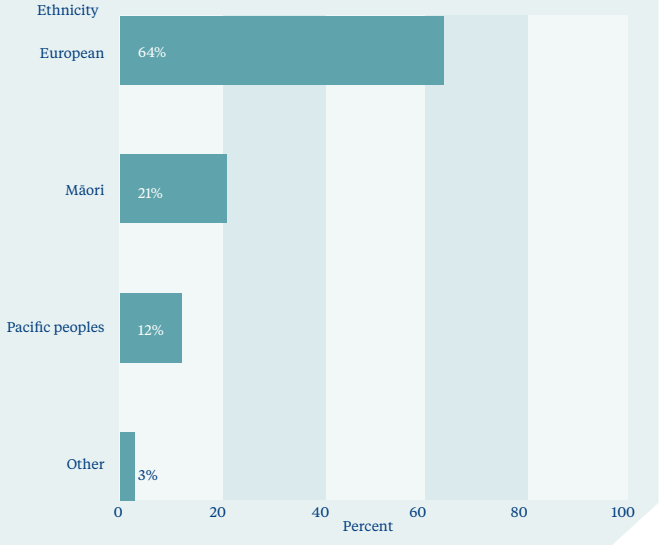


Figure 5: Ethnicity



During July and August 2010 the most births occurred in the Counties Manukau District Health Board (DHB), followed by Waitemata and Canterbury DHBs.

Table 3: DHB where birth occurred

DHB	Percent
Auckland	9
Bay of Plenty	5
Canterbury	10
Capital & Coast	6
Counties Manukau	13
Hawke's Bay	4
Hutt Valley	3
Lakes	2
MidCentral	4
Nelson Marlborough	3
Northland	4

DHB	Percent
Otago	4
South Canterbury	1
Southland	3
Tairawhiti	1
Taranaki	3
Waikato	9
Wairarapa	1
Waitemata	11
West Coast	1
Whanganui	1

Sample size

A sample of 3235 women was achieved. The sample under-represented women under the age of 25 and over-represented women between 30 and 39 years of age.

The sample was also skewed towards European women.

Figure 6: Age

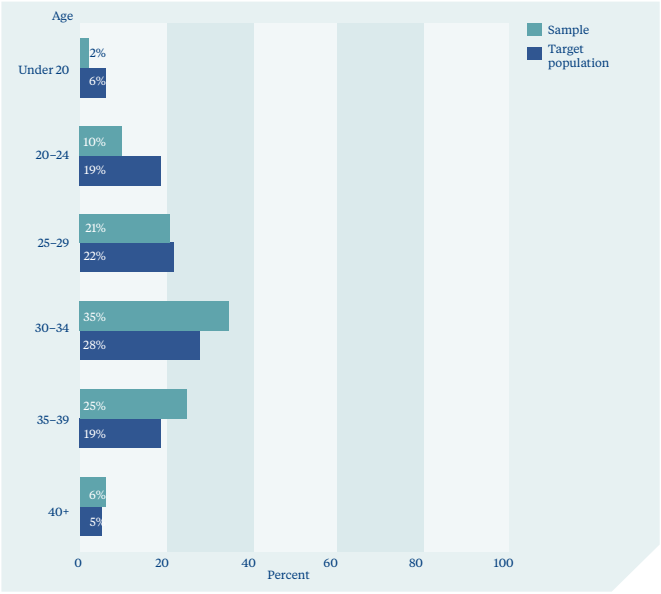
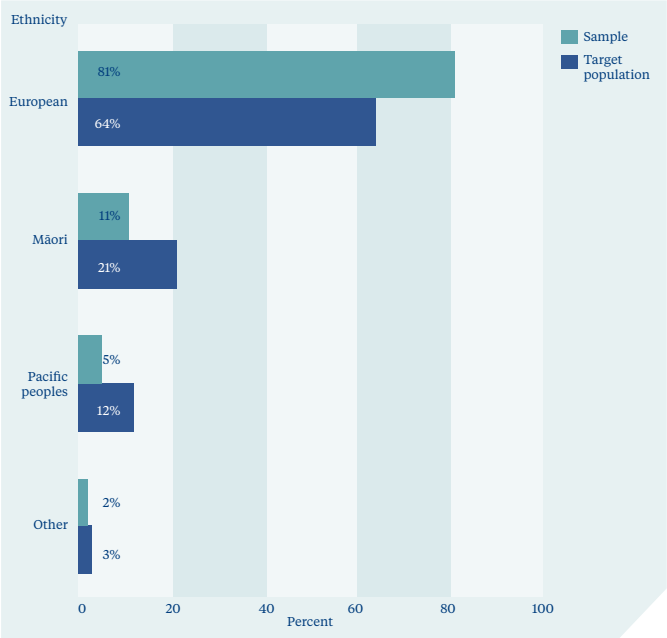


Figure 7: Ethnicity



With the exception of the significant under-representation of Counties Manukau DHB and the over-representation of Canterbury DHB, the sample almost matched the proportion of births in each DHB from the target population.

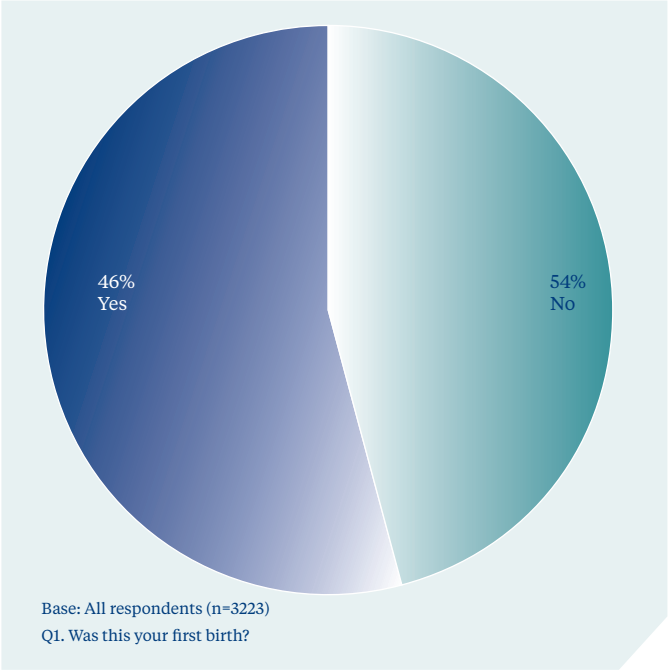
Table 4: DHB where birth occurred

DHB	Target population (%)	Sample percent (%)
Auckland	9	9
Bay of Plenty	5	4
Canterbury	10	13
Capital & Coast	6	7
Counties Manukau	13	8
Hawke's Bay	4	4
Hutt Valley	3	4
Lakes	2	2
MidCentral	4	4
Nelson Marlborough	3	4
Northland	4	3

DHB	Target population (%)	Sample percent (%)
Otago	4	5
South Canterbury	1	1
Southland	3	3
Tairawhiti	1	1
Taranaki	3	3
Waikato	9	10
Wairarapa	1	1
Waitemata	11	11
West Coast	1	1
Whanganui	1	1

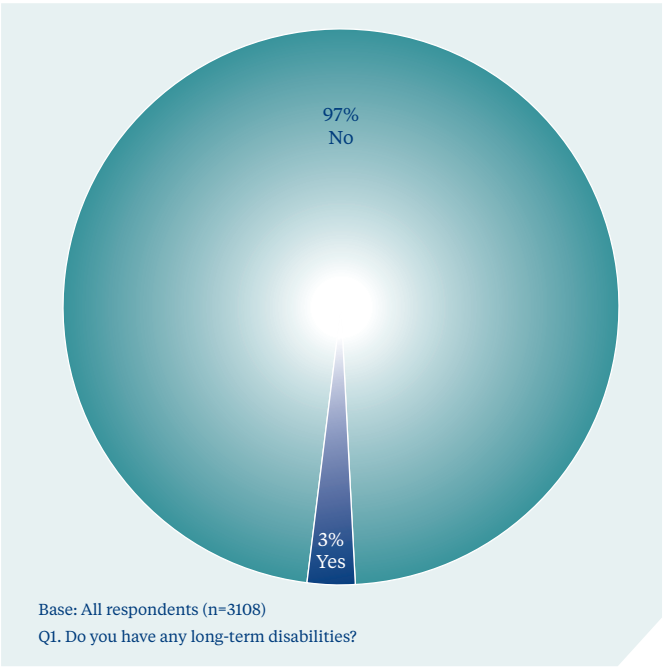
Although no information is available for the target population on the proportion of women with disabilities or having their first birth, the following charts illustrate the prevalence of these characteristics among the women who participated in this research.

Figure 8: Proportion of women for whom it was their first birth



Base: All respondents (n=3223)
Q1. Was this your first birth?

Figure 9: Proportion of women who had a disability



Base: All respondents (n=3108)
Q1. Do you have any long-term disabilities?

Response rate

Surveys were sent to 8286 women; 3235 were completed and returned for processing. Taking into account the 368 surveys that were returned to sender, the response rate for the survey was 41 percent. This is higher than the response rates achieved in previous research.

Table 5: Response rates

2002 (%)	2007 (%)	2011 (%)
39.6	37.5	40.9

Efforts to increase response among Māori and Pacific women were of only limited success.

Table 6: Response rates by ethnicity

Ethnicity	2007 (%)	2011 (%)
European	48.9	51.0
Māori	20.1	23.2
Pacific	13.8	17.1
Other	31.3	28.6

A slightly lower response rate was achieved among women under the age of 25, compared with the research carried out in 2007.

Table 7: Response rates by age group

Age	2007 (%)	2011 (%)
Under 20	17.8	15.8
20–24	22.0	21.8
25–29	38.1	39.0
30–34	45.6	50.3
35–39	46.8	53.0
40+	49.2	46.7

Response rates by DHB are shown below. The highest response was from the Otago DHB area, and the lowest was from the Counties Manukau DHB area. No comparative information was available from the previous research.

Table 8: Response rates by DHB

District Health Board	2011 (%)
Auckland	38.6
Bay of Plenty	39.4
Canterbury	47.8
Capital & Coast	45.0
Counties Manukau	25.7
Hawke's Bay	41.9
Hutt Valley	44.5
Lakes	40.6
MidCentral	40.0
Nelson Marlborough	52.6
Northland	36.9
Otago	55.6
South Canterbury	54.2
Southland	46.6
Tairawhiti	30.8
Taranaki	38.9
Waikato	43.7
Wairarapa	44.6
Waitemata	40.1
West Coast	44.8
Whanganui	45.5

Weighting

The data has been weighted by age and ethnicity to account for the under-representation of women under 25 years of age, and Māori and Pacific women.

This process ensures that the views of women under 25 years of age and Māori and Pacific women are given more weight so that the results of European women and older women do not overshadow these key groups.

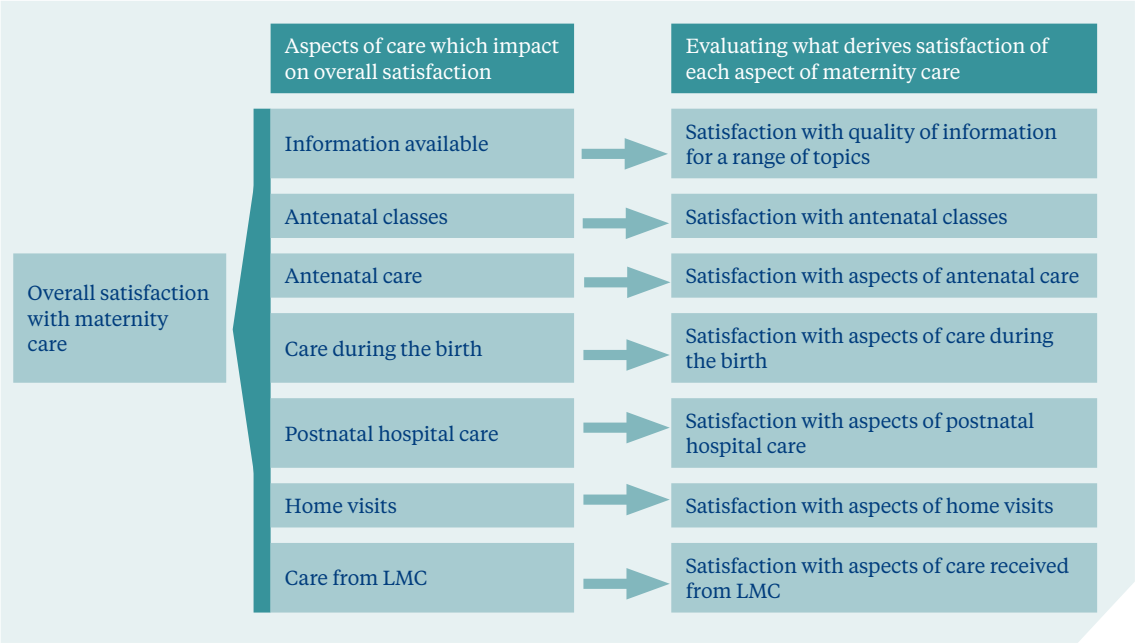
Analysis

Regression analysis was conducted to look at the relationship between:

- overall satisfaction with care received and satisfaction with different areas of maternity care
- satisfaction with each area of maternity care and satisfaction with more detailed aspects of care within each area.

The purpose of this analysis was to identify the relationship between satisfaction with different areas and overall ratings. This relationship is illustrated below.

Figure 10: Areas of maternity care



A factor analysis of the explanatory statements (detailed aspects of care within each area of maternity care) was conducted first. This identified groups of statements that women rated similarly. These groups of statements, or factors, were then included in the regression analysis.

For example, for the quality of information provided, women rated their satisfaction with information on breastfeeding and infant sleeping similarly. These statements formed the factor 'Information about caring for the baby'. This factor was then used in the regression analysis that looked at the relationship between satisfaction with information and satisfaction with detailed aspects of that information. The results of the regression analysis identified the impact 'information about caring for the baby' had on mothers' overall satisfaction with the quality of information available.

Further information relating to the factor analysis and regression analysis that was carried out can be found in Appendix I.

Notes to the report

Statistical significance

Throughout the report, any reported differences in women's perceptions are statistically significant. That is, the difference has been identified as a 'true' difference in women's perceptions rather than a result of natural variation from surveying a random sample.

Satisfaction and dissatisfaction

Throughout the report women's satisfaction or dissatisfaction is referred to. This is the combined result of 'very satisfied' and 'quite satisfied' or 'very dissatisfied' and 'quite dissatisfied'.

Performance

Throughout the report reference is made to the 'performance' of areas of maternity care. This reflects the percentage of women satisfied with a particular area of care. For example, if 90 percent of women were satisfied with an area of maternity care, then performance of this area of care would be considered 90 percent.

Young mothers

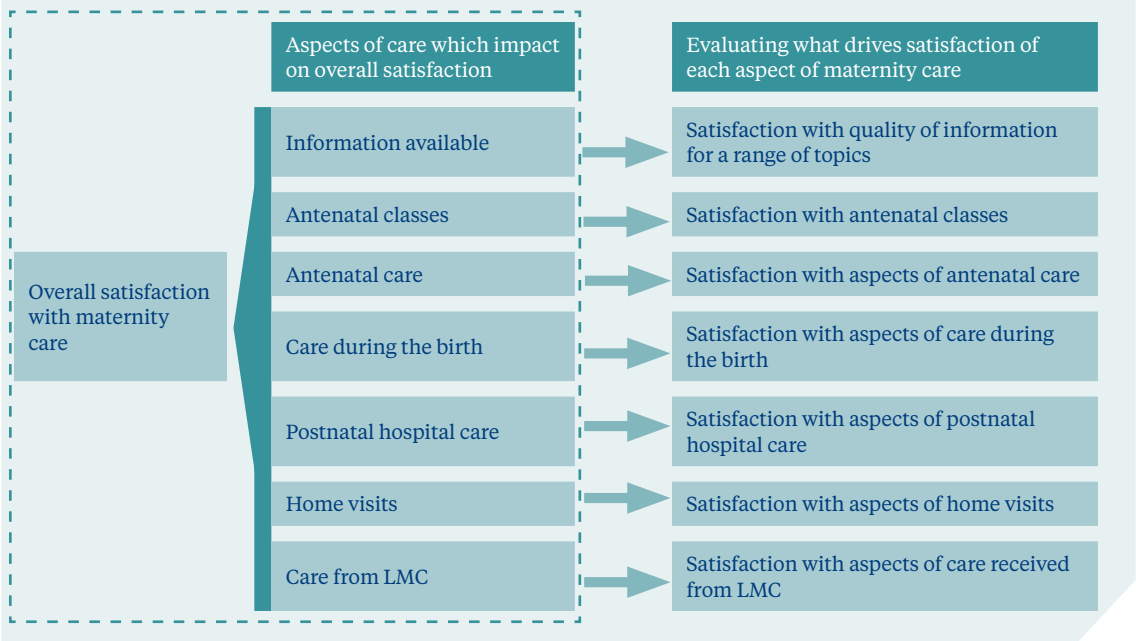
The Ministry of Health identifies women who have given birth at the age of 24 or younger as 'young mothers' for policy purposes. Any reference to 'young mothers' in the report will be in relation to these women.

Overall satisfaction with maternity care

Introduction

This section of the survey looked at the high-level drivers of women's satisfaction with maternity care. Women were asked to rate their satisfaction with particular areas. The following diagram highlights the areas this section focuses on.

Figure 11: Areas of maternity care



Regression analysis was used to assess the relative impact each area had on women's overall satisfaction with maternity services.

Based on these results, priority areas for improvement have been identified.

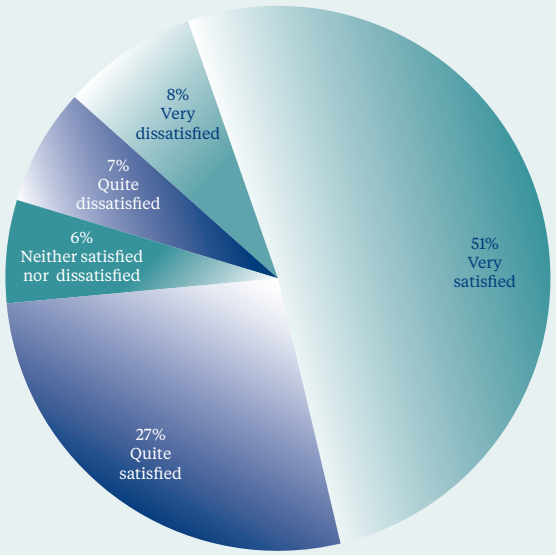
When considering their antenatal care, care during labour and birth, and postnatal care, around half of all women (51%) were 'very satisfied' with the care they received. A further 27 percent of women were 'quite satisfied' with the overall care they received.

The following women were more likely to be satisfied with the overall care they received:

- women for whom it was not their first birth (significantly more likely to be 'very satisfied' than women for whom it was their first birth – 55% cf 46%)
- women who had a 'planned' home birth (78% 'very satisfied' cf 51% average)
- women who received eight or more home visits from their LMC after the birth (65% 'very satisfied' cf 51% average).

Around one in six women (15%) were dissatisfied ('very dissatisfied' or 'quite dissatisfied') with the overall care they received. Women with disabilities were more likely to be dissatisfied with the care they received (26% 'very dissatisfied' or 'quite dissatisfied').

Figure 12: Overall satisfaction



Base: All respondents – excluding those who answered not applicable (n=3205)

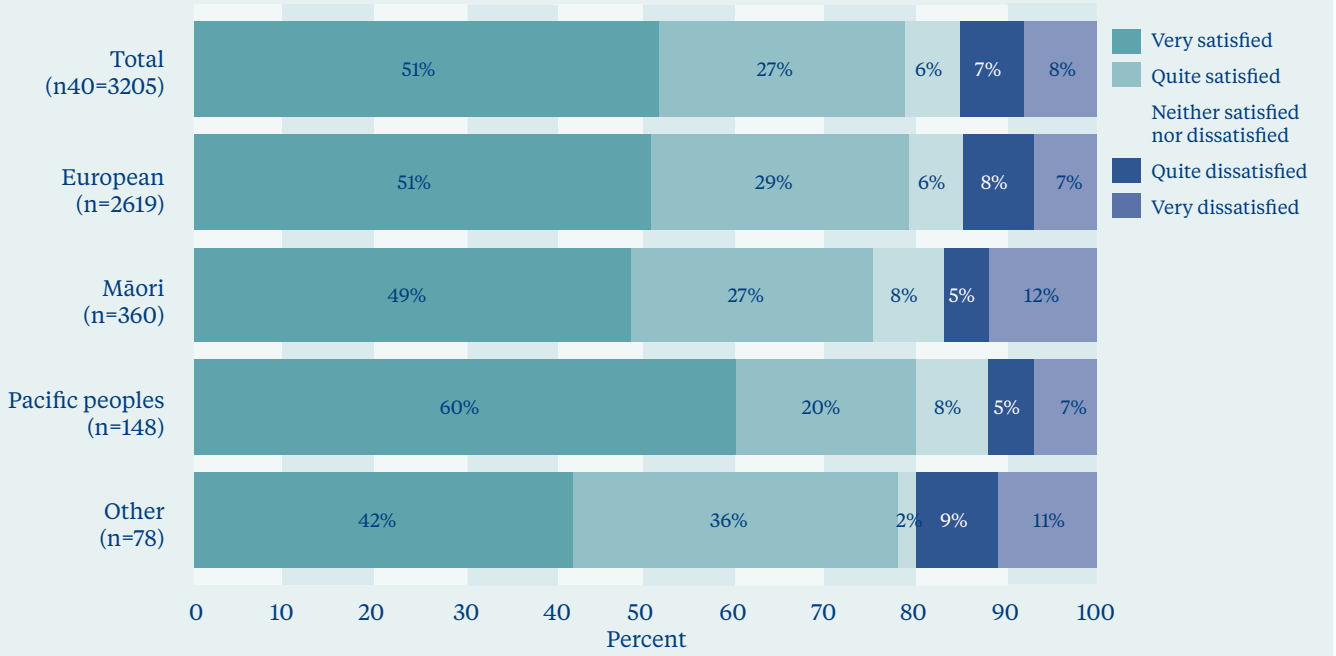
Q29. Thinking about your antenatal care, care during labour and birth, and postnatal care, and taking everything into consideration, overall, how satisfied were you with the care you received?

There were no significant differences in ratings of overall satisfaction by DHB.

Ethnic groups' overall satisfaction

Overall satisfaction with maternity care was similar among all ethnic groups, although Pacific women were significantly more likely to be 'very satisfied' with the overall care they received (60% cf 51% average).

Figure 13: Overall satisfaction by ethnicity



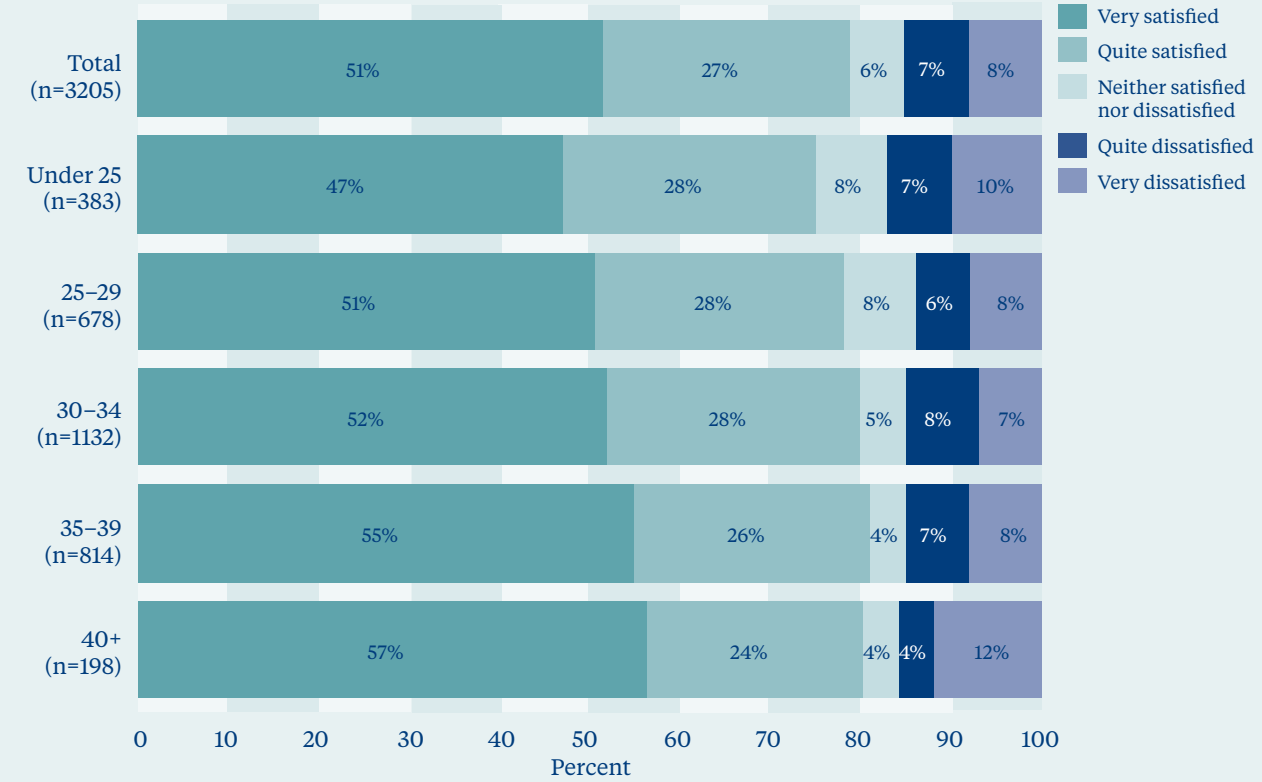
Base: All respondents – excluding those who answered not applicable

Q29. Thinking about your antenatal care, care during labour and birth, and postnatal care, and taking everything into consideration, overall, how satisfied were you with the care you received?

Age groups' overall satisfaction

Satisfaction with overall care received was similar across all age groups, satisfaction increasing slightly with age.

Figure 14: Overall satisfaction by age



Base: All respondents – excluding those who answered not applicable

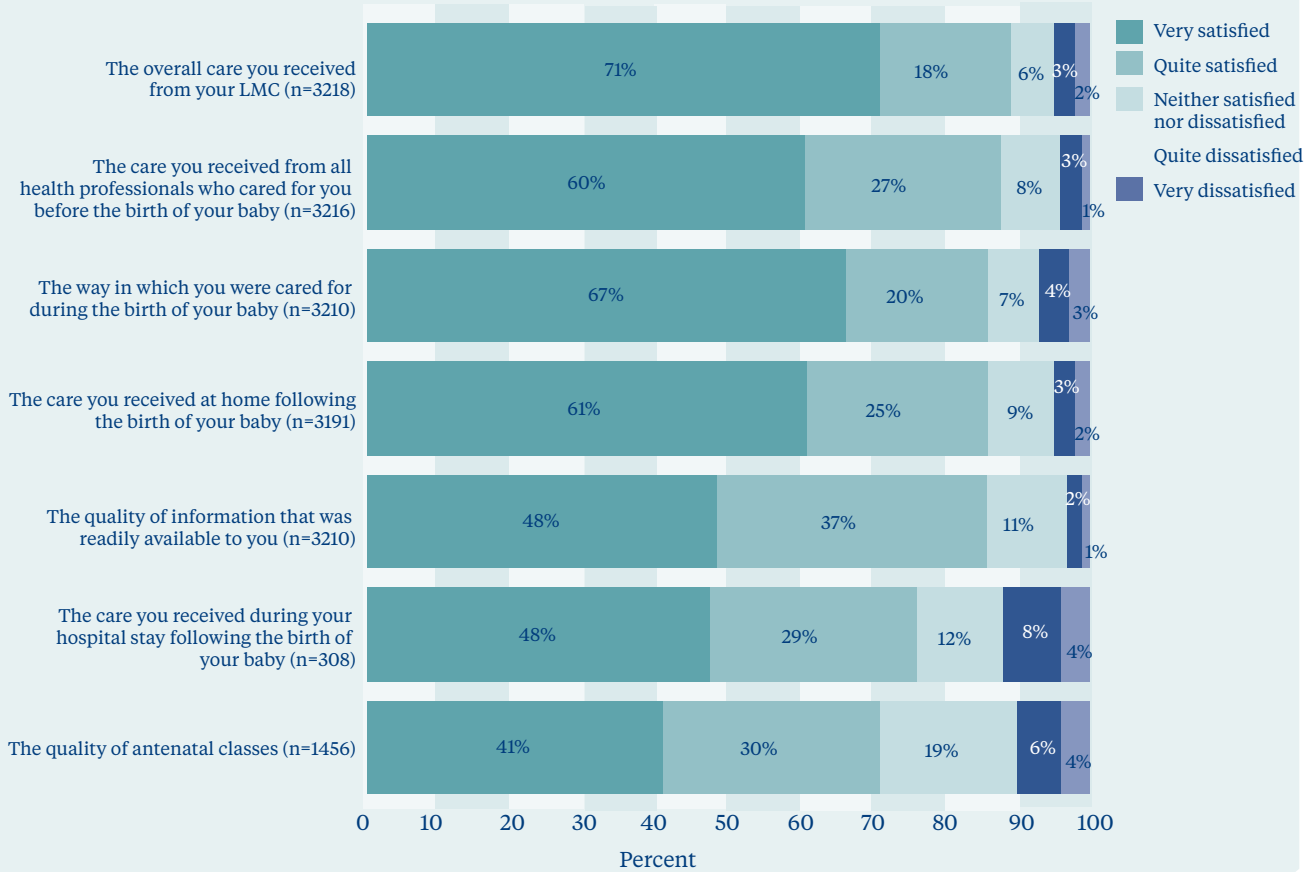
Q29. Thinking about your antenatal care, care during labour and birth, and postnatal care, and taking everything into consideration, overall, how satisfied were you with the care you received?

Satisfaction with areas of maternity care

Women were also asked to rate their satisfaction with individual aspects of maternity care. The strongest performing area was the overall care received from LMCs; around nine in ten women (89%) were satisfied with this area of maternity care.

Around three-quarters (77%) of women were satisfied ('very satisfied' or 'quite satisfied') with the care received during their hospital stay following the birth of their baby and the quality of antenatal classes (72%). This was lower than for the other areas of maternity care.

Figure 15: Satisfaction with areas of maternity care



Base: All respondents – excluding those who answered not applicable

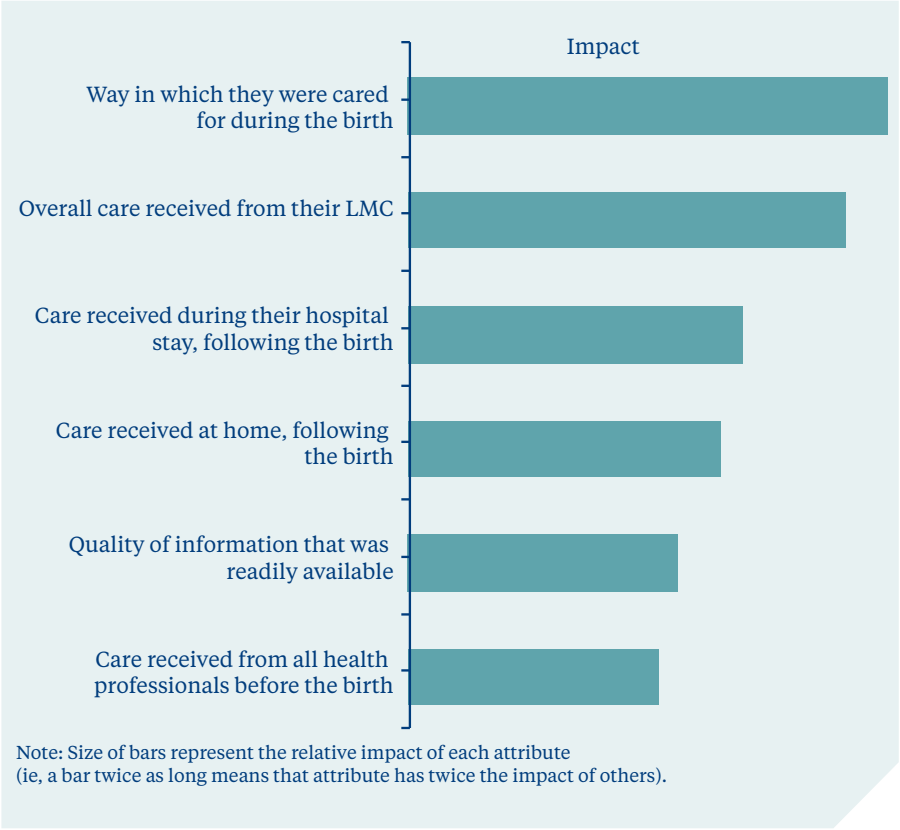
Q28. Thinking now about your overall experience, how satisfied were you with . . .

Drivers of satisfaction

Regression analysis was used to identify the impact specific areas of maternity care had on women's overall satisfaction.

The way in which women are cared for during the birth and the overall care they received from their LMC had the most impact on women's satisfaction. That is, a high standard of care during the birth was more likely to result in women being satisfied with their overall care. The relative impact of each aspect of care is illustrated below.

Figure 16: Impact on overall satisfaction



Note: Size of bars represent the relative impact of each attribute (ie, a bar twice as long means that attribute has twice the impact of others).

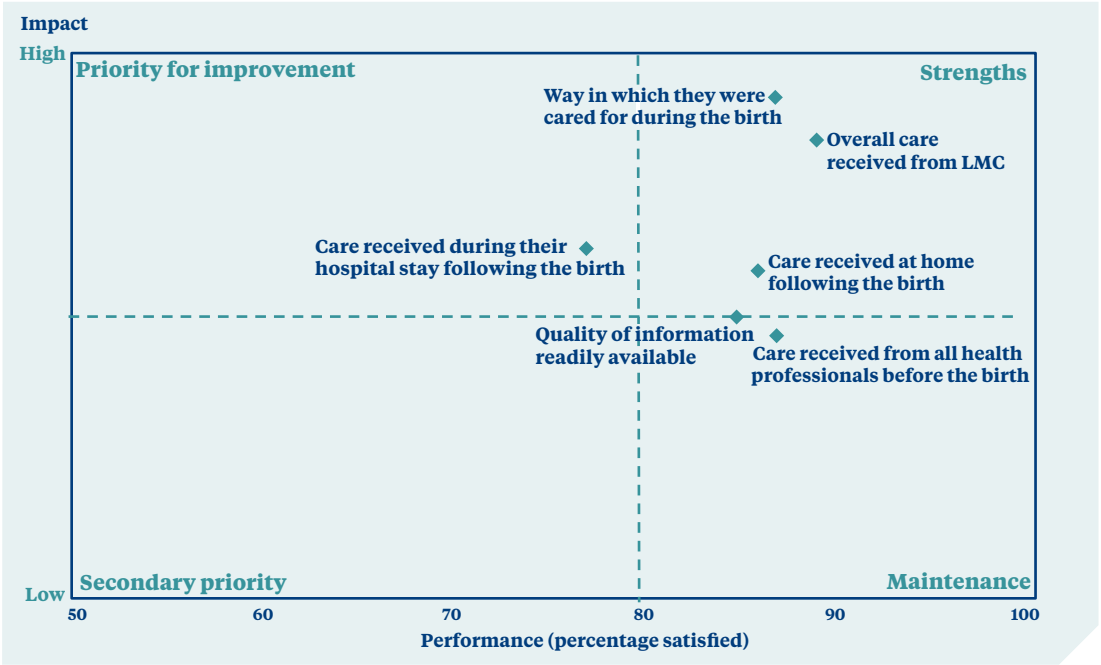
In conducting this analysis, it was found that satisfaction with antenatal classes did not have a statistically significant impact on women's overall rating of the care they received. This does not mean that antenatal classes were not important to these women; it simply means that the quality of antenatal classes did not impact on their satisfaction with the overall care they received.

Priorities

The relationship between the performance of each area of care and its impact on overall satisfaction is shown on the grid below. The y-axis measures the attribute's relationship with women's overall satisfaction and the x-axis measures the performance of each area of maternity care. Lines are used to cut the grid into four quadrants: strengths, priority for improvement, maintenance and secondary need for improvement. The exact position of these lines is subjective, as it is the relative performance (or relationship with overall satisfaction) of each area of care that we are trying to show.

Care received during the hospital stay following the birth is identified as a priority area for improvement, as performance in this area was somewhat weaker than in other aspects of care. Care during the hospital stay had the third highest impact on overall satisfaction, yet was the only aspect of care in which fewer than eight in every ten women were satisfied.

Figure 17: Improving overall satisfaction



The way in which women are cared for during the birth, overall care from LMCs and care received at home following the birth can all be considered relative strengths of maternity care. Given their slightly lower impact on overall satisfaction, the quality of information readily available and care from all health professionals before the birth need to simply be maintained in their current state.

Summary

In summary, the majority of women were satisfied with the overall care they received during their pregnancy, during the birth, during any hospital stay after the birth, and at home up until six weeks after the birth. Around half of all women indicated they were 'very satisfied' with the overall care received, and Pacific women were more likely to be 'very satisfied'.

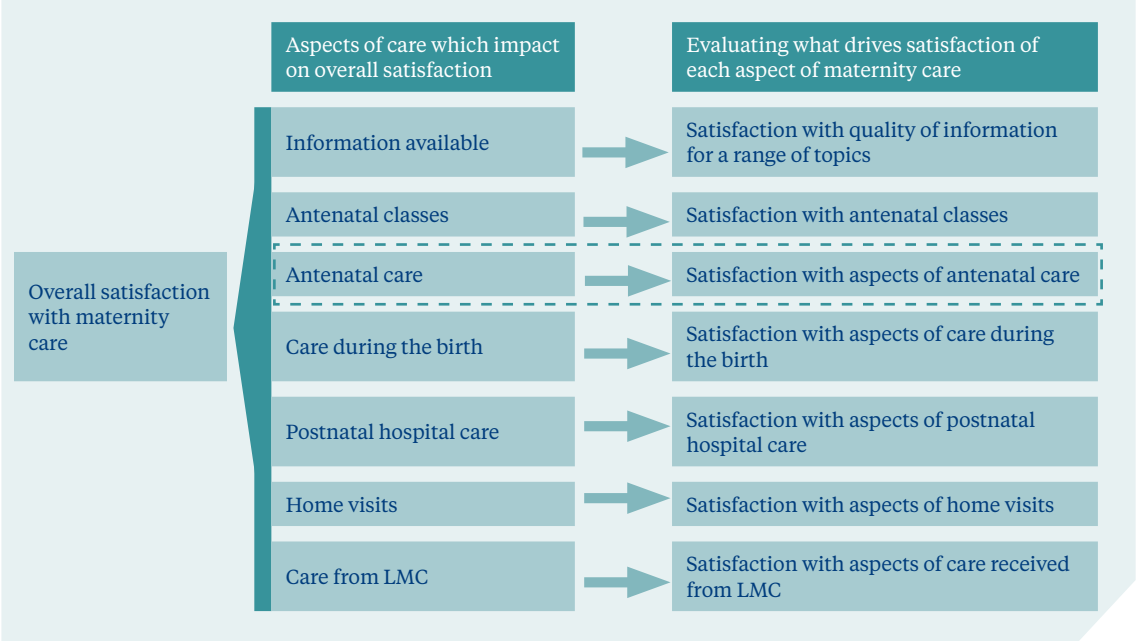
The way in which women are cared for during the birth was identified as having the most impact on overall satisfaction with care received. It is promising that around eight in every ten women surveyed were satisfied with this individual aspect of care. Satisfaction was lower for care received during the hospital stay after the birth – the aspect that had the third highest impact on overall satisfaction with care received. Thus, care received during hospital stays after the birth is identified as the priority area for improvement.

The pregnancy

Introduction

This section looks at the care received by women during their pregnancy (antenatal care). Women's satisfaction with the different aspects of care is evaluated in order to understand what drives satisfaction with this area of maternity care. Information on initial contact with a health care provider and services paid for during the pregnancy are also included in this section. The diagram below illustrates where this fits in relation to overall satisfaction.

Figure 18: Areas of maternity care



Women were asked to rate their satisfaction with each of the following:

- responsiveness of LMC or back-up to their health needs
- time spent with LMC or back-up
- convenience of location where appointments with LMC or back-up took place
- familiarity with people who would care for them if for any reason LMC was unavailable
- referrals to other agencies or health professionals LMC or back-up made
- specialist services used
- consistency of up-to-date medical information.

Regression analysis was used to establish the relative importance of each aspect in relation to women's satisfaction with antenatal care.

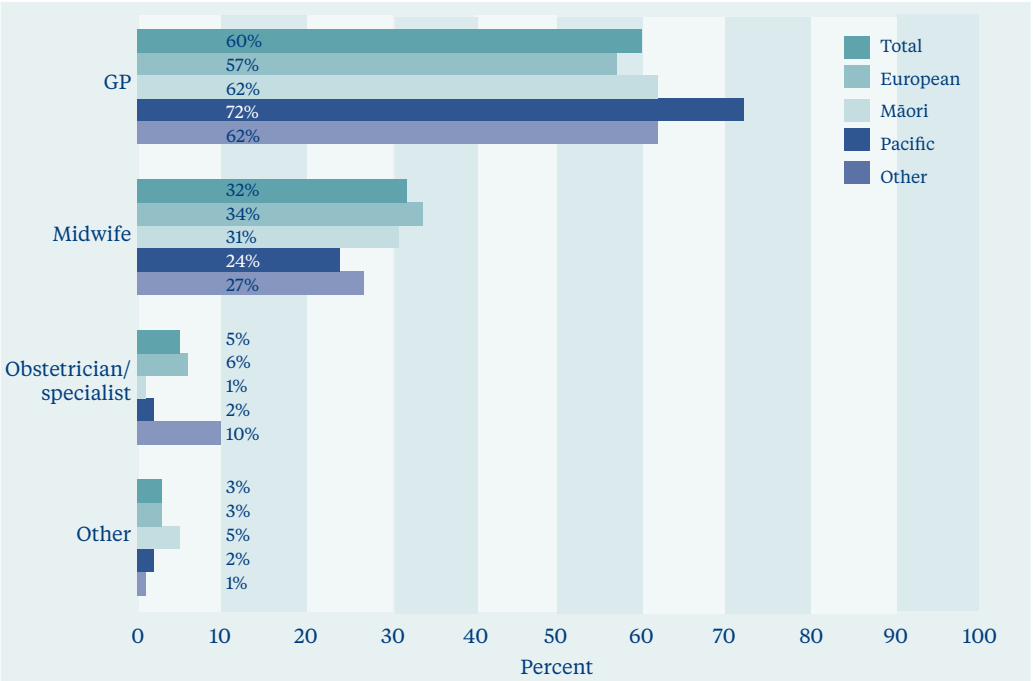
Initial contact with health care provider

Upon finding out, or suspecting, that they were pregnant, the women in this research were most likely to approach a general practitioner (GP). Six in every ten women (60%) approached a GP, while nearly a third (32%) approached a midwife.

Initial contact by ethnicity

Pacific women were significantly more likely to approach a GP compared with all other ethnic groups (72%). While an atypical behaviour among all women, women of 'other' ethnicities were significantly more likely to approach an obstetrician or specialist in the first instance (10% cf 5% average).

Figure 19: Health care provider first approached, by ethnicity



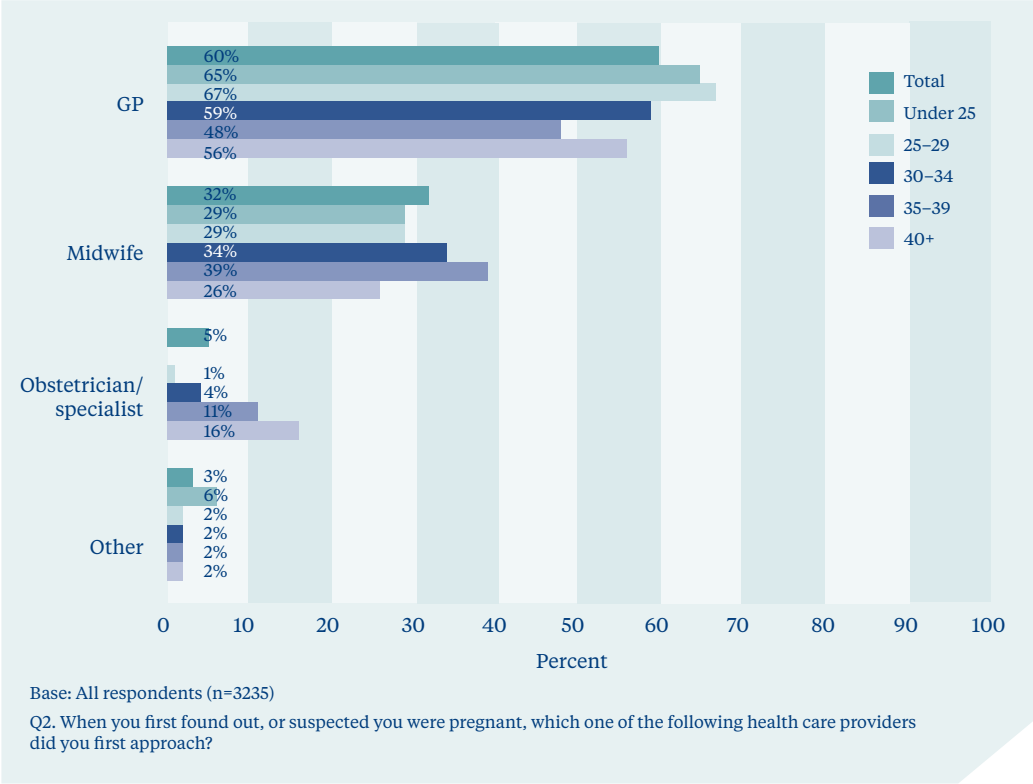
Base: All respondents (n=3235)

Q2. When you first found out, or suspected you were pregnant, which one of the following health care providers did you first approach?

Initial contact by age group

Those aged 35–39 were less likely to first approach a GP (48% cf 60% average) and significantly more likely to approach a midwife (39%) or obstetrician or specialist (11%). Those aged 40 or older were more likely to initially approach an obstetrician or specialist (16% cf 5%).

Figure 20: Health care provider first approached, by age



Base: All respondents (n=3235)

Q2. When you first found out, or suspected you were pregnant, which one of the following health care providers did you first approach?

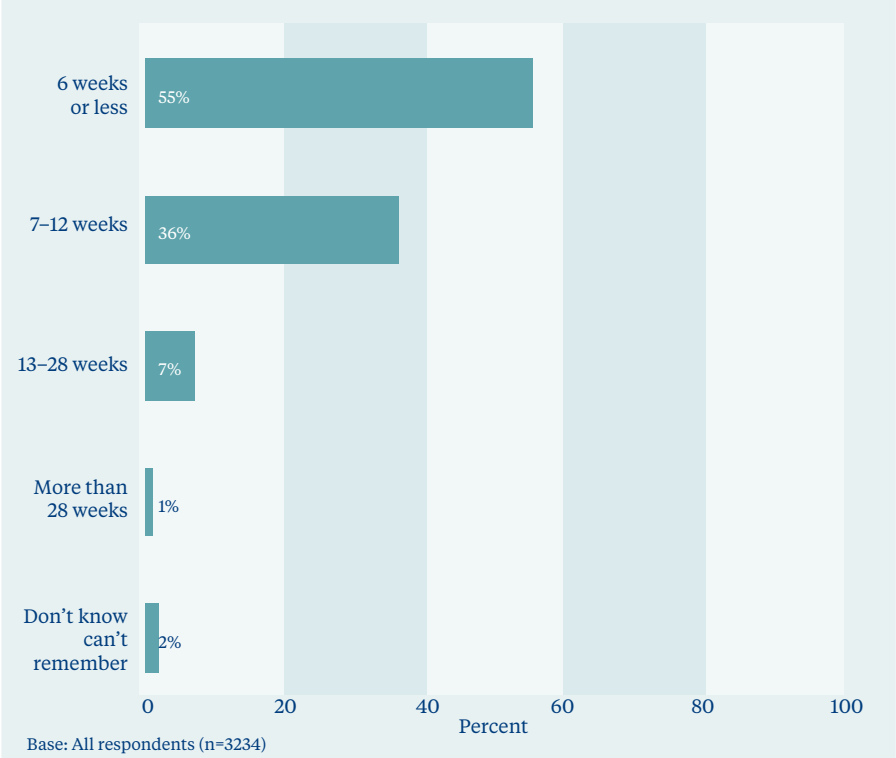
None of the women under the age of 25 involved in this research approached an obstetrician or specialist in the first instance.

Women for whom it was their first birth were more likely to have approached a GP (74% cf 48% among women for whom it was not their first birth), while women for whom it was not their first birth were more likely to approach a midwife (45% cf 17% of women for whom it was their first birth).

Time when women first contact health care provider

Just over half of all women contacted a health care provider within the first six weeks of their pregnancy.

Figure 21: Time of first contact with health care provider



Base: All respondents (n=3234)

Q3. How many weeks pregnant were you when you first made contact with this health care provider?

The following were variations from the norm.

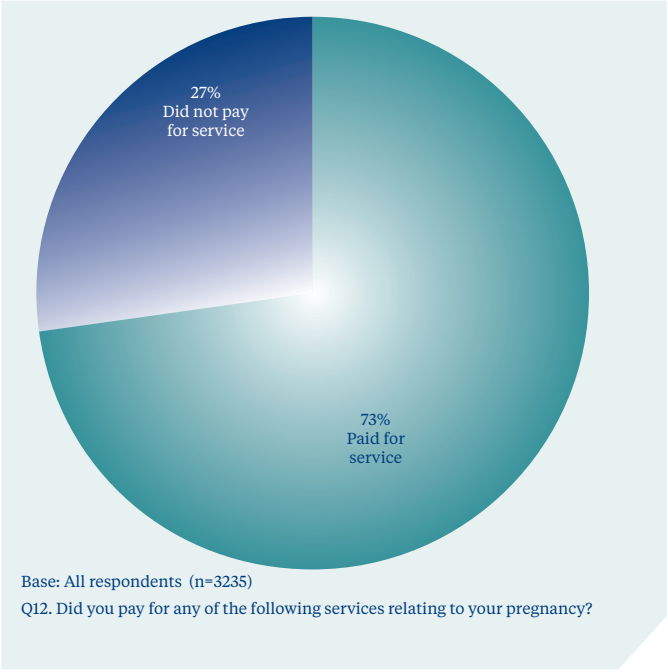
- Women for whom it was not their first birth were more likely to contact a health care provider in weeks seven through twelve of their pregnancy (41% cf 31% for women for whom it was their first birth).
- Māori women were more likely to make contact with a health care provider during weeks seven through twelve (44% cf 36% average).
- Pacific women were more likely to approach a health care provider in weeks 13–28 of their pregnancy (17% cf 7% average).

Services paid for during the pregnancy

Nearly three-quarters (73%) of all women paid for services relating to their pregnancy. Women who were less likely to pay for services were:

- women for whom it was not their first birth (29% cf 24% of women for whom it was their first birth)
- women under the age of 25 (37%)
- Māori women (40%)
- Pacific women (48%).

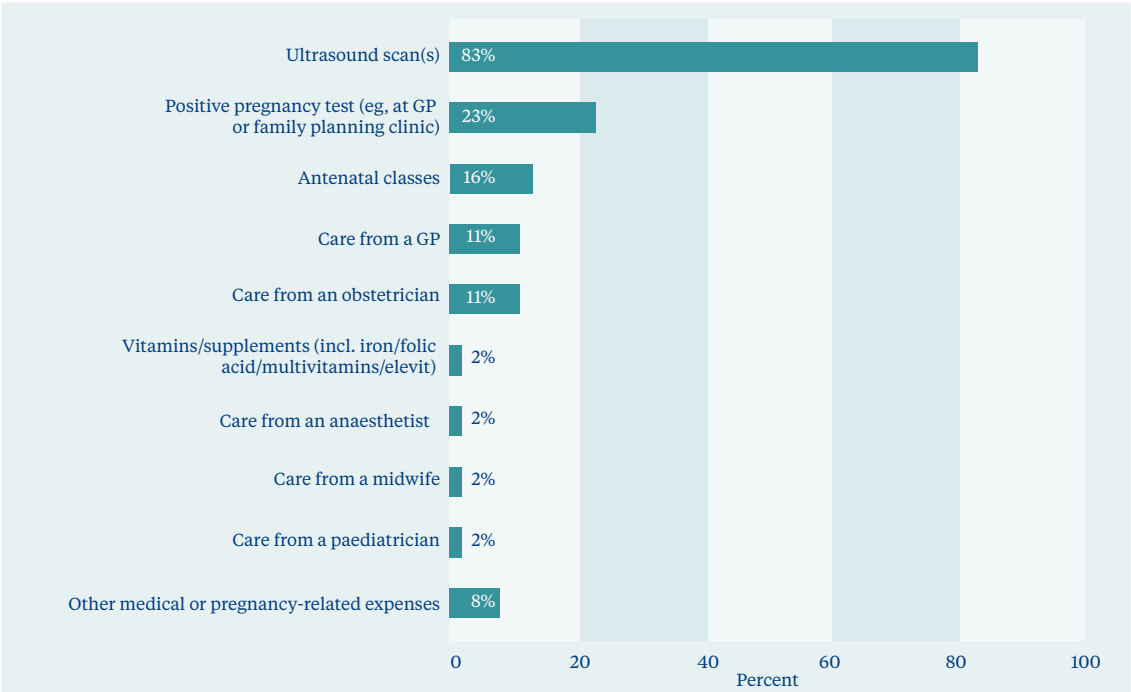
Figure 22: Women who paid for services relating to pregnancy



Base: All respondents (n=3235)
Q12. Did you pay for any of the following services relating to your pregnancy?

The most common service that women paid for was an ultrasound scan.

Figure 23: Maternity services paid for

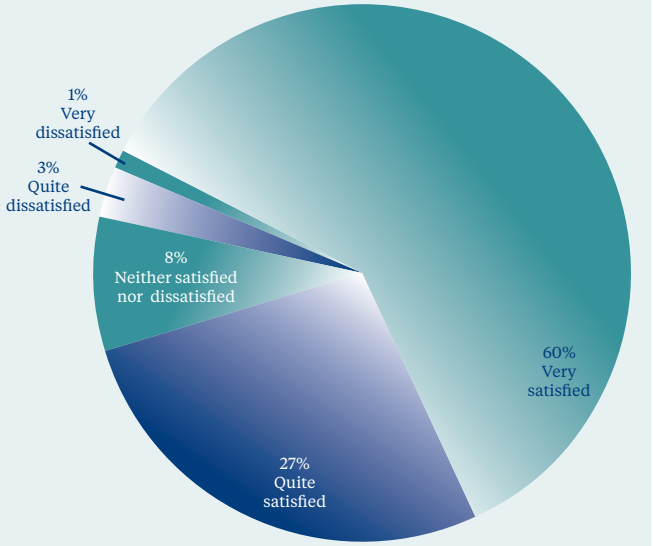


Base: Those who paid for services (n=2511)
Q12. Did you pay for any of the following services relating to your pregnancy?

Satisfaction with care during pregnancy

The majority of women were satisfied with the care received during their pregnancy, six in every ten being 'very satisfied'.

Figure 24: Satisfaction with care during pregnancy



Base: All respondents – excluding those who answered not applicable (n=3216)

Q28. Thinking about your overall experience, how satisfied were you with the care you received from all health professionals who cared for you before the birth of your baby?

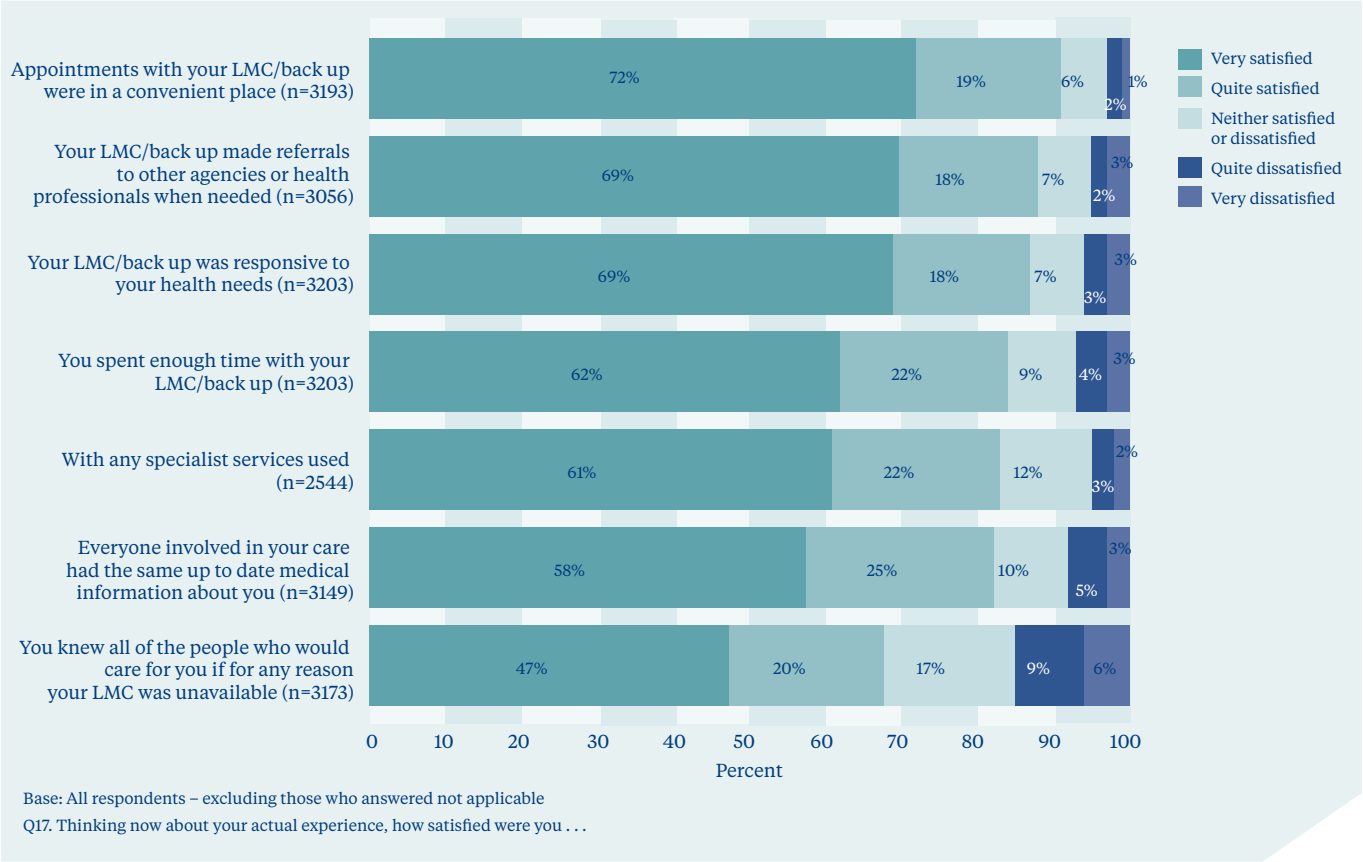
Those who had an obstetrician or specialist as their LMC during the pregnancy were more likely than averge to be satisfied with the care received (93% 'very satisfied' or 'quite satisfied' cf 87% average).

A small level of dissatisfaction existed with the care received during the pregnancy. Women with a disability were more likely to be dissatisfied (12% cf 4% of women without disabilities).

Satisfaction with aspects of care during the pregnancy

Satisfaction with aspects of care received during the pregnancy was also evaluated. The highest performing aspect was the appointments with LMCs or back-ups being in a convenient place; around seven in ten women (72%) were 'very satisfied' with this aspect of care.

Figure 25: Satisfaction with aspects of care during pregnancy



Base: All respondents – excluding those who answered not applicable

Q17. Thinking now about your actual experience, how satisfied were you . . .

The lowest satisfaction ratings related to the familiarity women had with the people who would care for them if for any reason their LMC was unavailable.

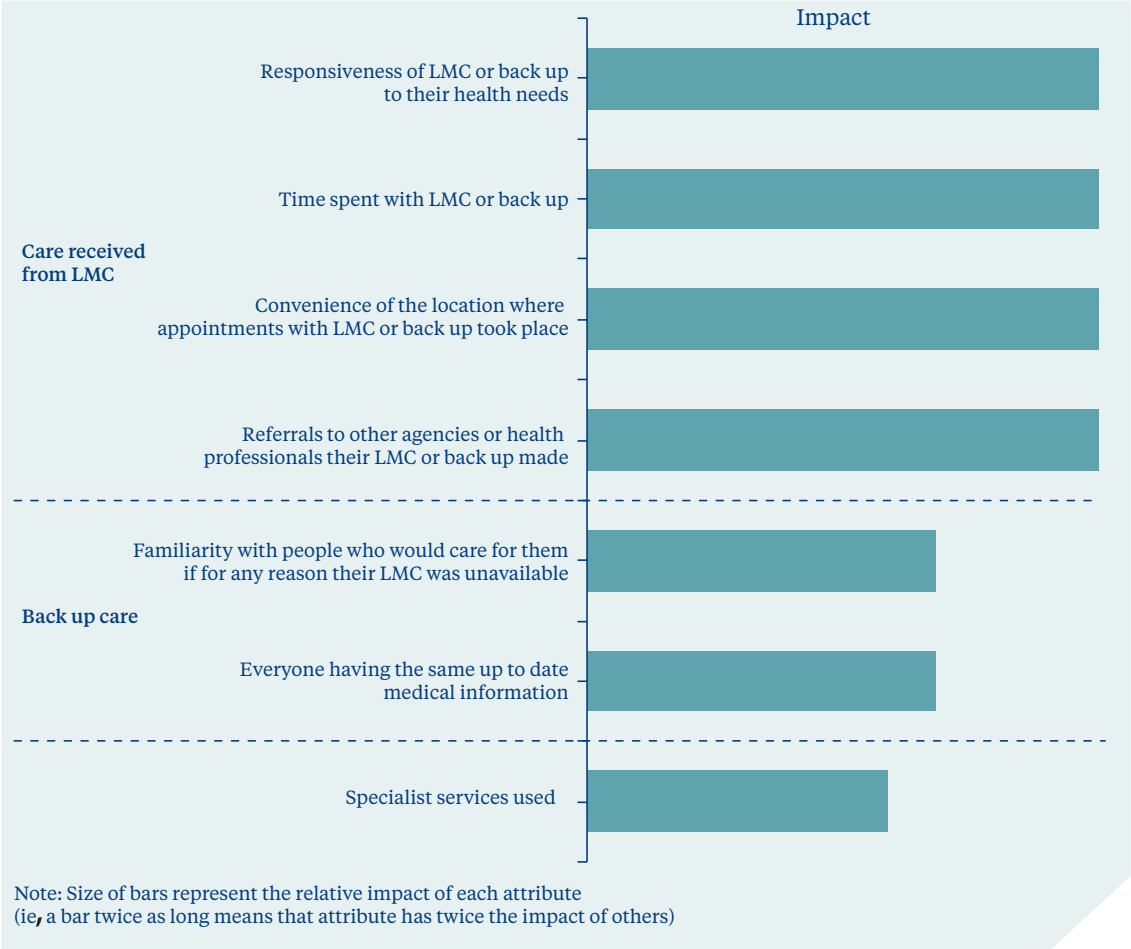
Drivers of satisfaction

Factor analysis was undertaken on the aspects of antenatal care covered in the survey. The results of this analysis can be grouped into three key themes:

- care received from LMC
- back-up care
- specialist services used.

Each of the aspects of care looked at within each theme were rated a similar way by women, meaning they had a similar impact on women's satisfaction with care received during their pregnancy. The relative impact of each theme is illustrated below.

Figure: 26: Impact on satisfaction with care during pregnancy



Care received from LMCs was identified as having the most impact on satisfaction. That is, a high standard of care from the LMC was more likely to result in women being satisfied with their overall care during the pregnancy.

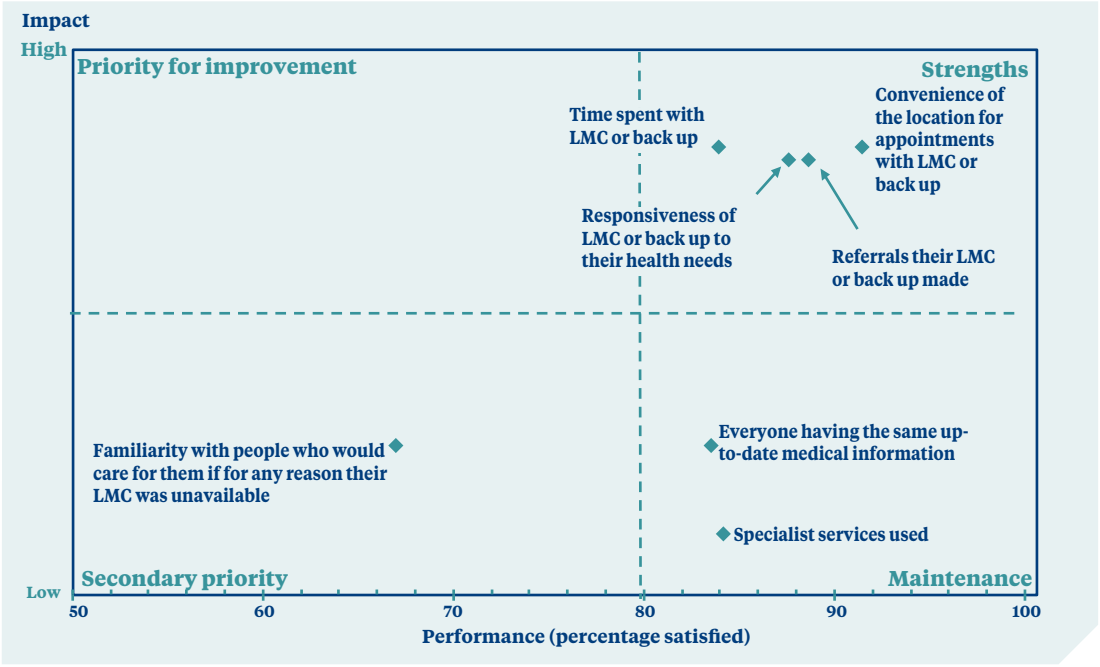
Priorities

Again, the relationship between the performance of each aspect of care and its impact on women's satisfaction was reviewed to establish priority areas for improvement in antenatal care.

The care received from LMCs was the aspect that had the most impact on women's satisfaction with care received during the pregnancy, and is currently performing well. At least eight in every ten women were satisfied with aspects of care received from their LMC, meaning they can be considered strengths of maternity care.

Although relatively lower in terms of its impact on women's satisfaction, familiarity with people who would care for them if their LMC was unavailable is identified as a secondary priority for improvement. As aspects related to back-up care have the second largest impact on women's satisfaction, this aspect of care should be the focus for Ministry of Health in terms of improving care received during the pregnancy.

Figure 27: Improving care received during pregnancy



Summary

Women currently report positive experiences with care received during their pregnancy. Six in every ten women were 'very satisfied' with the care they received. The majority of women approached a GP in the first instance, when they found out or suspected they were pregnant, and this was most likely to have been within the first six weeks of their pregnancy. However, the time taken to approach a health care provider was significantly longer for Pacific women.

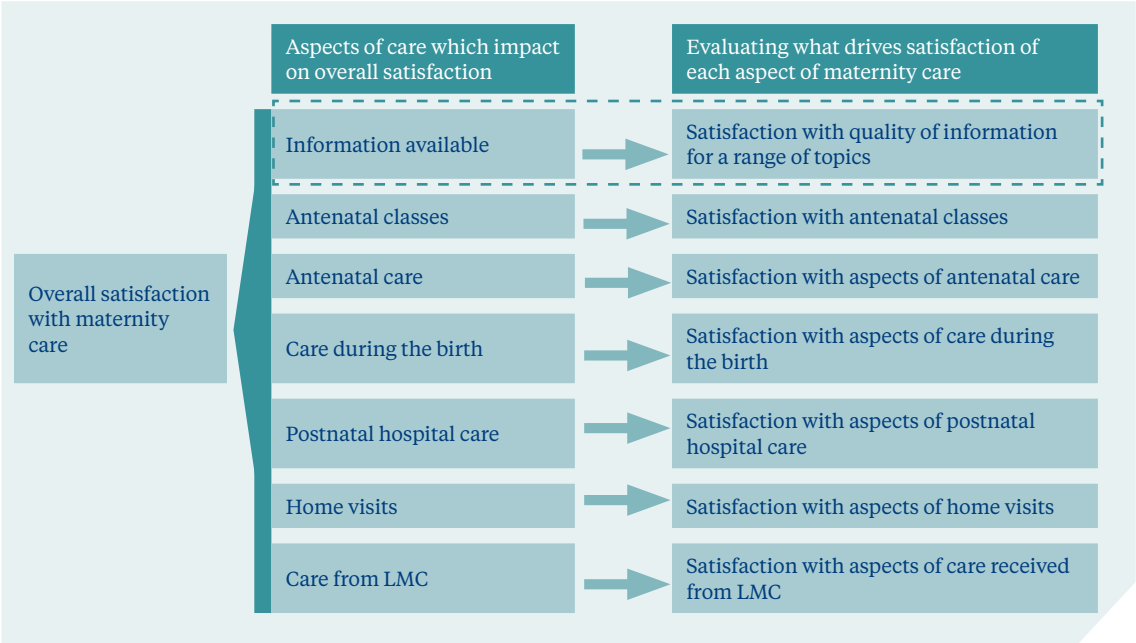
The main area of focus, in relation to care received during the pregnancy, should be women's familiarity with people who would care for them if for any reason their LMC was unavailable. Women perceived this aspect of care to be somewhat weaker than all other aspects of care related to their pregnancy.

Sources of information

Introduction

This section reviews the sources of information that are available to women throughout pregnancy and following the birth of their child. Women's satisfaction with the quality of information they received on a range of topics was included in regression analysis to evaluate what drives overall satisfaction with this area of maternity care. The areas covered in this section are highlighted below.

Figure 28: Areas of maternity care



The range of topics covered in the survey were:

- selection of LMC
- pregnancy in general
- scans
- antenatal screening for Down syndrome and other conditions
- childbirth
- management of pain during birth
- breastfeeding
- infant sleeping
- newborn hearing screening
- newborn metabolic screening
- selection of Well Child provider
- immunisation.

Best methods for obtaining information

At least eight in every ten women believed their LMC or another health care provider was the best method for obtaining information about the following:

- scans
- antenatal screening for Down Syndrome and other conditions
- childbirth
- management of pain during birth
- breastfeeding
- newborn hearing screening
- newborn metabolic screening
- selection of Well Child provider
- immunisation.

Table 9 : Perceived best methods for obtaining information

	Antenatal classes (%)	Friends or family (%)	LMC or another health care provider (%)	A helpline (%)	Internet searches or websites (%)	Reading books and brochures (%)	Other (%)
Selection of LMC (n=2890)	4	56	40	3	16	11	10
Pregnancy in general (n=3139)	30	52	73	2	46	61	2
Scans (n=2879)	2	12	91	1	10	13	2
Antenatal screening for Down syndrome and other conditions (n=2906)	5	7	90	0	16	24	2
Childbirth (n=3133)	41	46	84	1	28	48	3
Management of pain during birth (n=3062)	38	26	84	0	17	33	3
Breastfeeding (n=3043)	26	40	84	2	15	37	9
Infant sleeping (n=2975)	14	50	60	4	28	47	6
Newborn hearing screening (n=2872)	5	3	88	1	3	16	7
Newborn metabolic screening (n=2998)	9	4	93	0	2	15	3
Selection of Well Child provider (n=2672)	7	20	88	1	3	9	4
Immunisation (n=3035)	11	22	84	1	16	35	5

Base: All respondents – excluding those who answered not applicable
Q13. Which methods were the best for obtaining information?

Around half of all women considered friends or family to be the best method for obtaining information about selecting a LMC, pregnancy in general and infant sleeping. Very few women cited a helpline as the best method for obtaining information about maternity care, while books and brochures stood out as the second best method for obtaining information about pregnancy in general.

Overall satisfaction with the quality of information

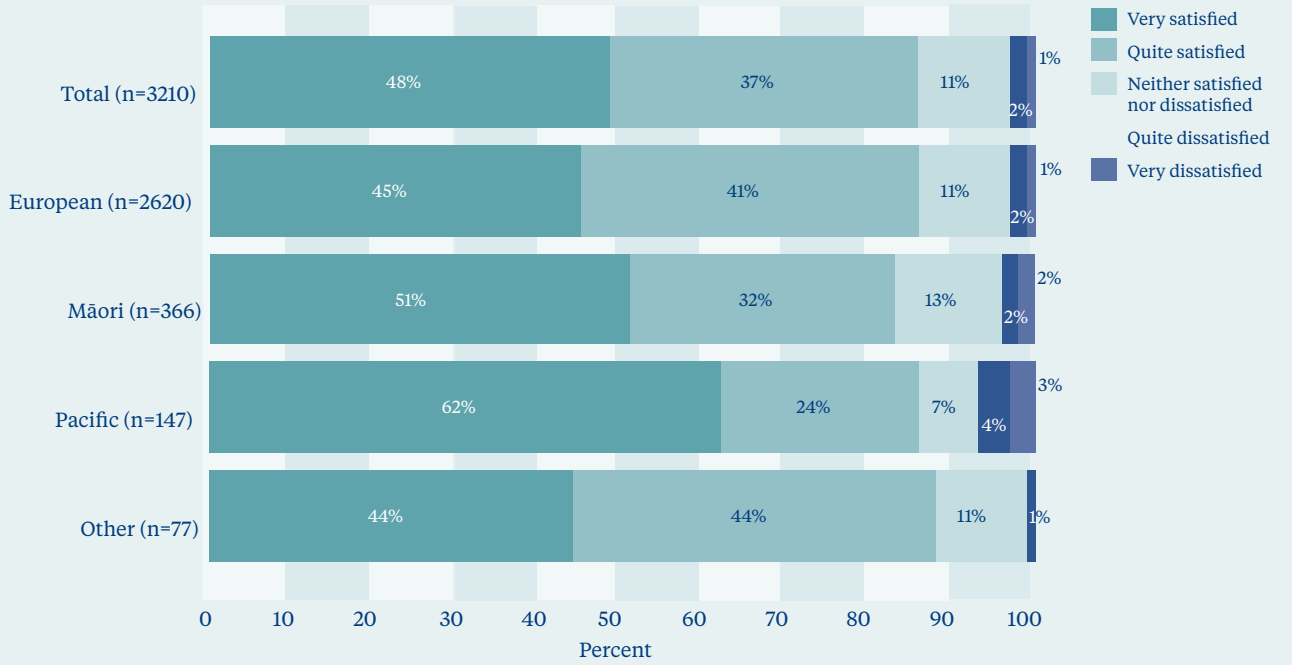
The majority of women (85%) were satisfied ('very satisfied' or 'quite satisfied') with the quality of information they received. Women who planned to have a home birth were more likely to be satisfied with the quality of information (97% rating 'very satisfied' or 'quite satisfied' cf 85% average).

There was a small level of dissatisfaction with the quality of information. The following women were more likely to be dissatisfied ('very dissatisfied' or 'quite dissatisfied'):

- Pacific women (7% cf 4% average)[1]
- women with disabilities (11% cf 3% of women without a disability).

Interestingly, Pacific women were also more likely to be 'very satisfied' with the quality of information (62% cf 48% average).

Figure 29: Satisfaction with the quality of information that was readily available



Base: All respondents – excluding those who answered not applicable

Q17. Thinking now about your overall experience, how satisfied were you with . . .

1 The average of all mothers who were 'very dissatisfied' or quite dissatisfied' does not add to the sum of the individual results in the chart due to rounding.

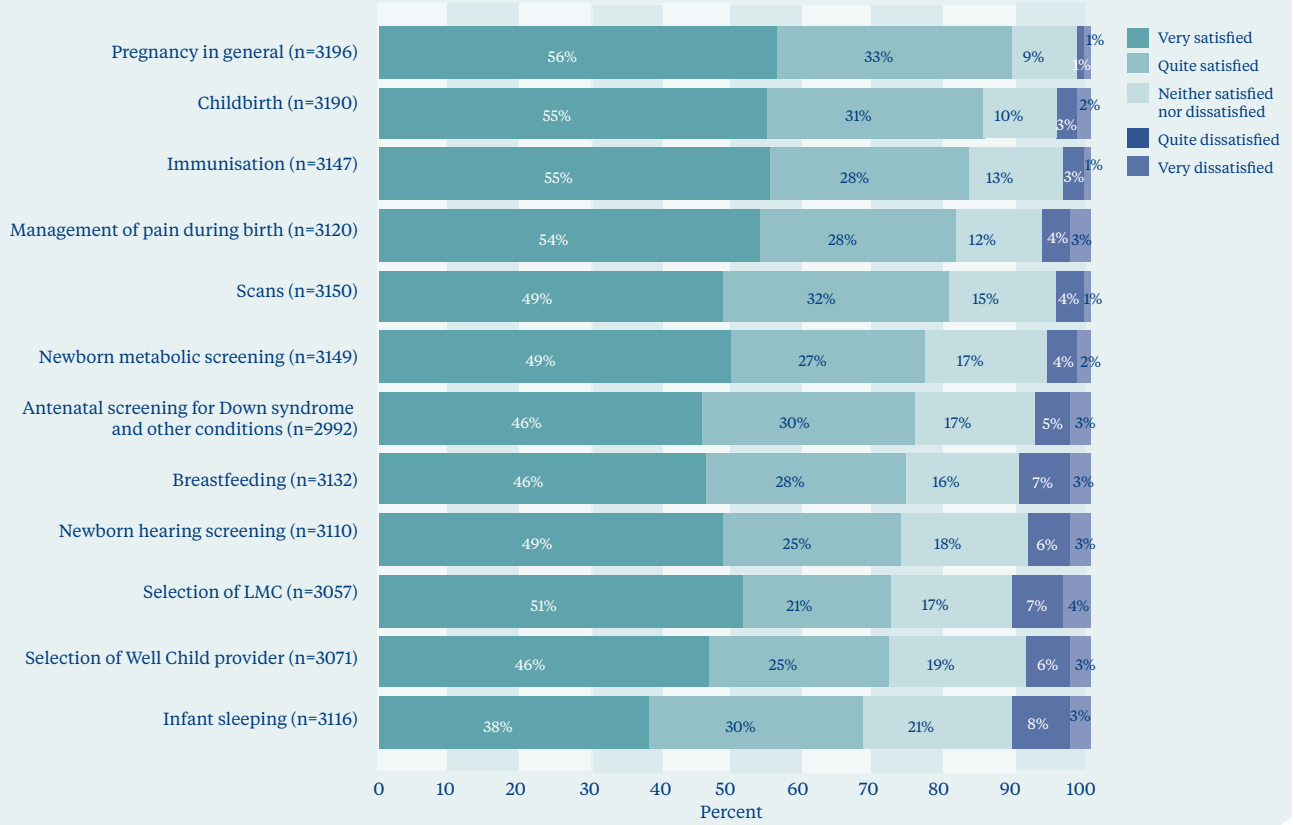
Satisfaction with each topic

Women were asked to rate their satisfaction with the quality of information provided on a range of topics.

More than half of all women were satisfied ('very satisfied' or 'quite satisfied') with the quality of information for all topics covered in the survey. The highest performing area was information about pregnancy in general, with around nine in every ten women (89%) satisfied with the quality of this information.

Information on infant sleeping was the weakest area. Around four in ten women (38%) were 'very satisfied' with the quality of this information: significantly lower than for all other topic areas.

Figure 30: Satisfaction with the quality of information for each topic



Base: All respondents – excluding those who answered not applicable

Q14. How satisfied were you with the quality of information on each of the following?

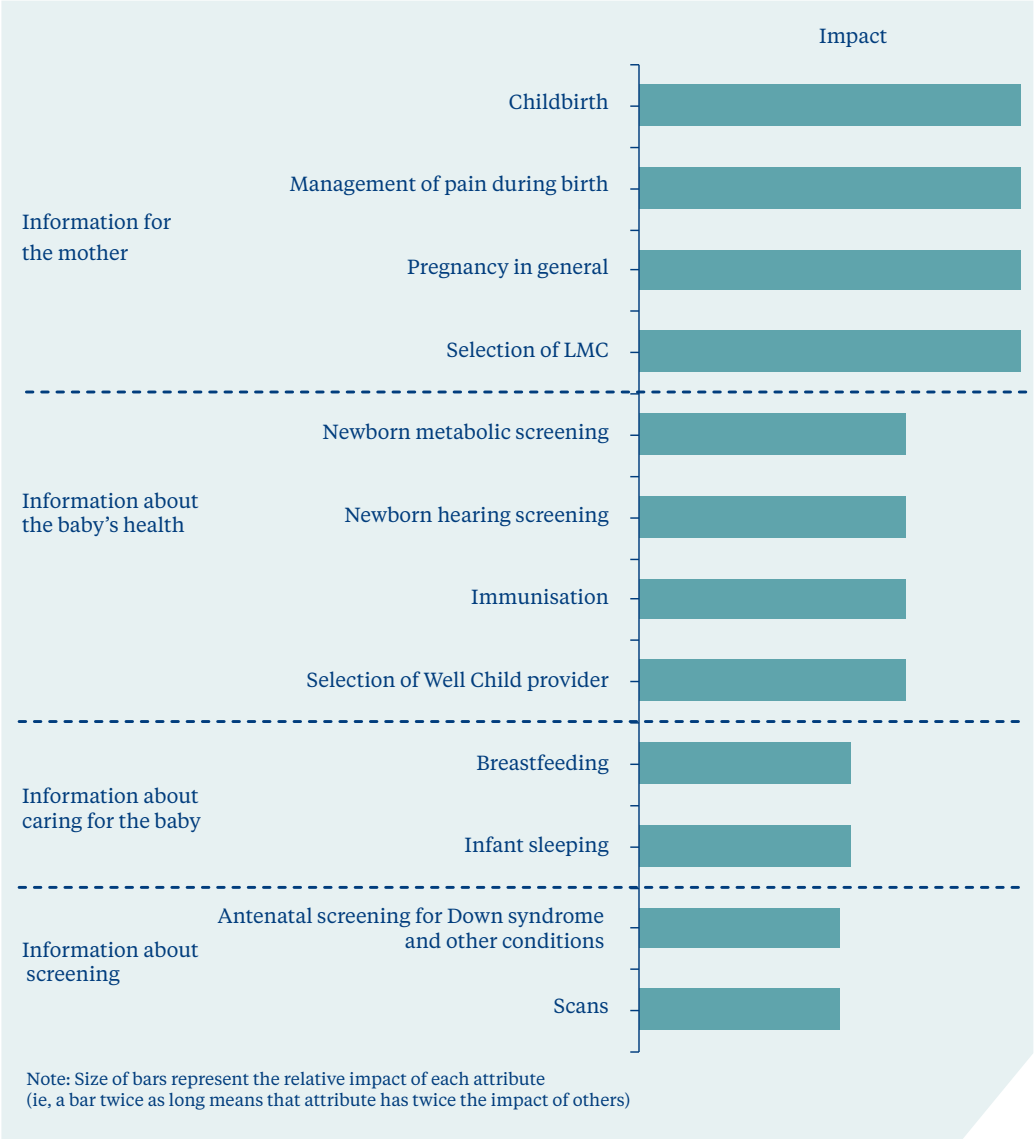
Drivers of satisfaction

Factor analysis was undertaken on the topics of information covered in the survey. The results of this analysis can be grouped into four key themes:

- information for the mother
- information about the baby's health
- information about caring for the baby
- Information about screening.

The topics within each theme were rated a similar way by women, meaning the impact they had on women's satisfaction with the quality of information readily available was also similar. The relative impact of each aspect on women's satisfaction is illustrated below.

Figure 31: Impact on satisfaction with information sources



Information for the mother was identified as having the most impact on women's satisfaction with the quality of information readily available. Information about scans was deemed to have the least impact, relative to all other areas of information.

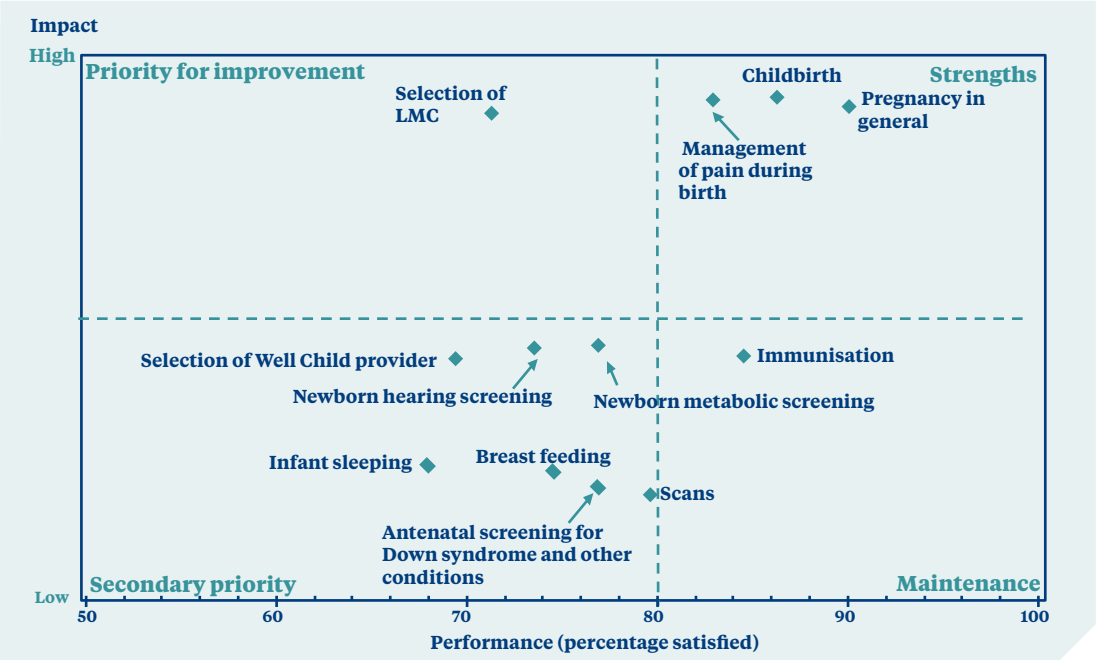
Priorities

The relationship between the impact of each area of care on women's satisfaction and its current performance has been reviewed to determine information sources that are a priority for improvement.

Information regarding the selection of a LMC is identified as a priority for improvement. This area had the most impact on women's satisfaction with the quality of information readily available, yet the percentage of women satisfied was lower than for other areas of information for the mother (eg childbirth, management of pain during birth and pregnancy in general).

Many of the areas of information about screening and caring for the baby are identified as secondary priorities. These areas should be focused on after the main priority (information about selecting a LMC) is addressed.

Figure 32: Improving quality of information



Information regarding childbirth, management of pain during the birth and pregnancy in general (all information for the mother) can be considered strengths of maternity care.

Summary

In summary, the majority of women were satisfied with the quality of information readily available. The LMC was considered the best source of information for the majority of topics covered in the survey, while friends and family were considered the best source for information about selecting a LMC.

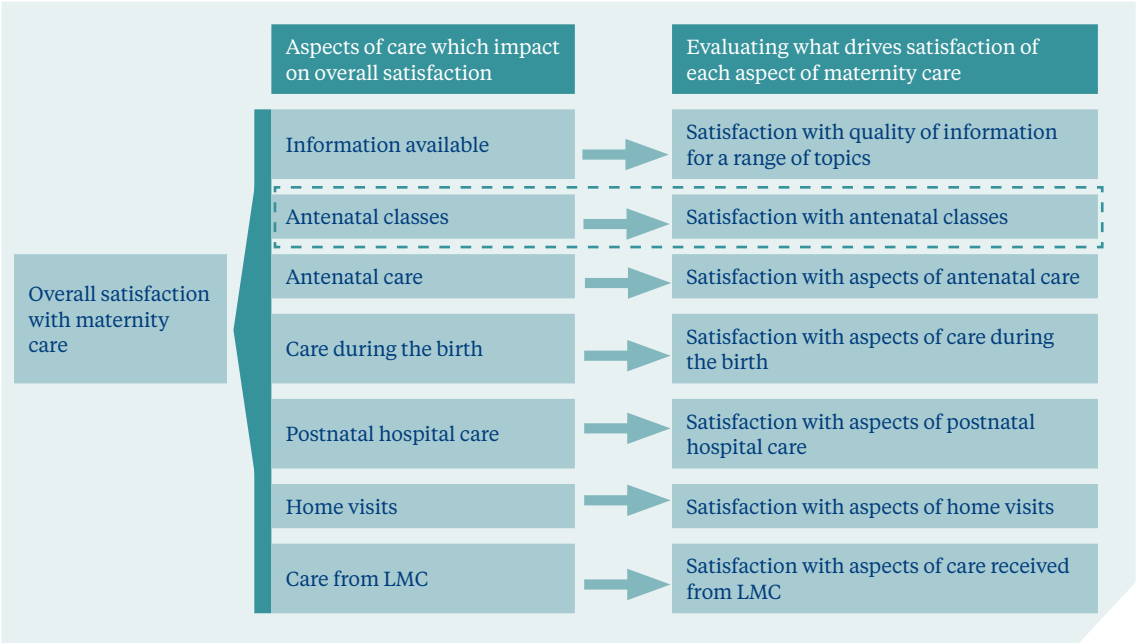
Information about selecting a LMC was identified as having the most impact on women's satisfaction with the quality of information readily available. Taking the current performance of this area into account, information about selecting a LMC is a priority area for improvement.

Antenatal classes

Introduction

This section reviews women's satisfaction with antenatal classes. It also evaluates the reasons women have for not attending an antenatal class. The relationship this has to overall satisfaction with care received is highlighted below.

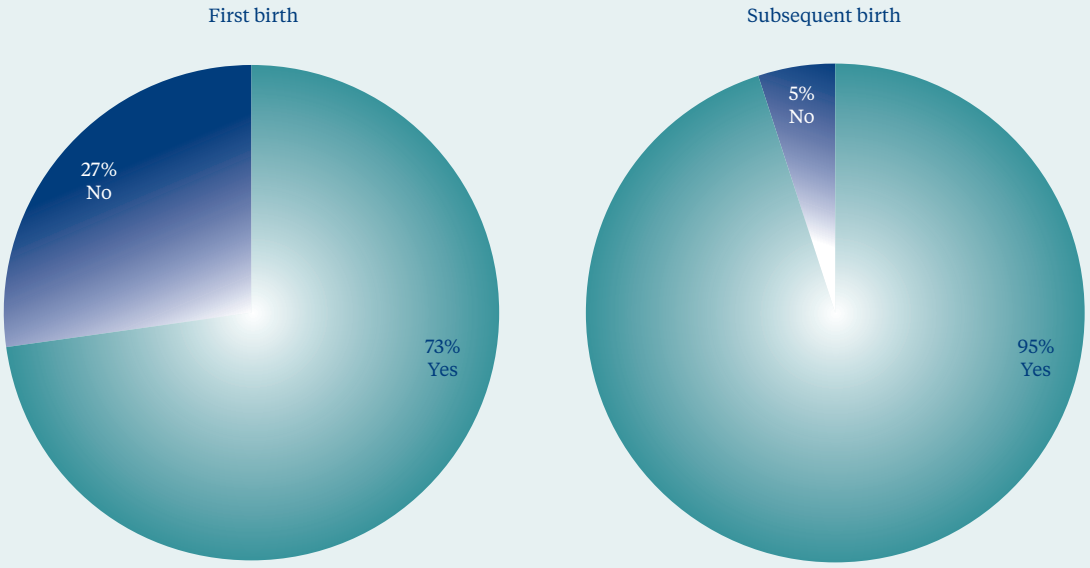
Figure 33: Areas of maternity care



Attendance at antenatal classes

Around three-quarters of women for whom it was their first birth (73%) attended an antenatal class. In comparison, only 5 percent of women for whom it was not their first birth attended a class.

Figure 34: Attended antenatal classes

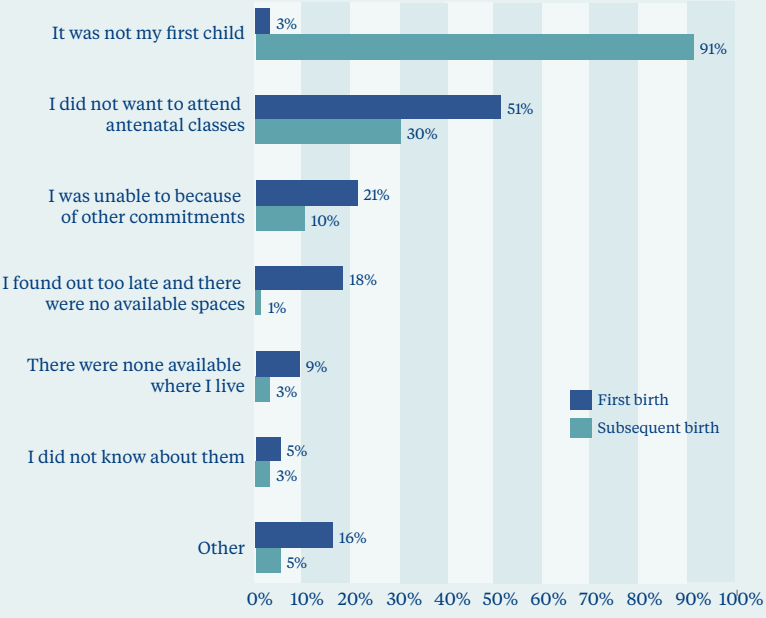


Base: All respondents (first birth n=1353; subsequent birth, n=1843)
Q15. Did you attend antenatal (or childbirth education) classes, for this most recent pregnancy?

Reason(s) for not attending

Among the 27 percent of women for whom it was their first birth who did not attend antenatal classes, around half (51%) did not want to attend, two in ten (21%) could not due to other commitments, and a similar number (18%) found out too late and there were no available spaces.

Figure 35: Reason for not attending antenatal classes

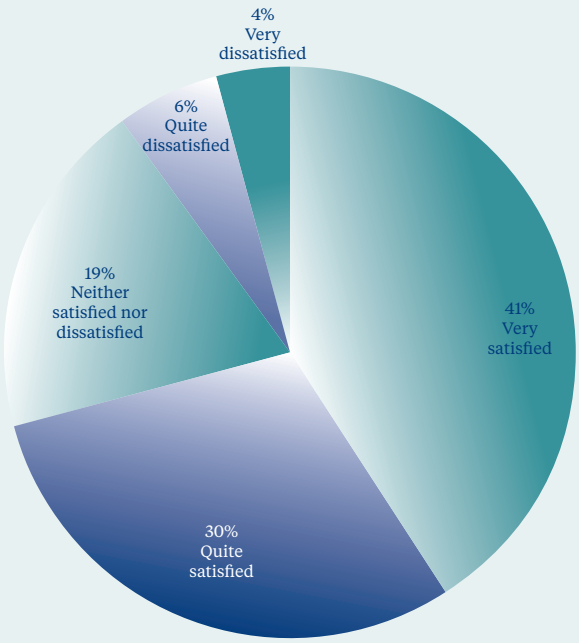


Base: Those who did not attend antenatal classes (first birth, n=242; subsequent birth, n=1681
Q16. For what reasons did you not attend antenatal classes?

Satisfaction with antenatal classes

The majority of women were satisfied with the quality of antenatal classes, with around four in ten (41%) 'very satisfied'.

Figure 36: Satisfaction with antenatal classes



Base: All respondents – excluding those who answered not applicable (n=1456)

Q29. Thinking now about your overall experience, how satisfied were you with the quality of antenatal classes?

Women for whom it was their first birth were significantly more likely to be satisfied (73% 'very satisfied' or 'quite satisfied' cf 66% among women for whom it was not their first birth).

A small level of dissatisfaction existed with the quality of antenatal classes. Women who gave birth at home were more likely to be dissatisfied (21% 'very dissatisfied' or 'quite dissatisfied' cf 10% average).

There were no differences in satisfaction among age groups or ethnicity.

Summary

In summary, women currently perceive antenatal classes to be beneficial. Women for whom it was their first birth were more likely to be satisfied with the quality of classes, while those who gave birth at home were more likely to be dissatisfied.

Antenatal classes were identified as an area that stood alone from other areas of maternity care, in the sense that they did not have any impact on women's overall satisfaction with care received. While there is no immediate need for change (based on a majority of women being satisfied), the needs of women who go on to give birth at home could be reviewed (given they were more likely to be dissatisfied with the quality of classes).

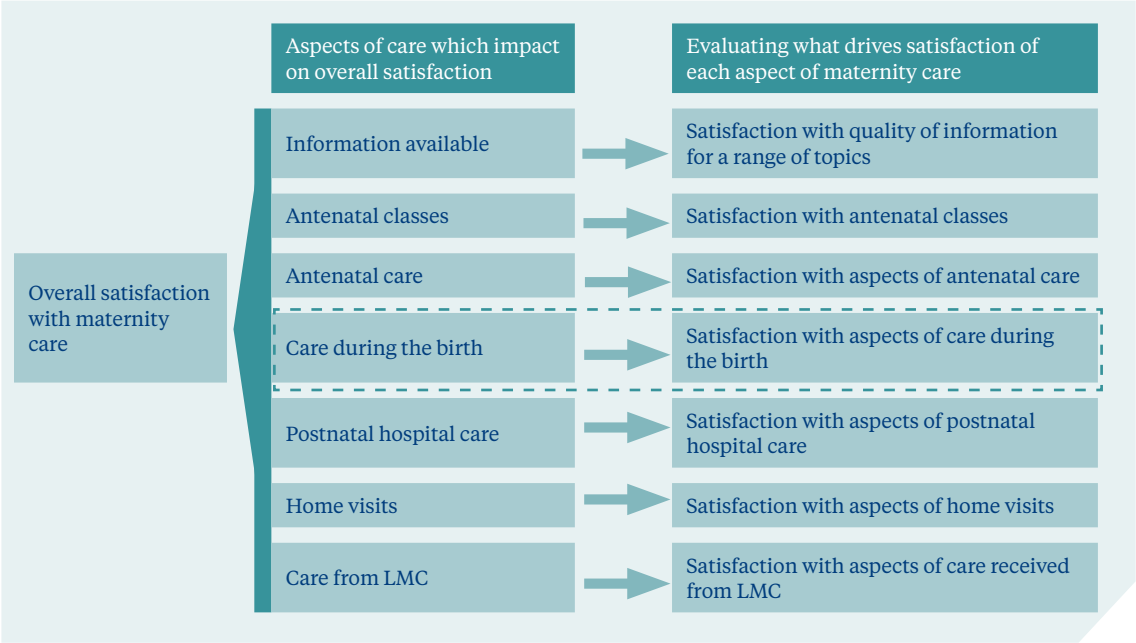
The birth

Introduction

This section looks at care received during the birth. Women's satisfaction with individual aspects of the care received is evaluated to understand what drives satisfaction with this area of maternity care.

The following diagram illustrates the areas covered in this section.

Figure 37: Areas of maternity care



Regression analysis was used to establish the relative impact of each individual aspect of care on women's satisfaction with care received during the birth.

The experiences of women who gave birth in hospital (either a small maternity hospital or the maternity unit of a general hospital) and those who gave birth at home are taken into account.

Location of the birth

The majority of women involved in this research (86%) gave birth in the maternity unit of a general hospital, and a further 8 percent gave birth in a small maternity hospital.

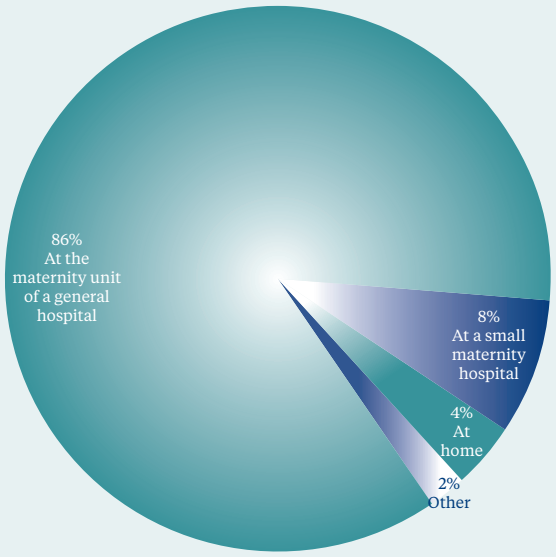
Only a small proportion of the sample (4%) gave birth at home. Women for whom it was not their first birth were more likely to have given birth at home (5% cf 2% among women for whom it was their first birth).

The location where women gave birth was largely where they had planned. Only 1 percent of home births were unplanned, while 11 percent of hospital births were unplanned. (A hospital birth that was not planned was not necessarily a planned home birth originally: women may have planned to give birth in a small maternity hospital but ended up giving birth in the maternity section of a general hospital.)

The following women were more likely to have given birth at a location they did not plan:

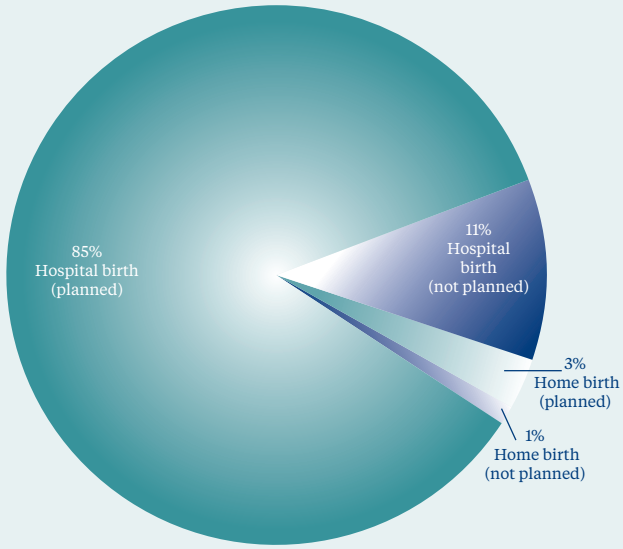
- women for whom it was their first birth (15% cf 10% of women for whom it was not their first birth)
- women under the age of 25 (17% cf 13% average)
- Māori women (17%).

Figure 38: Location where gave birth



Base: All respondents (n=3217)
Q18. Where did you give birth?

Figure 39: Hospital and home births in relation to women's plans[2]



Base: Those who gave birth at home or in hospital (n=3154)
Q18. Where did you give birth?
Q19. Was this where you planned to give birth?

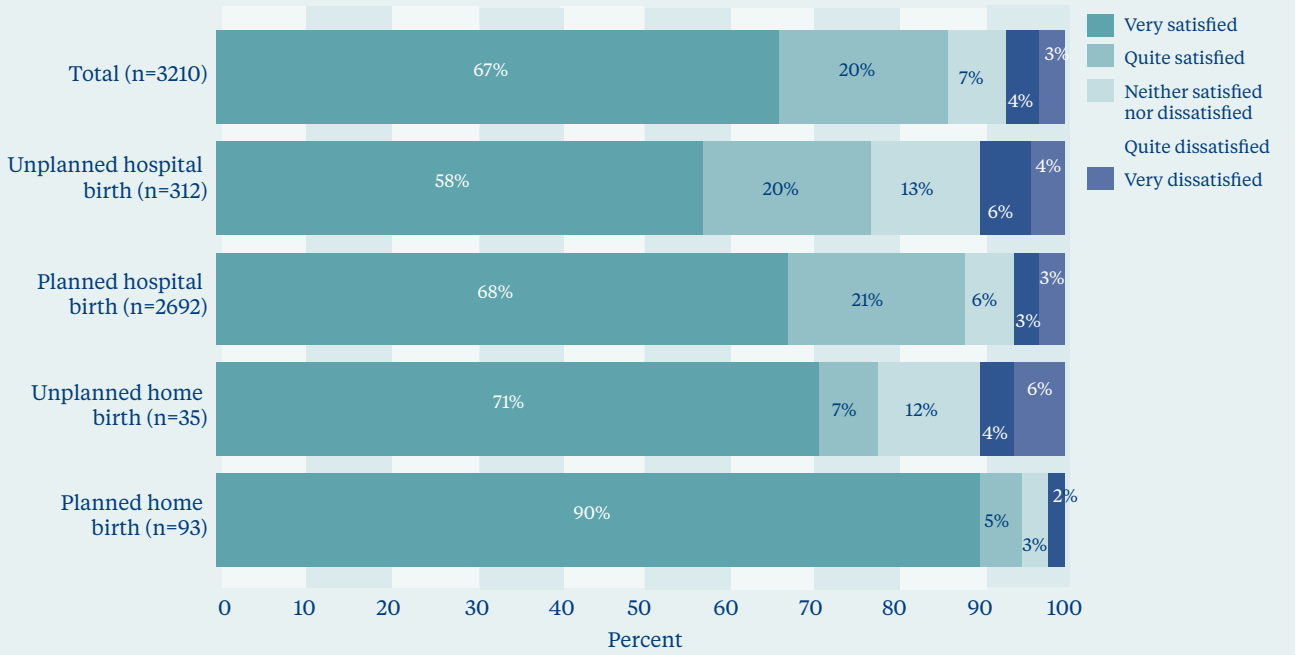
2 The number of home births and hosptial births that were not planned only adds to 12 percent due to a small number of mothers who gave birth in 'other' locations that were also not planned.

Satisfaction with the birth

Around two-thirds of women (67%) were 'very satisfied' with the way in which they were cared for during the birth. A further two in every ten (20%) were 'quite satisfied'.

Women who had a planned home birth were significantly more satisfied, with nine in ten (90%) 'very satisfied' with the care they received. Among women who gave birth in hospital, those who planned for this location were also more likely to be 'very satisfied' with the care received (68% cf 58% of women who did not plan to give birth in a hospital).

Figure 40: Satisfaction with the way women were cared for during the birth



Base: All respondents – excluding those who answered not applicable

Q28. Thinking now about your overall experience, how satisfied were you with the way in which you were cared for during the birth of your baby

A small level of dissatisfaction existed with care received during the birth. The following women were more likely to be 'very dissatisfied' or 'quite dissatisfied' with the care received:

- women with disabilities (13% cf 6% average)[3]
- women from the Hutt Valley DHB area (12%).

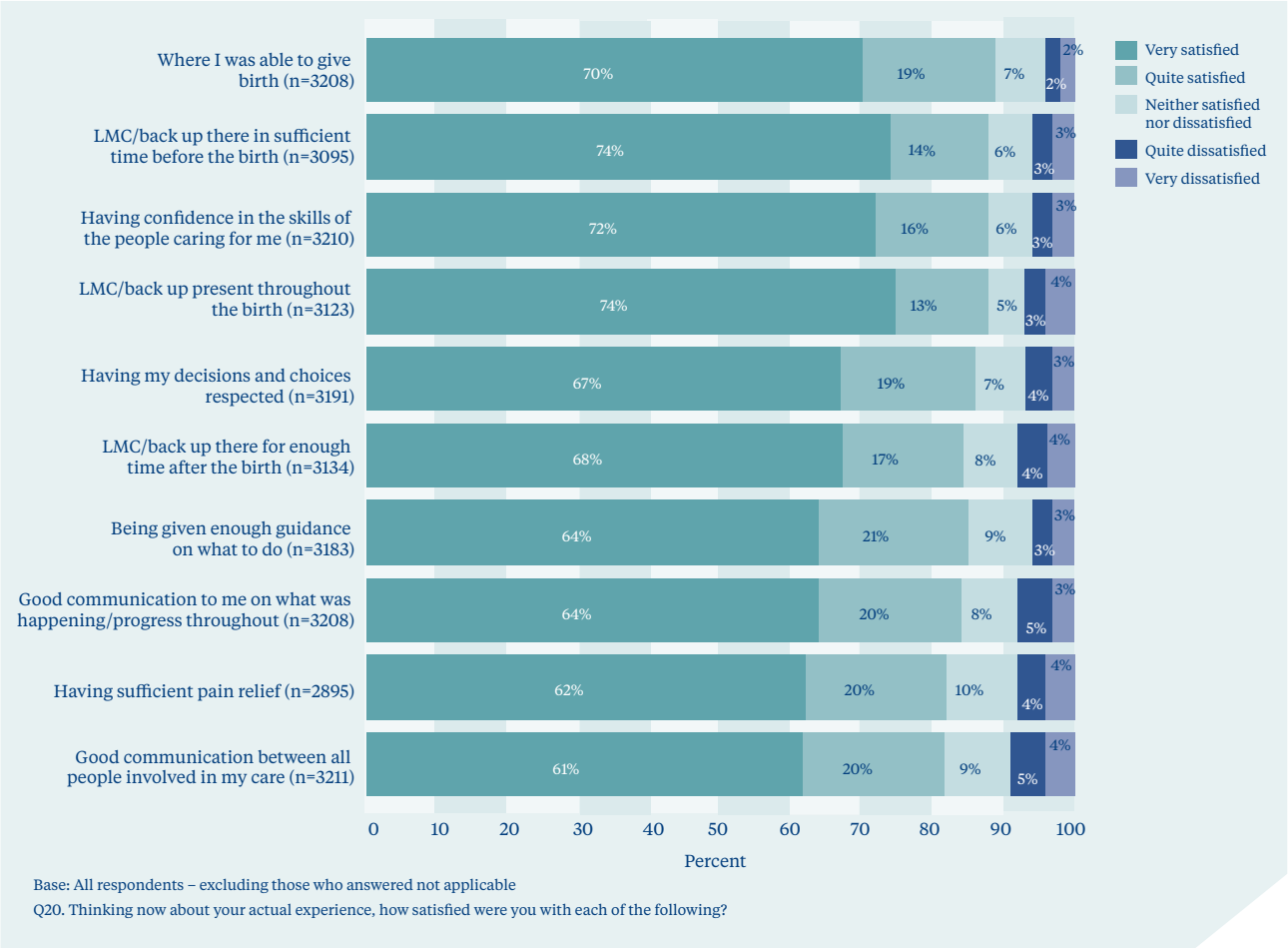
There were no differences in satisfaction among age groups or ethnicity.

3 The average of all mothers who were 'very dissatisfied' or 'quite dissatisfied' does not add to the sum of the individual results in the chart due to rounding.

Satisfaction with aspects of care during the birth

Women were also asked to rate their satisfaction with individual aspects of the birth. At least eight in every ten women were satisfied with each aspect of the birth.

Figure 41: Satisfaction with aspects of care during the birth



Base: All respondents – excluding those who answered not applicable

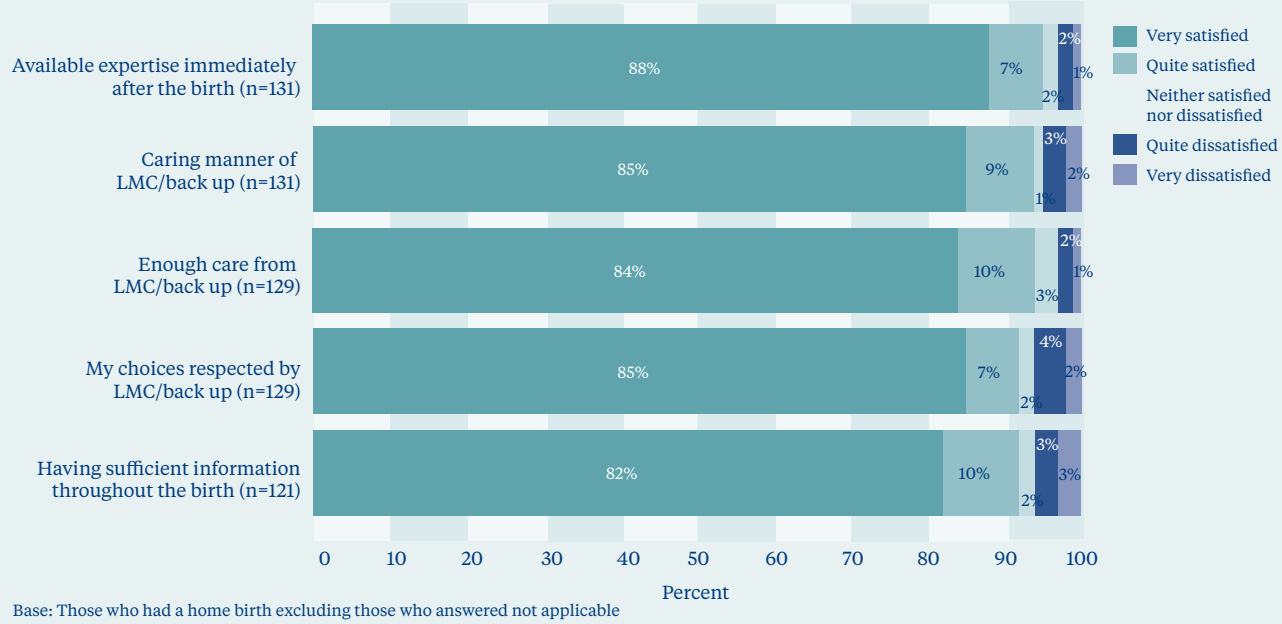
Q20. Thinking now about your actual experience, how satisfied were you with each of the following?

The highest performing areas were women's ability to give birth where they wanted to, their LMC or back-up being there in sufficient time before the birth, and having confidence in the skills of the people caring for them (88% 'very satisfied' or 'quite satisfied').

Satisfaction with aspects of care specific to home births

Women who gave birth at home were asked to rate their satisfaction with aspects of care related to a home birth. Around nine in every ten women were satisfied ('very satisfied' or 'quite satisfied') with individual aspects of care received during their home birth.

Figure 42: Satisfaction with aspects of care during home birth



Base: Those who had a home birth excluding those who answered not applicable

Q22. How satisfied were you with the following aspects of the care you received?

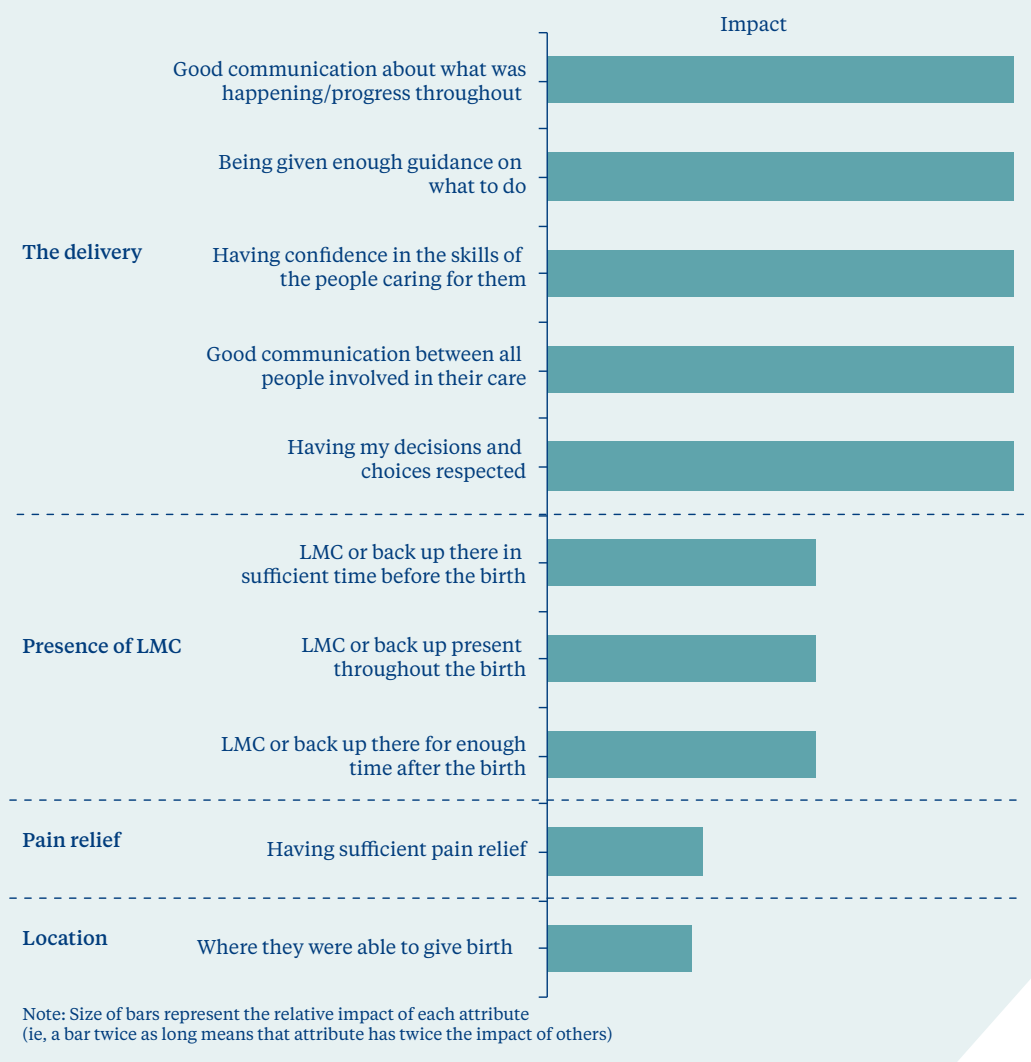
Drivers of satisfaction

Factor analysis was undertaken on aspects of care received during the birth. The results of this analysis can be grouped into four key themes:

- delivery
- presence of LMC
- pain relief
- location.

Each of the aspects of care within each theme were rated a similar way by women, meaning they had a similar impact on women's satisfaction with the way they were cared for during the birth. The relative impact each area had on women's satisfaction is illustrated below.

Figure 43: Impact on satisfaction with care during the birth



Note: Size of bars represent the relative impact of each attribute (ie, a bar twice as long means that attribute has twice the impact of others)

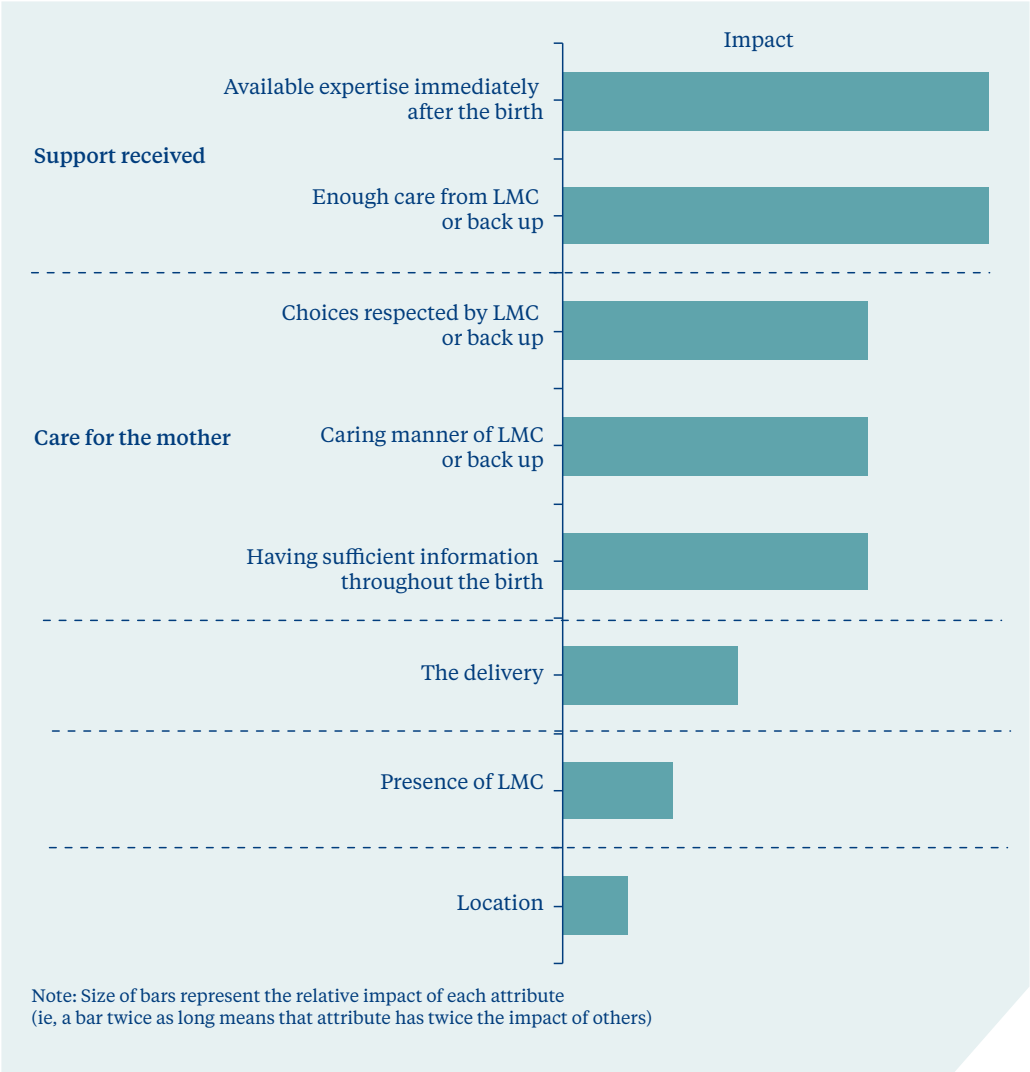
Care received during the delivery had the most impact on women's satisfaction with care received during the birth.

Two additional themes were identified for women who gave birth at home:

- care for the mother
- support received.

Among women who had a home birth, each of the aspects of care within each theme were rated a similar way, meaning they also had a similar amount of impact on women's satisfaction with care. The delivery, presence of the LMC and location (themes identified in relation to all births) were also identified as having some impact on the care received during a home birth; however, pain relief was identified as having no statistically significant impact on women's satisfaction with care during a home birth. The relative impact of each area is illustrated in figure 44.

Figure 44: Impact on satisfaction with care during home birth



Note: Size of bars represent the relative impact of each attribute
(ie, a bar twice as long means that attribute has twice the impact of others)

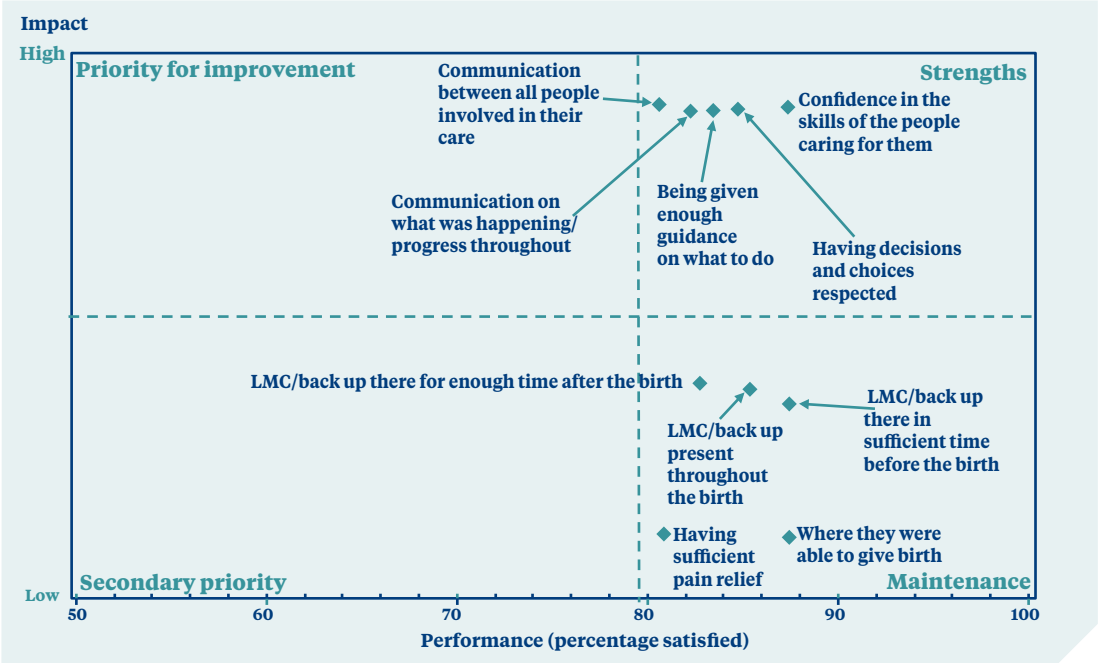
Support received in the form of available expertise after the birth and care from an LMC or backup was identified as having the most impact on women's satisfaction with care received during a home birth.

Priorities

The relationship between the impact on women's satisfaction and performance has been reviewed to establish priority areas for improvement within the area of care received during the birth.

Aspects of care relating to the delivery – which had the greatest impact on women's satisfaction – are performing well and can be considered strengths of maternity care. All other aspects of care during the birth simply need to be maintained at their current level.

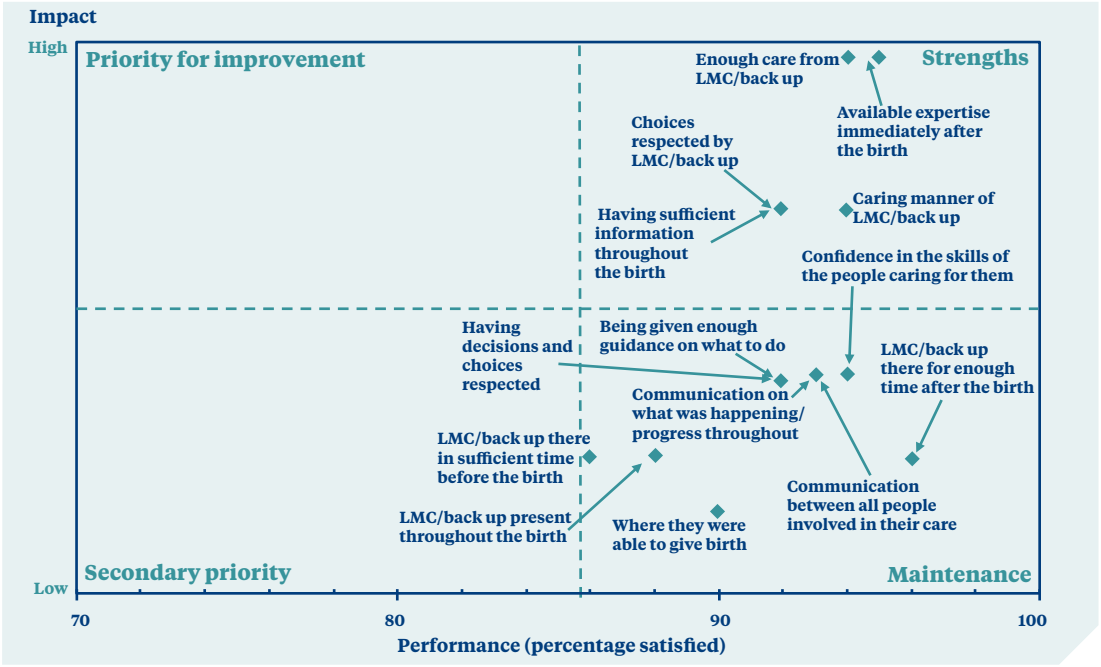
Figure 45: Improving care during the birth



Aspects of care relating to home births, particularly those that have the greatest impact on women's satisfaction, are performing well. The key areas of support received and care for the mother can be considered strengths.

Two aspects of care – LMC or backup being there in sufficient time before the birth and LMC or back-up being present throughout the birth – are identified as secondary priorities for improvement, given their lower performance relative to other aspects of care.

Figure 46: Improving care during home births



Summary

Care received during the birth (regardless of whether in a hospital or at home) is a clear strength of maternity care. The majority of women surveyed were satisfied with the care they received during the birth.

Aspects of care that had the greatest impact on women's satisfaction performed well, and there are no priority areas for improvement. The presence of the LMC is an area that can be focused on in relation to home births, but it is not identified as a priority at this stage.

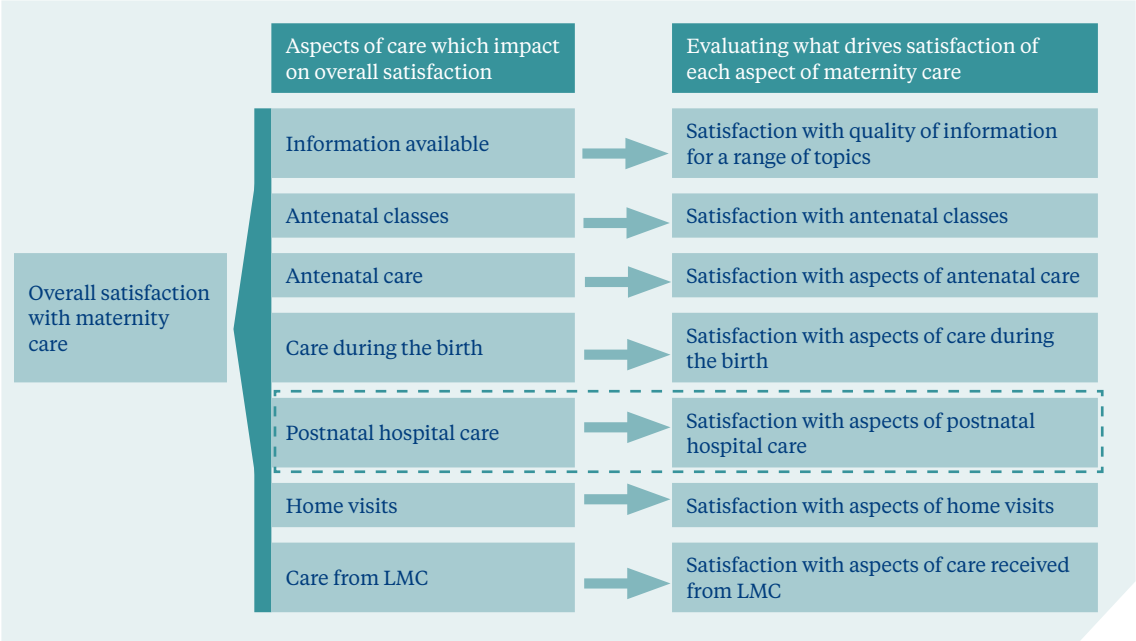
Postnatal hospital care

Introduction

This section looks at the care women received in hospital after the birth of their baby. Women's satisfaction with the individual aspects of care received during this period is evaluated in order to understand what drives satisfaction with this area of maternity care.

The following diagram illustrates the areas covered in this section, and the relationship with women's satisfaction with overall care received.

Figure 47: Areas of maternity care

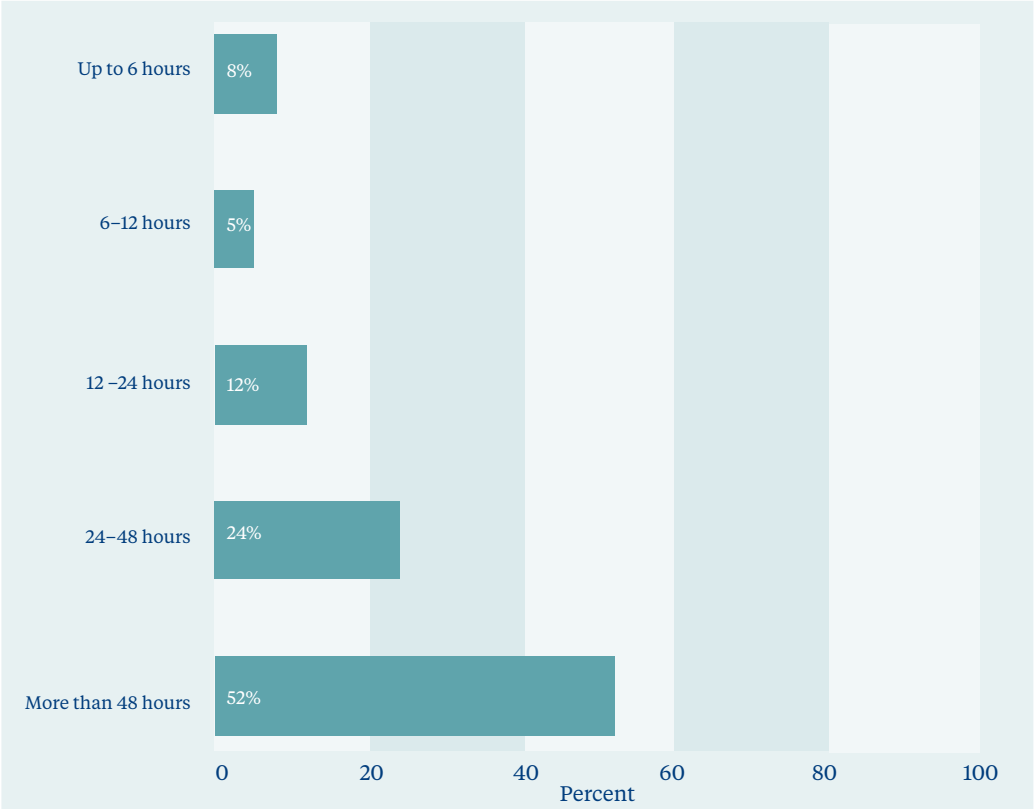


Regression analysis was used to establish the relative impact each individual aspect of care had on women's satisfaction with postnatal hospital care.

Hospital stays

The majority of women surveyed remained in hospital for at least 24 hours after the birth of their baby. Around half (52%) remained in hospital for more than 48 hours: most notably women for whom it was their first birth (62% of women for whom it was their first birth remained in hospital for more than 48 hours). In fact, very few women for whom it was their first birth left hospital within the first 24 hours (16% cf 31% of women for whom it was not their first birth).

Figure 48: Length of hospital stay after the birth



Base : All respondents – excluding those who answered not applicable (n=3096)

Q23. If you had your baby in hospital or stayed in hospital after the birth (including small maternity hospitals), how long was your hospital stay?

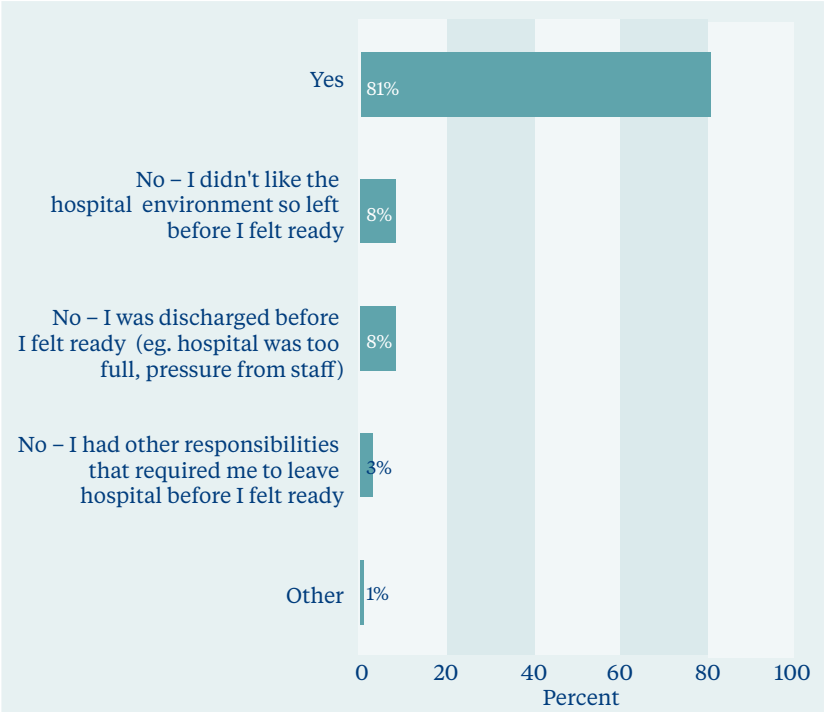
The following women were also more likely to have remained in hospital for more than 48 hours:

- women who needed hospitalisation before going into labour (66% cf 52% average)
- women who had a baby who required special medical attention (81%)
- women who needed special medical attention during or after the birth (68%)
- women from Hawke's Bay (63%), Canterbury (65%) and Southland (65%) DHB areas.

Leaving hospital

The majority of women (81%) felt ready to leave hospital when they were discharged. However, around one in every five women surveyed left before they felt ready.

Figure 49: Feeling ready to leave hospital



Base : All respondents who stayed in hospital – excluding those who answered not applicable (n=3073)

Q24. If you had your baby in hospital or stayed in hospital after the birth (including small maternity hospitals), when you left hospital, did you feel ready to leave?

The following women were less likely to feel ready to leave:

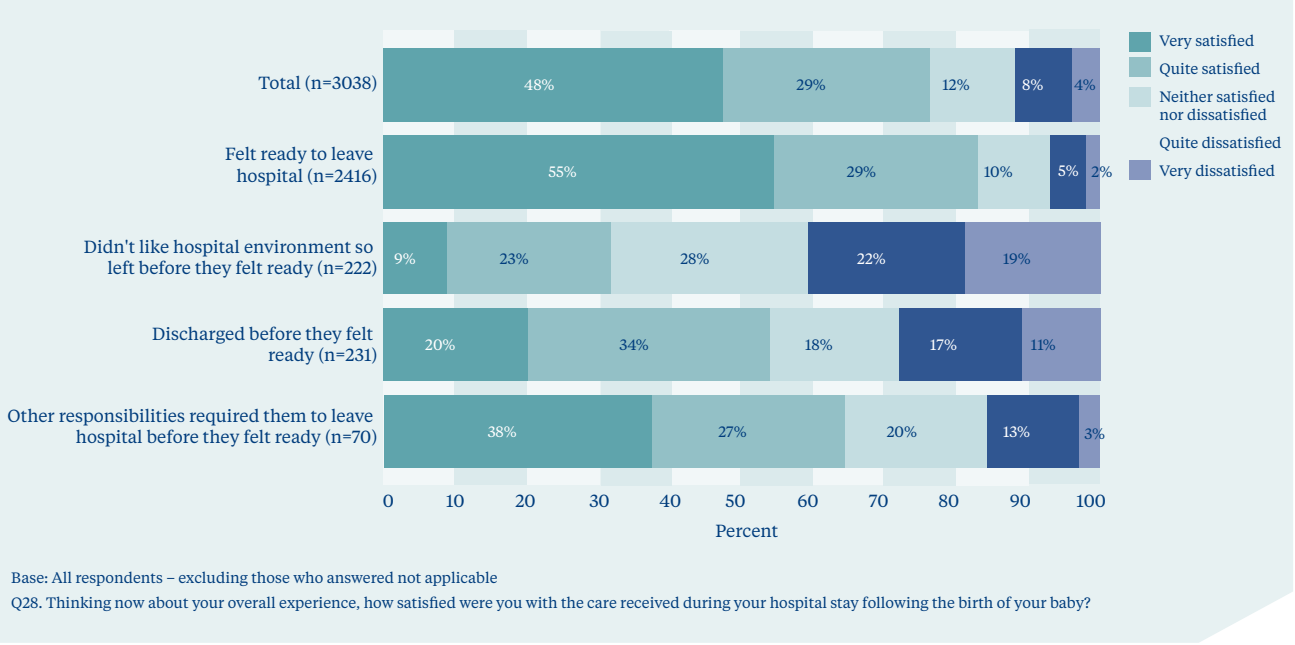
- women for whom it was their first birth (79% cf 83% of women for whom it was not their first birth)
- women with disabilities (72% cf 82% of women without disabilities)
- women from Hutt Valley DHB (73%).

Satisfaction with postnatal hospital care

Around three-quarters (77%) of women were satisfied with the postnatal care they received during their hospital stay. Around half (48%) were, in fact, 'very satisfied'.

Those who felt ready to leave hospital when they were discharged were significantly more likely to be 'very satisfied' with the postnatal hospital care they received (55% cf 48% average). In comparison, dissatisfaction (feeling 'very dissatisfied' or 'quite dissatisfied') was significantly higher among women who did not like the hospital environment so left early (41%) and women who were discharged before they felt ready (28%).

Figure 50: Satisfaction with postnatal hospital care



Base: All respondents – excluding those who answered not applicable

Q28. Thinking now about your overall experience, how satisfied were you with the care received during your hospital stay following the birth of your baby?

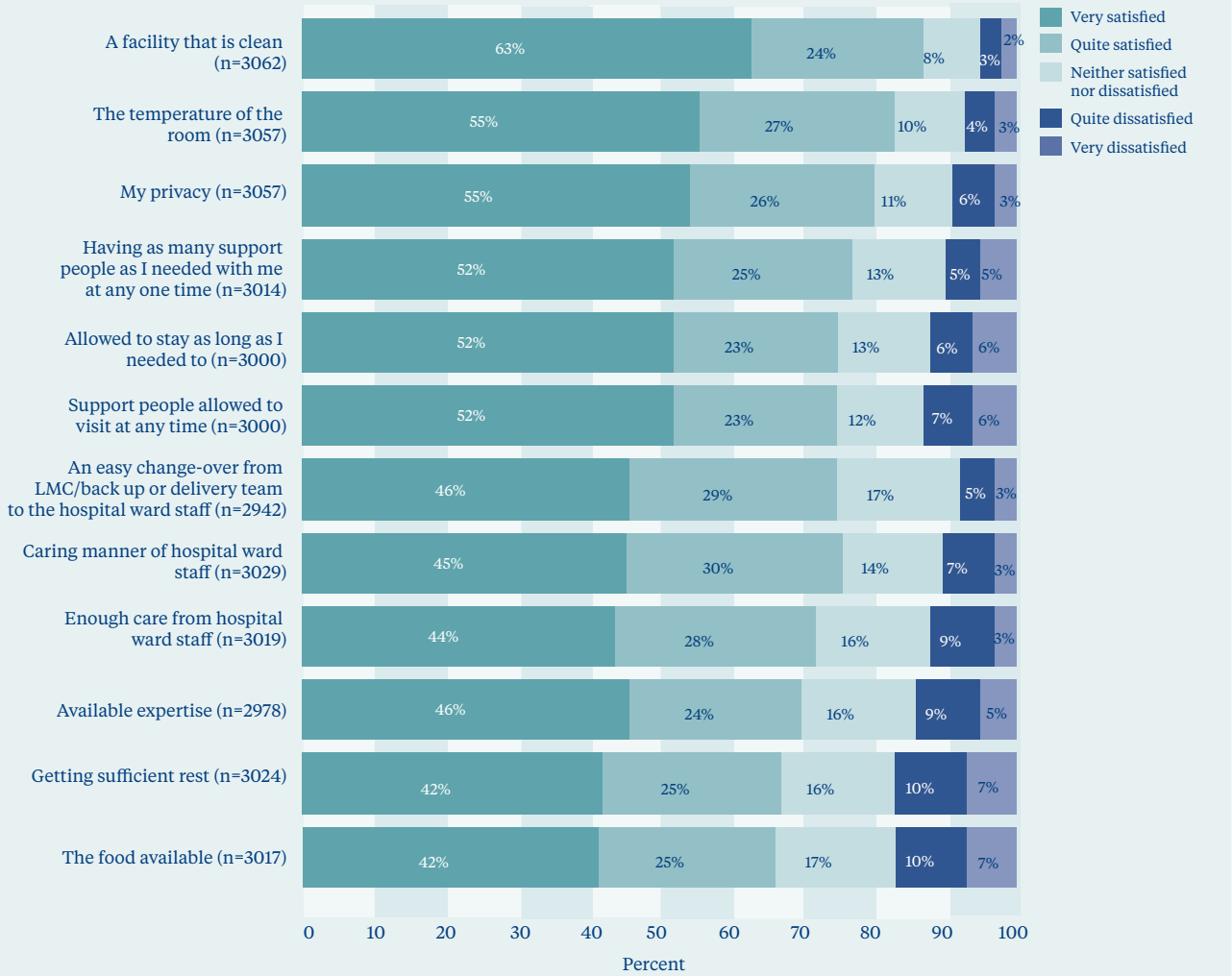
Women from the Canterbury DHB area were more likely to be satisfied with the care they received during their hospital stay following the birth of their baby (83% 'very satisfied' or 'quite satisfied' cf 77% average).

There were no differences in satisfaction among age groups and ethnicities. Satisfaction was also consistent among women experiencing various lengths of time in hospital, indicating the same standard of care was maintained throughout the stay.

Satisfaction with aspects of postnatal hospital care

Women were asked to rate their satisfaction on individual aspects of care received during their hospital stay following the birth. Satisfaction with individual aspects ranged from around two-thirds (67%) of women satisfied with the food available ('very satisfied' or 'quite satisfied') through to around nine in ten (88%) satisfied with the cleanliness of the facility.

Figure 51: Satisfaction with individual aspects of postnatal hospital care



Base : All respondents who stayed in hospital – excluding those who answered not applicable

Q25. Thinking now about your actual experience, how satisfied were you with each of the following?

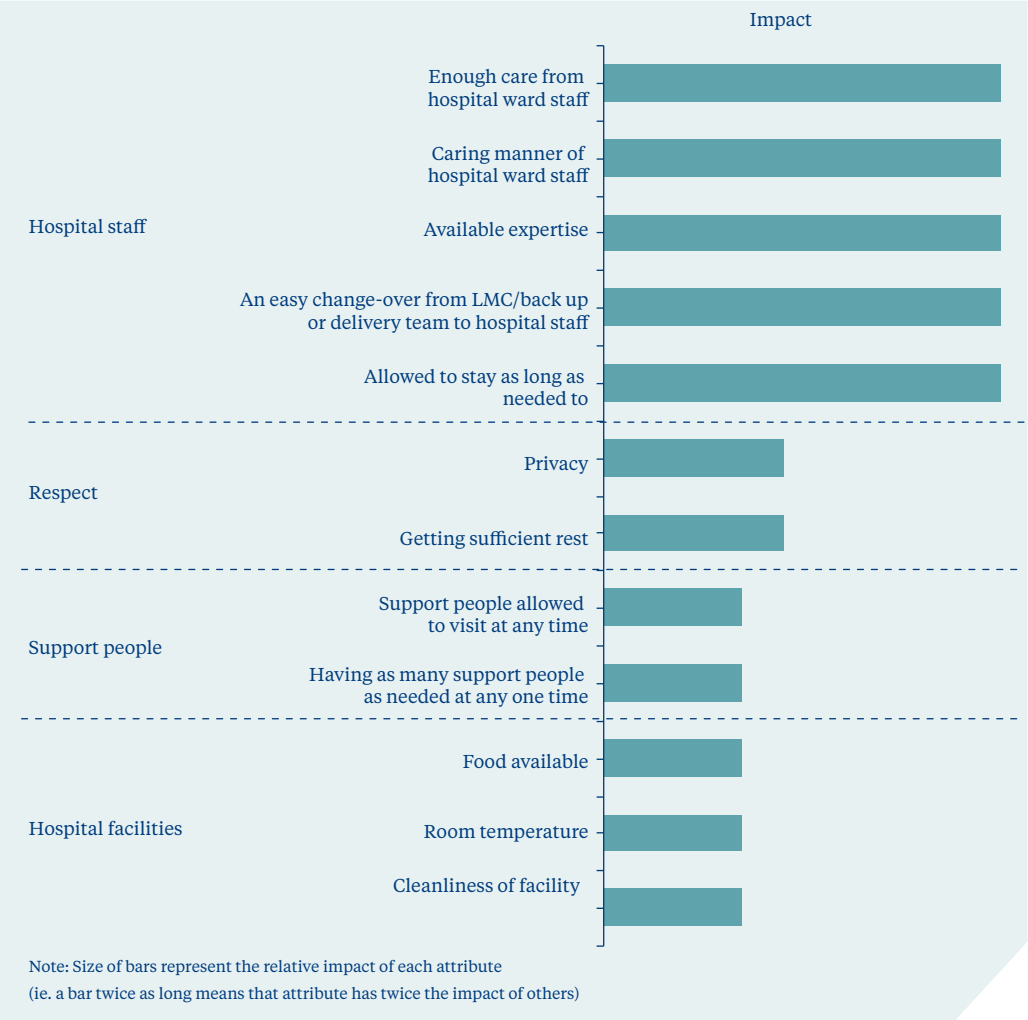
Drivers of satisfaction

Factor analysis was undertaken on individual aspects of postnatal hospital care. The results of this analysis can be grouped into four key themes:

- hospital staff
- respect
- support people
- hospital facilities.

Each of the aspects of care within each theme were rated a similar way by women, meaning they also had a similar impact on women's satisfaction. The relative impact each theme had on women's satisfaction is illustrated below.

Figure 52: Impact on satisfaction with postnatal hospital care



Hospital staff were identified as having the most impact, in terms of what drives women's satisfaction with postnatal hospital care. That is, a high standard of care from hospital staff was more likely to result in women being satisfied with the overall care received during their hospital stay.

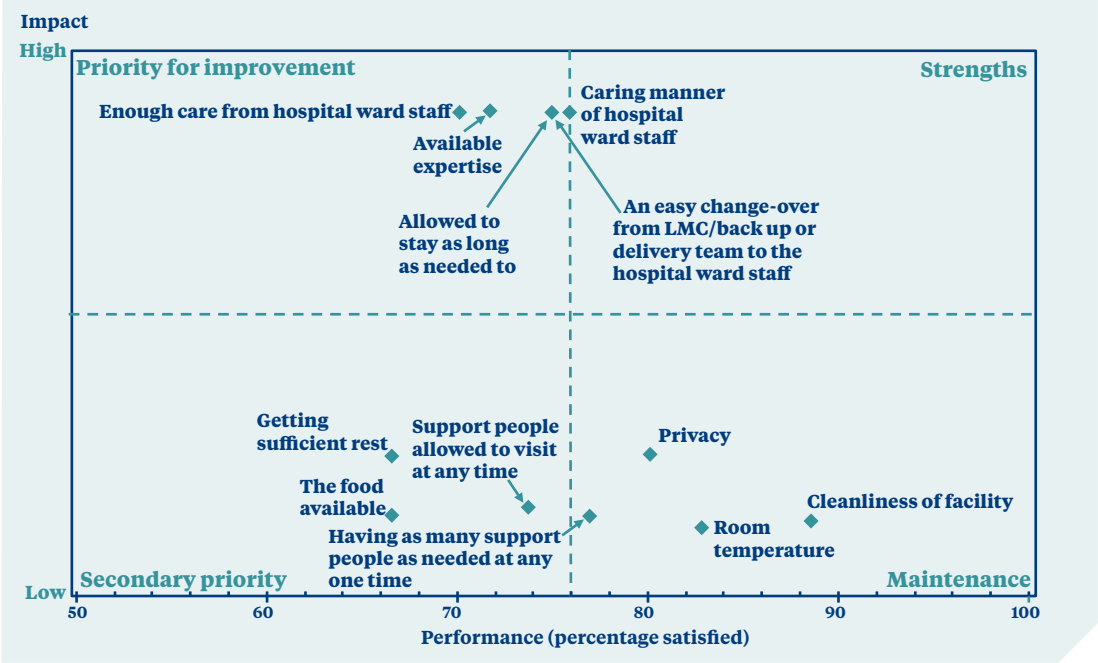
Priorities

The relationship between the impact on women's satisfaction and performance has been reviewed to establish priority areas for improvement within postnatal hospital care.

Relative to other aspects of postnatal hospital care, aspects associated with hospital staff were weaker in performance. In particular, aspects of care affected by staff numbers – receiving enough care from hospital ward staff and the availability of expertise – were a concern. These aspects are identified as priorities for improvement given the impact they had on women's satisfaction.

Several aspects of care associated with respect and the hospital's facilities are identified as secondary areas for improvement.

Figure 53: Improving postnatal hospital care



Summary

Postnatal hospital care is an area that the Ministry of Health needs to focus on; it had the most impact on women's overall satisfaction with the care they received from pregnancy through to six weeks after the birth, yet their satisfaction with this area was lower than for all other areas of maternity care.

Individual aspects of postnatal hospital care relating to hospital staff had the most impact on women's satisfaction with postnatal care, yet the performance of hospital staff, in terms of availability of staff (rather than quality of care) was somewhat weaker than other aspects of postnatal care. This is, therefore, a priority for improvement.

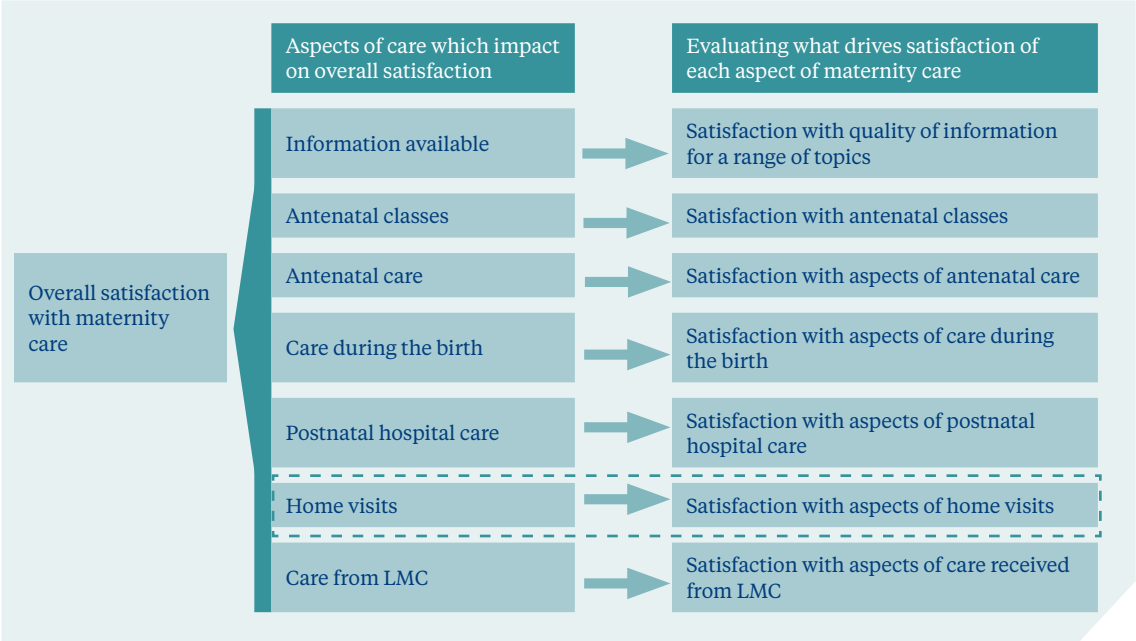
Home visits

Introduction

This section looks at care received during home visits made by LMCs after the birth. Women's satisfaction with individual aspects of the care received during home visits is evaluated in order to understand what drives satisfaction with this area of maternity care.

The following diagram illustrates the areas covered in this section.

Figure 54: Areas of maternity care



Regression analysis was used to establish the relative impact each individual aspect of care had on women's satisfaction with the care received during home visits.

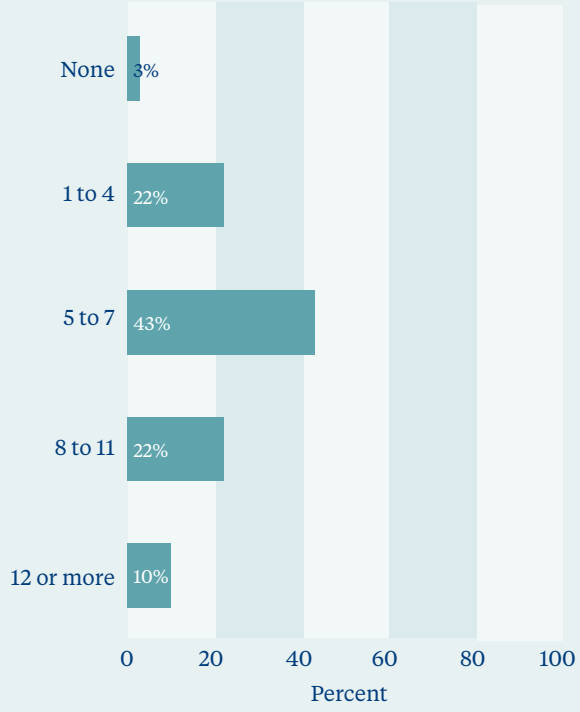
Number of home visits

The majority of women received at least five home visits from their LMC after giving birth – the minimum number required. However, a quarter of women surveyed did not receive five visits.

One in every ten women was likely to have received 12 or more home visits from their LMC. This was more likely to be the case for the following women:

- women for whom it was their first birth (13% received 12 or more home visits cf 8% for women for whom it was not their first birth)
- women who gave birth at home – whether it was planned or not (22% cf 10% of all women)
- young mothers[4] (15% cf 10% for all women).

Figure 55: Number of home visits received from LMC



Base: Those who had a LMC – excluding those who answered not applicable (n=3151)
Q26. After the birth of your baby, how many home visits did your LMC make?

Women with disabilities were unlikely to have received a higher than average number of home visits from their LMC, while women who had a GP or obstetrician or specialist as their LMC at birth, or had complications during the birth, were more likely to have no home visits.

Women from Auckland and Taranaki DHB areas were more likely to have received less than five visits (39% and 44%, respectively, cf 25% average).

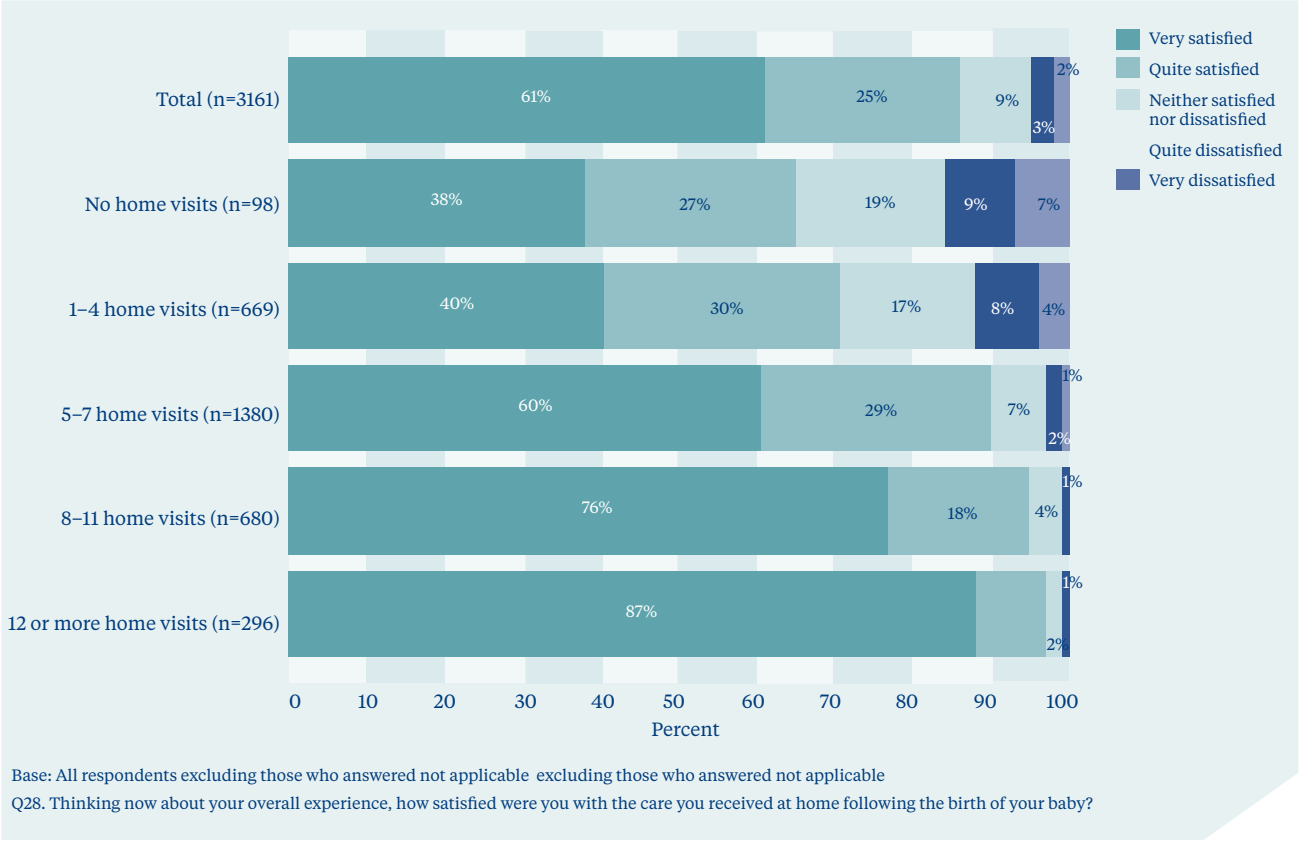
4 Young mothers are classified as those under 24 years of age.

Satisfaction with home visits

The majority of women (86%) were satisfied ('very satisfied' or 'quite satisfied') with the care they received during home visits from their LMC after the birth.

Satisfaction with care received increased with the number of home visits the LMC made. Nearly nine in every ten women (87%) who received 12 or more home visits were 'very satisfied' with the care they received.

Figure 56: Satisfaction with care received during home visits by number of visits



Base: All respondents excluding those who answered not applicable excluding those who answered not applicable

Q28. Thinking now about your overall experience, how satisfied were you with the care you received at home following the birth of your baby?

Women who gave birth at home, in particular in planned home births, were more likely to be satisfied with the care they received at home following the birth of their baby (98% cf 86% average).

Women with disabilities were less likely to be satisfied (74% cf 87% for women without disabilities).

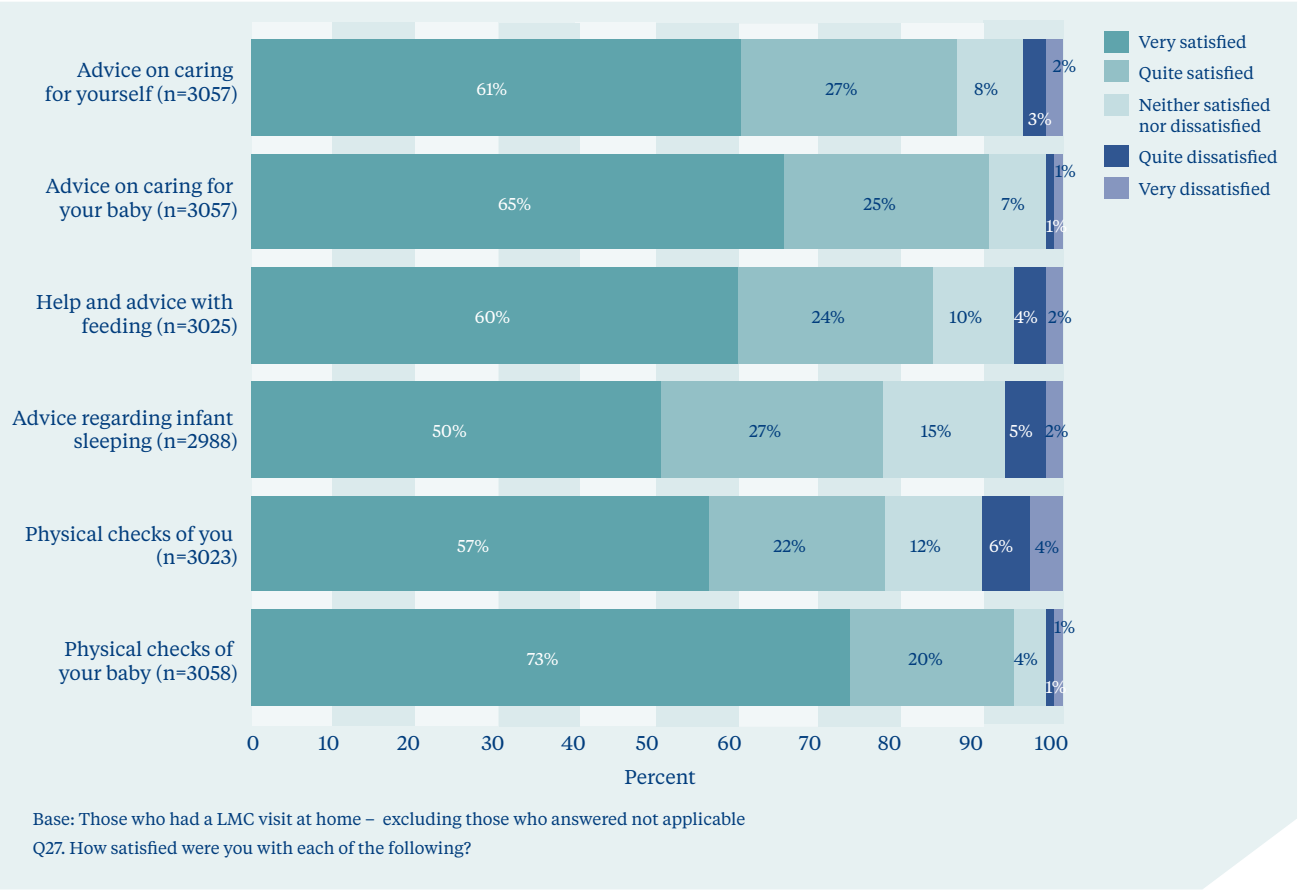
There was no difference in satisfaction among age groups or ethnicity.

Satisfaction with individual aspects

Women were asked to rate their satisfaction with individual aspects of care received during home visits from their LMC. The strongest performing area was physical checks of the baby, with around three-quarters (73%) of women 'very satisfied' with this aspect of care.

At least half of all women were 'very satisfied' with each individual aspect of care; however, satisfaction (feeling 'very satisfied' or 'quite satisfied') was lower for advice regarding infant sleeping and physical checks of the mother.

Figure 57: Satisfaction with individual aspects of home visits



Base: Those who had a LMC visit at home – excluding those who answered not applicable

Q27. How satisfied were you with each of the following?

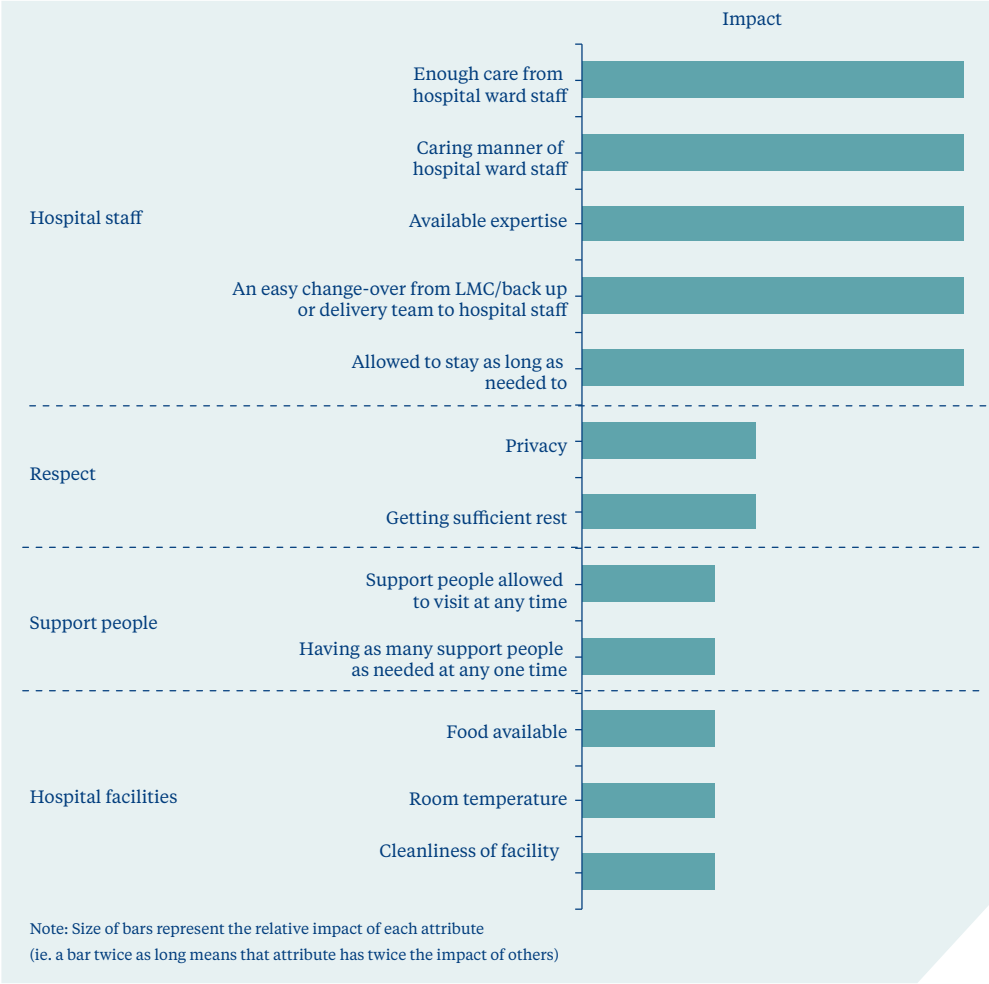
Drivers of satisfaction

Factor analysis was undertaken on individual aspects of postnatal care received during home visits. The results of this analysis can be grouped into three key themes:

- advice
- the baby's health
- the mother's health.

Each of the aspects within each theme were rated a similar way by women, meaning their impact on women's satisfaction was also similar. There was very little differentiation in the impact the three areas had on women's satisfaction with home visits; this is illustrated below.

Figure 58: Impact on satisfaction with home visits



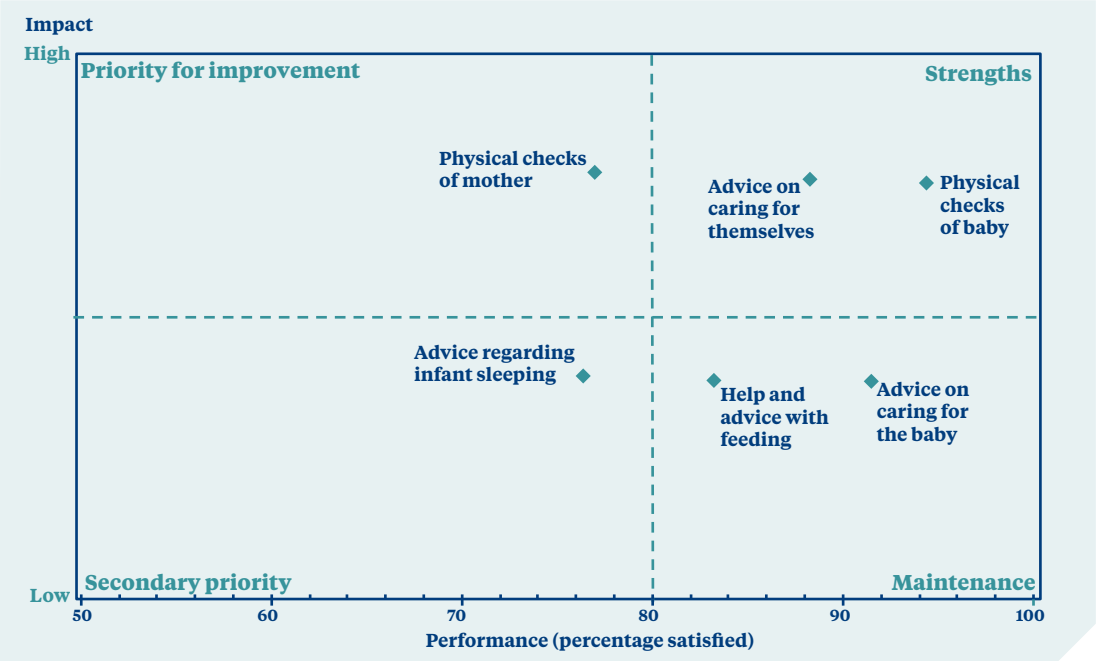
If anything, the mother's and baby's health were identified as having slightly more impact on women's satisfaction than advice received during home visits.

Priorities

The relationship between the impact on women's satisfaction and performance has been reviewed in order to identify priority areas for improvement within the area of home visits.

Physical checks of the mother are identified as a priority area for improvement. Advice regarding infant sleeping is identified as a secondary area for improvement, given it had slightly less of an impact on women's satisfaction with home visits.

Figure 59: Improving home visits



Advice to women on caring for themselves and physical checks of the baby can be considered strengths of maternity care.

Summary

In summary, the quality of home visits from LMCs following the birth of the baby is a strength of maternity care. While the majority of women surveyed were satisfied (either 'very satisfied' or 'quite satisfied') with the care received during these visits, a quarter of women did not actually receive the minimum of five home visits.

Physical checks of the mother are identified as a priority area for improvement, while advice regarding infant sleeping should also be a focal point given it had only a slightly lower impact on women's satisfaction than physical checks of the mother.

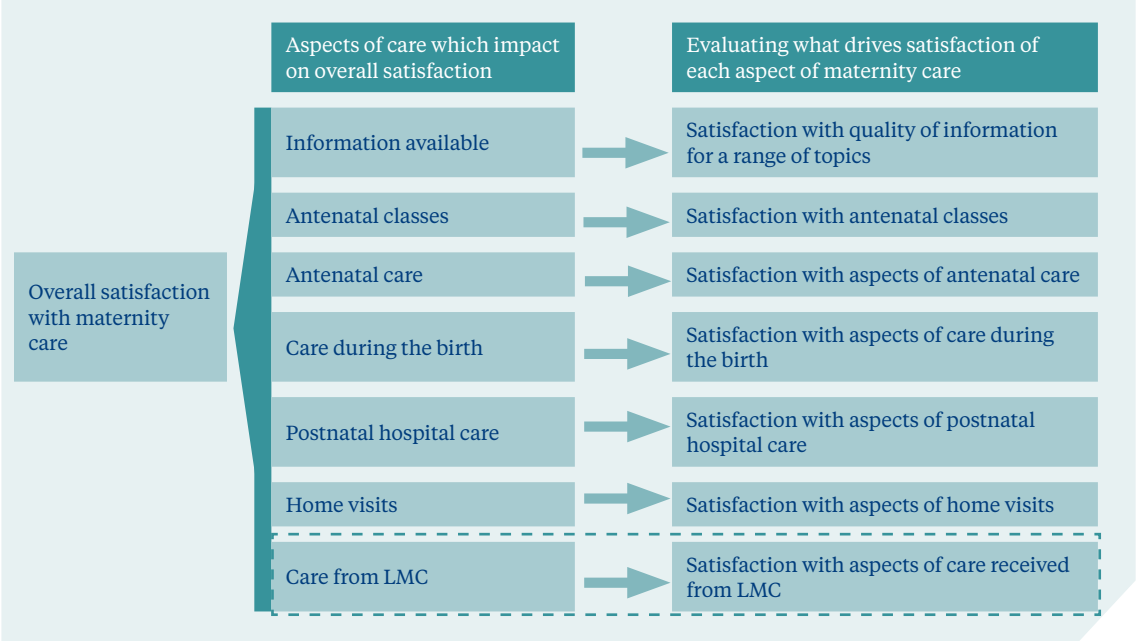
Lead Maternity Carer

Introduction

This section looks at care received from the Lead Maternity Carer (LMC) throughout the pregnancy, during the birth and hospital stay after the birth, and during home visits following the birth. Women's satisfaction with individual aspects of the care received from a LMC is evaluated in order to understand what drives satisfaction with this area of maternity care.

The following diagram illustrates what is covered in this section and the relationship with women's satisfaction with the overall care received.

Figure 60: Areas of maternity care

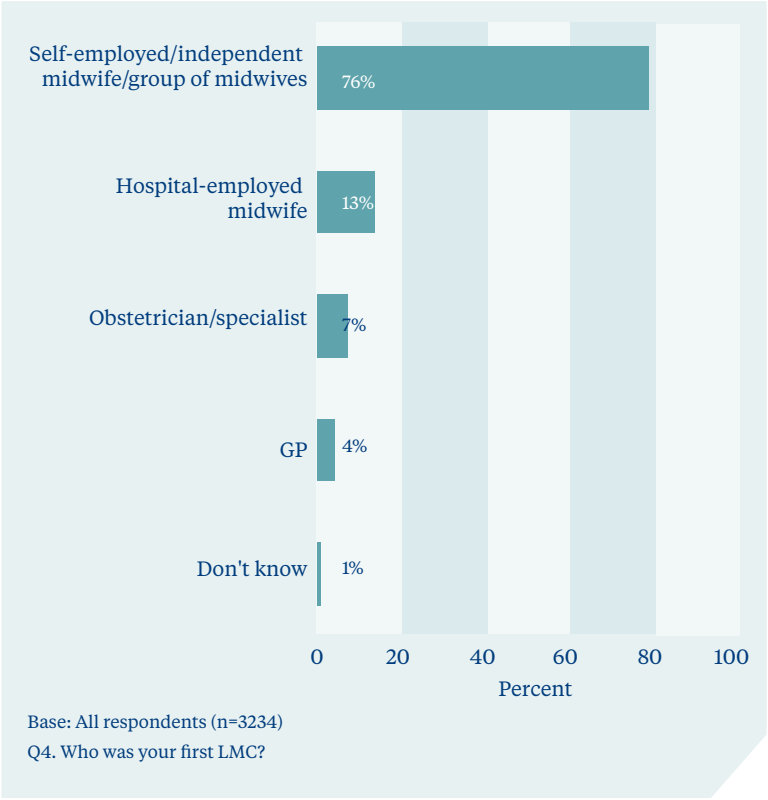


Regression analysis was used to establish the relative impact each individual aspect of care had on women's overall satisfaction with the care received from their LMC.

Choosing a LMC

Women have the option of choosing a LMC. The majority of women choose to have a LMC – only nine women involved in this research chose not to. The most common choice of LMC was a self-employed or independent midwife or group of midwives.

Figure 61: First LMC



Base: All respondents (n=3234)
Q4. Who was your first LMC?

The following women were more likely to chose a self-employed or independent midwife (or group of midwives):

- women planning a home birth (97% cf 76% average)
- women aged 25–34 (80%).

The following women were more likely to choose a hospital-employed midwife:

- women under 25 years of age (20% cf 13% average)
- Māori and Pacific women (17% and 26% respectively).

While only a small number of women selected an obstetrician or specialist as their LMC, this was more likely to be women 35 years of age or older (17% cf 7% average).

Only nine women involved in the research had chosen not to have a LMC. All nine also chose not to attend an antenatal class. For three of these women it was their first birth.

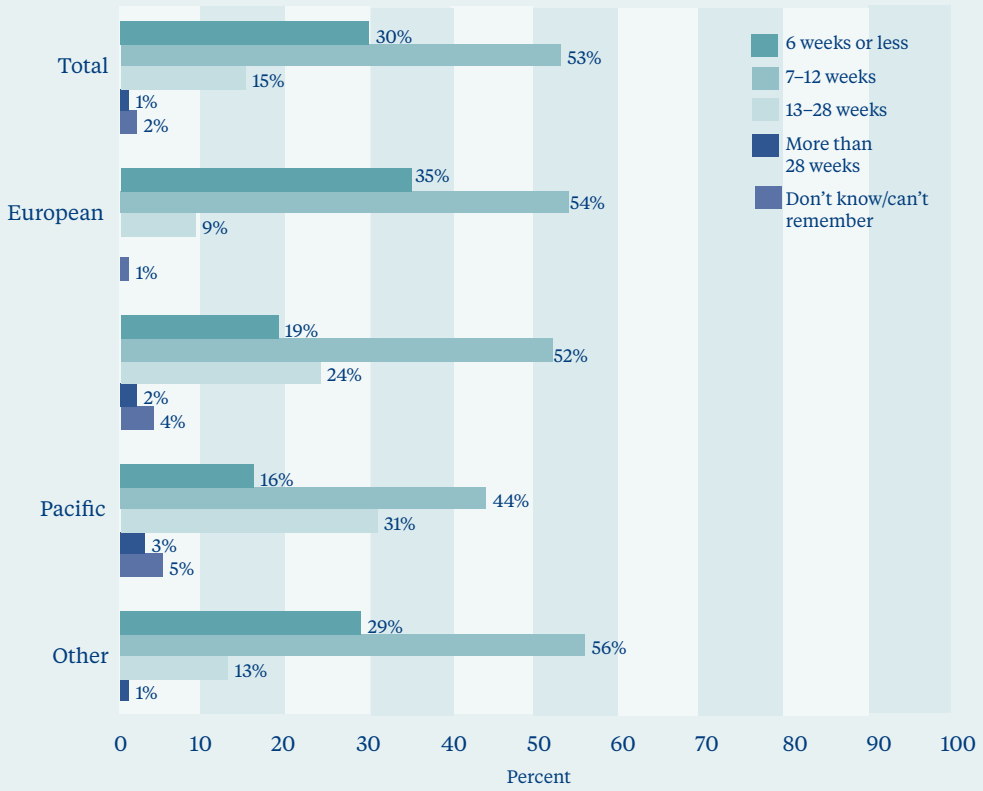
Three of the nine women chose to use the hospital team provided, while three indicated there was not enough information on how to choose a LMC, or did not even know they could choose one. Two women indicated there was a shortage of LMCs in their area, and the final woman did not want any antenatal care.

When LMC chosen

Three in every ten women surveyed (30%) chose their LMC within the first six weeks of their pregnancy. A further 53 percent chose their LMC in the first 7–12 weeks.

Māori and Pacific women were less likely to choose their LMC within the first six weeks of their pregnancy; both were more likely to make a decision in weeks 13–28.

Figure 62: Time when LMC selected

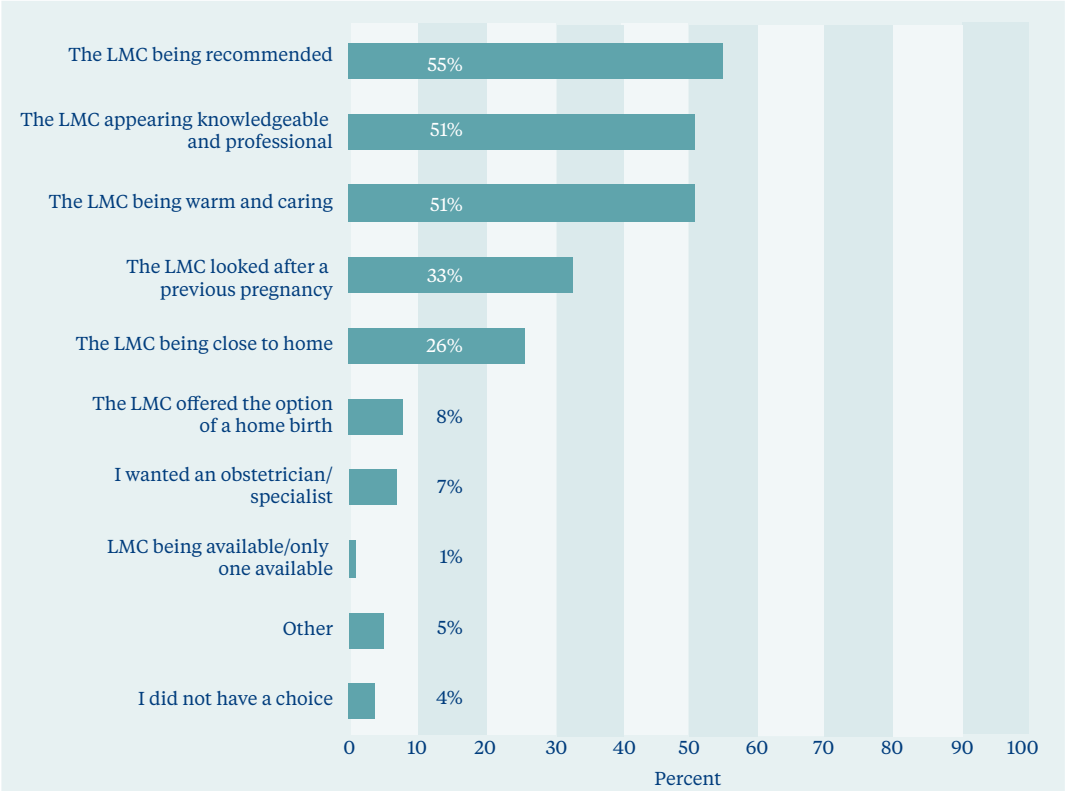


Base: Those who had a LMC (n=3147)

Q6. How many weeks pregnant were you when you chose your LMC?

There are three key factors which influence the choice of LMC: the LMC having been recommended, the LMC appearing knowledgeable and professional, and the LMC being warm and caring. Around half of all women surveyed cited these three factors as having influenced their decision when selecting a LMC.

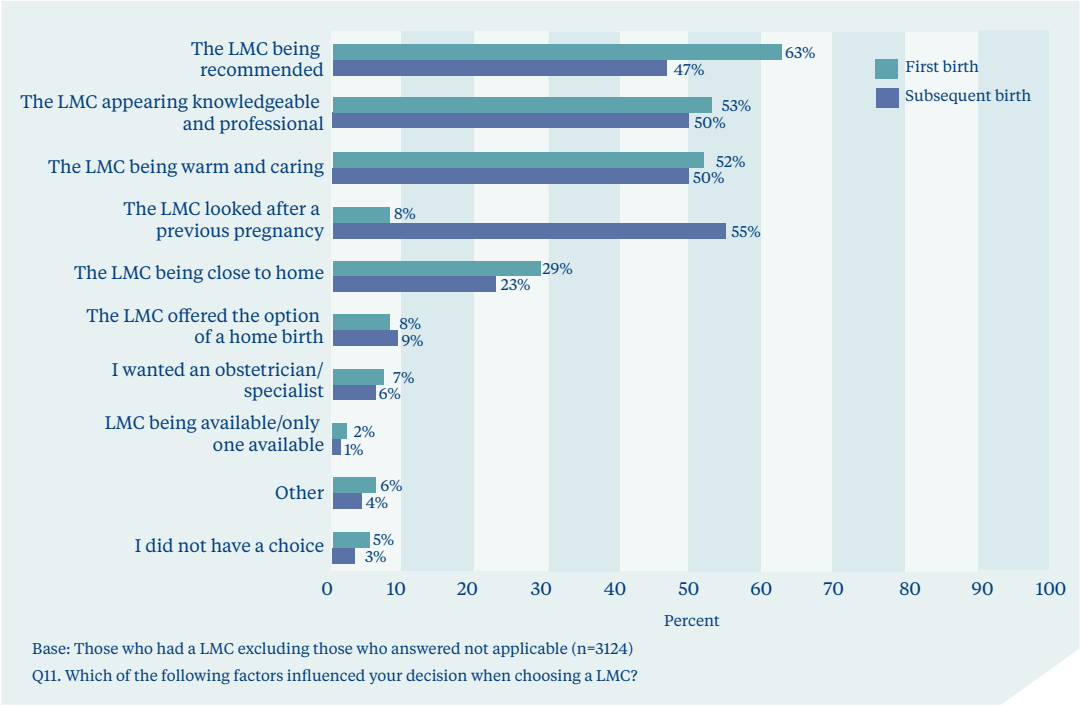
Figure 63: Factors influencing selection of LMC



Base: Those who had a LMC – excluding those who answered not applicable (n=3124)
Q11. Which of the following factors influenced your decision when choosing a LMC?

Women for whom it was their first birth were more likely to have been influenced by the LMC being recommended to them (63% cf 47% of women for whom it was not their first birth). Just over half of all women who had had a particular LMC look after a previous birth (55%) were influenced by this when selecting their LMC.

Figure 64: Factors influencing selection of LMC



Base: Those who had a LMC excluding those who answered not applicable (n=3124)

Q11. Which of the following factors influenced your decision when choosing a LMC?

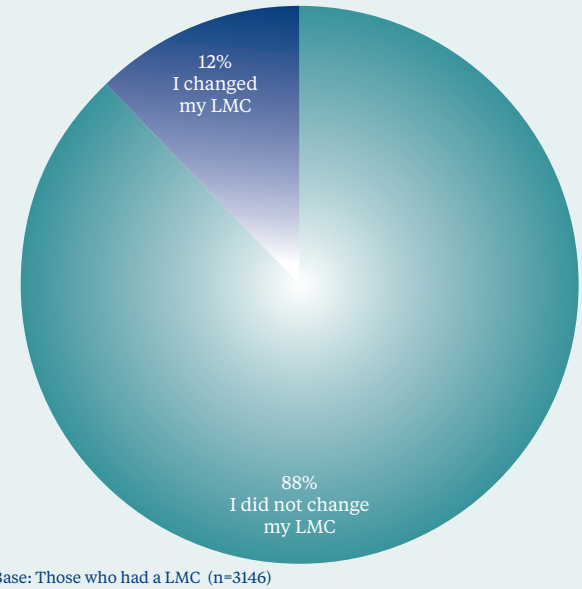
While women with disabilities were influenced by others' recommendations of the LMC, the LMC appearing knowledgeable and professional, and the LMC being warm and caring, they were also more likely to be influenced by whether the LMC offered the option of a home birth (16% cf 8% among women without disabilities).

Women from Auckland and Capital & Coast DHB areas were more likely to want an obstetrician or specialist (19% and 17%, respectively, cf 7% average).

Changing LMC

The majority of women (88%) did not change their LMC during their pregnancy. Women for whom it was their first birth were more likely to change their LMC (15% cf 9% of women for whom it was not their first birth). Women who had a GP as their first LMC were also more likely to change their LMC (23% cf 12% of all women).

Figure 65: Changing LMC during pregnancy

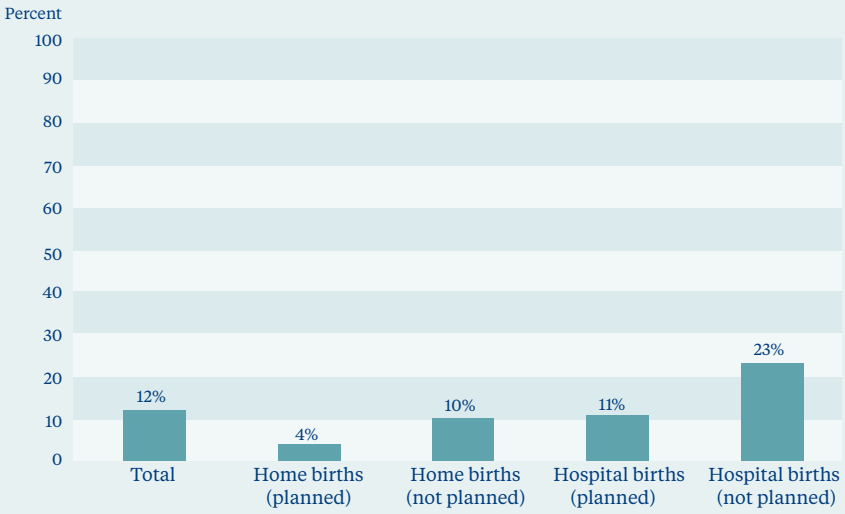


Base: Those who had a LMC (n=3146)

Q7. Did you have the same LMC throughout your pregnancy up until six weeks after the birth of your baby or did you make a change at any stage?

A change in LMC was also more likely to occur when the birth was at a location women did not plan; in particular a hospital birth which was not what had been planned.

Figure 66: Changing LMC during pregnancy



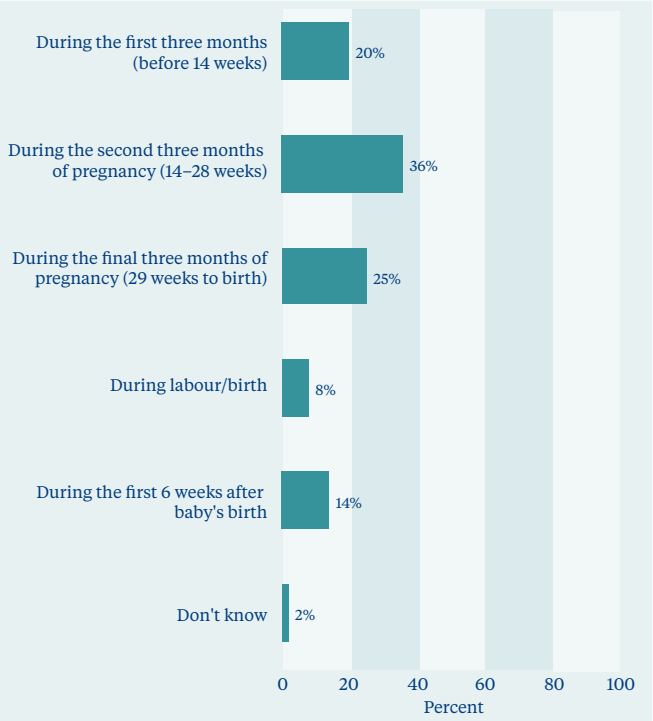
Base: Those who had a LMC (n=3146)

Q7. Did you have the same LMC throughout your pregnancy up until six weeks after the birth of your baby or did you make a change at any stage? (% who changed LMC)

The number of women changing LMC was similar among all age groups and ethnicities.

The most common time that women changed their LMC was during the second three months of their pregnancy.

Figure 67: Stage that LMC changed

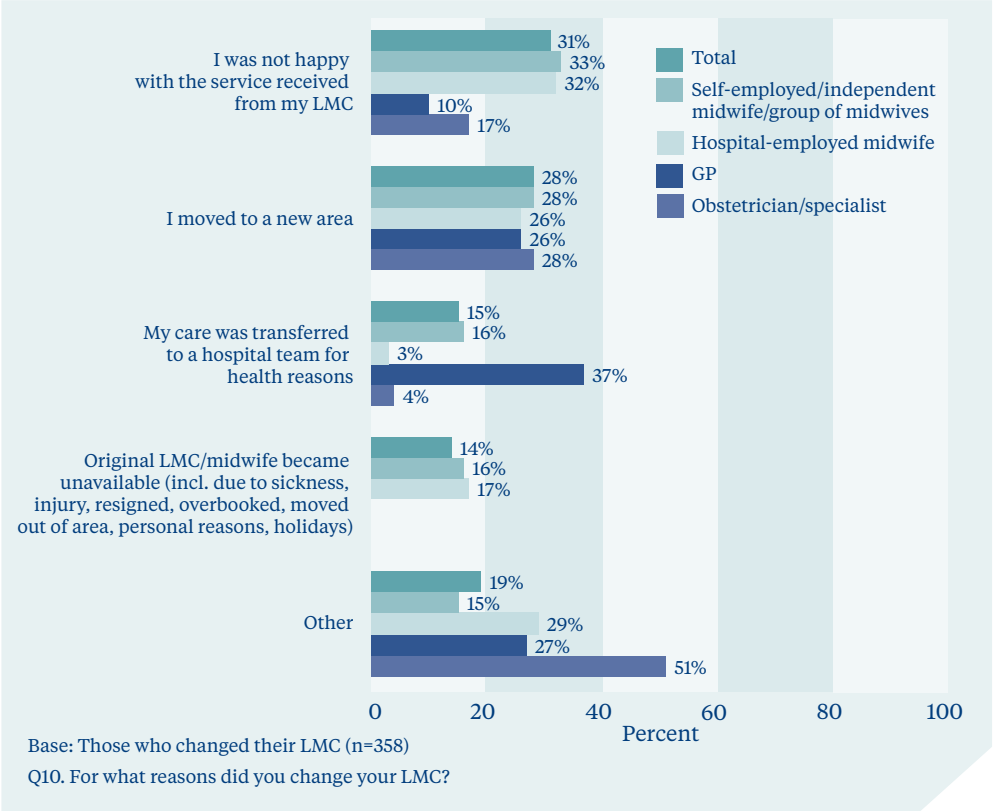


Base: Those who changed their LMC (n=358)

Q8. When did you change your LMC?

Around three in ten women changed their LMC as a result of the service received from them; in particular the service of midwives. Women who initially had a GP as their LMC were more likely to change their LMC because care was transferred to a hospital team for health reasons (37% cf 15% for all women).

Figure 68: Reasons for changing from first LMC



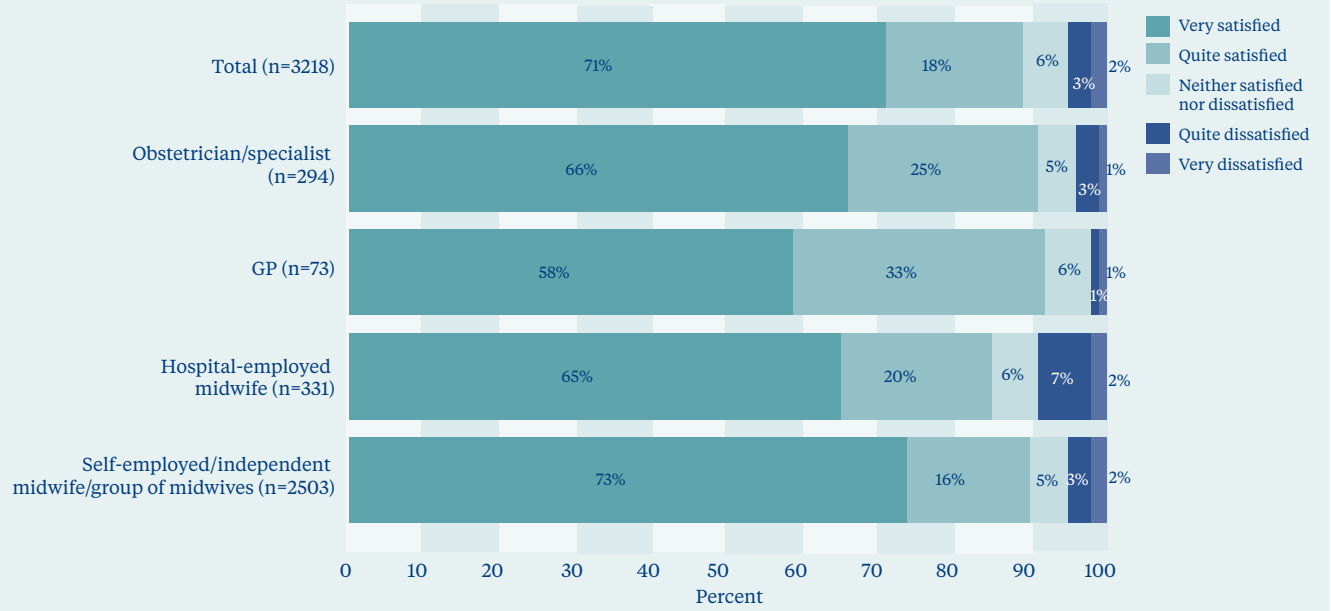
Base: Those who changed their LMC (n=358)

Q10. For what reasons did you change your LMC?

Satisfaction with LMC

Around seven in every ten women (71%) were 'very satisfied' with the overall care received from their LMC, and a further 18 percent were 'quite satisfied'. Compared with women who had an obstetrician or specialist, GP, or hospital-employed midwife, those who had a self-employed or independent midwife or group of midwives as their LMC at the time of the birth were more likely to be 'very satisfied' with the care received.

Figure 69: Satisfaction with care received from LMC



Base: All respondents – excluding those who answered not applicable

Q28. Thinking now about your overall experience, how satisfied were you with the overall care you received from your LMC?

The following women were more likely to be satisfied ('very satisfied' or 'quite satisfied') with the care received from their LMC:

- women who planned a home birth (98% cf 89% average)
- women 35–39 years of age (91%).

The following women were more likely to be dissatisfied ('very dissatisfied' or 'quite dissatisfied') with the care they received from their LMC:

- women with disabilities (12% cf 6% of women without disabilities)
- women who changed their LMC during their pregnancy (9% cf 5% among women who did not change their LMC)
- women from Hutt Valley DHB area (11% cf 6% average)
- women for whom it was their first birth (7% cf 5% of women for whom it was not their first birth).

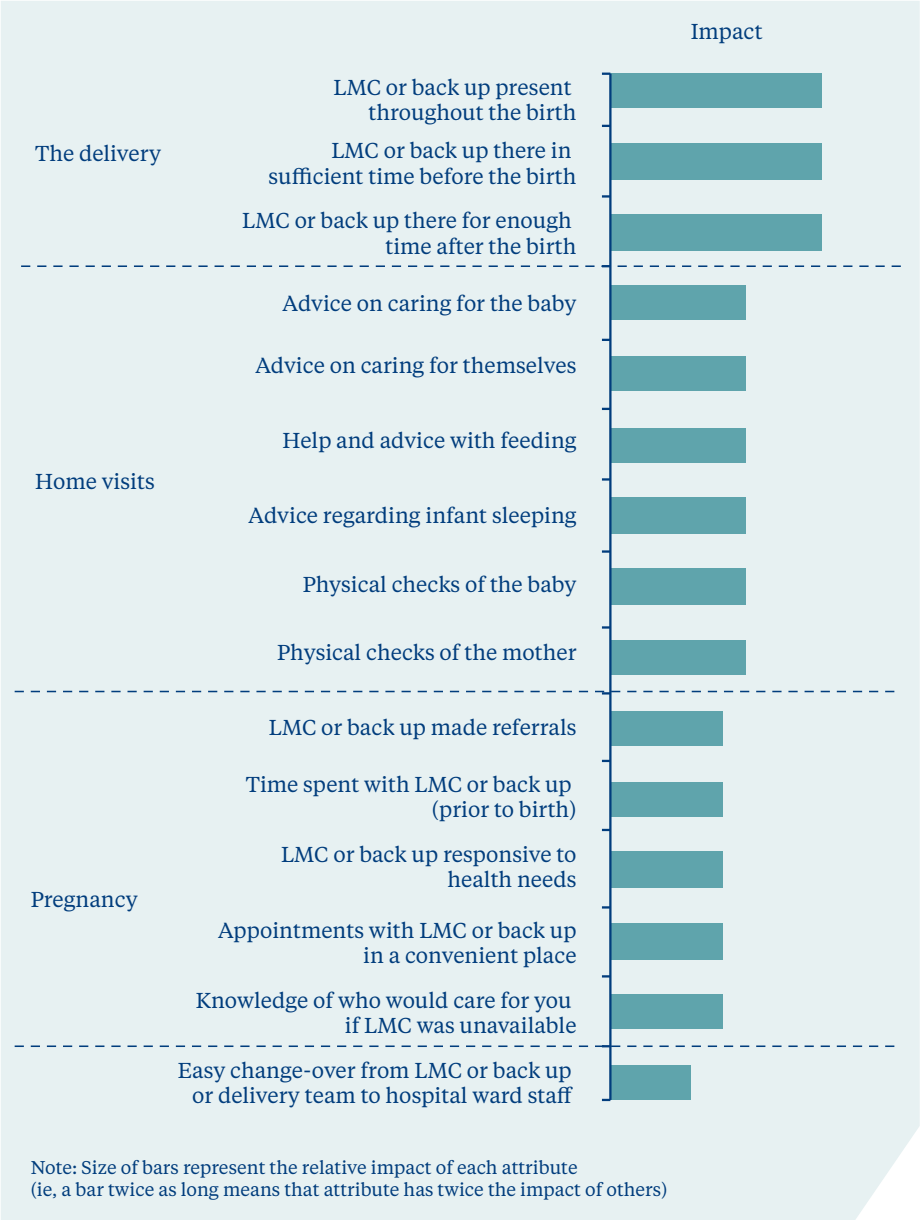
Drivers of satisfaction

Factor analysis was undertaken on the individual aspects of care received from LMCs. The results of this analysis can be grouped into four key themes (refer to appropriate sections of the report for more information):

- the pregnancy
- change-over with hospital ward staff (postnatal care)
- the delivery
- home visits.

Each aspect of care, within each theme, was rated in a similar way by women, meaning the impact they had on women's satisfaction was also similar. The relative impact of each area on women's overall satisfaction with care from their LMC is illustrated below.

Figure 70: Impact on overall satisfaction of care received from LMC



Note: Size of bars represent the relative impact of each attribute (ie, a bar twice as long means that attribute has twice the impact of others)

Aspects of care received during the delivery were identified as having the most impact on women's satisfaction, followed by care received during home visits after the birth.

Priorities

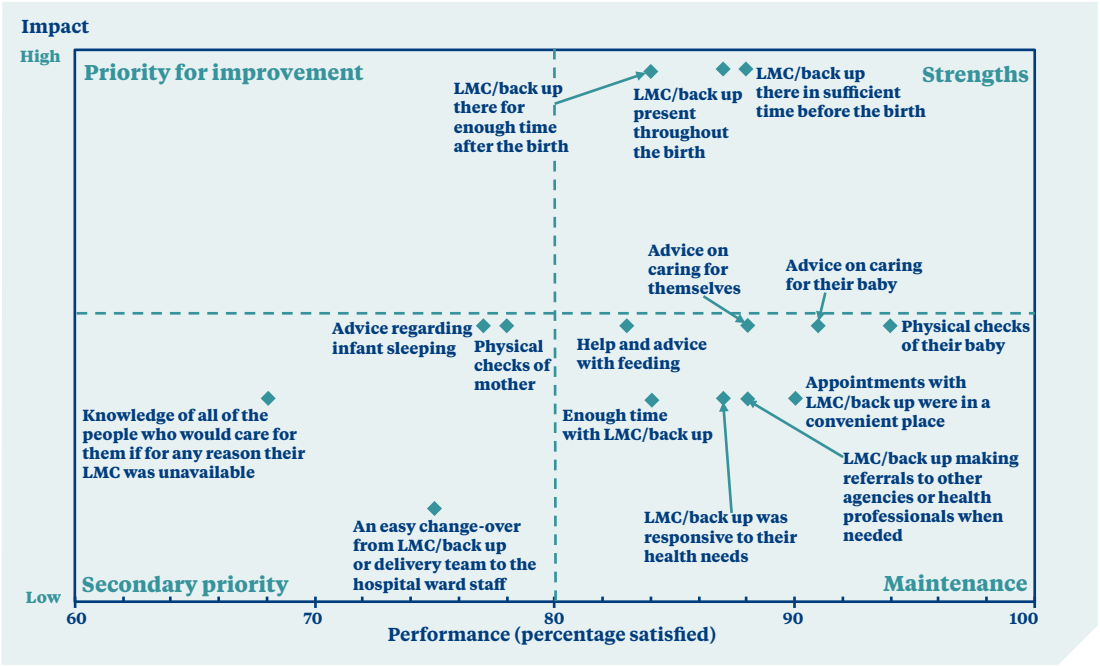
The relationship between the impact on women's satisfaction of each individual aspect of care and its current performance has been reviewed to determine priority areas for improvement in care provided by LMCs.

All of the aspects of care that had a high impact on women's satisfaction (care during the delivery) are performing well and can be considered strengths of maternity care.

The following aspects of care, although having a lower impact on women's satisfaction, are somewhat weaker in performance and are identified as secondary priorities for improvement:

- advice regarding infant sleeping
- physical checks of mother
- women's knowledge of who would care for them if LMC was unavailable
- change-over from LMC or back-up or delivery team to hospital ward staff.

Figure 71: Improving satisfaction with care received from LMC



Summary

In summary, care received from LMCs is a strength of maternity care, but there are some individual aspects of care that can be focused on. The majority of women surveyed were satisfied with the overall care received from their LMC. However, aspects of care relating to the pregnancy (women's knowledge of who would care for them if the LMC was unavailable) and home visits after the birth (advice regarding infant sleeping and physical checks of the mother) can be improved. The change-over between the LMC or back-up or delivery team to the hospital ward staff is also viewed as somewhat weaker than other aspects of care.

Young mothers

Introduction

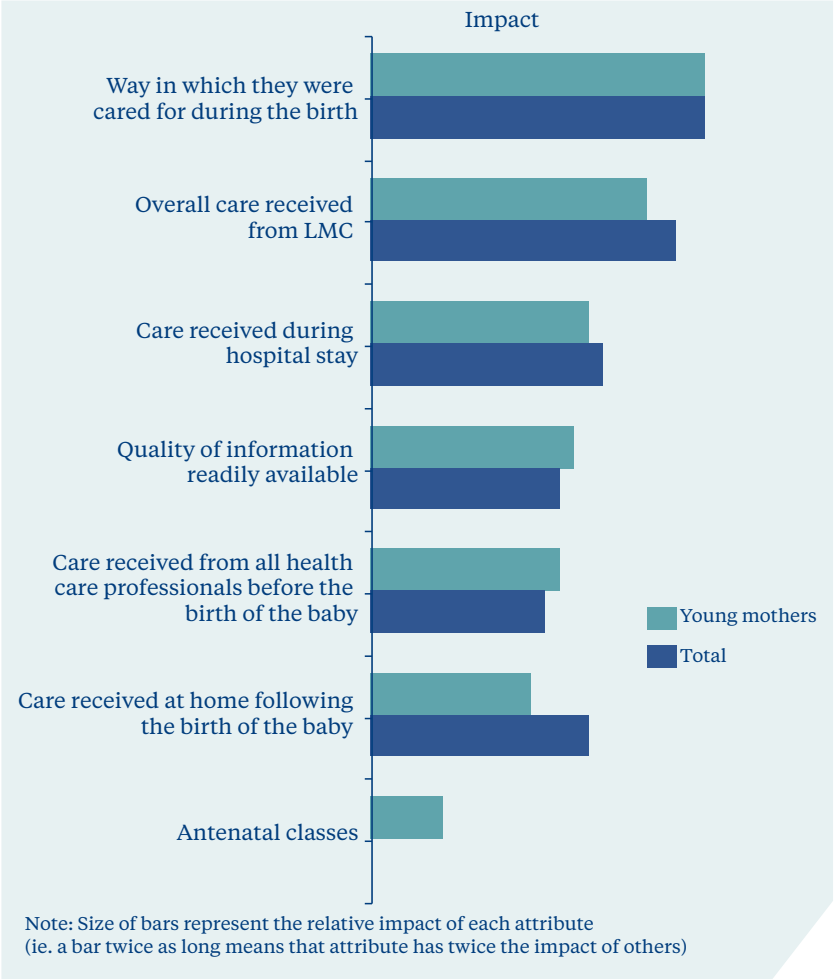
This section summarises the perceptions of young mothers. Young mothers were included in a separate regression analysis to establish the impact individual aspects of maternity care had on their level of satisfaction.

Drivers of satisfaction

The level of impact each area of maternity care had on young mothers' satisfaction with the overall care they received was similar to that of all women. However, antenatal classes were identified as having some impact on young mother's satisfaction, albeit less than other areas of care.

The relative impact of each area is illustrated below.

Figure 72: Impact on young mothers' satisfaction



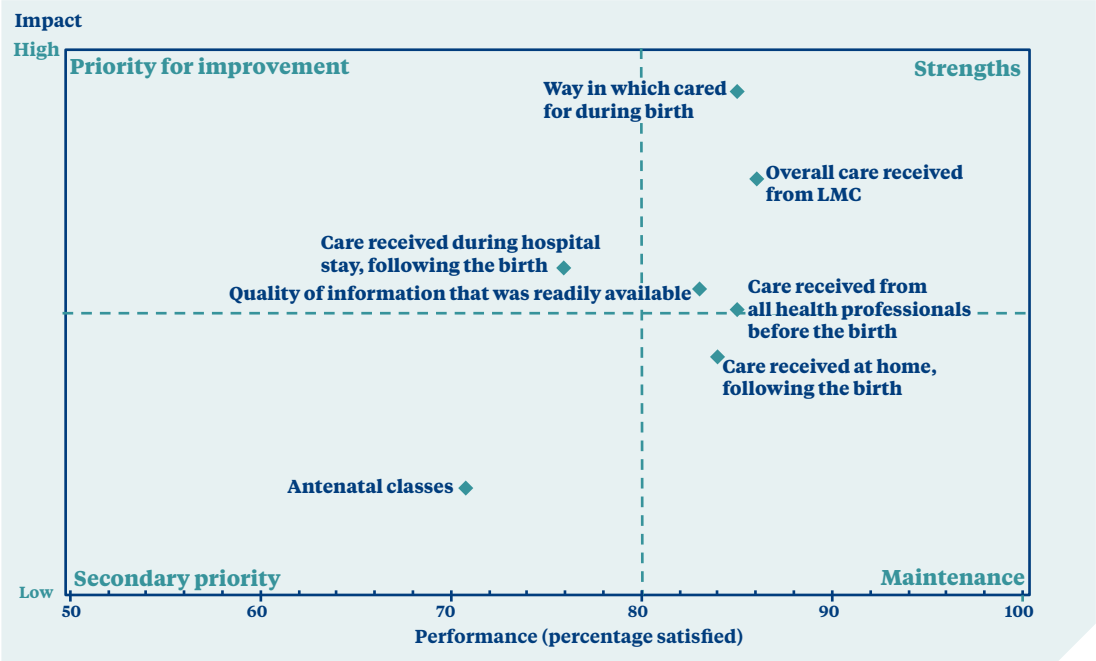
Note: Size of bars represent the relative impact of each attribute
(ie. a bar twice as long means that attribute has twice the impact of others)

Priorities

Care received during the hospital stay following the birth is identified as a priority area for improvement for young mothers. This is consistent with the findings for women of all age groups.

Although antenatal classes had relatively less impact on young mothers' overall satisfaction, they are identified as a secondary area for improvement. Compared to other aspects of care, young mothers were less satisfied with antenatal classes.

Figure 73: Improving satisfaction among young mothers



As with all other age groups, in order to improve young mothers' satisfaction with the care received during their hospital stay, staffing issues are the main area to focus on. However, the number of support people allowed and the ability for them to visit at any time had more of an impact on young mothers' satisfaction and also comprise an area that could be focused on for these women.

Māori women

Introduction

This section summarises the perceptions of Māori women. Māori women were also included in a separate regression analysis to establish the impact individual aspects of maternity care had on their level of satisfaction.

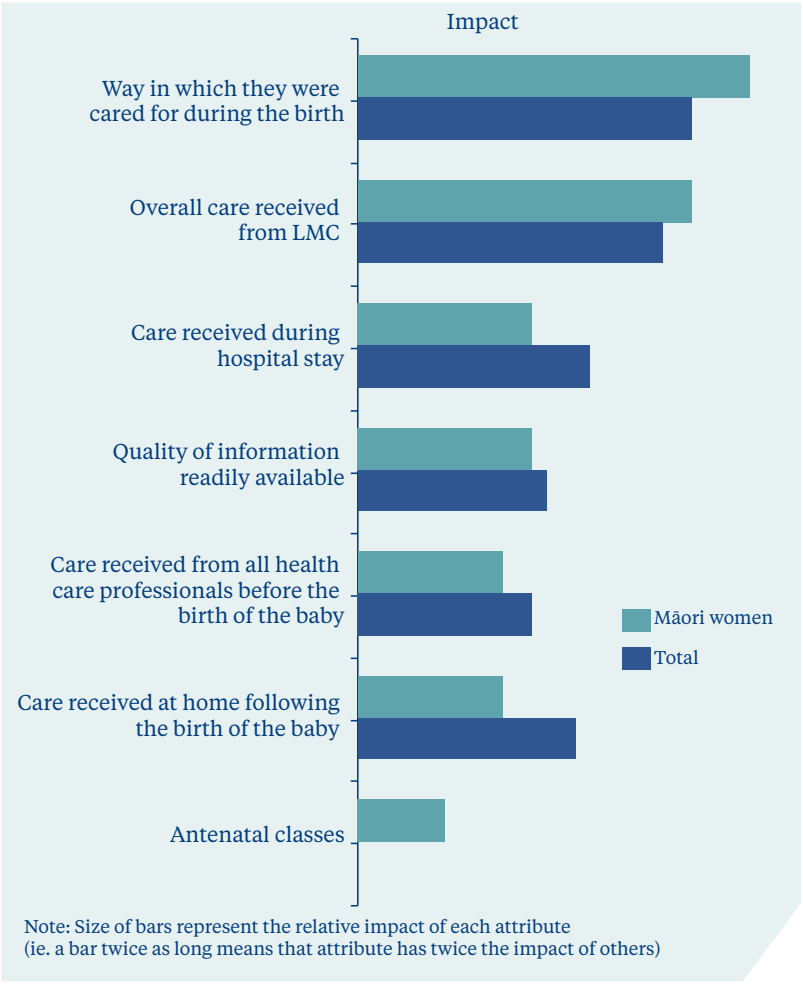
Drivers of satisfaction

The aspects of care that had the greatest impact on the satisfaction of Māori women were similar to that of all other women. However, the impact of the way in which they were cared for during the birth and the overall care received from the LMC on overall satisfaction with care received was stronger among Māori women.

Antenatal classes were also identified as having some impact on Māori women's satisfaction, albeit less than other areas of care.

The relative impact of each area is illustrated below.

Figure 74: Impact on Māori women's satisfaction



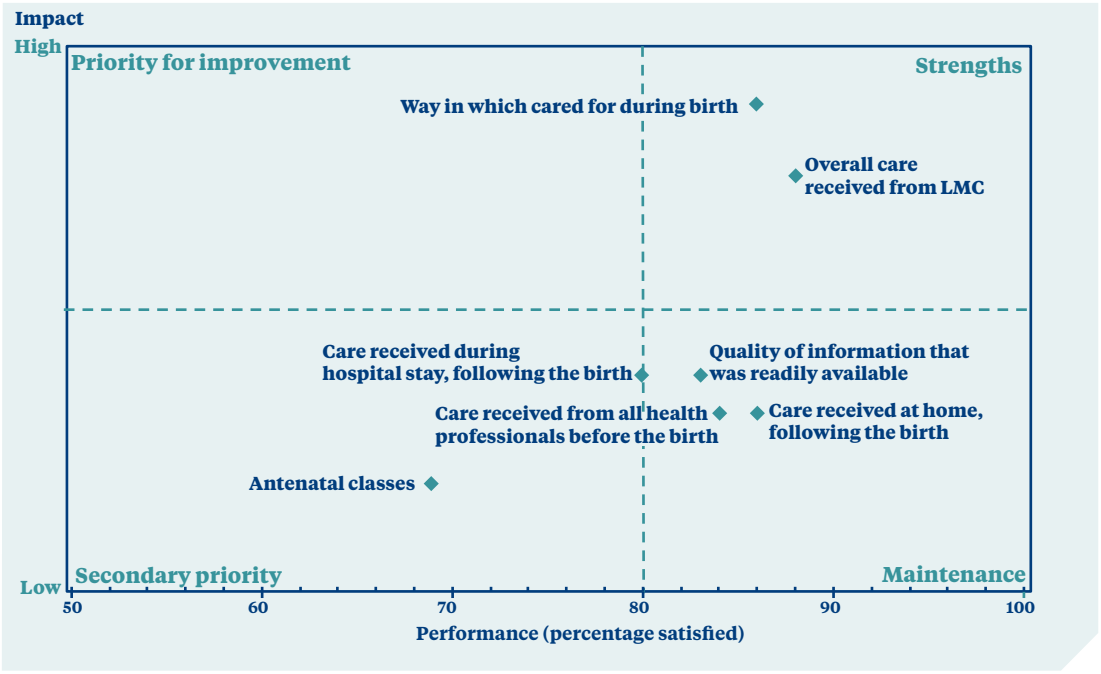
Note: Size of bars represent the relative impact of each attribute
(ie. a bar twice as long means that attribute has twice the impact of others)

Priorities

The areas of care identified as having the most impact on Māori women's satisfaction – the way in which they are cared for during the birth and overall care from the LMC – are performing well.

There are no priority areas for improvement among Māori women – care received during the hospital stay had less of an impact on Māori women's satisfaction and was performing at an acceptable level in their opinion. Antenatal classes are identified as a secondary priority for improvement, as Māori women were relatively less satisfied with this aspect of care.

Figure 75: Improving satisfaction among Māori women



Pacific women

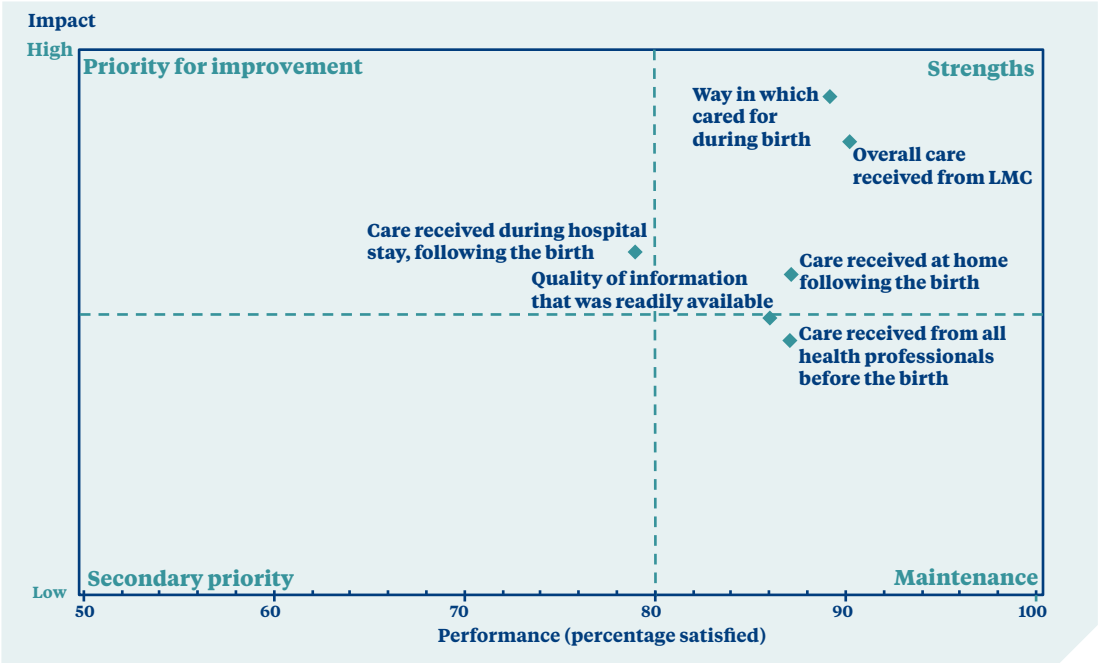
Introduction

This section summarises the perceptions of Pacific women. The number of Pacific women involved in this research did not allow for an accurate regression analysis to be carried out. However, using the results from the regression analysis carried out on all women, priority areas can still be identified. [5]

Priorities

Pacific women had similar levels of satisfaction compared with the average of all women. Based on the impact each area of care has on all women's satisfaction, the care received during the hospital stay after the birth is also identified as a priority area for improvement among Pacific women.

Figure 76: Improving satisfaction among Pacific women



5 This does not assume that Pacific women's satisfaction was impacted to a similar degree by the aspects of care that impacted all other women's satisfaction.

Women with disabilities

Introduction

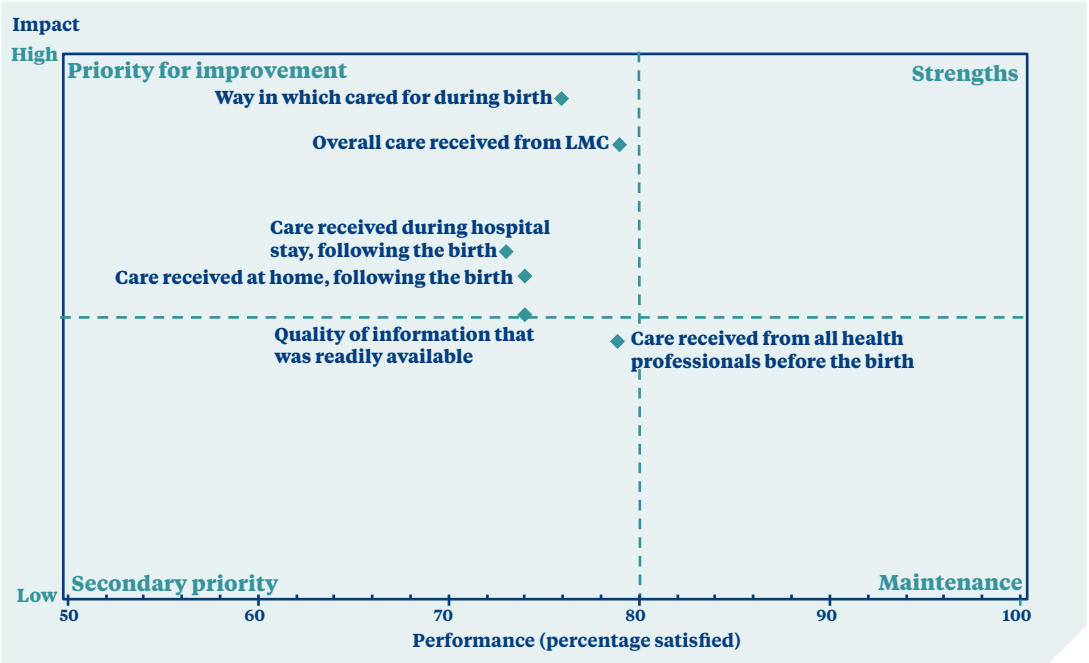
This section summarises the perceptions of women with disabilities. The number of women with disabilities involved in this research did not allow for an accurate regression analysis to be carried out. Using the results from the regression analysis carried out on all women, priority areas can still be identified.

Priorities

Women with disabilities were, comparatively, less satisfied with all aspects of maternity care.

The overall care from the LMC is close to being considered a relative strength of maternity care among these women. However, care received during their hospital stay after the birth, care received at home (following the birth) and the quality of information that was readily available are all identified as priority areas for improvement.

Figure 77: Improving satisfaction among women with disabilities



Women's additional comments

Introduction

Women were given the opportunity in the survey to provide additional comments relating to the maternity care they received. Of the 3235 women surveyed, 2423 (75%) provided additional comments. This section of the report summarises these comments.

Additional comments

Around a quarter of women who provided additional comments (26%) specifically mentioned the great care or service received from their midwife. The following examples illustrate the comments women made regarding their midwife.

> I had a fantastic midwife which made the whole experience so much easier.

> The quality of care from midwife team was amazing! After having a baby in London then one here, we are so lucky with our system ... I really want to be a part of what they did for me! So I am looking at a new career pathway . . .

> I had a high-risk pregnancy and received the most professional and quality care from my midwife and specialists through the public system. I felt very well cared for and . . . felt very fortunate to deliver my baby in a modern, clean hospital and have very well trained and caring health professionals looking after me the whole time.

A further one in six (15%) mentioned great care or service from their LMC (without specifying if this was a midwife, GP or obstetrician), while a similar number mentioned the great care or service of hospital staff. The following comments are typical of what women said regarding their LMC and the hospital staff.

> My care via my LMC was exceptional before during and after birth.

> My LMC was very caring and respectful of me and my family [and] any choices I made during and after my pregnancy.

> I had an emergency C Section and the hospital staff were brilliant. Most of the help I got with breastfeeding was through the nurses.

> I was satisfied with the care I received during labour. The nurses who were caring for me at the time of birth told me everything they were doing when I was giving birth. They gave me clear instructions on what I had to do.

Approximately one in ten women (11%) said they had a very happy experience or that it was the best birth they had. The following examples show the types of comments women made about their experience.

> My experience was fantastic, my specialist was wonderful. The hospital was clean, the staff were wonderful and helpful and my care after with my midwife, she was amazing, very caring and helpful.

> I was very happy with my experience, but I think I was lucky to have an easy pregnancy, birth and breastfeeding experience so I didn't require much from my LMC.

> I found the whole experience really exciting and felt very supported ...

> The experience I had this time around was much better. My previous delivery was a c-section so giving birth naturally was an amazing experience. My labour was fast and birth even faster. When my baby went into distress my midwife acted fast and nothing went wrong. Everyone involved – my midwife, the register and peds – were fantastic. It was the sort of experience I would have wished for my first birth.

Just less than one in ten women (9%) mentioned they had great care and support before, during and after their birth. The following comments are examples.

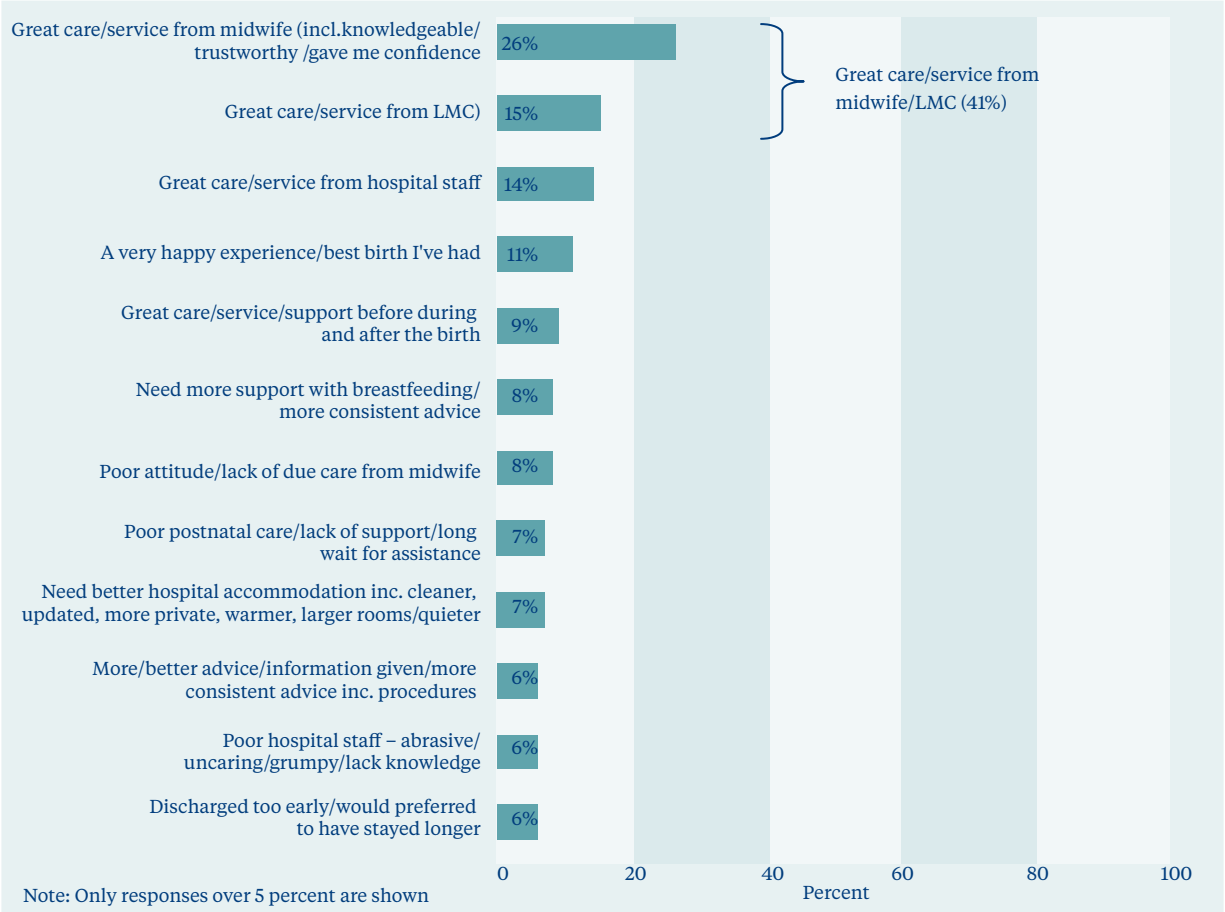
> Had excellent care throughout pregnancy from everyone involved. They all worked well together, no complaints at all.

> I am incredibly grateful to have had amazing support to birth both my children at home. The care I received was holistic, well informed, empowering and left me with a very positive view of birthing. I hope my girls receive the same level of care and have the same options if and when they have children.

> I had my baby in Nelson and was generally overwhelmed with the level of support, care and professionalism of maternity care. New Zealand should be very proud of the services it provides your pregnant women, families and children. I could not have asked for more care or better services to ensure my health and baby's health.

A wide range of other comments was provided. Those registering more than 5 percent of all comments are outlined in the following graph.

Figure 78: Additional comments



Note: Only responses over 5 percent are shown
Base: Those who provided additional comments (n=2423)
Q31. Please add any comments you wish to make about the antenatal care, care during labour and birth, and postnatal care you rec

The most common negative comments, comprising around 8 percent of responses (of those who provided comments), indicated women needed more support with breastfeeding or, at least, more consistent advice. A similar number also mentioned a poor attitude or lack of due care from the midwife. The following comments illustrate these responses.

> I felt while in hospital they were too busy to take time to show me things especially breastfeeding which really upset me and made me want not to be there.

> Breastfeeding support [is] a big issue for new mums. While LMC and ward staff [are] helpful and knowledgeable – all had different ideas which makes it very confusing.

> At times I found it difficult to navigate my way through the advice (and I received a lot of it) about feeding. I think that this was because of a kind of 'promote breastfeeding at all times' approach. I was keen to breastfeed and am still breastfeeding so this is not about that, it's just that sometimes I felt that this emphasis got in the way of information ...

> Disappointed with postnatal care provided by my midwife. Had a very unsettled newborn baby with reflux who did not sleep, did not feel my midwife supported me with managing baby's pain and infant sleeping. My GP and Plunket were a huge support with this. Midwife had lack of knowledge and kept telling me my baby's behaviour was normal for a newborn when clearly this wasn't the case. LMC (midwife) & midwives in hospital forced their personal opinions during antenatal care instead of offering impartial advice; this is very unsettling for a first time mother.

> I feel that due to having an elective Caesarean, my midwife didn't take the care that she would normally have taken. She never visited in hospital, was briefly there during the delivery and only visited a couple of times at home after.

Slightly fewer women (7%) mentioned the postnatal care was poor and felt there was a lack of support and a long wait for assistance. The following examples illustrate these concerns.

> Regarding postnatal care: after I'd given birth, some of the hospital ward staff were rather rude seeing me as a teenage mum. I had no idea what to do and one midwife in particular wouldn't help me even change a nappy, let alone show me either ...

> Postnatal visits perhaps could be for a longer period. 5–6 weeks doesn't seem long enough given they are with you throughout pregnancy.

> ... the postnatal care in hospital after being transferred to the ward was very poor, almost non-existent. I had had a Caesarean! The postnatal midwife care was also poor – very little advice or support, despite requests. So much focus is given to pregnancy and birth but NZ's post natal services and support are sadly lacking! Plunket should be involved from birth – not 6 weeks in. Midwives should be better trained and educated and offer postnatal support of greater frequency and substance. For both my children the postnatal support has been poor and very disappointing.

A further 7 percent of women said the hospital accommodation needed to be better, such as rooms updated to be more private, warmer and larger. The following comments are a selection from women who wanted better accommodation.

> Hospital facilities need to be updated to make [a] more pleasant, comfortable place for both mothers/babies and carers to work in. Sealing of draughty windows, comfortable beds for mums [and] infants, breastfeeding chairs and self-control of room temperature.

> It is very hard to expect four new mums to share a small room with four new babies, that aren't sleeping etc, and having visitors. I think there should be no more than two to a room.

> ... need to be cleaned regularly as when we got into a room, it still had towels and stuff used from a previous birth and when my baby was born we couldn't put her into the little plastic beds provided coz we didn't have any baby sheets or warmers that are supposed to be provided by the hospital for newborns; luckily we had our own.

> Sharing a room after the endurance of labour and having a baby is really unsuitable. You have no privacy to rest and recover. The bathroom was away from my baby and was unclean which is again unsuitable after having a baby.

A smaller percentage of women (6%) wanted better information given to them and more advice on aspects such as procedures. The following are comments that outline these concerns.

> Sometimes the different advice and techniques were a bit overwhelming; it seemed that until I was moved to be with my daughter in NICU, with every shift change, there was a different approach, advice and ways of doing things ...

> Information available is dependent on how much research you do yourself eg, on internet, reading books. A lot of information is not available readily unless you know the questions to ask.

> Had a caesarean section, still don't really understand why it all happened like that. Would have loved more clarity and some explanations what was going on. Went to hospital because I was 4 weeks early, couldn't have the home birth, so everything was very sudden. Some psychological care in hospital would have been good, especially after the caesarean.

> ... I had my 5th child and did not get a pregnancy pack info. Throughout the years of pregnancies and giving birth, you tend to lose track as to how to care for a newborn as they are only small for 3 months ... That's where the library comes in handy, easy take home maternity care, information that I can have in my own time. I did ask for a pregnancy information pack but was turned down as there were other mothers (who didn't have the amount of children I had) that needed it more than me.

A further 6 percent mentioned that the service received from hospital staff was poor. Staff were uncaring, lacked knowledge and were at times abrasive. The following are comments from women who experienced this.

> ... I sometimes felt that my LMC and nurses were a bit 'cold' because they do that every day, but for a new mum it is a very daunting experience. With the home visits from my midwife, she was a bit like a robot, just doing what is needed and not showing any tenderness toward my little baby.

> ... I spent a night in the postnatal ward and the night/afternoon staff were very unhelpful, inexperienced and rude. I couldn't wait to get discharged the next day ...

> The staff were not caring and did not come when needed. Some were but certain ladies were not helpful and very rude telling me to do my own bed and getting things on my own. I thought it was a hospital where people/staff are suppose to care and help you when needed. That was the downfall of the hospital, staff too busy talking to each other in corridors and not assisting the patients as soon as possible. I would not be going back to Middlemore Hospital in future because I'm not happy with the staff and how I was treated. Need to change staff and get people who really want to help patients and have passion about the job ...

Some women (6%) said they were discharged too early and would have preferred to have stayed a little longer. The following comments illustrate these concerns.

> My biggest concern with all of my 3 children's birth is the length of time we are allowed to stay in the birth centre. We only get to stay up to 48 hrs which is just not long enough ...

> After the birth of our baby I stayed in hospital for two nights. I asked if I could stay for 1 more night, but felt pressure from staff to leave, even after I explained I had no family available to take me home until the next day. ...

> I would have liked to have stayed longer in hospital or a private facility for new mothers for a week before coming home. So as to be better prepared for the baby care and getting breastfeeding established.

> Not happy with how quickly I was forced to shower and transfer to Birthcare; had so much epidural I could barely stand/walk yet was forced to vacate the room in the late evening 9–10pm after being in labour all day. That was the worst part of the birthing experience.

Appendix 1: Details of analysis

Satisfaction ratings for areas of maternity care were correlated with one another, as were the ratings for detailed aspects of care within each area of maternity care. For example, the correlation between the following sources of information – newborn hearing screening and newborn metabolic screening – was .70. Essentially this means that women who were satisfied with sources of information about newborn hearing screening were also likely to be satisfied with information about newborn metabolic screening.

Given that ratings were correlated, a factor analysis was conducted in order to identify groups of correlated statements (statements rated similarly by women). The following tables illustrate the results of the factor analysis for each area of maternity care, identifying groups of statements (or key themes) that women rated similarly.

Sources of information

Four key themes relating to sources of information were identified. The data highlighted in the below table illustrates the correlation between individual statements and the associated factor; in other words, it highlights the statements loading to that factor.

Table 10: Sources of information

Detailed topics	Information for the mother	Information about the baby's health	Information about caring for the baby	Information about screening
Newborn metabolic screening	.210	.803	.136	.221
Newborn hearing screening	.132	.801	.123	.173
Immunisation	.227	.711	.141	.141
Selection of Well Child provider (eg, Plunket)	.194	.664	.233	.171
Childbirth	.822	.164	.204	.122
Management of pain during birth	.802	.175	.188	.095
Pregnancy in general	.707	.179	.140	.270
Selection of LMC	.523	.326	.140	.187
Antenatal screening for Down syndrome and other conditions	.191	.271	.078	.821
Scans	.243	.226	.152	.806
Breastfeeding	.295	.148	.849	.091
Infant sleeping	.222	.398	.707	.169

The pregnancy

Three key themes relating to antenatal care were identified. The table below highlights the loading of each statement on to the three factors (or key themes).

Table 11: Details of analysis: the preganancy

Detailed aspects of care (satisfaction with)	Care received from LMC	Back up care	Specialist services used
Your LMC/back up was responsive to your health needs	.838	.316	.106
You spent enough time with your LMC/back up	.825	.344	.119
Appointments with your LMC/back up were in a convenient place	.757	.069	.284
Your LMC/back up made referrals to other agencies or health professionals when needed	.686	.280	.383
With any specialist services used	.216	.130	.910
You knew all of the people who would care for you if for any reason your LMC was unavailable	.303	.871	.136
Everyone involved in your care had the same up to date medical information about you	.260	.565	.549

The birth (hospital births)

Four key themes relating to care received in hospital during the birth were identified.

Table 12: The birth (hospital births)

Detailed aspects of care	The delivery	Presence of LMC	Pain relief	Location
Good communication to me on what was happening/progress throughout	.861	.248	.139	.121
Being given enough guidance on what to do	.806	.271	.145	.171
Having confidence in the skills of the people caring for me	.800	.298	.143	.158
Good communication between all people involved in my care	.793	.291	.164	.101
Having my decisions and choices respected	.709	.271	.352	.118
LMC/back up there in sufficient time before the birth	.264	.845	.091	.129
LMC/back up present throughout the birth	.306	.837	.118	.092
LMC/back up there for enough time after the birth	.294	.758	.174	.104
Having sufficient pain relief	.323	.206	.903	.117
Where I was able to give birth	.234	.177	.110	.949

The birth (home births)

An additional two themes were identified in relation to care received by women giving birth at home.

Table 13: The birth (home births)

Detailed aspects of care	Care for the mother	Support received
My choices respected by LMC/back up	.924	.294
Caring manner of LMC/back up	.913	.296
Having sufficient information throughout the birth	.838	.459
Available expertise immediately after the birth (e.g. help with feed)	.260	.940
Enough care from LMC/back up	.607	.707

Postnatal hospital care

Four key themes relating to postnatal hospital care were identified.

Table 14: Postnatal hospital care

Detailed aspects of care	Hospital staff	Respect	Support people	Hospital facilities
Enough care from hospital ward staff	.851	.215	.173	.227
Caring manner of hospital ward staff	.821	.159	.209	.250
Available expertise (e.g. help with feeding)	.771	.269	.164	.104
An easy change-over from LMC/back up or delivery team to the hospital	.754	.217	.236	.184
Allowed to stay as long as I needed to	.439	.426	.297	.041
My privacy	.254	.728	.351	.164
Getting sufficient rest	.331	.706	.258	.210
Support people allowed to visit at any time	.194	.245	.852	.180
Having as many support people as I needed with me at any one time	.393	.241	.749	.141
The food available	.232	.005	.279	.819
The temperature of the room	.183	.453	.048	.667
A facility that is clean	.212	.554	.035	.580

Home visits

Three key themes relating to care received during home visits were identified.

Table 15: Home visits

Detailed aspects of care	Advice	The baby's health	The mother's health
Advice regarding infant sleeping	.841	.159	.350
Help and advice with feeding	.799	.388	.207
Advice on caring for your baby	.638	.550	.348
Physical checks of you	.284	.272	.890
Advice on caring for yourself	.506	.431	.598
Physical checks of your baby	.283	.876	.304

Lead Maternity Carer

Four key themes relating to care received from the LMC were identified.

Table 16: Lead Maternity Carer

Detailed aspects of care	The pregnancy	Change-over with the delivery team	The delivery team	Home visits
Advice on caring for your baby	.224	.092	.147	.853
Advice on caring for yourself	.225	.076	.166	.829
Help and advice with feeding	.203	.103	.108	.811
Advice regarding infant sleeping	.203	.059	.087	.802
Physical checks of your baby	.203	.070	.180	.761
Physical checks of you	.243	.084	.172	.736
Your LMC/back up made referrals to other agencies or health professionals when needed	.780	.092	.184	.213
You spent enough time with your LMC/back up	.771	.005	.314	.271
Your LMC/back up was responsive to your health needs	.743	-.011	.336	.300
Appointments with your LMC/back up were in a convenient place	.736	.083	.075	.241
You knew all of the people who would care for you if for any reason your LMC was unavailable	.649	.097	.187	.201
My choices respected by LMC/back up	.038	-.009	.042	.010
Caring manner of LMC/back up	.033	-.005	.050	.031
Enough care from LMC/back up	.048	.014	.054	.053
LMC/back up present throughout the birth	.286	.037	.844	.157
LMC/back up there in sufficient time before the birth	.232	.033	.836	.211
LMC/back up there for enough time after the birth	.308	.152	.720	.249
An easy change-over from LMC/back up or delivery team to the hospital ward staff	.176	.921	.149	.292

These factors (groups of statements rated similarly by women) were then included in regression analysis to understand the impact each theme had on women's satisfaction with each area of maternity care and the impact each area had on women's overall satisfaction with the care they received (from when they first found out or suspected they were pregnant through to six weeks after the birth). The regression analysis results in a regression coefficient, which measures the level of impact each theme or area of maternity care had on women's satisfaction. This is reported in the form of a percentage. A higher percentage indicates a higher level of impact on women's satisfaction.

The following tables illustrate the results of the regression analysis.

Sources of information

The table below outlines the impact each key theme relating to sources of information had on women's satisfaction with this area of maternity care. Information for the mother had the most impact and information about screening had the least impact on women's satisfaction with the quality of information available.

Table 17: Sources of information

Key themes	Regression coefficient (%)
Information for the mother	36
Information about the baby's health	25
Information about caring for the baby	20
Information about screening	19

The pregnancy

Care received from the LMC had the most impact on women's satisfaction with antenatal care.

Table 18: The pregnancy

Key themes	Regression coefficient (%)
Care received from LMC	44
Back up care	30
Specialist services used	26

The birth (hospital births)

The delivery had the most impact on women's satisfaction with hospital care received during the birth. The presence of their LMC had the second most impact.

Table 19: The birth (hospital births)

Key themes	Regression oefficient (%)
The delivery	45
Presence of LMC	26
Pain relief	15
Location	14

The birth (home births)

Support received during a home birth had the most impact on women's satisfaction with care received at home during the birth. Pain relief was identified as having no impact on women's satisfaction with care received at home.

Table 20: The birth (home births)

Key themes	Regression coefficient (%)
Support received	39
Care for the mother	28
The delivery	16
Presence of LMC	10
Location	6
Pain relief	0

Postnatal hospital care

Hospital staff had the most impact on women's satisfaction with postnatal hospital care, followed by the respect they were shown.

Table 21: Postnatal hospital care

Key themes	Regression coefficient (%)
Hospital staff	46
Respect	21
Support people	16
Hospital facilities	16

Home visits

The key themes relating to care received during home visits had similar levels of impact on women's satisfaction with the care received during home visits. If anything, the mother's and baby's health had slightly more impact on women's satisfaction with this area of maternity care.

Table 22: Home visits

Key themes	Regression coefficient (%)
The mother's health	34
The baby's health	34
Advice	32

Lead Maternity Carer

The delivery team had the most impact on women's satisfaction with the care received from their LMC.

Table 23: Lead Maternity Carer

Key themes	Regression coefficient (%)
The delivery team	39
Home visits	25
Pregnancy	21
Change-over with the hospital ward staff	15

All areas of maternity care

Women's satisfaction with each area of maternity care was also included in regression analysis to understand the impact of each area on women's satisfaction with the overall care received. Care received during the birth had the most impact on women's satisfaction with the overall care received. This was followed closely by care received from their LMC. Antenatal classes were identified as having no impact on women's satisfaction.

Table 24: All areas of maternity care

Areas of maternity care	Regression coefficient (%)
Way in which they were cared for during the birth	23
Overall care received from their LMC	21
Care received during their hospital stay, following the birth (postnatal care)	16
Care received at home, following the birth (home visits)	15
Quality of information that was readily available	13
Care received from all health professionals before the birth (antenatal care)	12
Quality of antenatal classes	0

This analysis was also carried out among young mothers. Care received during the birth also had the most impact on young mothers' satisfaction with the overall care received. Antenatal classes had a small level of impact on young mothers' satisfaction.

Table 25: All areas of maternity care – young mothers

Areas of maternity care	Regression coefficient (%)
Way in which they were cared for during the birth	23
Overall care received from their LMC	19
Care received during their hospital stay, following the birth (postnatal care)	15
Quality of information that was readily available	14
Care received from all health professionals before the birth (antenatal care)	13
Care received at home, following the birth (home visits)	11
Quality of antenatal classes	5

This analysis was also carried out among Māori women. Care received during the birth had the most impact on Māori women's satisfaction with the overall care received. Antenatal classes also had a small level of impact on Māori women's satisfaction.

Table 26: All areas of maternity care – Māori women

Areas of maternity care	Regression Coefficient (%)
Way in which they were cared for during the birth	27
Overall care received from their LMC	23
Care received during their hospital stay, following the birth (postnatal care)	12
Quality of information that was readily available	12
Care received from all health professionals before the birth (antenatal care)	10
Care received at home, following the birth (home visits)	10
Quality of antenatal classes	6

There were insufficient numbers to conduct this analysis among Pacific women and women with disabilities.

2011 Maternity Consumer Survey of Bereaved Women

Executive summary

In 2011, for the first time, the Ministry of Health extended its Maternity Consumer Survey (which has historically been aimed at those who have experienced a live birth) to also include the views and experiences of women who had lost a baby in the perinatal period: between 20 weeks of pregnancy and 28 days following birth.

The overall objective of the Maternity Consumer Survey is to measure the level of satisfaction amongst women who have experienced New Zealand's maternity services. In addition, it is intended that the results of the surveys will:

- provide the Ministry with a comprehensive analysis of women's perceptions of maternity services
- enable the Ministry to assess the current framework for maternity services
- provide information to inform future planning.
- This report focuses specifically on the results of the Maternity Consumer Survey of Bereaved Women, which was conducted with women who had experienced a perinatal death.

Although some key aspects of the Maternity Consumer Survey of Bereaved Women were aligned with the main survey of women who had live babies, this was essentially the first survey of its type and so particular care was taken in its development. The survey was initially piloted with a group of bereaved women in order to test the methodological approach, the appropriateness of the question wording, the general flow of the survey and technical aspects of the questionnaire script.

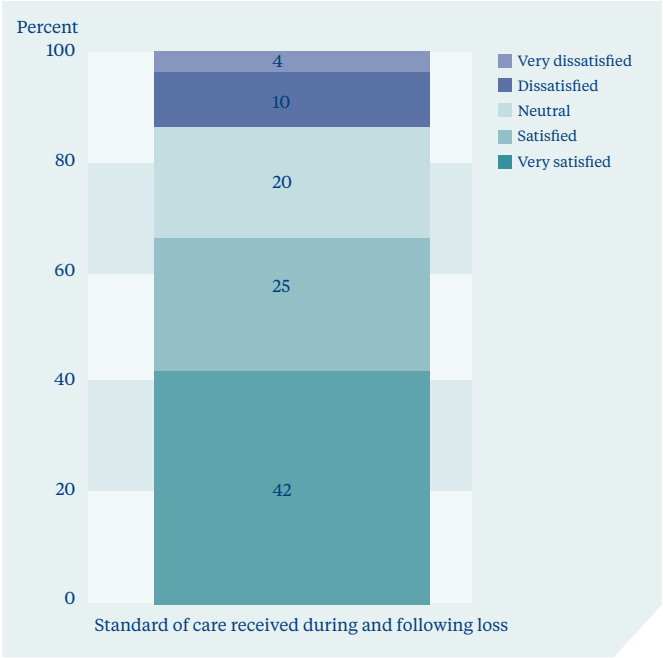
Following the pilot, pre-notification letters were sent to all prospective respondents informing them of the survey and inviting them to contact Research New Zealand if they were willing to take part. All n=102 interviews completed (including those from the pilot) were conducted by telephone between 28 April and 30 June 2011.

It should also be noted that due to their experience in this particular field, Sands New Zealand were involved in all stages of the development and piloting of the survey. Sands New Zealand is a parent-run, nationwide group that provides support and information to families who have experienced the death of a baby.

Overview

A total of 91 women participated in the survey representing 6% of women invited to participate. As illustrated in Figure 79, two-thirds of all respondents were satisfied with the overall standard of maternity care that they had received during and following the loss of their baby (67%, n=68). 42 percent (n=43) were 'very satisfied'.

Figure 79: Satisfaction with maternity care received during/following the loss of the baby (n=102)



This general level of satisfaction was reflected in other key aspects of respondents' maternity experience (Figure 2).

Prior to the baby's death, 70 percent of all respondents (n=71) were satisfied with the maternity care they had received (primarily from their lead maternity carer (LMC)).

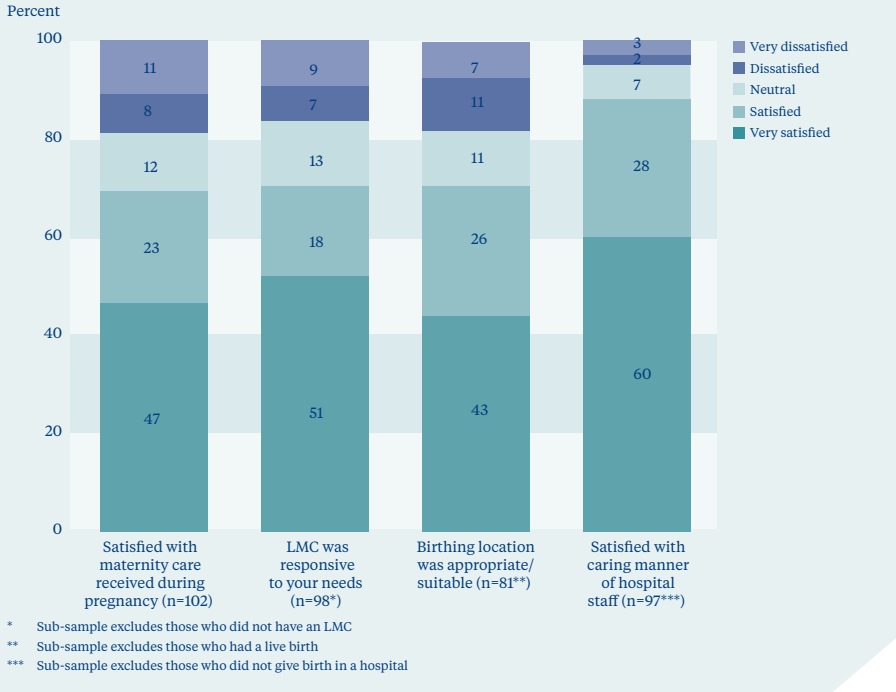
Sixty-nine percent of those who had an LMC were satisfied that their LMC had been responsive to their needs (n=68).

Similar proportions were satisfied that they had spent enough time with their LMC (73%, n=72), that their LMC made all necessary referrals to other agencies or health professionals (71%, n=70) and that everyone involved in their care had the same up-to-date information about them.

Sixty-nine percent of those who experienced a still-birth felt that the birthing location or surroundings were suitable/appropriate (n=56).

Eighty-eight percent of those who gave birth in a hospital were satisfied with the caring manner of hospital ward staff (n=85).

Figure 80: Satisfaction with key aspects of respondents' maternity experience



Most respondents also felt they had received enough information, care and support (Figure 85).

Of the respondents who had diagnostic testing during their pregnancy, 88 percent (n=56) said they received enough information about what the test results meant and what options were available to them.

All but one (95%, n=18) of those whose pregnancy was terminated felt that they were given all the information they needed to make an informed decision about ending their pregnancy.

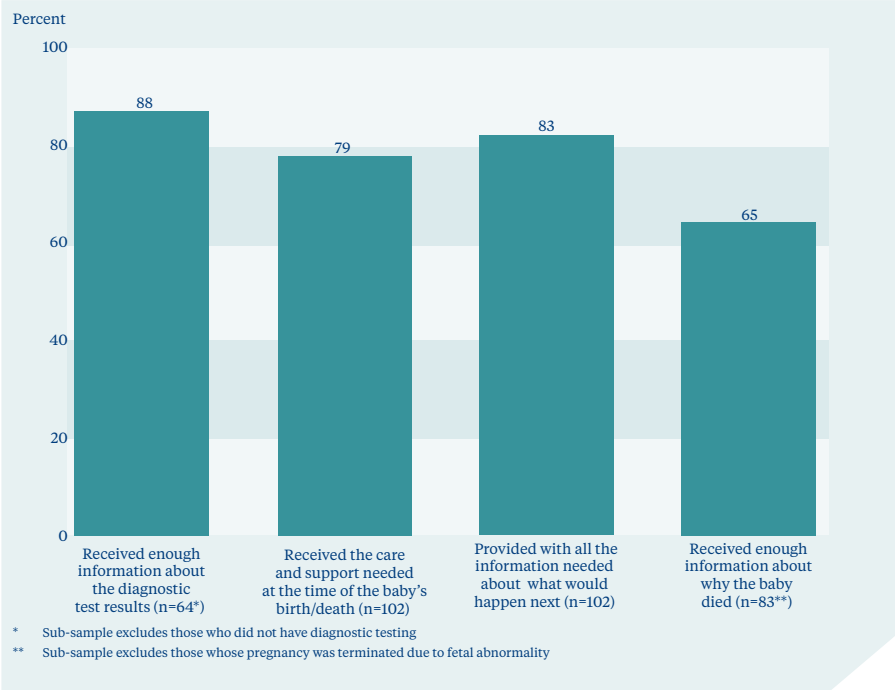
However (noting that the base numbers are small), 26 percent (n=5) of these women did not feel they were given enough time to make their decision.

Seventy-nine percent of all respondents (n=81) felt they received all of the care and support that they needed at the time of their baby's birth/death.

Eighty-three percent (n=85) also agreed that, immediately following their baby's birth/death, they were provided with all the information they needed about what would happen next.

Of those whose baby died during the pregnancy, during labour or after the birth, 65 percent (n=54) felt they were given enough information or explanation about why their baby had died.

Figure 81: Provision of information, care and support



Conclusion

While these results are generally positive and establish a baseline for future monitoring purposes, it should be noted that one in every seven respondents (14 percent) was dissatisfied with the overall standard of care they received during and immediately following the loss of their child.

This sub-sample of dissatisfied respondents is very small, and is largely comprised of women whose baby died during labour.

Suggested improvements

Although losing a child is always traumatic, the research highlights a number of actions that would help alleviate some of the stress and anxiety that accompanies such an event, as follows.

1. Ensure that the **birthing location or surroundings** are as suitable/appropriate as possible. One in three respondents commented on how emotionally difficult it was for them to be placed in close proximity to other women who were giving birth and/or nursing live babies.

2. Have a single point of contact to provide **practical information and advice**. This would be someone who can clearly explain what happens next, how, by whom and when (for example what happens to the baby's body, what the body will look like, how the family might interact with the baby's body, who they should contact to make funeral arrangements and what those arrangements entail, how they can access counselling/support services, and so on).

3. The timing and delivery of this information is also key. Not only should the information be provided as soon as practically possible (so the parents know what to expect, ideally before the event actually occurs), but it also needs to be delivered in an appropriate manner.

4. For peace of mind, particularly for those who are planning or hoping to become pregnant again in the future, it is also very important that a **clear explanation** is provided as to why the baby died.

Early involvement of a support person (such as someone from Sands New Zealand) and access to counselling services is also very important. On losing a child, the bereaved parent(s) needs to know that there are other people who understand what they have experienced and are experiencing.

Fourteen percent of all respondents said they would have liked to have received counselling or psychiatric help following the loss of their baby.

Background

This report provides the results of a benchmark survey of women who have experienced a perinatal death.

In 2009, New Zealand's perinatal related mortality rate[6] was 11.3 per 1000 births.[7] With over 60,000 live births registered in New Zealand each year, this mortality rate represents almost 700 perinatal deaths per annum.

In 2011, for the first time, the Ministry of Health has extended its Maternity Consumer Survey, which has historically been aimed at those who have experienced a live birth, to also include the views and experiences of women who have experienced a perinatal loss.

The overall objective of the Maternity Consumer Survey is to give women the opportunity to have a say about their experience of maternity services. In addition, it is intended that the results of the surveys will:

- provide the Ministry with a comprehensive analysis of women's perceptions of maternity services
- enable the Ministry to assess the current framework for maternity services
- provide information to inform future planning.

This report focuses specifically on the results of the 2011 Maternity Consumer Survey of Bereaved Women, which was conducted with women who had experienced a perinatal death.

It explores their views on the maternity care they received during their pregnancy and immediately following their loss.

6 The perinatal related mortality rate quoted is based on fetal deaths (including terminations of pregnancy and stillbirths) and neonatal deaths (up to 28 days) per 1000 total babies born at 20 weeks or beyond, or weighing at least 400 g if gestation is unknown.

7 PMMRC. 2011. *Fifth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2009*. Wellington: Health Quality & Safety Commission.

Methodology

Overview

The 2011 Maternity Consumer Survey of Bereaved Women is the first survey of its type to have been undertaken in New Zealand. The survey was conducted partly in response to the requests of bereaved women and maternity consumer and advocacy groups who represent their interests that their experiences of maternity services be heard and recorded. Prior to this survey, bereaved women had not been included in maternity consumer surveys. Given that the 2011 Survey of Bereaved Women was the first such survey to be undertaken, particular care was taken in its development. This included the following steps:

- an extensive pilot stage involving the testing of the draft survey questionnaire and proposed survey methodology with a sample of 11 bereaved women
- the survey proper, conducted after a consideration of the results of the pilot survey
- the involvement during all stages of Sands New Zealand (see note above).

Respondent definition

Approximately 700 women per annum in New Zealand experience a perinatal death.[8] This represents the population from which the sample for the 2011 Maternity Consumer Survey of Bereaved Women was drawn.

Sampling design, source and frame

After a consideration of the best possible source of a sample of the population defined above for the 2011 Maternity Consumer Survey of Bereaved Women, it was decided to source the sample from national mortality data held by the Ministry of Health, on the basis that this would provide the most accurate records.

Records held by the Ministry of Health for the period 1 June 2009 to 1 July 2010 accounted for 570 women who had lost 594 babies. After a data quality process was completed, the sampling frame for the survey was based on 557 women, all of whom were to be invited to participate in the survey.

Survey design

Design of the survey questionnaire was completed collaboratively by the Ministry of Health and Sands New Zealand.

Where possible, questions were included that would allow comparisons of the results of the survey with the results of the main 2011 Maternity Consumer Survey of women who had live babies.

Overall, questions were included that sought respondents' opinions about the following issues:

- satisfaction with LMCs
- screening and diagnostic testing, and the assistance provided to understand the results of testing and decision options
- satisfaction with where the birth took place, and events immediately after the birth[9]
- satisfaction with the level of support provided after the baby's birth
- satisfaction with the overall standard of care that was received.

8 Perinatal deaths are those that occur between 20 weeks of pregnancy and up to 28 days after birth.

9 For those who experienced a live birth, these questions were asked in relation to the events that occurred immediately after the baby's death.

A copy of the final survey questionnaire is available on the Ministry of Health website, www.health.govt.nz. It should be noted that almost all questions are of a 'closed' nature. That is, respondents were asked to respond to highly structured questions, and their answers were collected against pre-coded response categories. Interviewers invited respondents to provide any additional commentary at the conclusion of the interview, and this was collected by way of an open-ended question.

Ethical approval

With Research New Zealand's assistance, the Ministry of Health sought and successfully obtained ethical approval to proceed with the 2011 Maternity Consumer Survey of Bereaved Women.

This was subject to the completion of a pilot survey, which tested both the draft survey questionnaire and various methodological processes relating to:

- the recruitment of respondents
- how their informed consent would be obtained
- how the interview would be completed (eg, by telephone)
- how respondents who wanted additional information or support, either during or at the conclusion of the interview, would be assisted.

Pilot stage

The pilot survey was undertaken between 28 April and 16 May 2011 with the assistance of Sands New Zealand. Specifically, Sands New Zealand:

- took responsibility for identifying potential respondents from the bereaved women they had recently provided support to. Note that these respondents were selected on the basis that they were likely to be willing to participate in the survey pilot
- recruited these women for the purpose of the pilot survey and obtained their informed consent by way of a pre-survey notification letter and consent form
- provided names and contact details for consenting women to Research New Zealand
- attended the briefing with the Research New Zealand interviewers who would complete the interviewing for the pilot survey[10]
- attended the debriefing session with Research New Zealand's interviewers after the interviewing had been completed.

Sands New Zealand approached 27 women to participate in the pilot. Eleven of those who consented went on to complete the pilot survey. Another seven who initially consented to participate were not able to be contacted for the pilot, but their names were subsequently put forward for the survey proper.

Eight of the women approached to participate in the pilot did not respond to the pre-notification letter. One other respondent contacted Sands New Zealand to say that she was happy with the maternity care she had received, but did not want to take part in the survey.

A report based on the results of the pilot was prepared and discussed with the project team at the Ministry of Health and Sands New Zealand. The recommendations for changes to the draft questionnaire and the survey methodology were relatively minor. They included the following.

The consent form was changed, so that respondents only had to return the form if they wanted to participate in the survey. On this basis, it was assumed that those who chose not to respond to the pre-notification letter did not want to participate.

In the questionnaire, most references to 'termination' were replaced with 'birth' in recognition of the fact that women who undergo a termination after 20 weeks also go through labour and give birth to that baby.

10 A select group of Research New Zealand's female interviewers completed the interviewing for the 2011 Maternity Services Satisfaction Survey of Bereaved Women. Each of the interviewers chose voluntarily to work on the project and was informed that if they changed their mind at any stage they would be reassigned to another survey.

Slight minor wording changes were also made to a few of the questions to help improve the flow of the survey and to make the questions sound more conversational.

Given the results of the pilot, the Ministry of Health gave approval to proceed with the survey proper. The Ethics Committee was advised of this decision.

The 2011 Maternity Consumer Survey of Bereaved Women

The survey period

The 2011 Maternity Consumer Survey of Bereaved Women was completed between 9 and 30 June 2011 from Research New Zealand's purpose-built CATI-enabled call centre.[11] This is a state-of-the-art facility, with 40 permanent work stations, which operates between 9 am and 9 pm weekdays (weekends as necessary).

Importantly, the call centre is IQS (Interviewing Quality Standards) accredited, which is the market research industry's highest interviewer quality standard. IQS is independently audited, and Research New Zealand has held its accreditation for 11 consecutive years.

Recruitment and obtaining informed consent

As noted above, all 557 women who had experienced a perinatal death in the period from 1 June 2009 to 1 July 2009 were invited to complete the 2011 Maternity Consumer Survey of Bereaved Women.

Whereas Sands New Zealand had obtained consent from bereaved women for the purposes of the pilot, and only provided the names and contact details to Research New Zealand for those who had provided consent, Research New Zealand took complete responsibility for obtaining consent for the survey proper. A copy of the pre-survey notification letter introducing the survey and requesting consent is on the Ministry of Health website, www.health.govt.nz.

Of the 557 women who were approached in this way, 101 provided their written consent (or confirmed by email or telephone). This represents a consent rate of 18 percent.

It should be noted that it is Research New Zealand's usual experience that the recruitment and consent process for surveys is completed in a relatively short timeframe of up to two weeks. In the case of this survey, the consent process took much longer, some bereaved women providing their consent some five weeks after the pre-survey notification letter had been sent to them. This is likely to reflect the sensitive nature of the subject topic of the survey.

Interviewing

Of the 101 women who consented to complete the 2011 Maternity Consumer Survey of Bereaved Women, 91 actually did so. This represents a response rate of 92 percent.

It should be noted that at no stage were survey reminders sent to these women, as this was considered to be inappropriate.

A minimum of five attempts were made to contact each bereaved mother once they had provided their consent. These attempts were made on different days and at different times.

The average telephone interview took 24 minutes to complete, but interviews ranged from as short as 10 minutes to as long as one hour. At the commencement of each interview, interviewers asked respondents to re-confirm their consent to complete the interview. At the completion of the interview, respondents were informed that if they wanted to talk to someone about their loss, they were welcome to contact Sands New Zealand or, if they preferred, Research New Zealand would arrange for a Sands New Zealand representative to contact them.

As had been done for the pilot, the interviewing team was extensively briefed by Sands New Zealand prior to the commencement of interviews for the survey.

While 91 bereaved women completed the interview, some called and spoke generally about their experiences or sent emails by way of a response.

11 'CATI' is an acronym for 'computer-assisted telephone interviewing'.

Interviewing outcome

Table 27 provides a breakdown of the total response from both the pilot survey and the survey proper. As relatively minor changes were made to the survey questionnaire as a result of the pilot, the respondents interviewed for the pilot and those interviewed for the survey have been combined.

The table also shows the number of bereaved women who were interviewed for the survey whose:

- pregnancy was terminated for medical or health reasons
- baby died during pregnancy
- baby died during labour
- baby died after he or she was born.

As the total achieved sample is relatively small, and the sub-samples even smaller, analysis and reporting by these sub-samples is not possible.

Table 27: Interviewing outcome

	Pilot n=	Survey n=	Total n=
Pregnancy terminated for medical or health reasons	1	18	19
Baby died during pregnancy	7	46	53
Baby died during labour	1	8	9
Baby died after he or she was born	2	19	21
Total	11	91	102

Accuracy

Given the size of the total achieved sample, results based on the total sample are subject to a relatively high margin of error of plus or minus 9.7 percent (at the 95 percent confidence level). This assumes that the achieved sample is a representative sample of the 557 women originally approached.

Note that the survey data has not been weighted.

Analysis

The survey results have only been analysed on the basis of the total achieved sample. It is for this reason that this report does not provide any reporting by the four sub-groups of bereaved women based on the manner in which their pregnancy was terminated or their baby died.

A profile of bereaved women

Table 28 below provides a demographic breakdown of the bereaved women who were interviewed for the 2011 Maternity Consumer Survey of Bereaved Women and the pilot survey. The main findings are as follows.

- The majority of women interviewed (79 percent) were aged between 25 and 39 years:
  - 30 percent were under 30 years of age
  - 30 percent were 30–34 years of age
  - 28 percent were 35–39 years of age.
- Three-quarters (77 percent) of all respondents were New Zealand European, 13 percent were Māori, 5 percent were Asian and 3 percent were of Pacific ethnicity.

- Respondents were located across all of the DHB areas, including:
  - Auckland (20 percent)
  - Waitemata (13 percent)
  - Canterbury (10 percent)
  - Waikato (9 percent)
  - Northland (8 percent)
  - Capital & Coast (7 percent).

Table 28: Demographic profile

	Total sample
Age	**Base= 102 (%)**
Under 25 years	9
25–29 years	21
30–34 years	30
35–39 years	28
40–44 years	8
Not specified	4
Ethnicity	**Base=100 (%)**
New Zealand European	77
Māori	13
Asian	5
Pacific	3
Other	3
DHB area	**Base=101***
Auckland	20
Bay of Plenty	3
Canterbury	10
Capital & Coast	7
Counties Manukau	6
Hawke's Bay	2
Hutt Valley	2
Lakes	4
MidCentral	5
Nelson Marlborough	1
Northland	8
Otago	5
Tairawhiti	1
Taranaki	2
Waikato	9
Waitemata	13
West Coast	1
Whanganui	1
Wairarapa	1
Total	100

* Total exceeds 100% because of multiple responses.

Constraints and limitations

When considering the results of the 2011 Maternity Consumer Survey of Bereaved Women and the Pilot survey, the following constraints and limitations apply.

1. Survey design – as noted, the survey questionnaire consisted of mostly questions of a 'closed' nature, with the focus placed on aspects of the maternity services provided that were of interest to the Project Team at the Ministry of Health. While every attempt was made to be inclusive of the entire birthing and termination process, including events pre- and post-birth, it is possible that the interview did not include some aspects considered important by bereaved women. To an extent, the opportunity to provide comment via the open-ended question at the end of the interview gave respondents the opportunity to raise these aspects.

   As noted, the average telephone interview length was about 24 minutes. While this is a reasonable amount of time, when the survey questionnaire was being designed it was necessary to balance the need for quality information with the time respondents could be reasonably expected to make available. As a result, the questioning focused on the key areas of interest, but even then some limitations were imposed.

2. Telephone interviewing methodology – of all the options available, this interviewing methodology was considered to be the most appropriate and the most cost-efficient. However, this constrained the ability to conduct the interviewing on an unstructured basis and explore bereaved women's experiences in-depth, and placed some more practical limitations on the amount of information that could be collected.

   Neither a paper-based, self-completion approach to the interviewing nor an internet approach would have resolved these constraints and limitations, and while a face-to-face interviewing approach may have produced more in-depth information, such an approach would have been much more costly.

3. Response – the response rate to the 2011 survey was below the average for surveys conducted by Research New Zealand, but this may have to do with the sensitive nature of the subject topic and the opt-in method of recruitment. Every practical step was taken to optimise response, including the mailing of pre-survey notification letters. The fact that the pilot gave no indication that the survey would achieve a lower than average response might have to do with the fact that the bereaved women participating in the pilot survey had an existing relationship with Sands New Zealand and that they had been pre-selected as likely participants.

   An alternative methodology (eg, a paper-based, self-completion approach, an internet approach or a face-to-face approach) would not necessarily have yielded a better response rate.

4. Analysis – the relatively small achieved sample of 102 respondents means that no analysis and reporting has been possible by the four sub-groups of bereaved women based on the manner in which their pregnancy was terminated or their baby died. The analysis and reporting of the survey results has only been possible on the basis of the total achieved sample.

5. Accuracy – the relatively small achieved sample of 102 respondents also means that the survey results are subject to a relatively high margin of error of plus or minus 9.7 percent (at the 95 percent confidence level). This means if 50 percent of the bereaved women who were interviewed were satisfied with the overall standard of care they had received, there is a 95 percent certainty that between 40.3 percent and 59.7 percent of the whole population were satisfied.

Recommendations

Three recommendations are made which would enhance future Maternity Consumer Surveys of Bereaved Women:

- the provision of a longer opt-in period: while a two-week recruitment period is appropriate for most surveys, the circumstances surrounding this survey suggest a longer recruitment period would be beneficial
- reminder activity: no reminder activity was undertaken for the 2011 survey. It is recommended at least one reminder letter is sent for future surveys (with a note made in the original pre-notification letter that this will be done unless a respondent opts out)
- survey promotion: a range of methods and channels could be used to promote the survey and encourage response (eg, maternity consumer and advocacy groups).

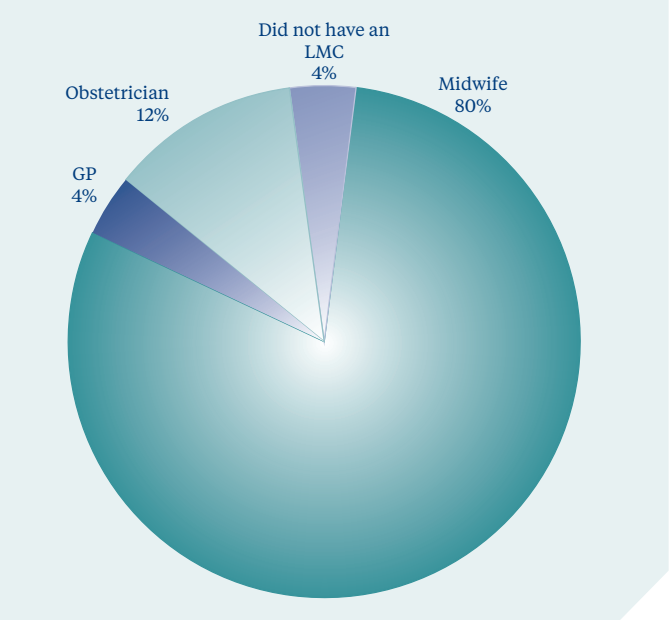
Lead Maternity Carers

The following section relates to maternity care received during the pregnancy, with a specific focus on respondents' LMCs.

Selecting a Lead Maternity Carer

As illustrated in Figure 82 below, most respondents (80%, n=82) reported that their LMC was a midwife.[12] Approximately one in ten (12%, n=12) had an obstetrician as their main carer, and 4 percent (n=4) a general practitioner (GP).

Figure 82: Lead Maternity Carer (n=102)



Very few (4 percent, n=4) reported that they did not have an LMC.

> I became pregnant through IVF and hadn't yet chosen an LMC.
>
> I had just arrived in New Zealand; I was in my 20th week.
>
> I hadn't filled in the paperwork.

12 Note: No distinction was made between community and hospital midwifes.

Satisfaction with the standard of maternity care received during the pregnancy

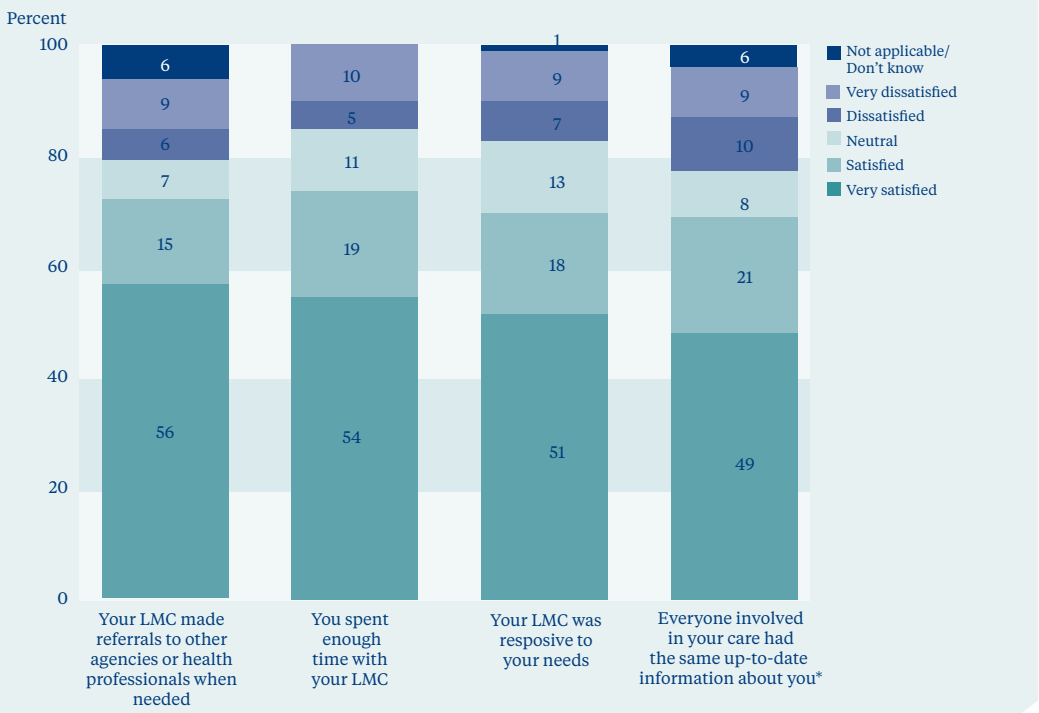
Respondents were asked to rate how satisfied they were with the standard of maternity care received during their pregnancy. Specific aspects of the service they received were measured on a scale of 1 to 5, where 1 = Very dissatisfied and 5 = Very satisfied. Three out of four of these aspects related specifically to the care provided by the LMC.

As illustrated in Figure 83 below, 73 percent of respondents (n=72) were satisfied that they had spent enough time with their LMC (54%, n=53 were 'very satisfied' in this regard).

Similar proportions were satisfied that their LMC made all necessary referrals to other agencies or health professionals (71%, n=70) and believed their LMC was responsive to their needs (69 percent, n=68).

While 70 percent of all respondents (n=71) were also satisfied that everyone involved in their care had the same up-to-date information about them, 19 percent (n=19) were dissatisfied with this particular aspect.

Figure 83: **Satisfaction with specific aspects of the care received during the pregnancy (n=98)**



* This statement was asked of everyone (n=102) including those who did bot have an LMC

Reflecting the above results, 70 percent of all respondents (n=71) were satisfied overall with the standard of maternity care they received during their pregnancy (47% or n=48 were 'very satisfied').

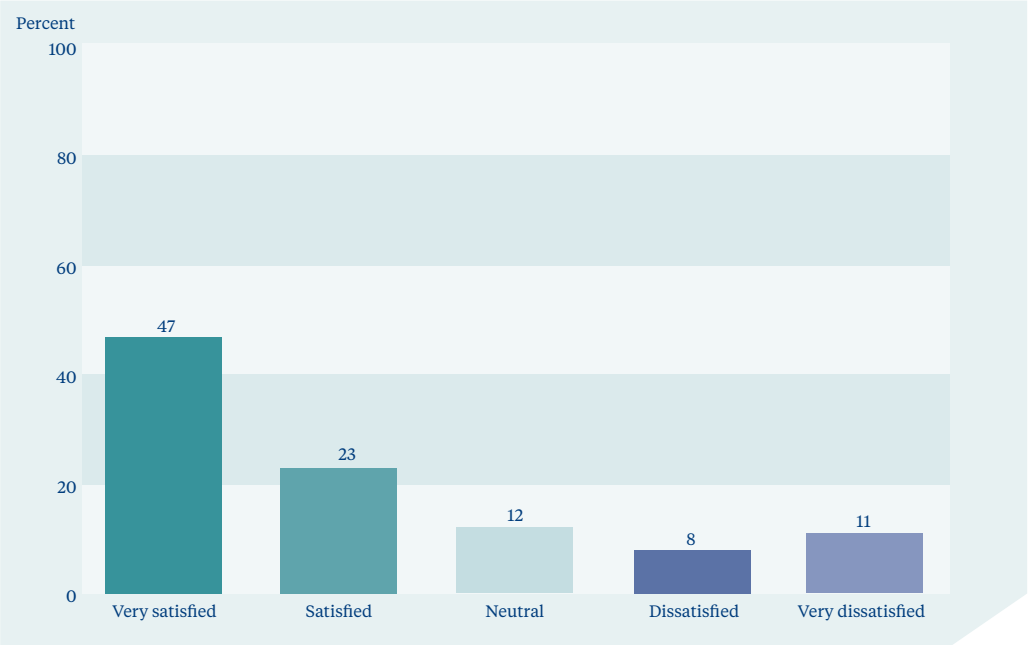
> The maternity services are fantastic.

> The staff at the hospital were absolutely wonderful, and [I] couldn't speak highly enough of them. They were so supportive.

While 12 percent (n=12) provided a 'neutral' response with regard to the overall standard of care they received during their pregnancy, one in five (19%, n=19) were dissatisfied.

> I was going to put in a complaint about my LMC. She gave me absolutely no support apart from booking a scan and giving me bad news late at night and then wondering why I am upset. She accused me of killing my baby because of my state of mind. She should be fired.

Figure 84: Overall satisfaction with the maternity care received during the pregnancy (n=102)



Early detection of potential problems or difficulties

This section explores the extent to which respondents had any early indications or prior warning that there was something wrong with their pregnancy.

Fifty-nine percent (n=60) of all respondents reported having some indication before the birth that there might be a problem with the pregnancy.

Two-thirds of these women (67%, or 39% of the total sample, n=40) said it was first suspected that there may be an issue when they were in their second trimester. A small proportion were alerted earlier (n=5), in their first trimester, while one-quarter (25%, n=15) did not find out until they had reached the third trimester (on a total sample basis, this latter group represents 15 percent of all respondents).

Forty percent of all respondents (n=41) said they had no prior indication of what was to come.

Table 29: Early indications of problems or difficulties

	Total
	Base =102%
During the first trimester (1–12 weeks)	5
During the second trimester	39
During the third trimester	15
There was no early indication of a problem	40
Don't know	1
Total	100

Total may not sum to 100% due to rounding.
Note that the low base number of respondents means that the results are indicative only.
Q8. About how many weeks into your pregnancy was it first suspected that there was a problem? [Baby terminated due to fetal abnormality]

Q44. Prior to your baby's death, was there any indication that there may have been a problem? If yes: At what point was this? [Baby died during pregnancy]

Q82. Before you went into labour, was there any indication that there may have been a problem, or that there may be difficulties with the birth? If yes: At what point was this? [Baby died during labour]

Q44. Prior to your baby's birth, was there any indication that there might be a problem? If yes: At what point was this? [Baby died after he/she was born]

Pre-screening

Almost all respondents (91%, n=93) recalled having an anatomy scan 18–20 weeks into their pregnancy. 72 percent (n=73) also reported having undergone pre-screening tests for Down syndrome and other conditions or birth defects.

Thirty-eight percent of these respondents (n=36) reported that one (or both) of the tests had indicated a possible problem with the pregnancy or baby's development (this equates to 35 percent of the total sample).

Sixty percent of those who had the anatomy scan or other pre-screening tests (n=58) said that, as far they knew, the tests had not identified any potential issues or problems with the pregnancy.

> One complaint that I did bring up with my midwife was regarding the ultrasound person, they don't want to be there, my last scan at 20 weeks was rushed. The people who do the scans need to treat each person with respect. If you're having a busy [or] bad day, just be aware. It was very rushed and I could feel my baby moving and reacting through that, and maybe I feel that if he hadn't been so rushed, maybe he could have picked up something was wrong, with my baby it was the umbilical cord so that's always going to be at the back of my mind.

Diagnostic testing

Sixty-three percent of all respondents (n=64) reported having diagnostic testing of some type during their pregnancy.

Forty-four percent (n=45) reported having a diagnostic ultrasound, 21 percent (n=21) had an amniocentesis and 8 percent (n=8) had a chorionic villus sampling. Another 20 percent (n=20) reported having an 'other' type of diagnostic testing.

Of those who had diagnostic testing or discussed this option, 83 percent (n=54) felt that they were given enough information about what the tests involved and what the potential risks were.

Information and support received when the problem was confirmed

Of those who underwent diagnostic testing, 88 percent believed that they were given enough information about what the test results meant, and what options were available to them (n=56).

Following the diagnostic tests, n=19 respondents made the decision to terminate their pregnancy (due to fetal abnormality).

All but one (95%, n=18) of those whose pregnancy was terminated felt that they were given all the information they needed to make an informed decision about ending their pregnancy.

However, 26 percent (n=5) of these women did not feel they were given enough time to make their decision.

Respondents whose pregnancy was terminated were asked if there was any additional information or support they would have liked at the time. While half (47% or n=9) could not think of anything additional that would have been of help at the time, below are some examples of the comments received by the remainder.

> My family did not have experience of this and gave advice as best they could with what they knew. When I lost another baby later on we did things differently. I didn't hurry the decision and my other children were involved.

> A guideline maybe, given to you that outlines the plans and preparation of what happens on that day. Like the birth and a death. Notifying the chaplain and organising the funeral service. I had two children by caesarean and didn't know what contractions were like; this baby was delivered naturally.

> Having an amniocentesis test at 15 weeks would have been more helpful than at 21 weeks.

> If it could have been picked up at 12 weeks instead of 20 weeks. More thorough screening in the 12 weeks scan, with more emphasis on any abnormalities. At 12 weeks it is still considered a medical abortion, but at 20 weeks you have to go through the whole labour process.

> I was fortunate that the nurse/midwife at the hospital was available 24/7 to clarify information. She turned up to the doctor's appointments and counsellor's appointments. There was information overload, so it was nice to know that she was available to help me.

> Just more communication in between, like before we got to the scan, we were not told that the problem was that serious. More time to make the decision whether to terminate the baby, because they still need to get the permission to terminate. It would have been nice to have at least a day.

> The initial ultrasound wasn't conclusive. The local obstetrician was fine but needed prompting from us to arrange for the specialist, which in hindsight was definitely required. If we had followed his initial advice, which was to continue the pregnancy, things would have been worse.

Other respondents (n=53) discovered that their baby had died in the womb.

While approximately half of these women (45%, n=24) lost their baby when they were in their second trimester, the rest were in their third trimester.

> We found out that the baby had died at 39 weeks and five days. It was the day before my due date.

These two groups of respondents received information, support and advice from a variety of different people when making their decisions about what would happen next (ie, whether to continue with the pregnancy or, for those whose baby had already passed, what to do with regard to the delivery of the baby). While 65 percent (n=47) said they received this information and support from their midwife, half (50 percent, n=36) mentioned their obstetrician, 12 percent mentioned family/friends (n=9) and 12 percent mentioned their specialist (n=9). Seventeen percent mentioned 'other hospital staff' (eg, delivery suite staff, radiologists, the fetal medicine team) (Table 30):

> The level of care by the hospital, my GP, my midwife and the Foetal Medicine Clinic in Auckland was outstanding. It wasn't a great experience but the fact that they all worked very hard to help us understand our choices and they supported us the whole way. The level of care was faultless, it was absolutely superb.

> I did go and see a paediatrician prior because it wasn't known whether my baby would survive to the birth or not and he gave us some options, talked us through what would happen if the baby was born alive etc, so I had quite informed information. But it was a decision that I had made based on [pause] Every mother will make decisions in her life based on the best information that she has at the time.

When asked to identify which of these people provided the most helpful information, support or advice when making their decision, 39 percent (n=28) identified their midwife, 28 percent the obstetrician (n=20), 12 percent the specialist (n=9) and another 12 percent 'other hospital staff' (n=9). Six percent said that the most helpful information, support or advice came from their family members or friends (n=4) (Table 30).

Table 30: People providing most helpful information

	All helpful people	Most helpful person
Base =	72%*	72%*
Midwife	65	39
Obstetrician	50	28
Other hospital staff	17	12
Family/friends	12	12
Specialist	12	6
GP	7	6
Registrar	6	4
Nurse	6	3
Sands New Zealand	4	1
Support worker/ counsellor	4	1
Other	1	0
New Zealand Down Syndrome Association	0	4
No one	0	1
Don't know	0	1

Total exceeds 100% because of multiple responses.

* Sub-sample is based on those respondents whose baby was terminated due to fetal abnormality or who died during the pregnancy.

Q16. Who was involved or provided information, support or advice to help you make your decision after you got your diagnostic results? [Baby terminated due to fetal abnormality]

Q54. Who was involved or provided information, support or advice to help you understand what had happened and what decisions needed to be made with regard to the delivery of your baby? [Baby died during pregnancy]

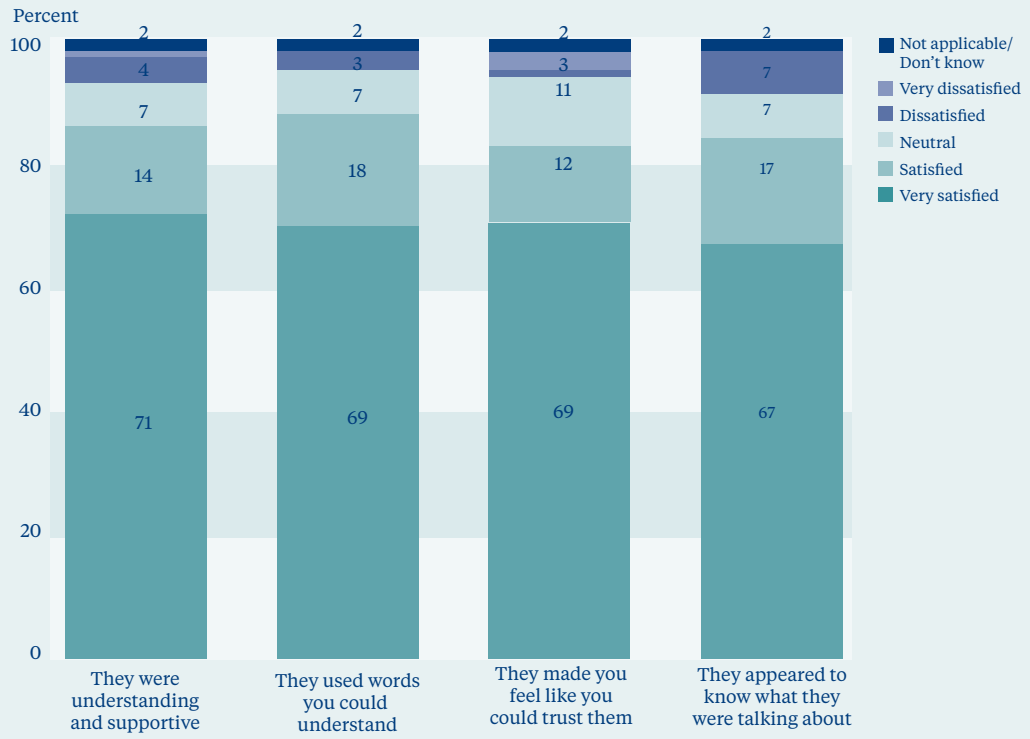
Q17. Which one of them provided you with the most helpful information, support or advice when you were making your decision? [Baby terminated due to fetal abnormality]

Q55. Who provided you with the most helpful information, support or advice? [Baby died during pregnancy]

Figure 85 shows how the 'most helpful' individuals were rated against a list of four key attributes. Respondents were asked to asked to rate each attribute on a scale of 1 to 5, where 1 = 'Strongly disagree' and 5 = 'Strongly agree'.

As illustrated, at least 80 percent (n=59) of those whose pregnancy was terminated due to fetal abnormality or whose baby died during the pregnancy agreed that each of the four attributes applied to their 'most helpful' person. Around two-thirds 'strongly agreed' with each statement.

Figure 85: Ratings of the person who provided the most helpful information, support and advice when making decision about the pregnancy/birth (n=72)*



* Sample is based on those whose pregnancy was terminated due to fetal abnormality, or whose baby died during pregnancy.

The birth

This section focuses on the birth, including respondents' views on the birthing location and the information and support that were provided at the time.

Appropriateness of the birthing location/surroundings

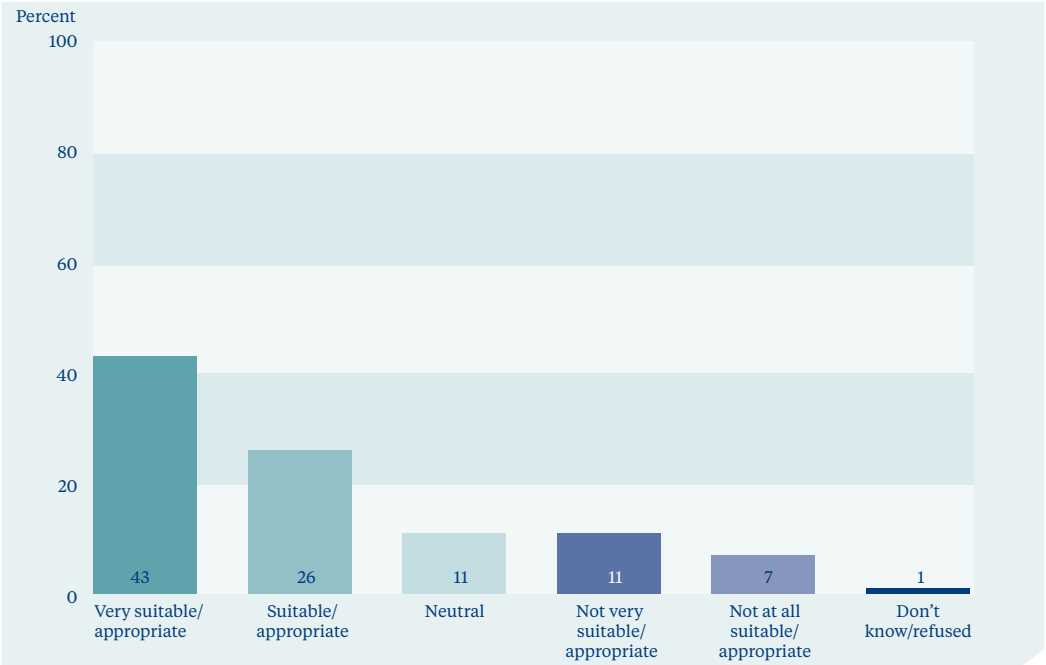
Respondents whose baby died during the pregnancy, during labour or after the baby was born were asked to identify where the birth had taken place.[13]

The majority (93%, n=77) said they gave birth in the maternity unit of a general hospital. Four percent had a home birth, while the rest (3%, n=3) gave birth at a small maternity hospital or special birthing unit.

Most (80%, n=24) of those whose baby died during labour or after he/she was born confirmed that they had given birth in the location that they had originally intended to give birth.

As shown in Figure 86 below, 69 percent of those who had a stillbirth (n=56) felt the birthing location was suitable or appropriate.[14] However, 11 percent (n=9) gave a neutral response, while 18 percent disagreed (n=15).

Figure 86: Perceived suitability or appropriateness of the (still)birth location (n=81)*



*Sub-sample excludes those who had a live birth.

Although 69 percent (n=56) of those who experienced a stillbirth felt the location or surroundings were 'suitable', many (63 percent, n=50) offered suggestions as to what they would change with regard to the location or surroundings to make it easier or more appropriate for women in the same situation.

13 Those whose pregnancy was terminated were not asked to identify where the termination took place.

14 Those who experienced a live birth were not asked about the appropriateness of the birthing location.

Most of the suggestions related to the proximity of the location to other mothers and newborn babies (this was mentioned by 35 percent, n=28 of those who experienced a stillbirth).

> Shouldn't have to be in a place where live babies are being born. It was bitter sweet – a lot of people would struggle with that.

> It would be nice to be separated, to not have to hear the sounds of healthy babies.

> If there weren't pregnant women and live babies that would be great. I didn't see any live babies; it was more that you have to walk out and you knew that there were other people who were going into labour with live children and you saw pregnant people around, and it feels like a bit of a slap across the face. But you can't avoid pregnant women the whole time. The maternity services are all on the same floor.

> The downside is that you're in a place where women have live babies, and so I don't know how they would do it any different but they put you in a separate room, your husband is able to stay with you, and they are incredibly compassionate that way, but having to walk out of the room and seeing pregnant women is really hard.

> We could hear people in labour on either side of us; this meant hearing the heartbeats of other babies, which was distressing.

> Not having it at the same location where the normal babies are being born.

> I wouldn't give birth in the general maternity suite where mothers are giving birth to live babies. If I had a choice it would be away from that environment.

> Not too sure; they were accommodating and had me away from everyone else – they could not have separated me further – but it is very hard to hear other babies crying.

> When I was transferred to the maternity hospital post delivery – without baby – I was placed in a room with other women and newborn babies crying.

> I wouldn't have women who knew they were having a stillbirth close to or in the same ward as women giving birth to live healthy babies. I could hear the babies and the women. It was very distressing.

Twelve percent (n=10) felt the surroundings or décor could be more welcoming or appropriate.

> It was just a bit of a cold environment. Even if they painted the corridor a better colour; you felt like you were getting wheeled through the meat works, down a long alley to the theatre door.

> Need the room to not look quite as medical.

> I just think I would make the room more homely – a few more pictures on the wall or something that didn't feel like a hospital.

> I would take away the noises, eg, fetal heart monitors, and the posters which promote breastfeeding.

> There were pictures of newborn babies and flyers about breastfeeding in the room.

> The pictures on the walls – they were of babies.

> I came in for an induction and it was a little difficult to find the proper place at the hospital. I realise this place has to be hard to find given the procedures and the possible abuse of privacy by protestors. Trying to find it made me think of our decision but – it was the right one. It's just that having the place a little out of the way highlighted the negative opinions of others.

> The rooms in hospital are pretty sterile; they are not very comforting.

Eleven percent (n=9) felt that more/better facilities could have been provided, not only for themselves, but also for their partners.

> I was in the exam room at this unit; because my baby was just 20 weeks it was not suitable for us to be in the maternity unit. It was not very comfortable. There should have been a proper bed. It was not even a proper hospital.

Probably better sleeping facility for the partners; there really needs to be a bed for them, especially during long labours.

I would add a television. It was in a special room outside the birthing suite. Labour is a long time and a television would help.

Better environment for the support people.

Probably having a toilet in the room, an en suite and if they had provided somewhere to sleep for my husband.

Seven percent (n=6) mentioned the desirability of better communication/understanding from hospital staff.

There needs to be a separate unit so staff know that those babies have been lost, because we had just given birth to the twins and a staff member came in and said 'oh how are they doing?' because they didn't realise that they had passed, so that was pretty disturbing.

Just as an example, after they had actually passed, a nurse from Neonatal came in and told us that they could have tried to save them. She was from Neonatal and they believe babies could be saved at 23 weeks, whereas the midwives don't believe until 24 weeks, so their information had not been passed on. That was really distressing having someone come in and say actually we could have saved them. It's that conflict within the hospital; once again it's passing on information.

It's a personnel issue, but none of the nurses in the theatre were aware that one of my babies had died; I had to tell them, each individual one of them. Each one of them would come out of the theatre and would be like 'oh are we having twins today?' By the third one my LMC yelled at them.

We knew that baby was 'stuck' and distressed but we had to wait. I was deemed not as urgent as other women that night. We were put in a queue.

I would probably change the way some of the midwives were at the hospital. I would change the way I was treated as I was pretty much left in the birthing room by myself with my family to give birth. The midwives did not know how to help the situation or support the situation. I felt pretty much isolated or on my own; there was no medical team or nothing.

Six percent (n=5) said they would have preferred a location that was closer to home, family and the rest of their support network.

I'd change the location because I had to go to Hamilton where I had no family. It would have been nice as well to have had my midwife be there.

Be closer to home. Make it warmer.

We had to go all the way to Dunedin, which is 2.5 hours away. There was nothing close to us. If we needed specialist care we had to go to Dunedin.

Information and support received (during and immediately following the birth)

Seventy-nine percent of respondents (n=81) felt they received all of the care and support that they needed at the time of their baby's birth.[15]

The only thing would be in respect to the social worker; I just felt that it was a waste of time to be honest with you. I can't complain at all about my experiences with the hospital, my midwife was just unbelievably fabulous; the professionals at the hospital in the specialised unit were fabulous. It was just the social worker. I've never had to deal with a social worker before but that was just a waste of time. I don't know if she was new or anything like that; I don't want it to be put down as a personal thing. I think if she had come to us armed with relevant information, if she had known ... I don't know how much information she was given about the reasoning behind the termination. There is no reason why they shouldn't know; it might be confidential but our baby had a heart condition. If she had come in with relevant information it would have been brilliant.

15 For those who experienced a live birth, this referred to the point at which their baby died.

We were fortunate; but we had a good nurse as well. I guess [that was] the advantage as far as information went; she gave us all the information that we would have got after we gave birth, before we gave birth. She did it in the reverse way but for us that was very good: we had time to plan, we knew what the outcome was going to be. All the pamphlets we got I think through Sands New Zealand and … it was very clear, like we could look through each thing and [think] 'oh we need to do this' and … to plan that prior to birth. But again that is our situation; it doesn't work for everybody. But for us … getting that information prior was brilliant for us. We walked out at midnight very clear where we were going forward and what to do.

Respondents were also asked if they felt they were provided with all the information they needed about what would happen next, following their baby's birth/death. Although most (83 percent, n=85) believed they did receive all the information they needed, half (51 percent, n=50) said that in hindsight it would have been useful to have received additional information.

Table 31: Additional information

	Total
	Base = 102%
Needed a support person/counsellor/Sands New Zealand to help us deal with the situation (someone who understood what we were going through)	15
Funeral preparations – where to go, who to contact, what happens to the body	10
Clear, consistent, step-by-step information about what would happen next and what I had to do	9
What to expect in terms of baby's appearance/how to interact with dead baby/make memories (eg, hold baby, take photos, let siblings see baby etc)	7
I wanted to know why my baby died	6
Practical information about the birth and after-effects – physical pain, what would happen to my body after the birth, milk flow etc	5
Would have been useful to have been provided with the information earlier to help us prepare in advance	2
Other	7
No additional information was needed	44
Don't know	5

Total exceeds 100% because of multiple responses.
Note that the low base number of respondents means that results are indicative only.
Q26. Looking back, what additional information would have been useful at that time?

15 percent of respondents (n=15) said it would have been good to have known about Sands New Zealand earlier, or to at least have had a counsellor or support person available to them – someone who understood what they were going through:

I only just found out about Sands New Zealand about a month ago; that is probably the one thing I would have liked to have known about earlier.

More emphasis on the Sands New Zealand components; contact with people who have been through the same thing. Offering to have someone contact me would have been helpful.

For somebody to have gotten in touch with Sands New Zealand; it would have been quite useful and helpful to talk to somebody who would have understood.

They need to have a grief counsellor with you when they tell you that news. My partner was in America at that time; I was on my own when they informed me that my babies were going to die.

The big thing for me was that it wasn't until just before I left that I got information about the Sands New Zealand group, and I feel it would have been better getting that earlier. That was the main thing.

It was a lot to take in. A counsellor would have been helpful. The social worker at the hospital had a lack of compassion and asked if we had a plot for my husband and I. I thought that was disgusting.

Ten percent (n=10) would have liked more information about funeral preparations (eg, where to go, who to contact, what happens with the body).

> It would have been useful to know that you don't have to involve a funeral director. We felt rushed when we were asked three times by someone in the hospital if we had already decided if we want a funeral director. We found it inappropriate at that time. We were after some practical advice as to where to go for a cemetery and things like that.

> Before I gave birth it would have been helpful to have been advised of who we could go to; which funeral homes for example. We had to do the research ourselves. We were given information by Sands New Zealand, but it was only about what would happen after the birth but not information about where we could go for funeral homes.

> I think probably just undertakers and how to access funeral services. I think staff are trying to be sensitive and they don't touch upon things that you really need information about. The most helpful person was a charge nurse who went into everything in this regard and it was really helpful. You are not in a frame of mind to make decisions and you need someone to lay the options out before you. You haven't got the foresight to ask what is available/needs to be done.

> Just to know what would happen; they asked me if I would like the funeral person to speak to me and I did not realise that by coming to speak to me it meant that they would be taking baby away – this was not explained to me at all.

Nine percent (n=9) said there was a need for clear, consistent, step-by-step information about what would happen next and what they had to do.

> Have somebody come in and verbally discuss it instead of just handing over a booklet.

> Just to be kept informed of what would happen next. I didn't have any idea at all of what was going to happen next.

> Overall if you had one person who took the parents aside for 10 minutes and said 'ok this is what we need do from here, let's quickly talk about this and then go be with your family' and then just been there and sat with them for the different things rather then having a barrage of different people. You're stunned; we sort of had a 24-hour period of build up but it wasn't at all expected; it's a whole different ball game than having a very sick newborn and then him dying. For us we were told on the Friday that he would be out of the NICU and all the pipes would be off, and he was dead by lunch.

Seven percent (n=7) would have liked to have been better prepared for how the baby would look and how they might interact/make memories.

> It's probably after the birth how to interact with a baby that had died, because I didn't hold it; I never held the baby. I kind of chose not to, but kind of wish I had. The other mistake I would have made: my older daughter even though she was two and ten months didn't get to see her but she was very aware of her, and when she did come to see me she asked where she was. I mean the obstetrician did ask if I was going to let her see her. I said no, you know she's two and a half. From a doctor's point of view you get it, but as a mother …

> Probably a bit more information about – they did tell us that when baby was born there would be changes to baby's appearance. There was a bit of … he was not as live babies are – a bit more discussion around that. We did get to see him but I was worried about it and would have appreciated a bit more information.

> The hardest thing would have been when we were in the hospital; the hospital midwives explained to us about how the boys would be treated in their post-mortem and [said] they had a teddy bear where the stitches would be, so when we could view the body after the post-mortem we would know what to expect. Then the funeral director spoke to us when we were at home: he really recommended not to see our babies after the post-mortem, so we had mixed signals about whether we should or shouldn't see our babies after a post-mortem. In hindsight it would have been good I suppose to have some more advice on what we could have expected after a post–mortem, and I guess what condition their bodies would be in. We didn't view them after that post-mortem; we went with our funeral director's recommendation not to see them. But more information on that would have been appreciated, because we have always wondered now; we never sort of took that opportunity to see them and you sort of always wonder, 'should we?' I don't know who would supply that information. Maybe a brochure on that?

I had twins and if somebody had said to me 'why don't you get a photo of both twins together', then I probably would have (one twin survived).

They didn't actually have a Sands New Zealand person come to see me until I got home; if I had had a Sands New Zealand person at the hospital it would have been much more helpful. I would have known about photos and other things for memories. I would also have liked to have held her – I was scared to, but it would have been good to hold her. Staff were good to me but they were dealing with live babies; they were not interested in dead ones.

Six percent said that at the time, the only additional information they wanted was to understand what had happened and why (cause of death).

I would have liked to have known why I was losing so many babies. I lost three in all – that is what I am not happy about.

When you give birth at 21 weeks you want to know why! You do not think about yourself; you think about why it happened.

I would've liked to have known the cause of my baby's death for next time to stop this from happening again.

It would have been good to know what happened. I am pregnant again and I had to wait until I passed 26 weeks to feel at ease.

If we had been told by the midwife about what could have been the cause as to why the first baby died, it would have saved this baby. The problem is the lack of communication between the health professionals. It's also lack of monitoring between pregnancies. I'd never go back to that maternity unit. Never.

Five percent (n=5) would have liked practical information about the birth and after-effects (eg, some were unprepared for the physical pain involved with the birth, the milk flow, etc).

The fact that your milk is going to come in; this should be discussed and/or treatment provided.

Practical things like what was going to happen to my body. I was sent home to see if the baby would actually come, to see if I would miscarry. I saw the obstetrician one more time at the hospital two days later and was discharged, so some form of postnatal care would have been good. I did not have the basic stuff about bleeding and so forth which you have help with – milk coming in – basic stuff. A list of people I could talk to if I needed help – I have a long history of depression – access to mental health if needed.

I was given the impression that I wasn't going to go through any pain because the baby was dead; they were going to give me really good drugs that meant that I wouldn't have to feel anything really, and that wasn't the case. That was the only slight disappointment that I had was that it actually was very painful; maybe they say that because you end up dreading it more knowing that you are going to go through pain and end up with a dead baby at the end of it, which is incredibly painful. But anyway that would be the only thing about the pre information; I wasn't given any clear indication that it actually was going to be as painful as childbirth.

Two percent (n=3) were satisfied with the information they received, but felt it would have been much more useful if they had received it earlier:.

When we got to the hospital to deliver the baby that was when they provided me with all these pamphlets on what to do when you have stillborn baby. They could have provided us with those pamphlets when we first found out that the baby was already dead. That would have given us two days to think about what we could do. Instead it was provided on the day they were to take the baby out, but your mind is only on what's happening.

Memory making

Almost all respondents (97%, n=99) said that they were given the opportunity to take something as a memory of their baby (eg, hand and footprints, photographs, a lock of hair).

Eighty-nine percent of all respondents (n=91) reported that they did take some form of memento or keepsake of their baby.

> Bereavement Care came up and did that. One person we had was brilliant. She was given a lot of care there, which is very important. Regardless of the outcome, baby is still yours, and she was treated with the same respect as any baby that was born alive.

> They gave me a copy of her feet, and I did get the hand print. I was happy with that. They didn't give the piece of hair that they said they would. I could have cut it myself, but you know – when you are upset at the time, you're mourning your baby; when you're in that mourning situation you can't think. But those things mean a lot to you after.

> Initially I did not want to take photos and locks of hair as a memory of baby, but the nurse took these anyway and told us to think about it later. I am now very pleased that she did this. I was given a little memory box, and others had knitted small clothes for her. I was so grateful. At first I didn't want to see the baby, but then I did and her being dressed up was amazing. These people were very supportive. I was just amazed; everyone involved was very supportive; it opened my eyes to the little organisations and support I didn't know existed. I take my hat off to them.

> With regards to keeping memories of the baby, personally I felt that they could have given me at least a day to take it all in instead of rushing in and doing it for us. It is not a criticism, as they were amazing. It's just too much to take in at that time.

Eight percent (n=8) chose not to take anything as a keepsake, while the remaining 3 percent said they were not provided with the opportunity to do so. This latter group were all women whose baby had died during the pregnancy.

> I found it was a bit too much. When you have a baby that is abnormal and there is no other way to go but to have it terminated, you just don't want to be reminded of it, you don't want people putting pressure on you to try and keep memories of it, when it's not really a baby, it's very abnormal. It's good that they say it but not too much; it was a bit over the top.

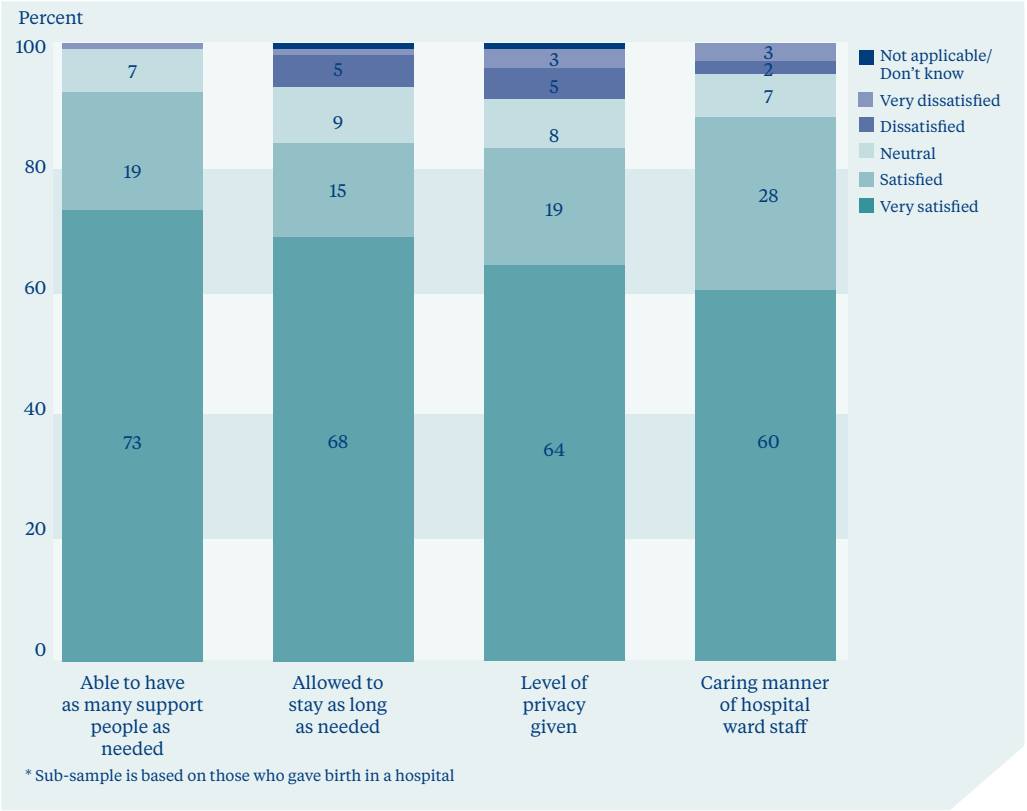
The hospital stay

Ninety-five percent of all respondents (n=97) gave birth in a hospital. As illustrated in Figure 91 below, most of these respondents were satisfied with key aspects of their hospital stay. More specifically:

- 92 percent (n=89) were satisfied that they were able to have as many support people with them as they needed (73 percent, n=71 were very satisfied)
- 88 percent (n=85) were satisfied with the caring manner of the hospital ward staff (60 percent, n=58 were very satisfied)
- 83 percent (n=80) were satisfied with the level of privacy they were given (64 percent, n=62 were very satisfied)
- 83 percent (n=81) were satisfied that they were allowed to stay in the hospital for as long as they needed (68 percent, n=66 were very satisfied).

Figure 87: Satisfaction with various aspects relating to respondents' hospital stay (n=97)*

Of those who gave birth in hospital, 82 percent (n=80) said that when they left the hospital, they felt they were ready to do so.



Of the n=16 respondents who felt they had left before they were ready, n=5 said they had left because they were discharged (eg, because the hospital was too full). The others left either because they had other responsibilities, because they did not like the hospital environment or because they were struggling emotionally to deal with the fact that they would be leaving hospital without their baby.

> I don't feel that I would ever have felt ready to leave without a baby to be honest.

> I didn't really want to leave because I knew my son was still there.

> The only reason I didn't want to leave is because I didn't have my baby.

> I knew he was under the most fantastic care possible but it is really hard when in your previous experience you take the baby home with you. Leaving without that capsule is a very weird thing. I had already been in hospital for over a month so I had to get home for my other child.

Understanding why the baby died

This section explores the level of information provided to respondents to help them understand why their baby died.

Provision of information as to why the baby died

Respondents whose baby died during the pregnancy, labour or after the birth were asked if they felt that they had been given enough information or explanation about why their baby had died. While 65 percent (n=54) did feel that they received enough information, one in three (35 percent, n=28) did not.

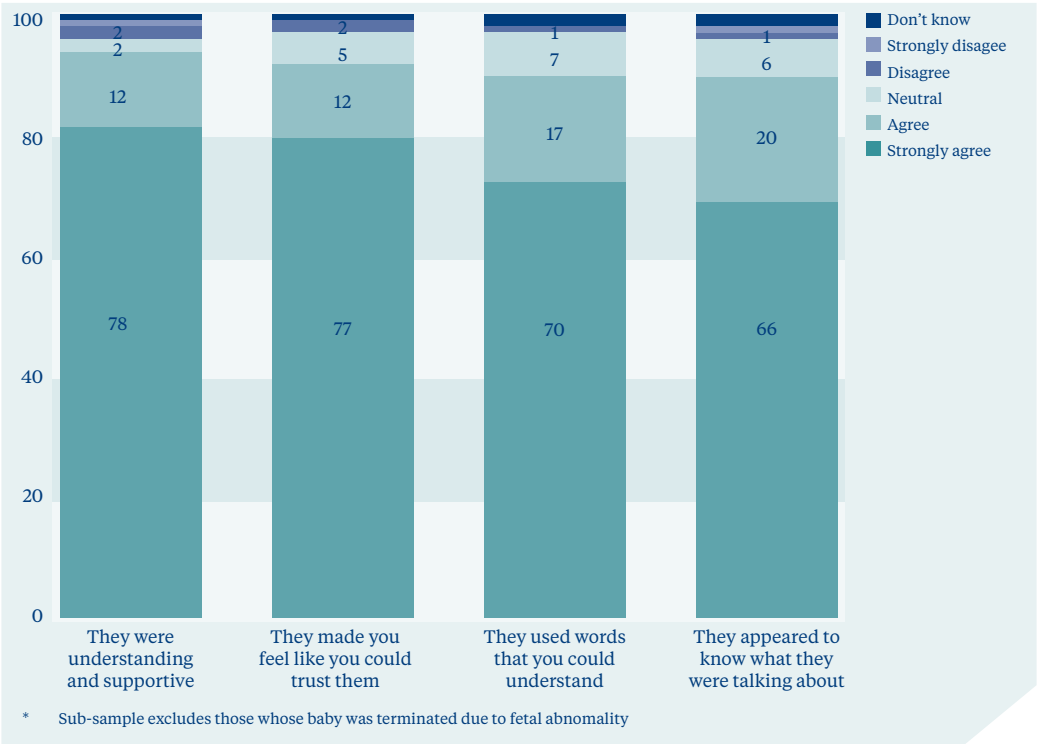
> The last scan I had, I had three people come and do my stomach and that was getting really distressing and the next morning my baby was dead. My husband and I came to our own conclusion that she was maybe annoyed at this amount of scanning; that's how we felt. The cause of death was the cord being wrapped around baby's neck three times, very tightly. My husband and I are thinking from that scan she must have been scared, got super-active and caught herself up in the cord – that's what we were thinking.

Of all the people who provided support and information at that stage, respondents most commonly identified their midwife as being the most helpful (42 percent, n=35). Twenty-seven percent (n=22) identified their obstetrician, 17 percent (n=14) the specialist and 13 percent (n=11) Sands New Zealand.

As illustrated in Figure 88, although the 'most helpful' person was rated highly in relation to most of the key attributes measured, their key strengths were in the following areas:

- being understanding and supportive (78 percent, n=65 strongly agreed; 90 percent, n=75 agreed overall)
- evoking a feeling of trust (77 percent, n=64 strongly agreed; 89 percent, n=74 agreed overall).

Figure 88: Satisfaction with the most helpful person in providing support and information following the baby's death (n=83)*



* Sub-sample excludes those whose baby was terminated due to fetal abnomality

Further diagnostic testing

Following the baby's death, two-thirds (64%, n=65) of respondents were asked if they wanted further diagnostic testing to be carried out.

Of those, 68 percent (n=44) agreed. On a total sample basis, this represents 43 percent of all respondents.

Of the n=36 respondents who were not asked about diagnostic testing, relatively few (n=8) said that they would have liked further diagnostic testing to have been done.

Post-mortem examinations

Most respondents (85%, n=86) said that following their baby's death, they were asked if they would like to have a post-mortem carried out to determine the cause of death.

Just over half (56%, n=48) of those who were asked if they wanted a post-mortem decided to go ahead with it. This equates to 47 percent of the total sample.

Those who decided against having a post-mortem for their baby were asked to identify their reasons. Please note that the following results are based on a fairly small sub-sample (n=38) and are indicative only.

n=23 of those who refused a post-mortem did not feel it was necessary, as they felt they already had all the information they needed with regard to the cause of death.

> We already knew why she had passed away.
>
> Because we already knew what was wrong and nothing could be achieved with the post-mortem.
>
> We didn't need to; the doctors and research may benefit, but not us necessarily. There was no need.
>
> Once we knew the cause of death we did not want to do anything further.
>
> Because we were comfortable with the facts; we already knew what was wrong with him.
>
> I already had an amnio done. They had spoken to me about everything and I think that was enough.
>
> I knew there was nothing wrong with her so didn't see the point.

n=9 were uncomfortable with the post-mortem procedure.

> We just felt that he had had enough and it was not going to bring him back and just the thought of him going through more – the cutting and all the rest of it.
>
> They had been through enough; I did not want to put them through any more stuff.
>
> Because the nurse explained to me that baby would lie in a freezer for three weeks and I just thought how terrible – he won't be in peace. But in hindsight I actually think that I should have had a post-mortem done because I wanted to make sure those things that were wrong were there, because he looked perfect. I could see none of the defects and no sign of Down syndrome features. He was just normal.
>
> I just didn't like the thought of him cut up – totally emotional more than anything.
>
> I did not want the last thought of them being cut open – I wanted them to remain as they were.

n=8 did not want to be parted from their baby; they wanted to spend time with the baby/have them close.

> The geographic distance – if baby could have been kept locally with us we would have but because baby would have had to travel away we didn't.
>
> I just thought at that point, I wanted the babies – I wanted them to myself and to spend as much time as I could with them before the funeral.
>
> Because we would've had to have been apart. We are in Whangarei and he would have had to go down to Wellington.
>
> We just wanted to keep him close to us.

For n=3, a post-mortem was against their beliefs.

> Because it was not culturally appropriate for my family, including the footprints and photographs. It was just not right for us.

> Was more to do with my beliefs – what will happen will happen.

> Because that's the way I was raised. The baby is so precious.

n=2 chose not to have a post-mortem as they felt the results may not have been conclusive.

> They did say that they couldn't guarantee that it would give them an answer as to why it happened. And he was really small and fragile.

> I was under the impression that post-mortem results are not quite conclusive.

Of the n=15 respondents who were not asked about a post-mortem, most (n=11) said that, had they been asked, they would have declined.

Support received following the loss

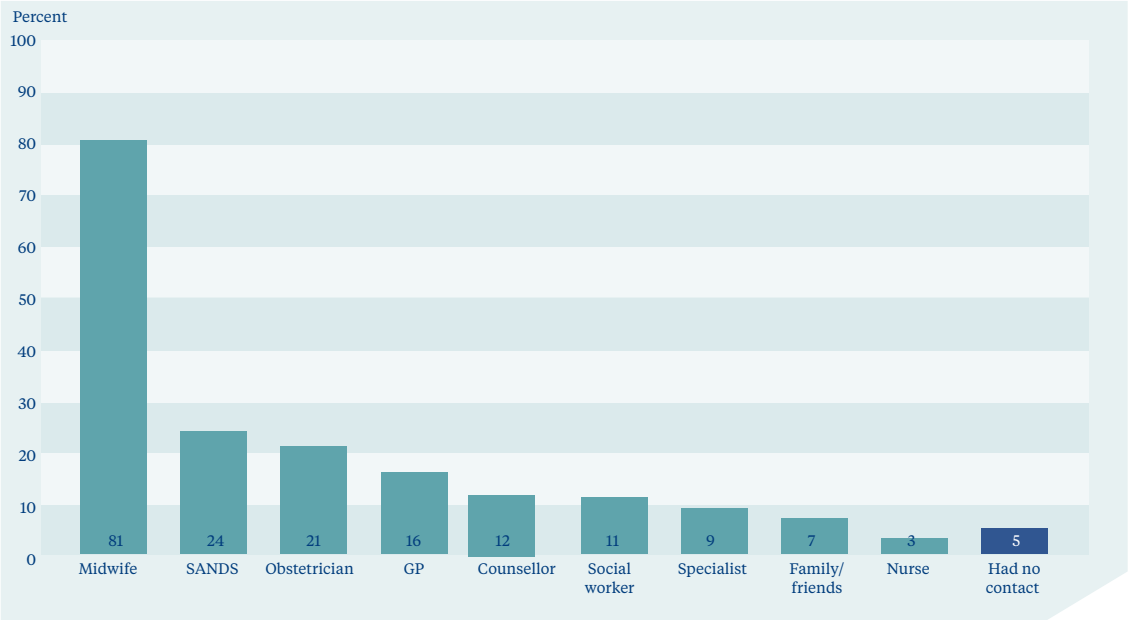
In the days and weeks that followed after the loss of their baby, most respondents received some form of contact either from their LMC, another health professional or a support agency.

Contact and support received

After leaving the hospital, 95 percent of respondents (n=97) received some form of follow-up contact.

As shown in Figure 89 below, 81 percent (n=83) were contacted by their midwife, 21 percent (n=21) had contact with an obstetrician, 16 percent (n=16) were contacted by their doctor/GP and 9 percent (n=9) were contacted by a specialist. With regard to counselling or support services, 24 percent (n=24) had contact with Sands New Zealand, 12 percent (n=12) had contact with a counsellor and 11 percent (n=11) reported seeing a social worker.

Figure 89: Contact received in the days and weeks following the loss (n=102)



When asked to identify which of these people was the most helpful or supportive during that time, 62 percent (n=63) mentioned their midwife, 13 percent (n=13) their obstetrician and 10 percent (n=10) Sands New Zealand:

> My midwife was really good in giving me support, but after the six weeks she was no longer legally allowed to give me that support and advice. After losing my baby, I had been seriously sick with breast infections and with my uterus; it would have been nice to go through that with my midwife, who had been there from the beginning. However, legally she needed to hand me over to my GP, but to have lost her support at that time was really difficult. I just felt that we should have that support for as long as we need to. It is a very slow process from losing your child to getting alright.

Although two-thirds of respondents (65 percent, n=66) said there was no additional contact, information or support that they would have liked to have received at that time, one in three (31 percent, n=32) said they would have liked more.

Fourteen percent (n=14) of all respondents said that after they had left the hospital, they would have liked to have received some form of counselling to help them with their grief (see Table 32):

> Just if there was – if you could get some counselling. It was pretty traumatic for us and we struggled.
>
> Looking back one thing I really needed was professional counselling. It is really, really difficult to handle.
>
> Some sort of counselling. It was a year later when I had the meltdown [and] I had to go for private counselling to deal with it. It would have been good if somebody could have visited me who had gone through the same situation.

Nine percent (n=9) would have liked to have received contact from their LMC.

> I would have liked the midwife to have been there throughout the birth and providing follow-up care. I did not see or hear from her again after the appointment in her office [prior to referral to hospital]. I suppose I just wanted someone helping me throughout the process, like you have when you have a baby that lives.
>
> More contact from my LMC. Because as soon as I found out – the same day that the LMC found no heartbeat and sent me for a scan was the last time I heard from her. It would have been good to have had more contact with her.
>
> I would have liked the midwife LMC to have come and checked on me to see that everything was fine, but she didn't. I went back to the same group of midwives later and she pretended that she did not recognise me at all.
>
> Yes definitely more from the LMC. I think they deal so much with the living children that they forget the others. I think this has to be addressed in their training. You build up this rapport with them over the weeks and then the baby is gone and there is no more contact. There's no understanding; you're just a statistic, but you are still having to cope with the loss.

Three percent (n=3) would have liked to have had contact from/with Sands New Zealand, particularly in the early days following their loss.

> It would have been helpful for somebody from Sands New Zealand to have [made] contact as soon as it [happened].
>
> If we had been given names of people that you could talk to, like Sands New Zealand.

Table 32: Additional contact, information or support received

	Total
	Base = 102%
Counselling or psychiatric help	14
More/any contact from my LMC	9
Contact with Sands New Zealand, or others who had been through the same experience	3
Follow-up contact from the hospital	2
Information on financial assistance/costs (ACC, funeral costs, paid parental leave etc)	2
Other	2
Did not need any additional information or support at the time	65
Don't know	4

Total exceeds 100 percent due to multiple responses.

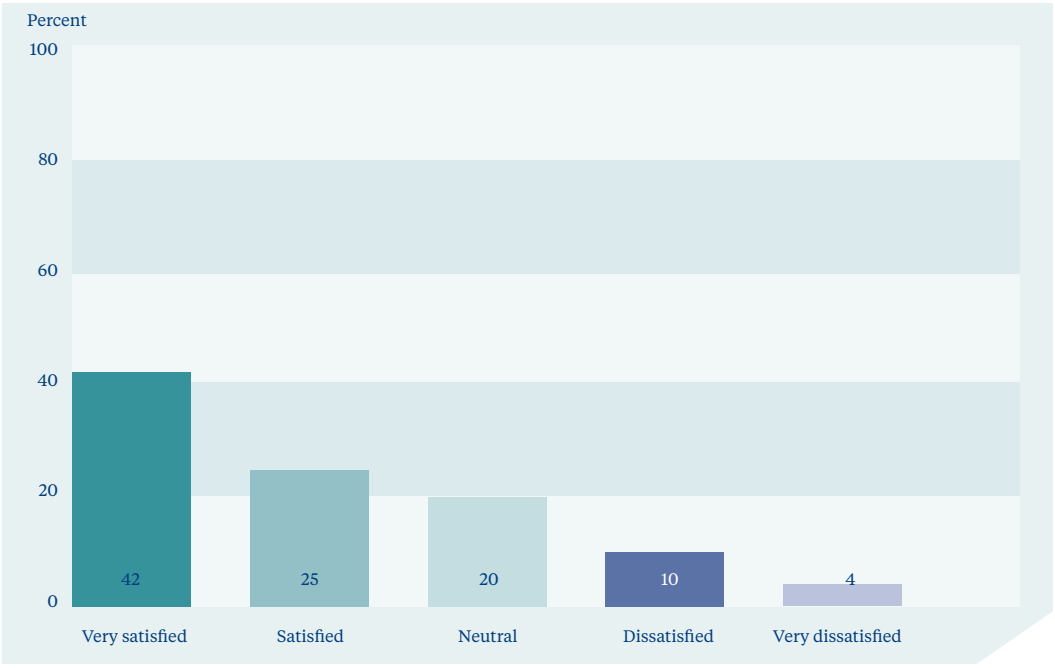
Note that the low base number of respondents means that results are indicative only.

Q43/Q80/Q115/Q151. Was there any additional contact, information or support you would have liked to have received at that time?

Overall satisfaction with the care received

While an earlier question measured respondents' satisfaction with the maternity care they received during their pregnancy, respondents were also asked at the end of the survey to rate their satisfaction with the overall level of care they felt they had received during and following the loss of their baby.

Figure 90: Satisfaction with the overall standard of care received during and following the loss of the baby (n=102)



As illustrated in Figure 90 above, two-thirds (67 percent, n=68) of all respondents were satisfied with the overall standard of care they received during and following the loss of their baby (42 percent, n=43 were very satisfied):

> I think the reality for us [was that] the standard of care and service and support that we got was just amazing; there is nothing that we had to complain about, nothing that we thought could have been done better, and I think those are kinds of stories that you don't hear often enough about the health service, so I think it's really important when people do have those experiences to share them as much as they possibly can, especially in a situation that a lot of people go through unfortunately, and to also know that we had two healthy children and that the support and service that we have got through their births and afterwards has been just as good, so I think that letting people know that we have seen both sides and actually the health system in New Zealand does work and it does do what it's supposed to do when you need it; that's a really important thing for us and really important for other people in the world to remember as well.

> I was very impressed with the overall service of the health system. You hear bad things about health services all the time, and I never had a problem, or cause to question that at all.

While 20 percent (n=20) provided a 'neutral' rating, 14 percent (n=14) were dissatisfied with the care that they received.

> I just had a problem with like being with the other people when they were having their babies and the funeral person taking the baby. Also then how I just didn't get any support afterwards when I was home from anyone other then my friends and family.

Communication within hospital staff needs to be looked at; for example my hospital notes were completely wrong, my date of birth was wrong, my mother's name was wrong, my doctor was wrong – it wasn't even my doctor – my children's names were wrong, the date of birth was wrong. I was left to correct those details myself when I asked to look at the notes. The professionalism of nurses was disgusting; there was lack of professionalism, telling me that I didn't need pain relief and I was their lowest priority because they were too busy. So many things, just completely wrong, leaving me ... alone for up to three hours on end because they thought I had an infection; they had left the placentas out so they had deteriorated, so test results were inconclusive. If they want any more information they can have my complaint letter. I have already taken further action.